

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365795	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Oasis Center for Rehabilitation and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE 850 East Midlothian Blvd Youngstown, OH 44507	
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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, interview and facility policy review, the facility failed to maintain a clean and sanitary homelike environment. This had the potential to affect all 92 residents residing in the facility. The facility census was 92. Findings include: On 01/12/26 between 9:45 A.M. and 11:00 A.M. an initial tour of the building was conducted. The following findings were observed:- room [ROOM NUMBER] was noted to have stained tiles in the room. A buildup of visible dirt and debris was noted behind the entrance door. The tiles in the bathroom were noted to be coming up. Visible dirt and debris were noted within the heating unit. Visible dirt and food were noted on the floor beneath the locked closet. The findings were verified by Certified Nurse Aide (CNA) #316 at the time of the observation.- room [ROOM NUMBER] was noted to have a buildup of visible dirt and debris behind the entrance door. Room floor tiles were noted to be stained. The bathroom was noted to have chipped floor tile. The bathroom door was noted with a hole in it. The toilet paper holder was noted to be broken. The bathroom sink was noted with visible dirt and what appeared to be beard shavings in it. Findings were verified by CNA #316 at the time of the observation.- room [ROOM NUMBER] was noted to have a buildup of visible dirt and debris behind the entrance door. Assistant Director of Nursing (ADON) #429 verified the findings at the time of the observation.- room [ROOM NUMBER] was noted with damaged tile next to A bed. ADON #316 verified the findings at the time of the observation.- The common area was noted to have a dirty floor. There was breakfast tray of food on an end table. The garbage was overflowing. ADON #316 verified the findings at the time of the observation. On 01/12/26 at 4:20 P.M. a subsequent tour of the building with Maintenance Director (MD) #409 revealed the following:- rooms [ROOM NUMBER] were noted to have a buildup of visible dirt and debris behind the entrance doors.- Rooms 404, 407, 408, and 412 were noted to have a buildup of visible dirt and debris behind the entrance doors.- room [ROOM NUMBER] was still noted to have a dirty bathroom sink with apparent beard shavings in it. The toilet paper holder was broken. Floor tiles in the bathroom were noted to be coming up. The bathroom door had a hole in it.- The common room on the 400 unit was noted to have a floor with visible dirt on it. The food tray remained on the end table.- rooms [ROOM NUMBERS] were noted to have a buildup of visible dirt and debris behind the entrance doors.- The mechanical lift on the 100 unit was noted to have visible dirt on the base of the unit. MD #409 verified the aforementioned findings at the time of the observation. A review of the facility policy titled; Homelike Environment, dated 02/2021, revealed residents were provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, home like setting. These characteristics include a clean, sanitary and orderly environment. This deficiency represents noncompliance investigated under Complaint Number 2678224.		

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews, and facility policy review, the facility did not ensure safe smoking practices within the facility for Residents #67 and #34. This affected two residents (#67 and #34) out of two residents reviewed for smoking. The facility census was 92. Findings Include: 1. Review of the medical record revealed Resident #67 was admitted to the facility on [DATE] with diagnoses of muscle weakness, chronic obstructive pulmonary disease (COPD), chronic kidney disease, disorders of bone density and structure, rheumatoid arthritis, pain in left hip, patient's noncompliance with other medical treatment and regimen due to unspecified reason, mental disorder, major depressive disorder, acquired absence of the right leg below the knee, tobacco use, anxiety disorder, and hypertension. Review of the Smokers List provided by the facility revealed as of 09/05/25, Resident #67 was on the independent smokers list. Review of the psych note dated 09/08/25 revealed the nurse practitioner observed Resident #67 lying in bed vaping. This resident has oxygen in her room. Review of the smoking assessment dated [DATE] revealed Resident #67 had no cognitive impairment, no visual deficit, and no dexterity problems. She was able to light her own cigarette, did not need adaptive equipment, and a care plan initiated to assure the resident is safe while smoking. Review of the care plan with a review start date of 11/24/25 revealed Resident #67 had a history of smoking in community/inappropriate smoking related to history of using tobacco products and cigarettes. Interventions instruct the resident residents, family members, responsible parties or visitors about smoking guidelines as necessary, instruct residents, family members, and visitors not to share lighted cigarettes, lighters or other smoking materials with other residents, instruct the resident to ask staff to provide/light smoking material, and place smoking material in designated area for storage. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #67 has a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Observation on 01/12/26 at 10:01 A.M. revealed Resident #67 had three Prime vaporizers on her bedside table. Interview on 01/12/26 at 10:05 A.M. Certified Nursing Assistant (CNA) #347 confirmed the vaporizers on the bedside table. There was a no smoking sign on Resident #67 door. Observation on 01/15/26 at 8:45 A.M. revealed an empty box of Geek vaporizers on Resident #67's bedside table. On 01/14/2026 at 10:35 A.M. interview with Activity Director #303 revealed that she does the smoking assessment on each smoker. She was the person who informed the residents if they were a supervised smoker or an independent smoker. If someone was being downgraded to a supervised smoker, she gave them an explanation why it happened. 2. Review of the medical record for Resident #34 revealed an admission date of 04/09/24 with diagnoses of chronic systolic congestive heart failure, COPD, heart failure, major depressive disorder, personal history of other mental and behavioral disorders, personality disorders, nicotine dependency, adjustment disorder, bipolar disorder, anxiety, depression, and tobacco use. Review of the Smokers List provided by the facility revealed as of 09/05/25, Resident #34 was on the independent smokers list. Review of the smoking assessment dated [DATE] revealed Resident #34 had cognitive loss, she had no visual deficits or dexterity problems. She was able to light her own cigarettes. For safety, oxygen needs to be removed before smoking. A plan of care was initiated to assure the resident is safe while smoking. Review of the care plan dated with a review start date of 12/05/25 revealed resident #34 had a history of smoking in the community. On 09/19/24, Resident #34 was educated on safe smoking policy and not smoking with oxygen on her wheelchair. Resident #34 agreed to comply with not having oxygen tank on her wheelchair when smoking. On 05/21/25, the facility educated Resident #34 about attempting to smoke in her room. Intervention included cigarettes and lighter will be held by her nurse. Review of the MDS 3.0 assessment dated [DATE] revealed Resident # 34 has a BIMS score of a 10, indicating moderate cognitive impairment. Observation on 01/12/26 at 10:23 A.M. revealed Resident (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#34 had a box of cigarettes on her bedside table. She also indicated she had her lighter in her jacket pocket. She showed surveyor a hard box with a disposable lighter. Interview on 01/13/26 at 1:55 P.M. Licensed Practical Nurse (LPN) # 401 confirmed Resident #34's lighter and cigarettes in a hard box were in her pocket of her jacket on her bedside table. Observation on 01/15/26 at 8:37 A.M. revealed a packet of Shield cigarettes on Resident #34's bedside table. Interview on 01/14/26 at 12:05 P.M. with the Activity Director #303 regarding Resident #34 confirmed that the care plan dated 05/21/25 would still be active and she should be giving her lighter to the nurse. Review of the undated facility policy titled Smoking Policy - Residents revealed smoking is prohibited inside the building in all areas. Any smoking-related privileges, restrictions, and concerns shall be noted on the care plan. The staff shall consult the care plan to determine any restrictions on smoking privileges. Residents who have independent smoking privileges shall be permitted to keep cigarettes, pipes, tobacco, or other smoking articles in their possession. These residents will be issued lockboxes to maintain their smoking materials. Failure to secure smoking materials when not in use may result in loss of independent smoking privileges.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **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 medications were stored in a safe fashion. This affected one resident (#43) of 92 residents observed for medications at the bedside. The facility census was 92. Findings include: A review of medical records for Resident #43 revealed a date of admission of 10/08/25. Significant diagnoses included chronic congestive heart failure, acute respiratory failure with hypoxia, diabetes mellitus type II with hyperglycemia, acute pulmonary edema, gastroesophageal reflux disease, hypertension, and shortness of breath. Significant orders included, Isosorbide 10 milligrams, 1 tablet by mouth three times a day for hypertension, Atorvastatin 40 milligrams give one tablet by mouth daily for cholesterol, Nifedipine 90 milligrams, give one tablet by mouth one time daily for hypertension, hydrochlorothiazide 25 milligrams, give one tablet by mouth daily for hypertension, Magnesium 400 milligrams, give one tablet by mouth daily as a supplement, spironolactone 25 milligrams, give one tablet by mouth daily for edema, Lasix 40 milligrams, give one tablet by mouth one time daily for congestive heart failure, Klor-Con 20 milliequivalents, give one tablet two times daily for potassium supplement, Lisinopril 10 milligrams, give one tablet by mouth one time daily for hypertension, Jardiance 10 milligrams, give one tablet by mouth one time daily for diabetes, and Hydralazine 50 milligrams, give one tablet by mouth three times daily for hypertension. A care plan dated 12/17/25 for Resident #43 was reviewed. Resident #43 was not care planned for self-administration of medication. A quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10, indicating Resident #43 had moderate cognitive impairment. A review of Resident #43's assessments revealed Resident #43 was not assessed for medication self-administration. A review of the medication administration record (MAR) dated 01/01/26 through 01/31/26 revealed all oral medications were signed off as given from 01/01/26 through 01/12/26. On 01/12/26 at 10:00 A.M. an observation of Resident #43 revealed a clear medication cup with eight medications in it on the bedside table. Housekeeper #376 verified the pills in the medication cup at the time of the observation. On 01/13/26 at 11:08 A.M. an interview with Assistant Director of Nursing (ADON) #429 revealed there were no current residents in the facility who were on a medication self-administration program. A review of the policy titled Administering Medications, dated 04/2019, revealed medications are administered in a safe and timely manner, and as prescribed. A review of the policy titled Storage of Medications, dated 11/2020, revealed the facility stores all drugs and biologicals in a safe, secure and orderly manner.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility to ensure call lights were in reach. This affected two residents (#24 and #41) of 92 residents observed for call lights. The facility census was 92. Findings include: 1. A review of the medical records for Resident #24 revealed the date of admission as 12/13/24. Significant diagnosis included unspecified dementia, adult failure to thrive, anxiety, unspecified other amnesia, personal history of other mental and behavioral disorders, age-related cognitive decline, and unspecified non-traumatic intracerebral hemorrhage. There were no significant orders regarding the citation. A care plan dated 12/02/25 revealed Resident #24 was at risk for falls related to cognitive impairment, and gait balance problems. Interventions included to be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed. An annual Minimal Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of four out of 15, indicating Resident #24 had severe cognitive impairment. The assessment also revealed Resident #24 needed supervision or touching assistance with all activities of daily living. An observation on 01/12/26 at 9:50 A.M. revealed Resident #24 to be in bed. The call light was noted to be on the floor at the foot of the bed. Certified Nurse Aide (CNA) #316 verified the findings at the time of the observation. 2. A review of medical records for Resident #41 revealed the date of admission as 10/22/15. Significant diagnosis included major depressive disorder, diabetes mellitus type II, suicidal ideations, mild cognitive impairment, personal history of other mental and behavioral disorders, Alzheimer's disease, unspecified dementia, unspecified mood disorder, legal blindness, chronic viral hepatitis B and psychosis not due to a substance or known physiological condition. There were no significant orders regarding the citation. A care plan dated 12/26/25 revealed Resident #41 required assistance with activities of daily living. Interventions included encourage the resident to use the call bell system for assistance. The care plan further revealed Resident #41 was at risk for falls related to being legally blind and anoxic brain damage. Interventions included be sure the resident's call light was within reach and encourage the resident to use the system to call for assistance as needed. An annual MDS assessment dated [DATE] revealed a BIMS score of nine out of 15, indicating moderate cognitive impairment. The assessment also revealed Resident #41 was a partial to moderate assist for all activities of daily living and had severely impaired vision. An observation on 01/12/26 at 9:55 A.M. revealed Resident #41 to be in bed. The call light was on the floor. Assistant Director of Nursing (ADON) #429 verified the findings at the time of the observation. A review of the facility policy titled; Answering the Call light, dated 03/2021, revealed when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.		