

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365975	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2025
NAME OF PROVIDER OR SUPPLIER Park Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Pine Avenue St Clairsville, OH 43950	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, review of video footage, and interview the facility failed to ensure a resident was treated with respect and dignity. This affected one resident (#22) of four residents reviewed for change in condition. The facility census was 86. Findings include: Record review revealed Resident #22 was re-admitted to the facility on [DATE] with diagnoses including unspecified intracapsular fracture of right femur, muscle wasting and atrophy, and need for assistance with personal care. Review of a minimum data set (MDS) dated [DATE] revealed Resident #22 had impaired cognition, no behaviors, was dependent on staff for transfers, and had occasional pain of five. Review of an Authorization for Electronic Monitoring in Resident Room form dated 05/12/25 revealed Resident #22's power of attorney installed a fixed position video camera with recording in her room. Review of a video provided by Resident #22's family dated 07/04/25 at 10:51 A.M. revealed Registered Nurse (RN) #162 exiting Resident #22's bathroom, raise her hand to block her face from the camera, walk over to the camera and stand in front of it, obscuring the view of Resident #22 when she was brought out of the bathroom. The camera was motion activated and due to being blocked, had stopped recording. Review of an education training document dated 07/11/25 revealed RN #162 received education on Electronic Monitoring policy and stated I put my hand up because the light turns color when it starts recording and it was a reaction to that because I hate cameras. Interview on 08/19/25 at 10:15 A.M. with Director of Nursing (DON) #141 confirmed the video of RN #162 blocking Resident #22's camera. Review of a policy titled Electronic Monitoring in Resident Rooms dated 03/23/22 revealed the facility will not intentionally obstruct, tamper with, or destroy any electronic monitoring device or any recording made by an electronic monitoring device. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number 2583102.</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
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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, review of video footage, and interview, the facility failed to ensure a resident was provided the opportunity for urination in the bathroom versus being told to urinate in her incontinence brief. This affected one resident (#22) of four residents reviewed for change in condition. The facility census was 86. Findings include: Closed record review revealed Resident #22 re-admitted to the facility on [DATE] with diagnoses including unspecified intracapsular fracture of right femur, muscle wasting and atrophy, and need for assistance with personal care. Review of a minimum data set (MDS) assessment dated [DATE] revealed Resident #22 had impaired cognition, no behaviors, required moderate assistance for transfers, and was frequently incontinent of bladder and bowel. Review of a care plan dated 04/28/25 revealed Resident #22 had an alteration in elimination related to hip fracture and revision, back pain, dementia, stroke, diabetes, overall decline in mobility, falls, and bowel and bladder incontinence. The goal was for Resident #22 to be clean, dry and odor free. Interventions included but were not limited to toileting program, monitor and provide hydration as needed, monitor and record bowel movements every shift, provide incontinence care as needed, and monitor for signs and symptoms of a urinary tract infection. Review of video footage (provided by Resident #22's family and shared with the Administrator and Director of Nursing) dated 06/18/25 at 9:38 P.M. revealed Resident #22 was in her room and asked Certified Nursing Assistant (CNA) #189 if she could go to the bathroom. CNA #189 responded, we'll get you cleaned up. Resident #22 was then being transferred to her bed and stated, I need to go to the bathroom. CNA #189 stated, it's hard to go on the toilet when your leg's been busted up. CNA #189 did not assist Resident #22 to the bathroom. Interview on 08/20/25 at 3:40 P.M. with CNA #189 revealed he had received education on incontinence care recently. CNA #189 stated Resident #22 was forgetful and he did not redirect the resident appropriately, instead opting to instruct her to go (urinate) in her (incontinence) brief because he was about to change her anyway and would get her cleaned up. Interview on 08/20/25 at 4:00 P.M. with the Administrator revealed he personally educated CNA #189 about incontinence care after being made aware of the footage of him declining to take Resident #22 to the bathroom. This deficiency represents non-compliance investigated under Complaint Number 2583102.</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on closed record review, hospital documentation review, review of a facility investigation, review of video footage, policy review and interviews, the facility failed to timely and comprehensively assess, notify a physician, and provide timely and necessary care and services to Resident #22 after she complained of hip pain as a result of a dislocated right hip. This resulted in Immediate Jeopardy and Actual Harm beginning on 07/21/25 at 1:10 A.M. when Resident #22 voiced complaints of pain and staff continued to provide personal care, assisting the resident into her bathroom and transferred the resident to bed without first assessing the resident. Licensed Practical Nurse (LPN) #113 administered a dose of as needed narcotic pain medication but failed to comprehensively assess the resident related to the pain. On 07/21/25 at 2:01 A.M. review of video footage revealed staff entered Resident #22's room to attempt to place a hip abductor wedge at which time the resident yelled out in pain upon movement of her leg. Staff exited the room and per video footage they did not return until 5:05 A.M. Video footage revealed Resident #22 was yelling out and at 5:11 A.M., Certified Nursing Assistant (CNA) #168 removed blankets from Resident #22, who had a visibly severe internal rotation to her leg, and began to undress the resident as the resident was screaming in pain. CNA #168 did not stop undressing Resident #22 and proceeded to re-dress her as Resident #22 was observed on video screaming in pain. At 5:18 A.M., CNA #169 and LPN #113 entered Resident #22's room and assisted CNA #168 to stand-pivot Resident #22 to her wheelchair as the resident was screaming. Resident #22 remained out of her room in the wheelchair until 10:56 A.M., when CNA #145, Physical Therapist (PT) #260, and Certified Occupational Therapy Assistant (COTA) #250 transferred Resident #22 from her wheelchair into her bed using a gait belt and attempted a stand/pivot transfer. Resident #22 was briefly seated at the edge of bed while crying out. An x-ray was subsequently ordered. On 07/21/25 at 1:51 P.M. Radiology Technician (RT) #400 expressed concern about the image captured (noting the dislocation of the resident's hip). Emergency Medical Transportation (EMT) was called and arrived at 2:58 P.M. Resident #22 left the facility at 3:16 P.M. to be taken to the hospital where she was diagnosed with a dislocated right hip requiring surgical intervention. This affected one resident (#22) of four residents reviewed for falls. The facility census was 86. On 08/19/25 at 3:03 P.M., the Administrator, Director of Nursing (DON) #141 and #185, Regional Clinician (RC) #300 were notified Immediate Jeopardy began on 07/21/25 at 1:10 A.M. when Resident #22 voiced complaints of hip pain that was not comprehensively or adequately assessed and treated. Between 1:10 A.M. and 10:56 A.M. Resident #22 continued to complain of severe pain to the hip area captured on video footage of the resident screaming and crying out due to the pain while staff proceeded to manipulate/move the leg providing routine care. An x-ray was not obtained until 1:51 P.M. which confirmed the hip dislocation. The resident was not transferred to the hospital until 07/21/25 at 3:16 P.M. The Immediate Jeopardy was removed on 07/21/25 and the deficiency subsequently corrected on 07/26/25 when the facility implemented the following corrective actions. On 07/21/25 at 2:40 P.M., preliminary results of Resident #22's x-ray were reported to Physician #230 by Registered Nurse (RN) #127. Physician #230 ordered Resident #22 to be transferred to the hospital for evaluation and treatment. Physician #225 was updated by RN # 127. The resident was transferred to the hospital on [DATE] at 3:16 P.M. and did not return to the facility following the hospitalization. On 07/21/25 at 2:40 P.M. Resident #22's family/responsible party was notified by RN #127. On 07/22/25 at 4:00 P.M. CNA #168 was immediately re-educated by the Administrator and DON #141 regarding performing activity of daily living (ADL) care to residents with increased pain or signs of distress ensuring stopping ADL care and notifying nursing staff with s/s of pain, distress or changes in functioning. On 07/22/25 at 4:30 P.M. (via phone) LPN #113 was immediately re-educated by the Administrator and DON #141 regarding conducting timely and thorough assessments with change in condition and notification to physician. On 07/22/25 at 6:00 P.M. (via phone) CNA #169 was immediately re-educated by the Administrator and DON #141 regarding performing ADL care to residents with increased pain or signs of distress ensuring stopping ADL care and notifying nursing staff with s/s of pain, distress or changes in functioning. On 07/22/25 at 10:00 P.M. a skin sweep was completed by DON #185 and facility wound nurse for possible injuries and changes in condition for current residents unable to be interviewed and all other current residents were interviewed for potential changes in condition warranting interventions. 82 residents were assessed. On 07/22/25 the facility Change</p>		