

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 03/23/2026
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on medical record review, facility policy review, facility investigation file review, police report review, resident observation, and resident and staff interview, the facility failed to report an allegation of staff to resident sexual abuse. This affected one resident (#171) of three residents reviewed for abuse. The facility census was 84. Findings include: Review of the medical record for the Resident #171 revealed an admission date of 02/17/24. Diagnoses included stroke, constipation, peripheral vascular disease, oxygen dependence, depression, hard of hearing, visual deficits, unspecified dementia without behavioral disturbances, lung disease, arthritis, and high blood pressure. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/03/26, revealed the resident had severe cognitive impairment with a brief interview for mental status score of 6/15. Further review revealed Resident #171 required extensive assistance of two staff for bed mobility, transfers, and ambulation. Review of the behavior and mood MDS assessments revealed no behaviors since prior annual assessment completed in November of 2025 and severe depression present with no change since prior assessment. Review of the plan of care initiated on 02/25/22 and on-going revealed Resident #171 had alterations in mood/behaviors and occasionally exhibits delusional thinking and yelling out with interventions in place. Observation and interview on 03/19/26 at 11:43 A.M. with Resident #171 revealed the resident was resting in bed and calm. Resident #171 quickly appeared guarded in posture and defensive in demeanor when asked about any incident of abuse occurring on 03/10/26 or 03/12/26. Resident #171 reported that she was told by the Administrator and the two police officers that she was safe now and that man would no longer be allowed to care for her. Resident #171 further reported she was told not to discuss the incident but would not elaborate who said that. Attempts were made twice for elaboration of events by Resident #171, but she raised her voice and adamantly declined to answer any further questions related to alleged incident. Interview on 03/19/26 at 12:15 P.M. with the social worker designee (SWD) # 202 revealed she was made aware of an allegation of sexual abuse against certified nurse aide (CNA) #340 by Resident #171 on Tuesday 03/10/26 around 7:45 A.M. SWD #202 was notified by licensed practical nurse (LPN) #328 about Resident #171's allegation against CNA #340. SWD #202 further reported that she asked the Human Resources Director (HRD) #224 to go with her to interview Resident #171 as the nursing administration and the facility Administrator was not at the facility yet. Further interview with SWD #202 revealed she spoke with Resident #171 who appeared upset and was yelling about a man trying to put his thing in her mouth. SWD #202 asked Resident #171 if she knew who the man was and Resident #171 responded a man's proper name. Resident #171 was then asked if the man was still here and Resident #171 stated yes and reported he had a white sweatshirt on and dark hair. SWD #171 did confirm that CNA #340 was wearing a white sweatshirt that shift and had dark hair. She further reported that she told CNA #340 not to go into Resident #171 room anymore and to wait in the nursing office. SWD #202 further reported that Resident #171 complained of her right wrist hurting and she left the HRD #224 to get a nurse to check on Resident #171's wrist. SWD #202 reported that the facility Administrator was notified by phone call of the events and spoke with CNA #340 on speaker phone in the presence of the SWD #202 and HRD #224. CNA #340 was advised by the Administrator to (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
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>leave the facility and was escorted out by staff at 9:17 A.M. pending investigation. Interview on 03/19/26 at 12:45 P.M. with Human Resource Director (HRD) #224 revealed she was made aware of an allegation of sexual abuse against CNA # 340 by Resident #171 on Tuesday 03/10/26 around 7:45 A.M. when SWD #202 came to her office Tuesday morning on 03/10/26 and asked her to assist her with interviewing Resident #171. HRD #224 reported she called the Administrator while in Resident #171's room and had the Administrator on her cell phone in speaker phone mode to hear the interview and reported events. HRD #224 further confirmed that the Administrator discussed the events with herself, SWD #202, and CNA #340 in her office via speaker phone and determined CNA #340 needed to leave the facility until further investigation could be completed when the Administrator got on site. Review of the facility's internal investigation revealed a file folder with date 03/10/26 and provided by the assistant director of nursing (ADON) #216. The file included an individual written statement authored by LPN #328 indicating the following, I have never witnessed CNA #340 be abusive or threatening to any residents at any time. There were three additional similar statements from CNA #236, CNA #350, and LPN #341. There were no witness statements from SWD #202 or HRD #224. There was no detailed statement from LPN #328 who was caring for Resident #171 or CNA #340 had been providing care to Resident #171. There was no documentation in Resident #171's medical record regarding the events. Further review of the facility's investigation for 03/10/26 revealed a summary of incident determining that Resident #171 was confused and combative with CNA #340 during personal care but no abuse occurred. Resident #171's son was notified via phone of incident and reported that Resident #171 gets that way when she has a urinary tract infection. Resident #171's son reported to nursing staff that he did not think an investigation was warranted and he liked the male CNA #340. Review on 03/18/26 at 4:30 P.M. of the Ohio Department of Health Gateway reporting abuse allegation reporting software revealed no Self-Reported Incidents (SRI) entered for 03/10/26 for the facility. Further review revealed a SRI was reported on 03/12/16 for allegation of physical abuse of Resident #171 by CNA #340. There was no allegation of sexual abuse listed. Interview on 03/19/26 at 1:20 PM with registered nurse (RN) #365 confirmed the initial SRI entered into the system on 03/12/26 was entered as physical abuse and not sexual abuse. RN #356 further reported she was unclear why the Administrator selected physical abuse and not sexual abuse but speculated that at the time of the entry prior to full investigation it was unclear if the allegations were physical abuse due to resident stating she was hit in the face or if allegations were sexual abuse and the allegation of sexual abuse was not determined until full investigation was completed. Interview on 03/19/26 at 4:00 P.M. with the ADON #216 verified there were no signed statements from CNA #340, SWD #202, or HRD #224 for the 03/10/26 investigation. The ADON #216 further verified that the signed statements of CNA #236, CNA #350, and LPN #341 did not provide details of event and were not witness statements. ADON #216 confirmed that the Administrator was aware on 03/10/26 of the alleged incident. ADON #216 further revealed the facility did not continue into a deeper investigation on 03/10/26 or report the allegation of staff to resident sexual abuse to the Ohio Department of Health due to Resident #171's son stating he did not feel an investigation was needed and his mother may have an urinary infection. Review on 03/23/26 of Police Report # CL-26-0454 filed on 03/12/26 indicated the police responded to a report of abuse sexual in nature. Further review of the police report revealed that the Administrator reported to police that the incident occurred on Tuesday 03/10/26 but the facility was not made aware of the allegation until SR #171 after the son reported concerns on 03/12/26. (Please note the Administrator's statement to the police on 03/12/26 was not accurate as the Administrator was aware of the allegation on 03/10/26). Review of facility policy titled Abuse, Neglect, Exploitation & Misappropriation of Resident Property, dated 11/21/16, revealed the facility was to report any allegations or suspicion of all types of abuse to the state agency prior to investigation of the allegation. This deficiency represents non-compliance investigated under Complaint Number 2806392.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on medical record review, policy review, facility self-investigation report review, review of police reports, resident observation, and interviews with residents and staff, the facility failed to complete a thorough investigation for an allegation of staff to resident sexual abuse. In addition, the facility failed to protect residents after an allegation of staff to resident sexual abuse when they permitted a specified perpetrator to continue to work and provide care to residents. This affected one resident (#171) of three residents reviewed for abuse, and eight residents (#102, #111, #121, #122, #124, #134, #142, and #143) who were provided care by a specified perpetrator who was the perpetrator identified in a staff to resident sexual abuse allegation and allowed to work. The facility census was 84. Findings include: Review of the medical record for the Resident #171 revealed an admission date of 02/17/24. Diagnoses included stroke, constipation, peripheral vascular disease, oxygen dependence, depression, hard of hearing, visual deficits, unspecified dementia without behavioral disturbances, lung disease, arthritis, and high blood pressure. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/03/26, revealed the resident had severe cognitive impairment with a brief interview for mental status score of 6/15. Further review revealed Resident #171 required extensive assistance of two staff for bed mobility, transfers, and ambulation. Review of the behavior and mood MDS assessments revealed no behaviors since prior annual assessment completed in November of 2025 and severe depression present with no change since prior assessment. Review of the plan of care initiated on 02/25/22 and on-going revealed Resident #171 had alterations in mood/behaviors and occasionally exhibited delusional thinking and yelling out with interventions in place. Observation and interview on 03/19/26 at 11:43 A.M. with Resident #171 revealed she was resting in bed and calm. Resident #171 quickly appeared guarded in posture and defensive in demeanor when asked about any incident of abuse occurring on 03/10/26 or 03/12/26. Resident #171 reported that she was told by the Administrator and the two police officers that she was safe now and that man would no longer be allowed to care for her. Resident #171 further reported she was told not to discuss the incident but would not elaborate who said that. Attempts were made twice for elaboration of events by Resident #171, but she raised her voice and adamantly declined to answer any further questions related to alleged incident. Interview on 03/19/26 at 12:15 P.M. with the social worker designee (SWD) # 202 revealed she was made aware of an allegation of sexual abuse against certified nursing aide (CNA) # 340 by Resident #171 on Tuesday 03/10/26 around 7:45 A.M. by licensed practical nurse (LPN) #328. SWD #202 further reported that she asked the Human Resources Director (HRD) #224 to go with her to interview Resident #171 as the nursing administration and the facility Administrator was not at the facility yet. Further interview with the SWD #202 revealed she spoke with Resident #171 who appeared upset and was yelling about a man trying to put his thing in her mouth. SWD #202 asked Resident #171 if she knew who the man was and Resident #171 responded a man's proper name. Resident #171 was then asked if the man was still here and Resident #171 stated yes and reported he had a white sweatshirt on and dark hair. SWD #171 did confirm that CNA #340 was wearing a white sweatshirt that shift and had dark hair. She further reported that she told CNA #340 not to go into Resident #171 room anymore and to wait in the nursing office. SWD #202 further reported that Resident #171 complained of her right wrist hurting and she left the HRD #224 to get a nurse to check on Resident #171 wrists. SWD #202 reported that the facility Administrator was notified by phone call of events and spoke with CNA #340 on speaker phone in the presence of the SWD #202 and HRD #224. CNA #340 was advised by the Administrator to leave the facility and was escorted out by staff at 9:17 A.M. pending investigation. Interview on 03/19/26 at 12:45 P.M. with Human Resource Director (HRD) #224 revealed she was made aware of an allegation of sexual abuse against CNA # 340 by Resident #171 on Tuesday 03/10/26 around 7:45 A.M. when SWD #202 came to her office Tuesday morning on 03/10/26 and asked her to assist her with interviewing Resident #171. HRD #224 reports she called the Administrator while in Resident #171 and had him on her cell phone in (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>speaker phone mode to hear the interview and reported events. HRD #224 further confirmed that the Administrator discussed the events with herself, SWD #202, and CNA #340 in her office via speaker phone and determined CNA needed to leave the facility until further investigation could be completed when the Administrator got on site. Interview on 03/19/26 at 1:00 P.M. with LPN #328 revealed she was the nurse on duty caring for Resident #171 on 03/10/26. LPN #328 reported she was approached by CNA #340 and was told that Resident #171 was being combative when CNA #340 tried to get her off the bed pan. LPN #328 then went to assess Resident #171 and found her to be very agitated, and Resident #171 was reporting he tried to put his thing in my mouth; you know that thing and gestured toward her own private area then the nurse's private area. LPN #328 reported not everything Resident #171 was saying was making sense, but she knew she should report the concern. LPN #328 then went to SWD #202 and reported concerns since administration was not at the facility yet. LPN #328 confirmed on 03/12/26 she was asked to write a statement about the Resident #171's cognitive and behavioral status only for 03/10/26 but nothing about Resident #171 statements or allegations of sexual abuse. LPN #328 did confirm there was a nothing in the medical record regarding Resident #171 having delusions and the Resident #171's son asking about a urinalysis on 03/10/26 in the medical record. LPN #328 denied any recent changes with Resident #171's cognition or mental status leading up to or since the alleged incident on 03/10/16. Review of the facility's internal investigation revealed a file folder with date 03/10/26 and provided by the assistant director of nursing (ADON) #216 to the surveyor. The file included an individual written statement authored by LPN #328 indicating the following, I have never witnessed CNA #340 be abusive or threatening to any residents at any time. There were three additional similar statements from CNA #236, CNA #350, and LPN #341. There were no witness statements from SWD #202 or HRD #224. There was no detailed statement from LPN #328 who was caring for Resident #171 or CNA #340 who had been providing care to Resident #171. There was no documentation in the medical record regarding the events. Further review of the facility's investigation for 03/10/26 revealed a summary of incident determining that Resident #171 was confused and combative with CNA #340 during personal cares but no abuse occurred. Resident #171's son was notified via phone of the incident and reported that Resident #171 gets that way when she has a urinary tract infection. Resident #171's son reported to nursing staff that he did not think an investigation was warranted and he liked the male CNA #340. Interview on 03/19/26 at 4:00 P.M. with the ADON #216 verified that there were no signed statements from CNA #340, SWD #202, or HRD #224 for the 03/10/26 investigation. The ADON #216 further verified that the signed statements of CNA #236, CNA #350, and LPN #341 did not provide details of event and were not witness statements. ADON #216 further revealed the facility did not continue into a deeper investigation on 03/10/26 or report the incident to the Ohio Department of Health due to Resident #171's son stating he did not feel an investigation was needed and his mother may have urinary infection. Review of the schedule and time punch card dated 03/10/26 revealed CNA #340 clocked out at 9:17 A.M. and did not continue to work on 03/10/26. Further review of time punch card and daily assignment sheet revealed the CNA #340 returned to work on 03/11/26 for a full shift and was assigned as the shower aide for eight residents (#102, #111, #121, #122, #124, #134, #142, and #143). Review of the nursing aide schedule for March 2026 revealed that on 03/12/26 CNA #340 was placed on administrative leave while a facility investigation was being completed for allegations of sexual abuse of Resident #171. As of 03/19/26 CNA #340 had not yet returned to the facility for assignment. This was verified by the ADON on 03/19/26 at 1:00 PM. Interviews on 03/19/26 at 1:00 P.M. with the DON and ADON verified that on 03/10/26 CNA #340 was directed by the Administrator to leave facility pending investigation for allegations of sexual abuse made by Resident #171. The DON further reported CNA #340 did computer module training from home on abuse and prevention for the remainder of the day on 03/10/26. Further interview with the ADON revealed that since the facility did not complete any further investigation after speaking with Resident #171's son that afternoon, CNA #340 was allowed to return to work on his next scheduled shift on 03/11/26. The DON verified that CNA (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>#340 was assigned a different unit and was the shower aide on 03/11/26. The DON was able to verify there were eight residents (#102, #111, #121, #122, #124, #134, #142, and #143) who received showers from CNA #340 on 03/11/26. CNA #340 was then removed from work on 03/12/26 after a formal allegation of sexual abuse was made by Resident #171's son and another investigation was started at the facility. Review of facility policy titled Abuse, Neglect, Exploitation & Misappropriation of Resident Property, dated 11/21/16, revealed the facility is to report any allegations or suspicion of all types of abuse to the state agency prior to investigation of the allegation. This deficiency represents non-compliance investigated under Complaint Number 2806392.</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>Based on medical record review, review of the social services job description, and resident and staff interviews, the facility failed to provide medically related social services for a resident who had a change in her psychosocial status. This affected one resident (#171) of three residents reviewed for abuse. Findings include: Review of the medical record for Resident #171 revealed an admission date of 02/17/24. Diagnoses included stroke, constipation, peripheral vascular disease, oxygen dependence, depression, hard of hearing, visual deficits, unspecified dementia without behavioral disturbances, lung disease, arthritis, and high blood pressure. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/03/26, revealed the resident had severe cognitive impairment with a brief interview for mental status score of 6/15. Further review revealed Resident #171 required extensive assistance of two staff for bed mobility, transfers, and ambulation. Review of the behavior and mood MDS assessments revealed no behaviors since prior annual assessment completed in November of 2025 and severe depression present with no change since prior assessment. Review of the plan of care initiated on 02/25/22 and on-going revealed Resident #171 had alterations in mood/behaviors and occasionally exhibits delusional thinking and yelling out with interventions in place. Review of the medical record for Resident #171 revealed no evidence of an incident where the resident alleged staff to resident sexual abuse documented in the resident's medical record. There were no social services notes or psychosocial assessments by social services entered in the medical record on 03/10/26 through 03/19/26. Observation and interview on 03/19/26 at 11:43 A.M. with Resident #171 revealed she was resting in bed and calm. Resident #171 quickly appeared guarded in posture and defensive in demeanor when asked about any incident of abuse occurring on 03/10/26 or 03/12/26. Resident #171 reported that she was told by the Administrator and the two police officers that she was safe now and that man would no longer be allowed to care for her. Resident #171 further reported she was told not to discuss the incident but would not elaborate who said that. Attempts were made twice for elaboration of events by Resident #171, but she raised her voice and adamantly declined to answer any further questions related to alleged incident. Interview on 03/19/26 at 12:15 P.M. with the social worker designee (SWD) # 202 revealed she was made aware of an allegation of sexual abuse against certified nurse aide (CNA) # 340 by Resident #171 on Tuesday 03/10/26 around 7:45 A.M. by licensed practical nurse (LPN) #328. SWD #202 further reported that she asked the Human Resources Director (HRD) #224 to go with her to interview Resident #171 as the nursing administration and the facility Administrator was not at the facility yet. Further interview with the SWD #202 revealed she spoke with Resident #171 who appeared upset and was yelling about a man trying to put his thing in her mouth. SWD #202 asked Resident #171 if she knew who the man was and Resident #171 responded with a man's proper name. Resident #171 was then asked if the man was still here and Resident #171 stated yes and reported he had a white sweatshirt on and dark hair. SWD #202 did confirm that CNA #340 was wearing a white sweatshirt that shift and had dark hair. She further reported that she told CNA #340 not to go into Resident #171's room anymore and to wait in the nursing office. SWD #202 further reported that Resident #171 complained of her right wrist hurting and she left the HRD #224 to get a nurse to check on Resident #171's wrist. SWD #202 reported the facility Administrator was notified by phone call of events and spoke with CNA #340 on speaker phone in the presence of the SWD #202 and HRD #224. Continued interview with SWD #202 revealed she had met with Resident #171 several times since the alleged incident to follow up on her emotional and cognitive status and frequently checked in with her just to chat. SWD #202 verified there she did not document the behaviors or allegations of Resident #171 on 03/10/26 in the medical record. SWD #202 further verified she had not documented any follow visits with Resident #171 or any updated assessments of her psychosocial status since the alleged event. Review of the job description for the Social Worker Designee dated and signed by SWD #202 on 05/06/24 revealed job responsibilities to included: (continued on next page)</p>

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>providing guidance on various emotional, mental, environmental and/or physical concerns or limitations and accurately document psychosocial needs, interactions and follow up actions with residents and families. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number 2806392</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>Based on review of medical records, review of facility investigations, review of police reports, facility policy reviews, observations, and interviews with residents and staff the facility failed to provide effective administration when the facility's Administrator knowingly failed to report an allegation of staff to resident sexual abuse of Resident #171 and the Administrator knowingly provided false information to investigating police officers. This affected one resident (#171) of three residents reviewed for abuse. The facility census was 84. Findings include:Review of the medical record for the Resident #171 revealed an admission date of 02/17/24. Diagnoses included stroke, constipation, peripheral vascular disease, oxygen dependence, depression, hard of hearing, visual deficits, unspecified dementia without behavioral disturbances, lung disease, arthritis, and high blood pressure.Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/03/26, revealed the resident had severe cognitive impairment with a brief interview for mental status score of 6/15. Further review revealed Resident #171 required extensive assistance of two staff for bed mobility, transfers, and ambulation. Review of the behavior and mood MDS assessments revealed no behaviors since prior annual assessment completed in November of 20256 and severe depression present with no change since prior assessment. Review of the plan of care initiated on 02/25/22 and on-going revealed Resident #171 had alterations in mood/behaviors and occasionally exhibits delusional thinking and yelling out with interventions in place.Observation and interview made on 03/19/26 at 11:43 A.M. with Resident #171 revealed she was resting in bed and calm. Resident #171 quickly appeared guarded in posture and defensive in demeanor when asked about any incident of abuse occurring on 03/10/26 or 03/12/26. Resident #171 reported that she was told by the administrator and the two police officers that she was safe now and that man would no longer be allowed to care for her. Resident #171 further reported she was told not to discuss the incident but would not elaborate who said that. Attempts were made twice for elaboration of events by Resident #171, but she raised her voice and adamantly declined to answer any further questions related to alleged incident.Interview on 03/19/26 at 12:15 P.M. with the social worker designee (SWD) # 202 revealed she was made aware of an allegation of sexual abuse against CNA # 340 by Resident #171 on Tuesday 03/10/26 around 7:45 A.M. by licensed practical nurse (LPN) #328. SWD #202 further reported that she asked the Human Resources Director (HRD) #224 to go with her to interview Resident #171 as the nursing administration and the facility Administrator was not at the facility yet. Further interview with the SWD #202 revealed she spoke with Resident #171 who appeared upset and was yelling about a man trying to put his thing in her mouth. SWD #202 asked Resident #171 if she knew who the man was and Resident #171 responded a man's proper name. Resident #171 was then asked if the man was still here and Resident #171 stated yes and reported he had a white sweatshirt on and dark hair. SWD #171 did confirm that CNA #340 was wearing a white sweatshirt that shift and had dark hair. She further reported that she told CNA #340 not to go into Resident #171 room anymore and to wait in the nursing office. SWD #202 further reported that Resident #171 complained of her right wrist hurting and she left the HRD #224 to get a nurse to check on Resident #171 wrist. SWD #202 reported that the facility Administrator was notified by phone call of events and spoke with CNA #340 on speaker phone in the presence of the SWD #202 and HRD #224. CNA #340 was advised by the Administrator to leave the facility and was escorted out by staff at 9:17 A.M. pending investigation.Interview on 03/19/26 at 12:45 P.M. with Human Resource Director (HRD) #224 revealed she was made aware of an allegation of sexual abuse against CNA # 340 by Resident #171 on Tuesday 03/10/26 around 7:45 A.M. when SWD #202 came to her office Tuesday morning on 03/10/26 and asked her to assist her with interviewing Resident #171. HRD #224 reports she called the Administrator while in Resident #171 and had him on her cell phone in speaker phone mode to hear the interview and reported events. HRD #224 further confirmed that the Administrator discussed the events with herself, SWD #202, and CNA #340 in her office via speaker phone and determined CNA (continued on next page)</p>		

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 03/23/2026
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.			
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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>needed to leave the facility until further investigation could be completed when the Administrator got on site. Interview on 03/19/26 at 1:00 P.M. with LPN #328 revealed she was the nurse on duty caring for Resident #171 on 03/10/26. LPN #328 reported she was approached by CNA #340 and was told that Resident #171 was being combative when CNA #340 when he tried to get her off the bed pan. LPN #328 then went to assess Resident #171 and found her to be very agitated and reporting he tried to put his thing in my mouth; you know that thing and gestured toward her own private area then the nurse's private area. LPN #328 reported not everything Resident #171 way saying was making sense, but she knew she should report the concerns. LPN #328 then went and reported concerns to SWD #202 since administration was not at the facility yet. LPN #328 confirmed she was not asked to write a witness statement about events on 03/10/26 and was asked on 03/12/26 to write a statement about the residents cognitive and behavioral status for 03/10/26. LPN #328 did confirm there was a note in the medical record regarding the resident having delusions and the son asking about a urinalysis on 03/10/26 but no reference to the alleged incident or Resident #171 statements. LPN #328 denied any recent changes with Resident #171 cognition or mental status leading up to or since the alleged incident on 03/10/16. Review on 03/18/26 at 4:30 P.M. of the Ohio Department of Health Gateway abuse neglect and misappropriation reporting software revealed no Self-Reported Incidents (SRI) for allegation of sexual abuse entered for 03/10/26. Further review revealed a SRI reported on 03/12/26 by the facility Administrator for an allegation of physical abuse. Interview on 03/19/26 at 1:20 PM with registered nurse (RN) #365 confirmed the initial SRI entered into the system on 03/12/26 was entered as physical abuse and not sexual abuse. RN #356 further reported she was unclear why the Administrator selected physical abuse and not sexual abuse but speculated that at the time of the entry prior to full investigation it was unclear on if the allegations were physical abuse due to resident stating she was hit in the face or if allegations were sexual abuse and the allegation of sexual abuse was not determined until full investigation was completed. Interview on 03/19/26 at 4:00 P.M. with the ADON #216 confirmed that the Administrator was aware on 03/10/26 of the alleged incident of staff to resident sexual abuse. ADON #216 further revealed the facility did not continue into a deeper investigation on 03/10/26 or report incident to the Ohio Department of Health due to Resident #171's son stating he did not feel an investigation was needed and his mother may have urinary infection. Review of Police Report # CL-26-0454 filed on 03/12/26 revealed the police responded to a sex offense report. Further review of the police report revealed that the Administrator reported to police that the incident occurred on Tuesday 03/10/26 but the facility was not made aware of the allegation until Resident #171's son reported concerns on 03/12/26. However, interviews with SWD #202, HRD #240, and ADON #216 all confirmed the Administrator was immediately made aware on 03/10/26 of the alleged incident. Review of facility policy titled Abuse, Neglect, Exploitation & Misappropriation of Resident Property, dated 11/21/16, revealed the facility was to report all allegations or suspicion of any types of abuse to the state agency prior to investigation of the allegation. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number 2806392.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on medical record review and staff interview the facility failed to maintain an accurate and complete medical record. This affected one resident (#171) of three residents reviewed for abuse. The facility census was 84. Findings include: Review of the medical record for Resident #171 revealed an admission date of 02/17/24. Diagnoses included stroke, constipation, peripheral vascular disease, oxygen dependence, depression, hard of hearing, visual deficits, unspecified dementia without behavioral disturbances, lung disease, arthritis, and high blood pressure. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/03/26, revealed the resident had severe cognitive impairment with a brief interview for mental status score of 6/15. Further review revealed Resident #171 required extensive assistance of two staff for bed mobility, transfers, and ambulation. Review of the behavior and mood MDS assessments revealed no behaviors since prior annual assessment completed in November of 20256 and severe depression present with no change since prior assessment. Review of the plan of care initiated on 02/25/22 and on-going revealed Resident #171 had alterations in mood/behaviors and occasionally exhibits delusional thinking and yelling out with interventions in place. Review of medical record for Resident #171 revealed there was no documentation of the events on 03/10/26 related to the allegations of staff to resident sexual abuse. Observation and interview made on 03/19/26 at 11:43 A.M. with Resident #171 revealed she was resting in bed and calm. Resident #171 quickly appeared guarded in posture and defensive in demeanor when asked about any incident of abuse occurring on 03/10/26 or 03/12/26. Resident #171 reported that she was told by the Administrator and the two police officers that she was safe now and that man would no longer be allowed to care for her. Resident #171 further reported she was told not to discuss the incident but would not elaborate who said that. Attempts were made twice for elaboration of events by Resident #171, but she raised voice and adamantly declined to answer any further questions related to alleged incident. Interview on 03/19/26 at 12:15 P.M. with the social worker designee (SWD) # 202 revealed she was made aware of an allegation of sexual abuse against CNA # 340 by Resident #171 on Tuesday 03/10/26 around 7:45 A.M. by licensed practical nurse (LPN) #328. SWD #202 further reported that she asked the Human Resources Director (HRD) #224 to go with her to interview Resident #171 as the nursing administration and the facility Administrator was not at the facility yet. Further interview with the SWD #202 revealed she spoke with Resident #171 who appeared upset and was yelling about a man trying to put his thing in her mouth. SWD #202 asked Resident #171 if she knew who the man was and Resident #171 responded a man's proper name. Resident #171 was then asked if the man was still here and Resident #171 stated yes and reported he had a white sweatshirt on and dark hair. SWD #171 did confirm that CNA #340 was wearing a white sweatshirt that shift and had dark hair. She further reported that she told CNA #340 not to go into Resident #171 room anymore and to wait in the nursing office. SWD #202 further reported that Resident #171 complained of her right wrist hurting and she left to get a nurse to check on Resident #171 wrist. SWD #202 reported that the facility Administrator was notified by phone call of events and spoke with CNA #340 on speaker phone in the presence of the SWD #202 and HRD #224. Continued Interview with SWD #202 revealed she had met with Resident #171 several times since the alleged incident to follow up on her emotional and cognitive status and frequently checked in with her just to chat. SWD #202 verified there she did not document the behaviors or allegations of Resident #171 on 03/10/26 in the medical record. SWD #202 further verified she had not documented any follow-up visits with Resident #171 or any updated assessments of her psychosocial status since the alleged event. Interview on 03/19/26 at 1:00 P.M. with LPN #328 revealed she was the nurse on duty caring for Resident #171 on 03/10/26. LPN #328 reported she was approached by CNA #340 and was told that Resident #171 was being combative when CNA #340 tried to get her off the bed pan. LPN #328 then went to assess Resident #171 and found her/him to be very agitated, and Resident #171 was (continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>reporting he tried to put his thing in my mouth; you know that thing and gestured toward her own private area then the nurse's private area. LPN #328 reported not everything Resident #171 was saying was making sense, but she knew she should report the concern. LPN #328 then went to SWD #202 and reported concerns since administration was not at the facility yet. LPN #328 did confirm she entered a note on 03/10/26 at 4:12 P.M in the medical record of Resident #171 noting she was having increased delusions and false beliefs. States she has some discomfort to left wrist after becoming combative. Son updated and stated she gets like this when she has a UTI. LPN #328 confirmed she did not record the statements, gestures, or emotional status of Resident #171 from the interview and assessment she observed earlier that morning. Interview on 03/19/26 at 4:00 P.M. with the ADON #216 verified that there was no documentation of the incident that occurred on 03/10/26 in the medical record and reported that the nurse noted resident was having increased delusions and complaints of left wrist pain but there was no detailed explanation of the what the delusions were or what led to the resident becoming combative. ADON #216 also confirmed that there was no entry made in the medical record for Resident #171 by social services department on 03/10/26 through 03/19/26. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number 2806392.</p>		