STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000	INITIAL COMMENTS ANNUAL SURVEY COMPLAINT INVESTIGATION COMPLAINT NUMBER OH00164054 ADMINISTRATOR: Cameron Shreve, #7077 CERTIFIED BED CAPACITY: 87 CENSUS IN HOUSE: 85 The following deficiencies are based on the annual survey and complaint investigation completed 03/27/25.	F 0000		

laboratory director's or provider/supplier representative's signature | title | (x6) date

CAMERON.SHREVE | 04/18/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0578	Continued From page 1	F 0578		
F 0578 SS=D	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance	F 0578	This plan of correction does not constitute an admission to any of the allegations contained within the State of Deficiency. Rather, this plan of corrections has been prepared and executed because state and federal law require it, and not because Park Health Nursing Home and Rehabilitation Center agrees with the citation. The facility maintains that the alleged deficiency does not individually or collectively jeopardize the health and safety of the residents. This plan of correction is not meant to establish any standard of care contract, obligation or position, and Park Health Nursing Home and Rehabilitation Center reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding. This plan of correction shall also operate as the facilities credible allegation of compliance. Please accept 4/22/2025 as our date of compliance. The facility will continue to ensure accurate advanced directives are maintained. On 3/25/2025, the unit nurse verified with resident #2 she wanted his advanced directives to remain a DNRCC. Order verified in her electronic medical record and the current DNRCCA form was replaced with signed DNRCC in her hard chart. An initial audit was conducted on 3/31/2025, by the facility DON with no negative findings noted on current resident's charts. The Regional clinical manager reviewed current facility process with Medical Records clerk, DON and ADON on 4/14/2025. By 4/17/2025, the DON and or designee will reeducate licensed nursing staff on facility process for obtaining advanced directives, maintaining advanced directives records, and managing	04/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0578	Continued From page 2 directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This STANDARD is not met as evidenced by: Based on medical record review, policy review and interview, the facility failed to ensure advanced directives were accurate. This affected one resident (#2) of 24 residents reviewed for advanced directives. The census was 85. Findings include: Review of Resident #2's medical record revealed an admission date of 02/25/25 with diagnoses including epilepsy, atherosclerotic heart disease, cerebrovascular disease, hyperlipidemia, chronic obstructive pulmonary disease, schizoaffective disorder, angina, Parkinson's disease, and adult failure to thrive. Review of the electronic medical record revealed on admission, the resident had Do Not Resuscitate Comfort Care Arrest (DNRCCA) orders (this status means that while full medical care is provided before a cardiac or respiratory arrest,	F 0578	changes to desired code status/advance directives. Weekly for 2 weeks, the DON and or designee will audit 5 random residents ensuring proper documentations and record keeping for current desired advanced directives. Negative findings will be corrected by ensuring proper records/orders, and reeducating staff. Negative findings will also be reported to the QA committee for review and recommendations. The DON is responsible for the ongoing compliance and the Administrator will review the weekly audits ensuring completion.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0578	Continued From page 3 cardiopulmonary resuscitation and advanced life support measures are not initiated upon arrest. Instead the focus shifts to comfort measures). On 03/03/25 the physician orders included an order for the code status to be changed to a Do Not Resuscitate Comfort Care (DNRCC) (only comfort measures will be provided). Review of the paper chart revealed advance directives were the first document when opening the record. Resident #2's paper chart contained a signed DNRCCA form. Interview 03/25/25 at 11:53 A.M. with Registered Nurse (RN) #40 verified there was a discrepancy between the electronic record and paper chart. RN #40 verified the advance directives did not match. Review of the facility's Resident Rights, Treatment and Advance Directive policy dated 11/22/26 included copies of Advance Directives will be placed on the chart.	F 0578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0602	Continued From page 4	F 0602		
F 0602 SS=D	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This STANDARD is not met as evidenced by: Based on record review, interview and review of a self-reported incident the facility failed to protect a resident from misappropriation and ensure the resident was reimbursed the monies. This affected one (Resident #10) of one residents reviewed for misappropriation. The facility census was 85. Findings include: Review of Resident #10's medical record revealed an admission date of 11/23/24 with diagnoses that included chronic atrial fibrillation, congestive heart failure and peripheral vascular disease. Further review of the medical record including the Minimum Data Set (MDS) 3.0 quarterly assessment with a reference date of 03/12/25 indicated Resident #10 had an intact cognition level.	F 0602	The facility will continue to ensure residents are free of misappropriation. On 3/27/2025, the facility Administrator reimbursed resident #10 $500.00. The Regional Administrator reviewed and educated Abuse/Misappropriation policy with Administrator on 3/28/2025. An initial audit was conducted on 3/28/2025 by facility Administrator to ensure no other misappropriation of resident's funds with no negative findings noted. By 4/17/2025, the Administrator and or designee will reeducate all staff on the facility's abuse/misappropriation policy. Weekly for 2 weeks, the Administrator and or designee will review the missing item log ensuring no additional misappropriation was reported. Negative findings will be corrected by ensuring missing items are investigated with resolution and staff reeducated. Negative findings will also be reported to the QA committee for review and recommendations. The Administrator is responsible for the ongoing compliance and the Regional Administrator will review the weekly audits ensuring completion.	04/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0602	Continued From page 5 Review of the facility self-reported incident (SRI) #25534 revealed on 12/21/24 at 10:30 A.M. Licensed Practical Nurse (LPN) #55 notified the Administrator of Resident #10's concern of missing money. LPN #55 contacted Resident #10's representative to gain information on the money. The representative indicated she had cashed a check for $545.00 for Resident #10 on 12/18/24. Approximately $45.00 of that was used, leaving $500.00 in a banker's envelope. Further review of the facility investigation revealed Resident #10 kept the money in her purse and had last seen the money on 12/20/24. The resident indicated she did not leave her purse unattended, taking her purse with her if she left her room. The concern of missing money was reported to the police per the request of Resident #10. A local police officer arrived to the facility on 12/21/24 at 11:15 A.M. and took a report including interviewing Resident #10. Interviews with staff and residents found no concerns of additional missing items, including cash. Further review of the facility SRI investigation revealed the allegation of misappropriation of resident money was unsubstantiated due to finding no evidence of any staff member taking the money and did not indicate the missing $500.00 was reimbursed to Resident #10. Interview with Resident #10 on 03/24/25 revealed approximately $500.00 in cash was taken from her purse, which was in	F 0602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0602	Continued From page 6	F 0602		

her resident room, prior to Christmas. Resident #10 indicated the cash had not been reimbursed by the facility.

Interview with the Ombudsman on 03/24/25 at 3:40 P.M. also indicated Resident #10 had approximately $500 in cash misappropriated from a purse in her room and the facility did not reimburse the resident.

Interview with Certified Nurse Aide (CNA) #23 on 03/26/25 at 4:05 P.M. revealed she was providing Resident #10 a shower in the facility shower room. When returning to the resident room, Resident #10 requested CNA #23 to check her nightstand for her purse. CNA #23 provided the purse to Resident #10 who indicated her money was missing. CNA #23 indicated she notified Licensed Practical Nurse (LPN) #55 of the missing money concern and assisted LPN #55 with searching Resident #10's room for the missing money but nothing was found.

Interview with LPN #55 on 03/26/25 at 4:10 P.M. revealed she was notified by CNA #23 of Resident #10's concern of missing money. LPN #55 indicated she and CNA #23 searched Resident #10's room, but did not find the missing cash. At this time LPN #55 notified the facility Administrator.

On 03/27/25 at 8:00 A.M. interview with the facility administrator verified the facility did not reimburse Resident #10 any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0602	Continued From page 7 money after the allegation of missing cash due to finding no evidence the cash was misappropriated by a staff member.	F 0602		
F 0656 SS=D	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 0656	The facility will continue to Develop and Implement comprehensive care plans. Resident # 2 continues to reside in the facility. No negative effects noted, comprehensive care plan was constructed by the MDS nurse for alteration in mood and behavior on 3/25/2025. Resident #2 current psychoactive care plan was reviewed and modified on 3/25/2025, by the facility MDS nurse. An initial audit of psychoactive care plans were completed by the MDS nurse on 4/15/2025, ensuring facility monitoring of the effectiveness of psychoactive drugs for targeted behaviors identified. Negative findings were corrected by updating care plans. The Interdisciplinary team, who are responsible for creating a comprehensive care plan, and revising care plans were reeducated by the Regional Clinical Manager on 4/14/2025, to ensure the care plans meet the current needs of the resident. Weekly for 2 weeks, the DON or designee will conduct a random audit of 5 residents who are taking psychoactive medications, ensuring monitoring for medication effectiveness for targeted behaviors is reflected on care plan. Negative findings will be corrected immediately by updating current care plan and reeducating staff. Negative findings will also be reported to the QA committee for review. The Administrator is will ensure completion of the weekly audits. The DON is responsible for the ongoing compliance.	04/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0656	Continued From page 8 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to develop a comprehensive plan of care for the use of psychotropic medication. This affected one (Resident #2) of five residents reviewed for unnecessary medication use.. Findings include: Review of Resident #2's medical record revealed an admission date of 02/25/25 with diagnoses including epilepsy, anxiety disorder, Parkinson's disease and adult failure to thrive.	F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0656	Continued From page 9 Review of the 03/04/25 modification of the admission Minimum Data Set Assessment (MDS) revealed the resident was moderately impaired for daily decision making and received antipsychotic and antianxiety medications. Physician orders included lorazepam (antianxiety medication) 0.5 milligrams (mg) three times a day and three times a day as needed for three months for generalized anxiety disorder, Seroquel (antipsychotic medication) 50 milligrams (oral tablet) at bedtime for schizoaffective disorder and Seroquel (oral tablet) 25 mg two times a day for schizoaffective disorder. Review of the plans of care revealed a comprehensive, measurable psychotropic plan of care was not developed. There were no behaviors identified to be monitored for the use of an antipsychotic medication. Interview 03/26/25 at 2:30 P.M. with Registered Nurse #37 verified there was not a plan of care developed for the use of psychotropic mediations. Further interview revealed there were no targeted behaviors identified to monitor the effectiveness of the antipsychotic drugs. The facility did not have a policy regarding psychotropic medications.	F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0656	Continued From page 10	F 0656		
F 0657 SS=D	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This STANDARD is not met as evidenced by:	F 0657	The Facility will continue to implement and revise care plans to meet the needs of each resident. Resident #26 and #133 continue to reside at the facility. Resident #26 Care plan for dialysis was revised by the MDS nurse on 3/26/2025 to ensure proper care for dialysis treatments. Resident #133 was reassessed by the Activities Director on 3/26/2025 and revised activities care plan on 3/26/2025. An initial audit was conducted by the MDS Nurse to ensure accuracy of current activity care plans for residents who are bed bound and did not participate in many activities. 9 resident identified and reviewed. No negative findings noted. Resident #26 is the facilities only dialysis patient at this time. No initial audit was needed to be completed at this time. The Interdisciplinary team, who are responsible for creating a comprehensive care plan, and revising care plans were reeducated by the Regional Clinical Manager on 4/14/25, to ensure the care plans meet the current needs of the resident. Weekly for 2 weeks, or as directed by the QA committee, the MDS nurse will audit care plans for residents on dialysis and 5 random residents for activities ensuring care plans are meeting the needs of the residents. Negative findings will be reported to the QA committee. Negative findings will be corrected by updating the care plans and reeducating staff. The Administrator will ensure weekly completion of audits and the DON is responsible for the ongoing compliance.	04/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0657	Continued From page 11 Based on record review, observation and interview, the facility failed to ensure plans of care were updated to reflect the residents' preferences and medical needs. This affected two Residents (#26 and #133) of 22 residents reviewed. The census was 85 Findings include: 1. Review of Resident #26's medical record revealed an admission date 06/29/23 and readmission date of 05/02/24 with diagnoses including morbid severe obesity. chronic atrial fibrillation, dependence on renal dialysis, type 2 diabetes with diabetic neuropathy, chronic peripheral insufficiency, acquired absence of right great toe and other right toes. osteoporosis, hypothyroidism, gastro esophageal reflux disease. lymphedema, anemia, hyperlipidemia, insomnia, absence of other left toes, chronic kidney disease Stage 4 (severe), angina pectoris, hypoxemia, glaucoma and hypertension. Review of the resident's dialysis plan of care initiated 01/18/24 revealed the care plan not individualized and did not identify the resident having a fistula (a surgically created connection between an artery and a vein, typically in the arm, to facilitate hemodialysis by providing a large accessible blood vessel for needle access). Review of the 03/06/25 Annual Minimum	F 0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0657	Continued From page 12 Data Set Assessment (MDS) included the resident was independent for daily decision making, with no behaviors, no weight gain or loss, and received dialysis. Interview 03/24/25 at 6:56 P.M. with Resident #26 included he had a fistula in his right arm for dialysis. Interview 03/26/25 at 3:32 P.M. with Registered Nurse (RN) #64 verified the plan of care was not updated to reflect the resident had a fistula. RN #64 verified the dialysis plan of care did not include the specific type of dialysis access the resident had and was not specific to what services the resident would need. 2. Review of Resident #133 revealed an admission date of 12/14/21 and readmitted 03/22/25 with diagnoses including metabolic encephalopathy, anemia, type 2 diabetes and rheumatoid arthritis. Care Plans initiated on 12/16/21 included resident does not engage in group activities. Resident preferred doing activities their room including watching TV and socializing on the phone with family and staff and resident preferences for daily life and person-centered care that are important or somewhat important include: Choosing own bedtime , Choosing what clothes to wear. Having family or significant other involved in care discussions. Neither plan of care was revised between 12/16/21 and 03/25/25 to	F 0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0657	Continued From page 13 reflect the residents significant changes or preferences. Review of the 12/24/24 Significant Change MDS included the resident was moderately impaired for daily decision making, found little interest or pleasure in doing things and feeling tired or having little energy. There were no delusions. The resident had verbal behaviors four to six days of the look back period. It was somewhat important to him to take care of his personal belongings or things, very important to choose bath type, bed time, very important to have family and close friends involved in care, very important to listen to music, enjoy favorite activity, go outside when the weather is good and very important to participate in religious activities. The resident was readmitted from the hospital 03/22/25 on continuous tube feeding. Observations 03/24/25 at 11:03 A.M. Resident #133 refused to be turned was screaming and the aide went to tell the nurse of refusal. On 03/25/25 at 11:53 A.M. Certified Nurse Aide #88 said he refused his catheter care. On 03/25/25 at 11:54 A.M. Licensed Practical Nurse #12 said he would not let her flush his gastrostomy tube. On 03/26/25 at 08:39 A.M. the resident was in bed sleeping. Interview 03/26/25 at 9:18 A.M. with CNA #90 revealed the resident usually refuses the carrots to contractured hands	F 0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0657	Continued From page 14 and was ongoing her. There were no observations of music, television, family, activities or clergy in the room. There were no observations of the resident out of bed. interview 03/25/25 03:06 P.M. with Activities #100 revealed the resident was a religious person. He use to get in the wheelchair and go to activities. He has not done much since he came back from the hospital. He had declined and doesn't seem to hold a conversation with them. Activities verified religion was important to the resident but had not been added to the resident's care plan until 03/25/25. Further interview revealed the care plan was not updated to reflect the resident was not getting out of bed and going to activities was not occurring.	F 0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0677	Continued From page 15	F 0677		
F 0677 SS=D	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This STANDARD is not met as evidenced by: Based on observations, interview, and medical record review the facility failed to ensure residents were assisted with routine nail care and showers. This affected two (Resident #9 and #70) of three residents reviewed for Activities of Daily Living. The facility census was 85. Findings include: 1. Review of Resident #9's medical record revealed an admission date of 02/01/20 with diagnoses that includes chronic obstructive pulmonary disease, hypertension and diabetes mellitus. Further review of Resident #9's medical record including the Minimum Data Set (MDS) 3.0 quarterly assessment with a reference date of 12/19/24 revealed Resident #9 had a moderately impaired cognition level, was dependent for bathing and set up assistance with personal hygiene. Review of the Certified Nurse Aide (CNA) Activities of Daily Living (ADL) Tasks revealed Resident #9 was provided a	F 0677	The facility will continue to offer showers and nail care to dependent residents. Resident #9 and #70 continue to reside at the facility. On 3/25/2025, direct care staff offered nail care to resident and resident accepted. CNA #80 were reeducated on offering nail care if nails appear soiled of jagged in between shower frequency. Resident #2 care plan for ADLs was reviewed by the IDT. Resident #70 was offered a shower on 3/26/2025 and accepted. STNA #80 was reeducated by Nurse Manager on 3/25/2025 to ensure offering showers per resident's preference and proper documentation of showers and refusals of showers. An initial audit of residents shower preferences was conducted on 4/10/2025, by DON. Shower schedules were reviewed and updated as needed. An initial observation audit of resident's finger nails was conducted on 4/9/2025 by DON. Negative findings were corrected by offering/performing nail care. By 4/17/2025, facility direct care staff and licensed nurses will be reeducated by the DON and nurse management team. Reeducation will consist of expectations of staff offering/providing daily grooming and hygiene care, such as but not limited to; showers per preference, hair care, oral care, dressing, shaving and nail care. Weekly for 2 weeks, or as directed by the QA committee, the DON and or designee will audit 5 random residents, ensuring showers and nail care is provided. Negative findings will be corrected by offering the resident a shower and or nail care and reeducating the staff. Negative findings will be reported to the QA committee for review. The Administrator will ensure the completion of the audits. The DON is	04/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0677	Continued From page 16 shower and nail care on 02/24/25, 03/01/25, 03/03/25, 03/06/25, 03/08/25, 03/13/25, 03/15/25, 03/19/25, 03/24/25 and 03/25/25. Review of Resident #9's plan of care revealed the resident required assistance with ADLs. Observation of Resident #9 on 03/24/25 at 9:28 A.M. revealed long, dirty and untrimmed fingernails. Interview with Resident #9 on 03/24/25 at 3:17 P.M. revealed staff do not cut or clean her fingernails. Additional observations of Resident #9's fingernails on 03/25/25 10:02 A.M. again revealed long, untrimmed and unclean fingernails. Interview with Resident #9 on 03/25/25 at 10:02 A.M. revealed it had been awhile since she last had any nail care completed. On 03/25/25 at 10:05 A.M. interview and observation of Resident #9's fingernails with CNA #80 verified the fingernails were long, untrimmed and unclean. CNA #80 indicated fingernails are to be trimmed and clean with each resident shower. 2. Review of Resident #70 revealed a 07/29/25 admission with diagnoses including Parkinson's disease, psychotic disorder with delusions, vitamin D	F 0677	responsible for the ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0677	Continued From page 17 deficiency, type 2 diabetes, and anxiety disorder. The admission shower preference sheet dated 07/29/24 indicated a preference for three to four showers a week. Review of the 01/27/25 Quarterly MDS revealed the resident was severely impaired for daily decision making, had hallucinations, delusions, rejection of care, physical and verbal behaviors, He had upper and lower functional impairment on both sides and dependent for bathing. Interview 03/24/25 at 11:47 A.M. with Resident #70's wife revealed the facility was not brushing his teeth, showering and completing dressing changes. He was supposed to be getting showers three times a week and he sometimes doesn't get two a week. They have been better since she brought it to their attention but still doesn't get enough. Review of the shower schedule revealed the resident was a Sunday, Wednesday, and Friday dayshift shower. Review of the Certified Nurse Aide TASK in the electronic record revealed for the last 30 days there was no evidence of the resident receiving a shower between 03/16/25 and 03/23/25 or on 03/12/25. The facility brought a "baths for the day" sheet from 03/21/25 that indicated the	F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0677	Continued From page 18 resident received a bed bath on 03/21/25 not a shower as preferred. There was no explanation as he received a bed bath instead of a shower as preferred. Interview 03/26/25 at 8:59 A.M. with Certified Nurse Aide #80 revealed they leave it up to his wife to say if she wants him to be showered. Interview 03/27/25 at 12:19 P.M. with Registered Nurse #37 verified the resident did not receive a shower three times a week as preferred. This deficiency represents non-compliance investigated under Complaint Number OH00164054.	F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0684	Continued From page 19	F 0684		
F 0684 SS=D	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This STANDARD is not met as evidenced by: Based on medical record review and interview the facility failed to ensure an anticoagulant (Eliquis) medication was administered per orders after the resident received a new diagnoses of pulmonary embolism (blockage of the main artery to the lung or one of its branches). This affected one (Resident #76) of six reviewed for unnecessary medication review. Findings included: Medical record review revealed Resident #76 was admitted to the facility on 11/07/24 with diagnoses including chronic atrial fibrillation, heart failure, cerebrovascular disease, and chronic obstructive pulmonary disease. On 03/18/25 pulmonary embolism was added to the diagnosis list. Review of Resident #76's progress note dated 03/16/25 revealed the nurse at the	F 0684	The Facility will continue to ensure anticoagulants are administered as ordered. Resident #76 continue to reside at the facility. The DON reported missing doses to PCP, with no further recommendations needed. Nurse identified as marking medication as unavailable and not given was reeducated regarding the pharmacy contingency box that allows nurses to pull medications without waiting on pharmacy to deliver. An initial audit of residents on anticoagulant medication was conducted by DON on 4/1/2025, ensuring medication was given timely and as ordered. No negative findings noted. By 4/17/2025, licensed nurses will be reeducated by the DON on the pharmacy contingency box ensuring medications such as anticoagulants are given timely and as ordered. Weekly for 2 weeks or as directed by the QA committee, the DON will randomly review 5 residents who are on an anticoagulant ensuring they are receiving their medications as prescribed. Negative findings will be corrected immediately by reporting findings to the PCP for recommendations and reeducating licensed nurse. Negative findings will be reported to the QA committee for review. The Administrator will ensure completion of the weekly audits. The DON is responsible for the ongoing compliance.	04/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0684	Continued From page 20	F 0684		

emergency room reported the resident was being admitted for a diagnosis of pulmonary embolism.

Review of Resident #76's hospital record dated 03/16/25 revealed the cardiologist was called due to the resident having bilateral pulmonary embolism and potential right heart strain for consideration of thrombectomy. The resident and family decided not to further procedure with aggressive measures and wished to attempt conservative management. At this time recommended Eliquis if tolerated due to resident had significant hematuria on Eliquis in the past.

Review of Resident #76's progress note dated 03/17/25 revealed the resident had returned to the facility via stretcher.

Review of Resident #76 orders/Medication Administration Record dated 03/17/25 revealed Eliquis 5 milligrams (mg) one tablet two times daily (upon rise and bedtime). The bedtime dose was marked "9" (see nursing note).

Review of Resident #76's medication administration progress note revealed on 03/17/25 at 10:44 P.M., Eliquis was not administered due to the medication was not available and on the way from pharmacy.

Interview on 03/27/25 at 12:16 P.M., with Director of Nursing (DON) #70 confirmed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0684	Continued From page 21 Eliquis was not administer at bedtime on 03/17/24 and was available in the facility's contingency medication box, however the nurse never pulled the medication. The DON confirmed the resident was recently diagnosed on 03/16/25 with a pulmonary embolism.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0686	Continued From page 22	F 0686		
F 0686 SS=D	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This STANDARD is not met as evidenced by: Based on medical record review, review of operational manual, review of policy, review of statement, observation and interview the facility failed to ensure low air loss mattress was functioning properly. This affected one (Resident #240) of four residents reviewed for pressure ulcers. Findings include: Medical record review revealed Resident #240 was admitted to the facility on 10/03/23 with diagnoses including pressure ulcers, peripheral vascular disease (PVD), metabolic encephalopathy, muscle weakness, anemia, and spondylolisthesis of lumbar	F 0686	The facility will continue to ensure low air loss mattresses are functioning properly. Resident #240 continues to reside at the facility. On 3/25/2025, the Administrator removed mattress and pump and replaced it with a functioning mattress and pump. Resident # 240 skin was assessed and noted with no new identified areas. RN #60 reeducated by the facility wound nurse on properly monitoring the low air loss mattresses for proper functioning. An initial audit of current residents with low air loss mattresses were audit for function on 3/27/2025 by DON. No negative findings were noted at time of audit. By 4/17/2025 the DON and or designee will reeducate the licensed nurses and direct care staff on ensuring proper function of low air loss mattresses and how to troubleshoot alarms to pumps per manufacturer guidelines. Weekly for 2 weeks, or as directed by the QA committee, the facility wound nurse and or designee will randomly audit ill randomly audit 5 residents, ensuring low air loss mattress is set properly, functioning and not alarming. Negative findings will be immediately corrected by assessing mattress and resident and replacing mattress as appropriate. Negative findings will also be reported to the QA committee for review. The facility Administrator will ensure completion of the weekly audits. The DON is responsible for the ongoing compliance.	04/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0686	Continued From page 23 region. Review of Resident #240's five-day Minimum Date Set (MDS) dated 03/17/25 revealed the resident was at risk for pressure and currently had two stage I pressure ulcers (skin intact with non-blanchable erythema) . The resident was substantial/maximal assist with rolling left to right, sit to lying and lying to sitting. Review of Resident #240's pressure ulcer assessment dated 03/13/25 revealed the resident was at high risk for pressure due to PVD and currently had pressure ulcers and moderate risk related to non-compliance, fracture, renal disease, edema, anemia, infection, low hemoglobin, head of bed elevated the majority of the time. Review of Resident #240 at risk for alteration in skin integrity related to edema, fragile skin, anemia, history of skin impairment, incontinence, mobility impairment, fracture, bruise, brain bleed, colon cancer, peripheral vascular disease, and history of redness under breast dated 03/13/25 revealed the intervention was a low air loss mattress with perimeters. Set according to weight, alternating pressure. Check functions every shift. Review of Resident #240's orders dated 03/13/25 revealed low air loss mattress with perimeters. Set according to weight, alternating pressure. Check functions every shift.	F 0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0686	Continued From page 24 Review of Resident #240's treatment administration record (TAR) dated 03/2025 revealed on 03/24/25 and 03/25/25 staff had signed off that the low air loss mattress was functioning. Observation on 03/24/25 at 10:17 A.M., and 12:46 P.M., revealed the residents low air loss mattress panel was blinking red indicating low pressure. The alarm was muted. The resident was lying in bed. Further observation at 12:46 P.M., revealed the facility's Wound Nurse #21 and visiting wound Nurse Practitioner #500 had entered the resident's room. Review of Resident #240's progress note dated 03/24/25 revealed the wound nurse practitioner was in house and assessed Resident #240. The was a new skin tear partial thickness wound to right arm. Wound care completed with autolytic debridement. Resident reported she must have bumped arm. Additional observation on 03/25/25 at 12:54 P.M. and 3:18 P.M., revealed Resident #240 was lying in bed. The panel was till flashing low pressure and the alarm was muted. Interview and observation of Resident #240's mattress on 03/25/25 at 3:18 P.M., with Registered Nurse (RN) #35 reported she was not aware of any concerns with	F 0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0686	Continued From page 25 Resident #240 mattress. The RN confirmed the resident panel was blinking low pressure and the alarm had been silenced. The RN unmuted the alarm and the alarm started sounding. The RN reported she would have Medical Record #60 look at the mattress because he was the one that responsible for the mattress. The mattress was covered in a blue zipped cover and the resident was in bed therefore the RN nor the surveyor was not able to be visualized the cells to ensure all the cells were inflated or if there were any leaks in the mattress. The RN and Surveyor pressed on the mattress to ensure there was some air in the mattress. Interview on 03/25/25 at 3:39 P.M., with Medical Record #60 confirmed he was not aware Resident #240 low air low mattress was not functioning properly until now. MR #60 reported he just ordered a new mattress and it should be here tomorrow or Thursday. Interview on 03/25/25 at 3:57 P.M., with Wound Nurse (Licensed Practical Nurse (LPN)) #21 confirmed she had rounded with the Wound Nurse Practitioner yesterday 03/24/25 and didn't notice the low-pressure light was activated. The Wound Nurse confirmed the bed was not alarming. The resident had stage one pressure ulcers on her heels that were resolved yesterday. Interview on 03/25/25 at 4:27 P.M., with	F 0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0686	Continued From page 26 Director of Nursing (DON) #37 revealed the Administrator checked the mattress and changed out the malfunctioning pump. The DON reported the mattress did have some air in it and the new pump was working properly. Interview on 03/25/25 at 4:33 P.M., with the Administrator revealed he had switched out the pump and the resident reported she was not uncomfortable. Review of statement undated signed by the Wound Nurse Practitioner #500 confirmed she had evaluated the resident on 03/24/25 and did not detect the resident bottoming out in bed and the air mattress was inflated and the resident immersed properly. There was no evidence the Wound NP had noted the pump flashing/malfunctioning. Review of the Med Aire Plus 8 alternating pressure and low air loss mattress operator's manual undated revealed the mattress was designed to redistribute pressure, these systems offer a solution for the prevention and treatment of pressure ulcers and offers an optimal solution for pressure redistribution and microclimate control. The mattress redistribution mattress provided includes cell-on-cell design constructed of a base and air inflation cells. The air cells are eight inches in height and a static four inches air cell base. 10-inch-deep static perimeters	F 0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0686	Continued From page 27 surround the length of the mattress. The cover provided is a four-way stretch, low shear, vapor permeable, quilted cover easily zipped for removal and cleaning. The low-pressure indicator flickers when the pressure is below the pre-defined level. The audible/visible alarms turn on either when the pressure is low or the system fails to alternate. Press the "mute button" to mute the audible alarm. The alarm indicator will continue flickering. Re-press the Mute button to re-activate the audible alarm and to extinguish the Mute indicator. If low pressure examine if there is air leakage between the control unit and the mattress connection or from the air mattress tubes. Check the valves. Check the air-connecting tubes. Be sure no single cell was broken. DO NOT use any other control unit with this mattress system than the one provided by Drive. DO NOT change any components by yourself. If there was need for replacement or repair, always contact your authorized Drive dealer or service center. Review of the facility's policy titled "Skin Assessment" dated 12/02/15 and revised on 03/15/24 revealed the resident's response to preventative efforts and treatment interventions shall be monitored and approaches revised as appropriate.	F 0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0690	Continued From page 28	F 0690		
F 0690 SS=D	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate	F 0690	The facility will continue to ensure antibiotics are administered as ordered to treat urinary tract infections. Resident #236 continues to reside at the facility and has completed her round of ATB for UTI. Resident assessed by 4/10/2025 and was noted to be free of s/s of UTI. Immediate reeducation on transcribing orders was conducted by the DON with licensed nurse who readmitted resident #236 for hospital. An initial audit of antibiotic use in last 30 days was conducted by DON on 4/17/2025. The DON reviewed ATB for proper administration and timely administration of antibiotics. No negative findings were noted. By 4/17/2025, the DON and or designee will reeducated licensed nurses on proper transcription of antibiotic orders, ensuring timely administration, and notifying PCP when mediations are not available to be given. Weekly for 2 weeks, or as directed by the QA committee, the DON or designee will audit antibiotic orders ensuring proper transcription of orders and that they were administered timely and as prescribed. Negative findings will be corrected by notifying practitioner and reeducating staff. Negative findings will be reported to the QA committee for review. The Administrator will ensure completion of the weekly audits. The DON is responsible for the ongoing compliance.	04/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0690	Continued From page 29 treatment and services to restore as much normal bowel function as possible. This STANDARD is not met as evidenced by: Based on medical record review, review of the infection control log, and interview the facility failed to ensure antibiotics were administered as ordered to treat urinary tract infection. This affected one (Resident #236) of two reviewed for urinary tract infection. Findings included: Medical record review revealed Resident #236 was admitted to the facility on 03/08/25 at 2:22 P.M., with diagnoses including urinary tract infection, low back pain, muscle weakness, dementia, and depression. Review of Resident #236's five-day Mimumin Data Set (MDS) dated 03/15/25 revealed the resident was frequently incontinent of urine. Review of Resident #236's admission orders dated 03/08/25 revealed the resident was ordered Cefpodoxime (antibiotic) 200 milligrams (mg) two tablets by mouth twice daily for three days for a urinary tract infection. Review of Resident #236' Medication Administration records revealed no evidence Cefpodoxime was administered on 03/08/24 at bedtime. On 03/09/25 the	F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0690	Continued From page 30 rise dose was marked as administered, however the Director of Nursing (DON) #70 confirmed on 03/27/25 at 10:22 A.M., the Cefpodoxime was not administered uprise on 03/09/25 due to the medication was not available. The bedtime dose was not administered on 03/09/25. On 03/10/25 the rise and bedtime dose was not administered. The resident received the first dose on 03/11/25 and completed the three-day order on 03/13/25. Review of Resident #236 progress notes dated 03/08/25 to 03/11/25 revealed on 03/08/25 the physician was notified the Cefpodoxime was not available and ordered from pharmacy. There was no documented evidence the physician was notified the medication was not available on 03/09/25 or 03/10/24. On 03/10/25 at 7:30 A.M., the resident had went unresponsive while therapy had the resident on the toilet. Resident laid down and vitals were obtained. Temperature was 98.0, pulse 60, respirations were 16, and blood pressure was 98/59. The family was updated and doesn't want the resident sent out. Resident regained consciousness. The physician was updated and will continue to monitor. At 9:15 A.M., resident returned to her normal. Review of Resident #236's infection note dated 03/11/25 revealed the resident was started on Cefpodoxime for urinary tract infection this morning.	F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0690	Continued From page 31 Review of the infection control log dated 03/2025 revealed Resident #236 was admitted on 03/08/25 from the hospital with an UTI. A urine culture was collected 03/05/25 that grew Klebsiella pneumonia (bacteria). The resident was ordered Cefpodoxime 400 mg twice daily. Interview on 03/27/25 at 9:01 A.M., with DON #70 originally reported she didn't know why the Cefpodoxime was not administered from 03/08/25 till 03/11/25. The surveyor requested evidence when the pharmacy sent the Cefpodoxime. The DON confirmed the Cefpodoxime was not in the facility's contingency medication box. Additional interview on 03/27/25 at 10:22 A.M., with DON #70 confirmed pharmacy did not send the Cefpodoxime until night of 03/10/25 and staff started the medication on 03/11/25. The DON confirmed the resident had missed one dose of Cefpodoxime on 03/08/25 and two doses on 03/09/25 and 03/10/25. The DON confirmed there was not documented evidence the physican was notified on 03/09/25 or 03/10/25 the antibotic was not available or administered.	F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0698	Continued From page 32	F 0698		
F 0698 SS=D	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This STANDARD is not met as evidenced by: Based on record review, and interview, the facility failed to ensure care was appropriate for a resident receiving dialysis services. This affected one (Resident #26) of one resident reviewed for dialysis. Findings include: Review of Resident #26 revealed a 06/29/23 admission and readmission 05/02/24 with diagnoses including morbid severe obesity. chronic atrial fibrillation, dependence on renal dialysis, type 2 diabetes with diabetic neuropathy, chronic peripheral insufficiency, acquired absence of right great toe and other right toes. osteoporosis, hypothyroidism, gastro esophageal reflux disease. lymphedema, anemia, hyperlipidemia, insomnia, absence of other left toes, chronic kidney disease Stage 4 (severe), angina pectoris, hypoxemia, glaucoma and hypertension. Review of the resident's dialysis plan of care initiated 01/18/24 revealed the care plan was generic and did not identify the	F 0698	The facility will continue to ensure appropriate care is provided for residents receiving dialysis. Resident #26 continue to reside at the facility and receive dialysis services. On 3/26/2025, the licensed nurse reviewed orders with PCP and updated orders to reflect current care needs and emergency care needs for his fistula. Resident #26 care plan was reviewed by the MDS nurse on 3/26/2025, to ensure we are addressing care needs for fistula. Resident #26 is the facilities only dialysis patient at this time. No initial audit was needed to be completed at this time. On 4/14/2025, the Regional clinician reviewed facility practices for ensuring proper treatment for dialysis patients to the nursing IDT. Reviewing Comprehensive care planning and revision, order sets to ensure the facility is meeting the needs of current dialysis patients and reviewing dialysis notes ensuring we are aware of treatment changes and orders. By 4/17/2025, licensed nurses will be reeducated regarding transcribing and monitoring for different types of dialysis access such as a fistula and or vascath to ensure proper monitoring and proper documentation of a medical record to meet needs of patient. Weekly for 2 weeks, or as directed by the QA committee, the DON or designee will audit residents receiving dialysis ensuring proper orders are in place and care plan is updated to manage care needs. Findings will be corrected by reporting to PCP and obtaining orders. Reeducation will be provided to license nursing staff. Negative findings will also be reported to the QA committee for review. The Administrator will ensure weekly completion of the audits. The	04/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0698	Continued From page 33 resident having a fistula. Review of the physician orders included 02/11/25 1200 milliliter (ml) fluid restriction dietary 550 ml and nursing 650 ml, enhanced barrier precautions every shift for vascath, keep dressing to right arm from fistula clean and dry. change every 12 hours as needed for wound care AND every shift for wound care, Dialysis every Monday-Wednesday-Friday at 5:15 A.M. Review of the physician orders revealed there were no orders to check right arm fistula for bruit and thrill and not to take blood pressures in the right arm. The resident did not have a vascath. Review of the 03/06/25 Annual Minimum Data Set Assessment (MDS) included the resident was independent for daily decision making, with no behaviors, no weight gain or loss, and received dialysis. Review of the March treatment record revealed staff were signing daily a dressing to right arm fistula. Interview 03/24/25 at 6:56 P.M. with Resident #26 included he had a fistula in his right arm for dialysis. There was not a dressing covering the fistula. He revealed the nurses do not check the site. Interview 03/26/25 at 3:32 P.M. with Registered Nurse (RN) #64 verified the plan of care was not updated to reflect the resident had a fistula. RN #64 verified the	F 0698	DON is responsible for the ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0698	Continued From page 34 dialysis plan of care indicated a vas cath/or fistula and was not specific to what services the resident would need. Observation 03/25/25 at 06:15 P.M. revealed the resident did not have a dressing over the fistula in his right arm. The resident said he takes the dressing off the morning after dialysis. Interview 03/26/25 at 04:12 P.M. with Registered Nurse #37 verified the standard dialysis orders to check thrill and bruise and not to take blood pressure in right arm should have been ordered when the fistula was inserted in March 2024. Interview 03/26/25 04:16 P.M. with Registered Nurse #25 verified there was not an order to check thrill and bruise or for the blood pressure not to be taken on affected arm, She said she takes the dressing off the day after dialysis and verified they are signing off on the treatment sheet the dressing is always on.	F 0698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0755	Continued From page 35	F 0755		
F 0755 SS=D	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This STANDARD is not met as evidenced	F 0755	The facility will continue to ensure medications are available timely for administration. Resident #64 continues to reside at the facility and received his Ozempic on 3/26/2025. Resident #236 continues to reside at the facility and has completed her round of ATB for UTI without negative effects. Resident #238 continues to reside at the facility and received her Prevar 20 vaccine on 3/27/2025. Resident #236 was assessed by facility nurse on 4/10/2025 and was noted to be free of s/s of UTI. An initial audit of all medications to ensure timely availability for administration was conducted by DON 4/10/2025. No negative findings were noted. The DON and Administrator reviewed survey findings with facility pharmacist on 4/18/2025. The Administrator, DON and IDT reviewed facility processes for pharmacy orders and deliveries on 4/17/2025. Infection preventionist will monitor deliveries and administration of vaccinations and antibiotics ensuring they are provided timely. Admission orders will be reviewed in clinical meetings ensuring medications are available and given timely. By 4/17/2025, the DON and or designee will reeducated licensed nurses on proper transcription of pharmacy orders, ensuring timely administration, and notifying PCP when mediations are not available to be given. Weekly for 2 weeks, or as directed by the QA committee, the DON or designee will audit medications orders ensuring proper transcription of orders and that they were administered timely and as prescribed. Negative findings will be corrected by notifying practitioner and reeducating staff. Negative findings will be reported to the QA committee	04/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0755	Continued From page 36 by: Based on medical record review, observation, interview, and policy review the pharmacy failed to ensure medication were available timely for administration. This affected one (Resident #64) of three observed for medication administration, one (Resident #236) of two reviewed for urinary tract infections, and one (Resident #238) of one reviewed for respiratory infection. Findings included: 1. Medical record review revealed Resident #64 was admitted to the facility on 03/14/24 with diagnoses including type 2 diabetes mellitus and chronic kidney disease. Review of Resident #64's current orders revealed Ozempic subcutaneous solution pen-injector two milligrams (mg)/1.5 milliliters (ml) subcutaneously one time a day every Wednesday for diabetes. Observation on 03/26/25 at 7:38 A.M., of Resident #64 medication administration with Registered Nurse (RN) #92 revealed the resident Ozempic was not available to administer. The RN confirmed the Ozempic was only administered once a week on Wednesday and the medication should have been re-ordered last week and should have been available to administered today. Review of Resident #64's progress note	F 0755	for review. The Administrator will ensure completion of the weekly audits. The DON is responsible for the ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0755	Continued From page 37 dated 03/26/25 revealed pharmacy stated the Ozempic was re-ordered on 03/19/25 was too early to fill and did not send it. The physician was notified the scheduled dose today was unavailable and okay to give when available without ill effect. The pharmacy will ship stat today. Interview on 03/26/25 at 10:25 A.M., via email with the Director of Nursing (DON) #70 revealed there was an error with pharmacy stating it was too soon to fill when the nurse re-ordered it on 03/19/25. The DON reported she had spoken with the pharmacist who clarified that it was not too early to send and it would be sent stat today. The physician was notified and it was okay to administer when it arrives. 2. Medical record review revealed Resident #238 was admitted to the facility on 02/28/25 with diagnoses including obesity, diabetes, heart disease, and overactive bladder. Review of Resident #238's pneumococcal vaccine informed consent form dated 03/11/25 revealed the resident had consented for Prevnar 20. Review of Resident #238's medical record dated 03/11/25 to 03/27/25 revealed no evidence Resident had received the Prevnar 20. Review of Resident #238's orders and	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0755	Continued From page 38 Medication Administration Record (MAR) dated 03/17/25, 03/22/25, 02/24/25, 03/25/26, and 03/26/25 revealed new orders were entered for Prevnar 20; however, it was never received from the pharmacy for administration. Interview on 03/26/25 at 10:31 A.M. with Director of Nursing (DON) #37 and #70 revealed the resident had tested positive for the flu, however finished treatment on 03/15/25. The DON's reported they were not aware why the resident had not received the Prevnar 20 yet and would have to look into it. Interview on 03/26/25 at 2:21 P.M., with DON #37 confirmed the Prevnar 20 had not been administered yet due to there was an issue with pharmacy, however pharmacy was to send tonight. Review of Resident #238's progress note dated 03/26/25 revealed DON #37 spoke to pharmacy and they would send Prevnar 20 in tonight's delivery. Review of Resident #238's progress note dated 03/27/25 revealed pharmacy did not send Prevnar 20. Pharmacy notified and would send stat today. Interview on 03/27/25 at 8:27 A.M., with DON #37 revealed she would spoke to pharmacy and the Prevnar was supposed to be delivered last night. She would have to follow up to see why it was not delivered last night.	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0755	Continued From page 39 Review of the facility's policy titled "Immunization for Pneumonia, Influenza, and COVID-19" dated 07/03/23 revealed each resident would be offered the pneumococcal immunization. 3. Medical record review revealed Resident #236 was admitted to the facility on 03/08/25 at 2:22 P.M., with diagnoses including urinary tract infection, low back pain, muscle weakness, dementia, and depression. Review of Resident #236's admission orders dated 03/08/25 revealed the resident was ordered Cefpodoxime (antibiotic) 200 milligrams (mg) two tablets by mouth twice daily for three days for a urinary tract infection. Review of Resident #236' Medication Administration records revealed no evidence Cefpodoxime was administered on 03/08/24 at bedtime. On 03/09/25 the rise dose was marked as administered, however the Director of Nursing (DON) #70 confirmed on 03/27/25 at 10:22 A.M., the Cefpodoxime was not administered uprise on 03/09/25 due to the medication was not available. The bedtime dose was not administered on 03/09/25. On 03/10/25 the rise and bedtime dose was not administered. The resident received the first dose on 03/11/25 and completed the three-day order on 03/13/25. Review of Resident #236 progress notes	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0755	Continued From page 40 dated 03/08/25 revealed the physician was notified the Cefpodoxime was not available and ordered from pharmacy. There was no documented evidence the physician was notified the medication was not available on 03/09/25 or 03/10/24. Review of Resident #236's infection note dated 03/11/25 revealed the resident was started on Cefpodoxime for urinary tract infection this morning. Interview on 03/27/25 at 9:01 A.M., with DON #70 originally reported she didn't know why the Cefpodoxime was not administered from 03/08/25 till 03/11/25. The surveyor requested evidence when the pharmacy sent the Cefpodoxime. The DON confirmed the Cefpodoxime was not in the facility's contingency medication box. Additional interview on 03/27/25 at 10:22 A.M., with DON #70 confirmed pharmacy did not send the Cefpodoxime until night of 03/10/25 and staff started the medication on 03/11/25. The DON confirmed the resident had missed one dose of Cefpodoxime on 03/08/25 and two doses on 03/09/25 and 03/10/25. The DON confirmed there was not documented evidence the physician was notified on 03/09/25 or 03/10/25 the antibiotic was not available or administered.	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0757	Continued From page 41	F 0757		
F 0757 SS=D	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This STANDARD is not met as evidenced by: Based on medical record review and interview the facility failed to ensure medication were administered per parameters. This affected one (Resident #76) of six reviewed for unnecessary medication review. Findings included: Medical record review revealed Resident #76 was admitted to the facility on	F 0757	The facility will continue to ensure medications are administered per physician order. Resident #76 continues to reside at the facility. On 4/1/2025 the DON reviewed current medication order for midodrine and parameters with residents Dr Chiu. Dr. Chiu reviewed current blood pressures and ordered midodrine to be given daily and to discontinue blood pressure parameters to hold medication. An initial audit was conducted by the DON reviewing medications to treat hypertension and hypotension to ensure current medications with parameters are being followed. Negative findings were reported to the PCP for review and further recommendations. By 4/17/2025, the DON and or designee will reeducate licensed nursing staff on ensuring they are following the direction in the electronic MAR when completing a medication administration. Ensuring notifications are conducted timely when blood pressure results are outside the parameters given by the prescriber, following those parameters, and properly documenting in medical record. Weekly for 2 weeks or as directed by the QA committee, the DON will randomly audit residents on hypertensive or hypotensive medications ensuring parameters are being followed, prescribers are notified as directed and proper documentation is recorded in the medical record. Negative findings will be reported to the QA committee for review. Negative findings will be corrected by notifying the prescriber and reeducating staff. The Administrator will ensure completion of weekly audits. The DON is responsible for the ongoing compliance.	04/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0757	Continued From page 42 11/07/24 with diagnoses including chronic atrial fibrillation, heart failure, cerebrovascular disease, and chronic obstructive pulmonary disease. On 03/18/25 pulmonary embolism was added to the diagnosis list. Review of Resident #76's cardiac plan of care dated 11/19/24 revealed to administer medication as ordered. Review of Resident #76's orders dated 03/2025 revealed the resident was ordered Midodrine 10 milligrams (mg) three times daily (rise, lunch, and bedtime) for hypotension. If the systolic greater than 110 do not give. Review of Resident #76's Medication Administration Record (MAR) dated 03/2025 revealed nurse had administered Midodrine on 03/02/25 at lunch and bedtime when the resident blood pressure was 114/70. On 03/03/25 the nurse had administered Midodrine upon rise when the resident blood pressure was 112/62 and lunch and bedtime when the residents blood pressure was 114/78 for both doses. On 03/04/25 staff administered Midodrine at lunch and bedtime when the residents blood pressure was 120/68 for both doses. On 03/23/25 the resident received rise, lunch, and bedtime dose of Midodrine when the resident blood pressure was 120/84 for all three doses. Interview on 03/27/25 at 12:16 P.M., with	F 0757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0757	Continued From page 43 the Director of Nursing (DON) #70 confirmed the Midodrine was administered outside the parameters (systolic greater than 110) on 03/02/25 twice, 03/03/25 three times, 03/04/25 twice, and 03/23/25 three times. The DON confirmed she had reached out to the nurse and she had reported that she must have administered the medication if she had signed it off as administered.	F 0757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0812	Continued From page 44	F 0812		
F 0812 SS=F	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This STANDARD is not met as evidenced by: Based on observation, policy and interview, the facility failed to ensure food was stored, and prepared under sanitary conditions. This affected all the resident's in the facility except Residents #8, #63, #133, #183, #185 and #189 who do not receive nutrition from the kitchen. The facility census was 83. Findings include:	F 0812	The facility will continue to ensure food is stored properly and prepared under sanitary conditions. Dietary Manager immediately threw away bag of mixed vegetables, charbroil burgers, 58 cartons of Bordon whole milk, leftover chili and five-pound carton of Gordon Choice sour cream on noted in facility's initial tour on 3/24/2025. Dietary Manager immediately cleaned scoop on lid of thickener container, dust on all four pipes over stove cooktop on ansul system and dust/grease on shelf over cookout noted on facility's initial tour on 3/24/2025. An initial walk through of the kitchen and storage areas was conducted by the Administrator on 3/28/2025, to ensure proper storage, labeling and cleanliness of kitchen. No negative findings noted. Administrator reeducated all dietary staff on facility food storage-labeling and dating policy, cleaning schedule on 3/24/2025. Weekly for 2 weeks, the Dietary Manager and or designee will conduct an audit 3 x per week to ensure dietary staff is following facility policy in regards to proper food storage and cleaning schedule. Negative findings will be corrected immediately by reeducating dietary staff and reported to QA for review and recommendation. The Administrator will ensure the completion of weekly audits. The Administrator is responsible for ongoing compliance.	04/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0812	Continued From page 45 Initial tour of the kitchen 03/24/25 at 08:10 A.M. with Cook #18 revealed: - The walk in freezer had a bag of mixed vegetables and Charbroil burgers that had been entered and not resealed exposing the contents to the freezing air. - The walk in refrigerator had 58 individual cartons of Bordon whole milk with a sell by date of 03/12/25. - There was leftover chili in the walk in refrigerator not dated. - The walk in refrigerator had a five pound carton of Gordon Choice sour cream that expired 03/17/25. - The scoop was on the lid of a thickener container not contained in a case or bag. - There was dust on all four pipes over the stove cooktop on the ansel system. - The shelf over the cooktop was dusty and greasy Interview 03/24/25 at 8:32 A.M. with Cook #18 verified the outdated, unsealed, undated food as well as the scoup not contained in a sanitary manner and dusty shelf and ansel system. Review of the Food Storage-Labeling and Dating policy revised July 2018 included all food must have a date that includes	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0812	Continued From page 46 the month, day and year on the package indicating the date in which it entered the facility. Items must be dated after opening with a open date and a use by date. The use by date will be seven days unless the original manufacturer expiration date is before seven days. Leftovers can be held for seven days.	F 0812		
F 0881 SS=D	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This STANDARD is not met as evidenced by: Based on medical record review, review of the Center for Disease Control (CDC), review of infection control log, interview, and policy review the facility failed to ensure resident's meet criteria for antibiotics treatment. This affected one (Resident #238) of one reviewed for respiratory infection. Findings included: 1. Medical record review revealed	F 0881	The facility will continue to ensure criteria for antibiotic use is being met. Resident #238 continue to reside at the facility. Resident has completed antibiotic treatment with no adverse effects. An initial audit of the last 30 days of ATB use was conducted by the DON and infection preventionist on 4/17/2025. No negative findings noted. On 4/14/2025 the Regional Clinician met with the Senior DON, Facility DON (infection preventionist) and Nurse Managers to review current policies and procedures for ATB stewardship. By 4/17/2025, the licensed nursing staff will be reeducated on the ATB stewardship, criteria for antibiotic use, and clarifying antibiotic orders when doesn't meet criteria ensuring rational is documented in medial record. Weekly for 2 weeks, or as directed by the QA committee, the DON and or designee will audit 3 residents on ATB ensuring symptom criteria is met to treat with antibiotics. Negative findings will be reported to the QA committee and the prescriber will be notified for clarification and rationale for treatment if continuing ATB. The Administrator will ensure completion of the weekly audits. The DON is responsible for the ongoing compliance.	04/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0881	Continued From page 47 Resident #238 was admitted to the facility on 02/28/25 with diagnoses including obesity, diabetes, heart disease, and overactive bladder. Review of Resident #238's respiratory care plan dated 03/07/25 revealed diagnostic studies as ordered. Review of Resident #238's progress note dated 03/07/25 revealed the resident stated she had been coughing since yesterday, with worsening today and new symptom of slight dizziness. New order had been obtained for cough syrup and flu swab. Review of Resident #238's laboratory testing dated 03/08/25 revealed Resident #238 tested positive for Influenza A. Review of Resident #238's progress note dated 03/08/25 revealed the resident had tested positive for Influenza A. The nurse practitioner was notified. New orders for doxycycline 100 mg twice a day for 7 days and Prednisone 5 mg one time a day for five days. Review of Resident #238's provider note dated 03/09/25 revealed Resident #238 was an 85-year-old female who was not feeling well per staff. Staff advised she had a low-grade temperature and had flu testing. The testing returned and the resident was positive for influenza A but no high fever. Resident will be started on doxycycline 100 milligrams (mg) twice	F 0881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0881	Continued From page 48 daily for seven days and prednisone. The resident was congested and chest Xray was ordered to rule out pneumonia. Staff advised she had no body aches. Continue Tylenol and ibuprofen as needed for temperatures, body aches, influenza A, and low-grade fever. Review of the Resident #238's Medication Administration Record dated 03/2025 revealed Resident #238 had received doxycycline 100 mg twice a day for seven days for Influenza A from 03/09/25 to 03/15/25 and Prednisone 5 mg once a day for influenza A from 03/09/25 to 03/13/25. Review of Resident #238's paper and electronic medical record revealed no evidence a chest x-ray was obtained. Review of Resident #238's McGeer criteria for respiratory tract infection for influenza undated revealed staff had checked the resident met criteria as evidence by fever and new or increased cough. Per the criteria the resident must have a fever and at least three of the following to meet criteria (chills, new headache or eye pain, myalgias or body aches, malaise or loss of appetite, and sore throat. There was no evidence the resident had at least three additional criteria. Review of Resident #238's medical record dated 02/28/25 to 03/08/25 the resident had (chills, new headache or eye pain,	F 0881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0881	Continued From page 49 myalgias or body aches, malaise or loss of appetite, and sore throat. Review of Resident #238's temperatures dated 02/28/25 to 03/08/25 revealed the resident had one elevated temperature of 100.4 on 03/08/25. Review of the infection control log dated 03/2025 revealed Resident #238's date of onset of symptoms was 03/07/25. The resident had an upper respiratory infection and tested positive for Flu A and had congestion. The resident met criteria for antibiotic treatment. Review of the CDC flu guidelines dated 09/04/24 revealed the flu should not be treated with antibiotics. Antiviral drugs such as Tamiflu, Retenzas, Parivar, and Xofluza should be used and use precaution to protect others (hand hygiene, etc.) Review of the facility's policy titled "Antibiotic Stewardship Program" dated 11/28/27 revealed nursing staff shall assess residents who are suspected to have infection for symptoms. Laboratory testing shall be done in accordance with current standards of practice. McGeer criteria are sued to define infections and the Loeb minimum criteria are used to determine whether or not to treat an infection with antibiotics. Prescriptions for antibiotics shall specify the dose, duration, and indication for use. Reassessment of empiric antibiotics was conducted for	F 0881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365975	a. building _____ b. wing _____	03/27/2025

name of provider or supplier	street address, city, state, zip code
PARK HEALTH CENTER	100 PINE AVENUE ST CLAIRSVILLE OH, 43950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0881	Continued From page 50 appropriateness and necessity, factoring in results of diagnostic testing, laboratory reports, and/or changes in the clinical status of the resident.	F 0881		