STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365084	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasantview Care Center	7377 Ridge Rd Parma, OH 44129

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36650 Based on interviews, record review, review of the facilities self-reported incident (SRI), and policy review, the facility failed to ensure all injuries of unknown origin were timely reported to management and the State Survey Agency, Ohio Department of Health (ODH). This affected one (Resident #145) of one resident reviewed for abuse reporting. The facility census was 142. Findings include: Review of the closed medical record for Resident #145 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, osteopenia, atrial fibrillation, chronic pain, and convulsions. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #145 had impaired cognition. Resident #145 was dependent on staff for transfers, bed mobility (rolling left and right) and toileting. Resident #145 had impairment on one side of both lower and upper extremities. Review of the facilities SRI tracking number 258571 revealed the facility reported an injury of unknown origin to ODH on 03/24/25 at 11:46 A.M. The incident details included on 03/22/25, Resident #145 had redness and swelling on the right upper extremity. The x-ray results showed a proximal right humerus neck fracture. Staff were unaware of any falls or other injuries. Staff stated Resident #145 was able to roll to the right and hold the grab bar with her left hand for assistance. Review of the radiology report dated 03/22/25 at 9:30 P.M. of right shoulder revealed a significantly displaced acute proximal right humeral neck fracture with medial angulation. Greater than one shaft width displacement. The right humeral head remains in articulation with the glenoid with advanced degenerative changes of the joint space. Moderate degenerative change of the acromioclavicular joint. Reactive soft tissue swelling. Interview on 04/16/25 at 10:38 A.M. with Registered Nurse (RN) #301 stated she worked at the facility on 03/22/25 from 7 A.M. to 7 P.M. as the nursing supervisor. The floor nurse notified her of Resident #145's redness and swelling of the right upper arm. The nurse notified the Nurse Practitioner on call and got orders for an ultrasound and an x-ray. She worked the next morning and was told in the morning report that Resident #145 had a humerus fracture. RN #301 stated she did not do anything else related to the incident and did not notify the Director of Nursing (DON) or Administrator of the incident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 04/17/25 at 8:15 A.M. with the DON verified she was not notified of Resident #145's arm fracture until 03/24/25 at 8:00 A.M., when she returned to the facility. The verified the SRI was not reported to ODH until 03/24/25 at 11:46 A.M. The DON verified an injury of unknown origin were to be reported to her and the Administrator immediately and should be reported to ODH within two hours of identifying an injury of unknown origin. Review of the facility policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, dated 01/06/25 revealed all injuries of unknown source must be reported immediately to the Administrator or designee. The Administrator/designee should be notified by informing him/her in person, calling via telephone, or sending and email or text message. If abuse is alleged or a serious bodily injury, the Administrator or his/her designee will notify ODH immediately, but not later than two hours after the allegation is made or the serious bodily injury identified. This deficiency represents non-compliance investigated under Control Number OH00164638 and Complaint Number OH00164284.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36650 Based on closed record review, review of a facility self-reported incident (SRI), and interviews with staff and the coroner, the facility failed to ensure Resident #145 was provided adequate and necessary care and services during the provision of personal care to prevent an accident/injury. Actual harm occurred on [DATE] when Resident #145, who had right hemiplegia/hemiparesis and was dependent on staff for bed mobility and personal care sustained a significantly displaced acute proximal right humeral neck fracture with medial angulation during care provided by staff. The resident displayed increased pain as a result of the incident and required orthopedic surgical follow-up. This affected one resident (#145) of three residents reviewed for accident hazards. The facility census was 75. Findings include: Review of the closed medical record for Resident #145 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction (stroke) affecting the right dominant side, osteopenia, atrial fibrillation, chronic pain, and convulsions. Review of the plan of care dated [DATE] revealed Resident #145 was at risk for impaired functional range of motion related to inability to move extremities independently, potential for contractures, and weakness due to history of stroke. Interventions included if the resident refused offer again later in the day and administer medications as ordered for pain. An activities of daily living (ADL) care plan related to activity intolerance, fatigue, pain and history of stroke revealed interventions including providing care based on the residents' usual performance. The care plan revealed the resident was dependent on staff for toileting, personal hygiene, rolling left to right, and transferring. Resident #145 was to always wear a gown per family. The care plan included to instruct Resident #145 to use grab bars on the bed to assist with bed mobility. Staff to assist with the completion of activities of daily living (ADLs), two people assist for all care and encourage Resident #145 to fully participate. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #145 had impaired cognition. The assessment revealed Resident #145 was dependent on staff for transfers, bed mobility (rolling left and right) and toileting. Resident #145 had impairment on one side of both lower and upper extremities. Review of a facility SRI tracking number 258571 revealed on [DATE], Resident #145 had redness and swelling on the right upper extremity. An x-ray results showed a proximal right humerus neck fracture. The SRI revealed staff were unaware of any falls or other injuries. Staff stated Resident #145 was able to roll to the right and hold the grab bar with her left hand for assistance. Following this incident, the facility initiated a new intervention for two-persons assistance with care to be provided to Resident #145. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the radiology report dated [DATE] at 9:30 P.M. of right shoulder revealed a significantly displaced acute proximal right humeral neck fracture with medial angulation. Greater than one shaft width displacement. The right humeral head remains in articulation with the glenoid with advanced degenerative changes of the joint space. Moderate degenerative change of the acromioclavicular joint. Reactive soft tissue swelling. Review of the physician orders dated [DATE] revealed an order for Tramadol (narcotic pain medication to treat moderate to severe pain) 50 milligrams (mg) one tablet every six hours as needed to treat the resident's pain. On [DATE], an additional order for routine pain medication was added (Tramadol 50 mg two times daily; then discontinued on [DATE]) On [DATE], Oxycodone (narcotic pain medication to treat moderate to severe pain) five mg one tablet every six hours for pain was ordered. Review of an orthopedic surgery note dated [DATE] revealed Resident #145 was seen by the physician for acute pain of right shoulder and displaced fracture of proximal end of right humerus. Review of hospital records revealed Resident #145 was transferred to the hospital on [DATE] related to hypoxia (body does not receive enough oxygen) and was treated for pneumonia. Resident #145 received comfort measures in the hospital and expired on [DATE]. Interviews on [DATE] at 10:14 A.M. with Registered Nurse (RN) #300; at 10:38 A.M. with RN #301, at 11:10 A.M. with Licensed Practical Nurse (LPN) #302; at 11:15 A.M. with Certified Nursing Assistant (CNA) #303; at 3:12 P.M. with CNA #304; at 3:16 P.M. with #305; and at 3:27 P.M. with CNA #306 revealed Resident #145 had a contracture to her right arm/shoulder and was unable to move her arm more than a few inches. Interview on [DATE] at 3:36 P.M. with RN #307 revealed she was Resident #145's nurse the weekend of [DATE], and she worked day shift. RN #307 denied knowledge of any swelling of redness to Resident#145's right arm/shoulder. The RN revealed she did not know of any injury until she came back in to work on Sunday morning. She was told the resident had a fracture of her humerus and her arm was in a sling. The resident had an order for pain medications and needed an orthro appointment made. Interview on [DATE] at 10:38 A.M. with RN #301 revealed she worked on [DATE] from 7:00 A.M. to 7:00 P.M. as the nursing supervisor. The floor nurse notified her on the evening of [DATE] that Resident #145 had redness and swelling of the right upper arm and it was warm not hot. RN #301 stated she did not see anything else out of the ordinary. Interview on [DATE] at 2:29 P.M. with the Director of Nursing (DON) revealed Resident #145 right humerus fracture must have been sustained during care (as the resident was dependent on staff for care and had an inability to move her right arm/shoulder more than a few inches). However, the DON revealed she was unable to determine how Resident #145 sustained the fracture. Interview on [DATE] at 9:50 A.M. with CNA #318 revealed he was the CNA assigned to care for Resident #145 on [DATE]. He stated during the shift on [DATE], he did not believe Resident #145 acted any different than her normal. During the interview, CNA #318 denied knowledge of any swelling in Resident #145's hand or arm, and no bruising or discoloration noted. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on [DATE] at 10:03 A.M. with Coroner #402 revealed the preliminary findings for cause of Resident #145's death was contributed to heart disease, pneumonia, and a right arm fracture. Coroner #402 stated there was a bruise on the arm where the fracture was, and a small bruise on the back of the resident's hand. The coroner revealed resident had osteopenia prominently and it would not have taken much to break her arm. The coroner revealed the break likely could have occurred when staff were providing care. This deficiency represents non-compliance investigated under Control Number OH00164638 and Complaint Number OH00164284.