STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365447	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookview Healthcare Center	214 Harding Street Defiance, OH 43512

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, facility investigation information, staff interview and review of facility policy, the facility failed to ensure timely medical follow up for residents following a fall with injury. This affected one Resident (#10) of three residents reviewed for falls. The facility also failed to complete a wound dressing change per the physician's orders. This affected one (#79) of five residents reviewed for wound dressing changes. The facility census was 74. Findings include:1. Review of Resident #10's medical record revealed an admission date of 12/09/25. Diagnoses included ovarian cancer, abdominal lining cancer, general anxiety disorder, type II diabetes, major depressive disorder, adult failure to thrive, dementia, difficulty walking, unsteady on her feet, dysphagia, disorientation, and osteoarthritis.Review of Resident #10's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating Resident #10 was cognitively intact. Resident #10 required supervision only with toilet use, bathing, dressing, bed mobility and transfer. Resident #10 had hallucinations and displayed verbal behavioral symptoms, other behavioral symptoms not directed toward others, rejection of care and wandering behaviors four to six days during the review period. Review of Resident #10's care plan revised 02/16/26 revealed supports and interventions for risk for alteration in nutrition, alteration in skin integrity: left wrist skin tear, hematoma to head with bruising and fractured nose from fall, self-care deficit, required the special care unit, allergy to Meloxicam and Trazodone and risk for falls. Review of Resident #10's Fall Investigation documentation from her fall on 02/12/26 revealed Resident #10 had an unwitnessed fall in her room at approximately 4:45 A.M. Certified Nursing Assistant (CNA) #325 entered Resident #10's room for a check and change and noted Resident #10's bathroom light had been turned off. CNA #325 had reported to have left the light on to be able to make observations of Resident #10. In the process of making her way in the dark to turn on the bathroom light back on CNA #325 tripped over Resident #10's wheelchair and fell to the floor. Upon rising CNA #325 came in contact with Resident #10 who was also lying on the floor. CNA #325 turned the light on and found Resident #10 lying on the floor parallel to the bed with blood on her face and two pools of blood on the floor. CNA #325 notified the nurse and assisted Resident #10 back to bed. Licensed Practical Nurse (LPN) #390 cleaned Resident #10's facial wounds and completed assessments. Resident #10 reported facial pain and at 4:51 A.M. it was documented Resident #10 was provided Tylenol 650 milligrams (mg). The effectiveness of the Tylenol was documented as unknown. The on-call physician was contacted on 02/12/26 at approximately 6:45 A.M. and the facility received an order to send Resident #10 to the emergency room for evaluation and treatment. At approximately 7:00 A.M. Emergency Medical Services (EMS) was called and transported Resident #10 to the hospital emergency room for evaluation and treatment. Resident #10 arrived at the emergency room at 7:23 A.M. Review of Resident #10's Emergency Medical Services (EMS) run report dated 02/12/26 revealed the 911 call was received on 02/12/26 at 6:57 A.M. and the EMS was dispatched. The EMS arrived on the (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scene at 7:00 A.M. and arrived at Resident #10 at 7:01 A.M. The EMS departed the scene at 7:21 A.M. and arrived at the emergency room at 7:23 A.M. The call was closed at 7:39 A.M. It was noted nursing home staff had reported Resident #10 had fallen approximately two hours prior to the 911 call. Resident #10 was noted to have had a large hematoma on her forehead, bruising under both eyes, and a laceration to her upper lip rendering her teeth visible. It was noted Resident #10 had an allergy to Meloxicam and Trazodone. The injuries were consistent with the reported fall. Resident #10 reported a final pain score of nine on a scale of one to ten upon arrival at the destination. Review of Licensed Practical Nurse (LPN) #390's Coaching Program information revealed on 02/13/26 LPN #390 was educated on where the physician numbers were located. It was noted it was LPN #390 first time working in the building (agency) and he was unable to find where the physician contact information was located. A floor nurse had instructed him to fax the physician with the fall information which delayed the physician of being notified of Resident #10's fall. Interview on 02/24/26 at 2:24 P.M. with CNA #325 verified she was the staff who had discovered Resident #10 on 02/12/26 after she had fallen. CNA #325 reported she had last seen Resident #10 sleeping in bed around 4:30 A.M. and had last taken her to the toilet around 4:00 A.M. CNA #325 reported she had left Resident #10's bathroom light on so she could see Resident #10 without disturbing her with the overhead light. When CNA #325 had walked past Resident #10's room after caring for another resident, approximately 4:45 A.M. she noticed Resident #10's bathroom light was off, and the room was pitch black. CNA #325 reported she felt her way along the wall trying to get to the bathroom to turn on the light and ended up tripping over Resident #10's wheelchair and falling to the floor. While getting herself up CNA #325 reported she felt Resident #10 on the floor next to her. CNA #325 reported she got herself up and turned the light on. When she could see, she found Resident #10 lying on the floor next to her bed with blood on her face and blood on the floor. CNA #325 reported she immediately went to the agency nurse (LPN #390) and got his help. LPN #390 had her help get Resident #10 into her bed and after she was assessed and cleaned up he had her get Resident #10 dressed and out into the common area in the recliner. CNA #325 reported she gave shift change report and left the facility around 6:30 A.M. and at the time Resident #10 was still seated in the recliner in the common area. CNA #325 verified Resident #10's fall with significant injury happened around 4:45 A.M. and around 6:30 A.M. Resident #10 had not been transferred to the hospital. Interview on 02/24/26 at 4:12 P.M. with the Director of Nursing (DON) verified there was approximately two hour delay from when Resident #10 fell and when she was transferred to the hospital. The DON reported the LPN #390 had been educated on the proper timelines and procedures for contacting emergency services following a fall. Review of the facility policy titled, Accident/Incident Procedure, revised 04/28/25 revealed the charge nurse would notify the physician and obtain orders when an incident occurred. 2. Review of Resident #79's medical record revealed an admission date of 02/11/26. Diagnoses included cellulitis of the left lower limb, severe protein-calorie malnutrition, hyperlipidemia, acute kidney failure, hypocalcemia, essential hypertension, and dysphagia.Review of Resident #79's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #79 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 15. Furthermore, Resident #79 required partial/moderate assistance for personal hygiene.Review of Resident #79's care plan dated 02/15/26 revealed Resident #79 had an alteration in skin related to scattered scabbing covering the whole surface area of both legs with interventions that included to administer treatments as ordered and to assess, record, and monitor wound healing. Review of Resident #79's physician orders revealed an order with a start date of 02/19/26 that read to cleanse skin tear to right knee with normal saline, pat dry, cover with non-adherent dressing, wrap daily and as needed until healed.Review (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the progress note completed by Licensed Practical Nurse (LPN) #362 on 02/19/26 at 8:49 P.M. revealed Resident #79 had fallen in his room. Upon assessment, Resident #79 had two skin tears on his right knee that measured 4.4 x 4.5 centimeters (cm) and 2 x 2.5 cm. The physician was updated and new orders were given to cleanse the skin tears to the right knee with normal saline, pat dry, cover with non-adherent dressing, wrap daily and as needed until healed. Observation on 02/23/26 at 9:34 A.M. of wound care for Resident #79 with Wound Nurse Practitioner (WNP) #388 revealed the dressing on Resident #79's right knee was dated 02/21/26 and initialed. Concurrent interview with WNP #388 verified the dressing was dated 02/21/26 and initialed.Interview on 02/23/26 at 9:35 A.M. with Resident #79 verified the dressing change was not completed the day before.Review of Resident #79's Treatment Administration Record (TAR) for the month of February revealed the staff initials on the dressing dated 02/21/26 matched the TAR documentation for 02/21/26.Review of the facility policy titled Pressure Injury Treatment, with a last reviewed date of 04/28/25 revealed orders for treatment are obtained from or approved by the physician or nurse practitioner and orders are to be followed as written.This deficiency represents non-compliance investigated under Complaint Numbers 2629125 and 1266301.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, and policy review, the facility failed to ensure all medications ordered by the physician were administered to a resident. This affected one (#70) of eight residents review for medication administration. The facility census was 74.Findings include:Review of Resident #70's medical record revealed an admission date of 04/08/16. Diagnoses included Alzheimer's disease, diabetes mellitus due to underlying condition with diabetic polyneuropathy, psychotic disorder with delusions, hypertension, severe protein calorie malnutrition, and muscle weakness.Review of Resident #70's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #70 had severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of 03.Review of Resident #70's care plan dated 02/17/26 revealed Resident #70 was at risk for alteration in mood related to her diagnoses of anxiety, dementia, and depression with interventions that included to administer medications as ordered and to monitor for feelings of sadness.Review of Resident #70's physician orders revealed orders for the following medications:- Preservision AREDS 2 milligram (mg) oral capsule with instructions to give one tablet by mouth one time a day for macular degeneration.- Protonix Oral Tablet delayed release 40 mg with instructions to give one tablet one time a day for gastroesophageal reflux disease. - Refresh Tears Ophthalmic solution with instructions to instill one drop in both eyes four times a day for dry eyes.Observation on 02/23/26 at 9:05 A.M. with Licensed Practical Nurse (LPN) #362 revealed LPN #362 to be preparing medications for Resident #70. Concurrent interview with LPN #362 verified she would not be administering the Preservision AREDS, Protonix, or refresh eye drops due to the medications being unavailable. LPN #362 stated she would re-order the medications and call the physician to inform them of the missed medications.Review of Resident #70's Medication Administration Record (MAR) for the month of February revealed the Preservision AREDS, Protonix, and refresh eye drops were not administered on 02/23/26 due not being available for administration. Review of the medication error rate revealed there were 28 opportunities for medication administration and three errors due to omission of medications resulting in a medication error rate of 10.7%.Review of the facility policy titled Administering Medications, with a last reviewed date of 04/28/25 revealed medications must be administered in accordance with the orders, including any required time frames.This deficiency represents non-compliance investigated under Complaint Numbers 2629125 and 1266301.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, review of manufacturer instructions, and review of facility policy, the facility failed to ensure resident were not administered medications they were identified as having allergies to. This affected one (#10) of three residents reviewed for medication allergies. Additionally, the facility failed to remove medication patches prior to administering/applying another medication patch. This affected one (#78) of eight residents observed for medication administration. The facility census was 74. Findings include: 1. Review of Resident #10's medical record revealed an admission date of 12/09/25. Diagnoses included ovarian cancer, abdominal lining cancer, general anxiety disorder, type II diabetes, major depressive disorder, adult failure to thrive, dementia, difficulty walking, unsteady on her feet, dysphagia, disorientation, and osteoarthritis. Review of Resident #10's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating Resident #10 was cognitively intact. Resident #10 required supervision only with toilet use, bathing, dressing, bed mobility and transfer. Resident #10 had hallucinations and displayed verbal behavioral symptoms, other behavioral symptoms not directed toward others, rejection of care and wandering behaviors four to six days during the review period. Review of Resident #10's care plan revised 02/16/26 revealed supports and interventions for risk for alteration in nutrition, alteration in skin integrity, risk for falls, self-care deficit, required the special care unit, and allergy to Meloxicam and Trazodone. Review of Resident #10's history and physical provided to the facility prior to Resident #10's admission facility admission dated 11/14/25 revealed Resident #10 had an allergy to Trazodone. The medication was noted to increase depression and aggression and cause abdominal pains. Additionally, Resident #10 was allergic to Meloxicam which would cause her nausea. Review of Resident #10's pharmacy recommendations found a recommendation dated 01/08/26. The pharmacist noted Resident #10 was currently taking Hydroxyzine for treatment of insomnia and anxiety. It was recommended this medication not be used for geriatric patients due to side effects. Please consider switching to low-dose Zolpidem 5 milligrams (mg) or Trazodone 12.5-25 mg as an alternative. The physician reviewed the recommendation, agreed, and changed the order to Trazodone 50 mg daily. The order was started 01/21/26. Review of Resident #10's progress notes revealed a note dated 01/28/26 at 3:30 P.M. documented by Registered Nurse (RN) #346 reporting Resident #10 had an allergy to Trazodone. The physician was notified and made aware of alternatives. At 4:30 P.M. it was noted Resident #10's physician ordered Melatonin 5 milligrams every night and Trazodone was discontinued. Review of Resident #10's physician orders revealed an order dated 01/21/26 and discontinued 01/28/26 for Trazodone 50 milligrams (mg) give one tablet by mouth at bedtime for insomnia and anxiety. Review of Resident #10's corresponding Medication Administration Record (MAR) revealed Resident #10 received the medication (Trazodone), one of the medications she was allergic to, on five occasions, 01/21/26, 01/23/26, 01/24/26, 01/26/26 and 01/27/26. Interview on 02/23/26 at 2:16 P.M. with the Director of Nursing (DON) verified Resident #10 had (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	previously had an order for and was administered Trazodone. 2. Review of Resident #78's medical record revealed an admission date of 04/01/24. Diagnoses included type two diabetes mellitus, ataxia, hyperlipidemia, facial weakness following unspecified cerebrovascular disease, anxiety, dysphagia, and cognitive communication deficit. Review of Resident #78's quarterly MDS assessment dated [DATE] revealed Resident #78 had intact cognition with a BIMS score of 13. Furthermore, Resident #78 was dependent for all mobility and hygiene needs. Review of Resident #78's care plan dated 02/24/26 revealed Resident #78 had impaired cognition as evidence by deficits in memory, judgement, and decision making with interventions that included to administer medications as ordered and to review medications and record possible causes of cognitive deficits. Review of Resident #78's physician orders revealed an order for Rivastigmine Transdermal Patch 24 hour 4.6 mg/24 hour with instructions to apply one patch transdermally one time a day for dementia. Change the patch daily and place the patch in different areas of the body; remove old patch before applying a new one. Observation of incontinence care and a bed bath on 02/24/26 at 10:36 A.M. revealed Resident #78 had two Rivastigmine patches on his left shoulder/chest area. Interview on 02/24/26 at 10:58 A.M. with Licensed Practical Nurse (LPN) #362 verified Resident #78 had two Rivastigmine patches on at the same time. One patch was dated 02/24/26 and the other patch was dated 02/23/26. LPN #362 stated she had taken off a patch this morning when she applied the Rivastigmine patch and so Resident #78 must have had three patches on at the same time. Review of the manufacturer's instructions for the Rivastigmine patches revealed the previous days patch must be removed prior to applying a new patch. Review of the facility policy titled, Administering Medication, revised 04/28/25 revealed if a dosage was believed to be inappropriate or excessive for a resident, or a medication had been identified as having potential adverse consequences for the resident or was suspected of being associated with adverse consequences the person preparing or administering the medication shall contact the resident's attending physician or the facility's medical director to discuss the concern. The policy also stated medications must be administered in accordance with the orders, including any required time frames. This deficiency represents non-compliance investigated under Complaint Numbers 2629125 and 1266301.