STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365452	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearlview Rehab & Wellness Ctr	4426 Homestead Dr Brunswick, OH 44212

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review, review of personnel files, review of the facility's background check log, interview, and review of facility policy, the facility failed to implement their abuse policy regarding screening potential employees through background and reference checks and maintaining evidence those screenings were completed. This affected all 40 residents residing in the facility. Findings include: 1. Review of the personnel file for Certified Nursing Assistant (CNA) #220 revealed a hire date of 09/10/25. The personal reference check page contained the name and contact information for the references, however, there was no evidence the references were ever contacted. The unsealed envelope labeled confidential contained one blank sheet of paper and there was no evidence a background check had been completed. CNA #220's employment was terminated on 06/04/26 when law enforcement arrived to the facility and arrested CNA #220 for outstanding warrants. On 06/16/26 at 12:10 P.M., an interview with the Administrator verified CNA #220 did not have a background check completed. The Administrator stated when the incident occurred on 06/04/26, he pulled her personnel file and opened the confidential envelope to review her background check results only to find a blank piece of paper inside the envelope. On 06/16/26 at 12:35 P.M., an interview with Regional Nurse #217 stated the facility discovered the background check had not been completed for CNA #220 at the time of the incident on 06/04/26. On 06/17/26 at 12:35 P.M., an interview with the Administrator verified the reference checks were not completed for CNA #220. He said there was a lapse in Human Resources staff last year, including around the time of hire for CNA #220. Review of the facility's policy titled Abuse, Neglect and Exploitation, dated 2025, revealed screenings would be conducted for all potential employees including background checks, reference checks, and credential checks. The policy indicated the facility would maintain documentation of proof that the screenings occurred. 2. Review of the personnel file for the Director of Nursing (DON) revealed a hire date of 09/02/25. There was no evidence of a credentials check completed until 04/28/26, approximately eight months after hire. The personal reference check page contained the name and contact information for the references, however, there was no evidence the references were ever contacted. On 06/17/26 at 12:35 P.M., an interview with the Administrator verified the reference checks were not completed for DON and there was no evidence of a license verification prior to 04/28/26. He said there was a lapse in Human Resources staff last year, including around the time of hire for DON. Review of the facility's policy titled Abuse, Neglect and Exploitation, dated 2025, revealed screenings would be conducted for all potential employees including background checks, reference checks, and credential checks. The policy indicated the facility would maintain documentation of proof that the screenings occurred. 3. Review of the personnel file for Licensed Practical Nurse (LPN) #233 revealed a hire date of 08/20/25. The personal reference check page contained the names of the references, however, there was no contact information listed and no evidence the references were ever contacted. On 06/17/26 at 12:35 P.M., an interview with the Administrator verified the reference checks were not completed for LPN #233. He said there was a lapse in Human Resources staff last year, including around the time of hire for LPN #233. Review of the facility's policy titled Abuse, Neglect and Exploitation, dated 2025, revealed screenings would be conducted for all potential employees including background checks, reference checks, and credential checks. The policy indicated the facility would maintain (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	documentation of proof that the screenings occurred. 4. Review of the personnel file for Registered Nurse (RN) #232 revealed a hire date of 08/08/25. The personal reference check page contained the names of the references, however, there was no contact information listed and no evidence the references were ever contacted. On 06/17/26 at 12:35 P.M., an interview with the Administrator verified the reference checks were not completed for RN #232 He said there was a lapse in Human Resources staff last year, including around the time of hire for RN #232. Review of the facility's policy titled Abuse, Neglect and Exploitation, dated 2025, revealed screenings would be conducted for all potential employees including background checks, reference checks, and credential checks. The policy indicated the facility would maintain documentation of proof that the screenings occurred. 5. Review of the facility's background check log revealed it did not include former employees or applicants. On 06/16/26 at 4:10 P.M., an interview with the Administrator verified the background check log was incomplete because it only contained information for current employees. On 06/22/26 at 2:20 P.M., an interview with Business Office Manager (BOM) #202 stated when he started his position in January 2026, there was no background check log so he had to create one from scratch for all current employees. He further stated a couple employees had to be re-fingerprinted because they were hired in the 1980s and did not have electronic fingerprints on file. Review of the facility's policy titled Abuse, Neglect and Exploitation, dated 2025, revealed screenings would be conducted for all potential employees including background checks, reference checks, and credential checks. The policy indicated the facility would maintain documentation of proof that the screenings occurred. This deficiency represents non-compliance investigated under Complaint Number 3037008.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. Based on review of the facility's self-reported incident (SRI), facility investigation review, review of police reports, interviews, and review of facility policy, the facility failed to conduct a thorough investigation of an allegation of misappropriation of resident social security numbers. This had the potential to affect all 40 residents residing in the facility. Findings include:Review of the police report dated 06/04/26 at 5:29 P.M. revealed local law enforcement was dispatched to the facility regarding an anonymous tip that Certified Nursing Assistant (CNA) #220 had multiple felony warrants. CNA #220 was arrested at the facility and transported to jail. Review of the facility's self-reported incident (SRI), tracking number 275348, dated 06/04/26 revealed local law enforcement arrived to the facility asking to speak to CNA #220. Police revealed CNA #220 had an outstanding warrant for her arrest, arrested her, and removed her from the grounds. Police also notified the facility of an allegation that CNA #220 was stealing residents' social security numbers. There was no evidence the facility interviewed any staff regarding anyone accessing residents' information without authorization or suspicion of someone stealing social security numbers. The only staff statements were from the two staff members who interacted with the police officers upon their arrival to the facility and they did not include any information pertinent to the allegation made regarding social security numbers. In addition, there was no evidence that all resident power of attorneys (POAs) or guardians were notified of the allegation that social security numbers could be compromised. The facility's investigation included asking residents Has anyone in the building asked or talked to you about your social security number or other personal information? and Do you have any concerns regarding your personal information or missing personal papers or documentation? There was no indication that residents interviewed were notified of the allegation that social security numbers could be compromised or that residents/POAs were informed to monitor their financial data for discrepancies. There was also no evidence the facility conducted an audit to see if staff were accessing information without authorization. On 06/16/26 at 12:35 P.M., an interview with Regional Nurse #217 stated everything related to the facility's investigation of the incident with CNA #220 was provided. On 06/17/26 at 3:21 P.M., an interview with Director of Nursing (DON) confirmed all documentation for the facility's investigation of the incident were provided. Review of the Sherriff's Office booking history report dated 06/17/26 at 3:59 P.M. revealed CNA #220 was arrested due to probation violations from previous drug abuse charges and a warrant for theft. On 06/22/26 at 9:30 A.M., an interview with the Administrator verified the facility did not audit for staff access to residents' personal information. The Administrator also confirmed that no staff were interviewed regarding the allegation and POAs were not notified of the allegation. Review of the facility's policy titled Abuse, Neglect and Exploitation, dated 2025, revealed an immediate investigation was warranted when suspicion or reports of abuse, neglect, or exploitation occur. Procedures for investigations included identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; focus the investigation on determining if abuse, neglect, exploitation, and/or mistreatment occurred; and providing complete and thorough documentation of the investigation. Review of the facility's policy titled Identity Theft, dated 2026, revealed personal information would be protected, including names and social security numbers. Any department or individual aware of, or who may suspect, a potential breach of security or compromise of computer systems containing personal information must immediately report such incidents to their Health Insurance Portability and Accountability Act (HIPAA) security officer and Administrator. The policy indicated the facility would decide whether or not notification to individuals was warranted. This deficiency represents non-compliance investigated under Complaint Number 3037008.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on personnel file review and staff interview, the facility failed to ensure that required staff orientation and performance evaluations were completed as part of the competency assessment process. This had the potential to affect all 40 residents residing in the facility. Findings include:Review of the personnel file for Certified Nursing Assistant (CNA) #220 revealed a hire date of 09/10/25. There was no evidence of CNA #220 completing an orientation, an initial skills evaluation, a 30-day performance evaluation, or a 90-day performance evaluation. On 06/17/26 at 12:35 P.M., an interview with the Administrator verified the findings in CNA #220's personnel file. The Administrator stated there was a lapse in human resources (HR) staff at the facility until the new HR person was hired in January 2026. This deficiency represents an incidental finding identified during the investigation of Complaint Number 3037008.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews, the facility failed to serve mechanically altered foods at an appropriate texture. This affected one resident (#24) out of one reviewed for food textures and had the potential to affect six additional residents (#6, #19, #20, #25, #27, #39) identified by the facility as receiving pureed texture. The facility census was 40. Findings include: Review of the medical record for Resident #24 revealed an admission date of 07/18/24 with diagnoses including Alzheimer's disease, depression, hypertension, and chronic obstructive pulmonary disease. Review of the speech therapy Discharge summary, dated [DATE], revealed Resident #24 had dysphasia oropharyngeal phase and had recommendations for puree consistency diet. Review of the physician's orders for Resident #24 identified orders for a regular diet with dysphagia pureed texture effective 04/17/26. Review of the nutrition care plan, revised 05/14/26, revealed Resident #24 had the potential for malnutrition and altered hydration related to Alzheimer's, dementia, depression, anemia, and diet downgraded to puree. Interventions included provide and serve prescribed diet as ordered by physician effective 07/25/24 and monitor tolerance to diet and observe for episodes of coughing or choking after trying to swallow revised 08/21/24. Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/27/26, revealed Resident #24 had severe cognitive impairment, was dependent on assistance for eating, and required a mechanically altered diet. On 06/16/26 at 11:45 A.M., an observation of the lunch meal tray line revealed Resident #24's meal plated with visible lumps in the pureed meat entree. On 06/16/26 at 12:05 P.M., an observation of the dining room revealed Certified Nursing Assistant (CNA) #227 delivered Resident #24's plate to her table. At 12:14 P.M., CNA #227 began feeding Resident #24 her lunch, including the pureed meat entree which was not a smooth consistency with small visible lumps throughout it. On 06/16/26 at 12:14 P.M., an interview at the time of observation with CNA #227 confirmed the puree meat was lumpy. CNA #227 further stated pureed foods were not always completely smooth, and the puree consistency depended on what food items were pureed. CNA #227 said sometimes pureed items were smooth and sometimes there were lumps. On 06/23/26 at 12:52 P.M., an interview with Speech Therapist (ST) #222 revealed Resident #24 required a pureed diet because of her decline so a mechanical soft or ground meat texture would not be appropriate. ST #222 stated she would not expect any pureed foods to have visible lumps or bumps, and the consistency should be smooth. Review of the International Dysphasia Diet Standardization Initiative (IDDSI) guidance, dated January 2019, indicated pureed food texture did not require chewing and had a smooth texture with no lumps. This deficiency represents non-compliance investigated under Complaint Number 2588125.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of facility policy, the facility failed to ensure food was stored, prepared and serviced in a sanitary manner. This had the potential to affect all 39 residents who received food from the kitchen excluding Resident #2 who was identified by the facility as having orders for nothing by mouth. The facility census was 40. Findings include: On 06/15/26 at 8:34 A.M., an observation of the kitchen revealed the following: Reach-in freezer #1 had no visible interior thermometer and there was significant ice build-up within the freezer including on food products. Reach-in freezer #2 had significant ice build-up within the freezer including on food products. The walk-in cooler had a dark colored substance spilled on the floor that was sticky and there were multiple areas of a dark colored fuzzy substance throughout the cooler including by the light fixture, in the corner to the left of the door, two areas above the door, behind the fan, and a line approximately two feet in length on the wall to the right of the door. The reach-in cooler had a container of ricotta cheese that expired on 06/03/26. The dry storage room had one loaf of moldy bread, multiple food items stacked on the floor including a case of marinara sauce with cases of pasta, syrup, and honey stacked on top of the marinara sauce, one case of toasted oats, one case of applesauce with a case of pasta stacked on top of the applesauce. In addition, there were cases of non-food items stacked on the floor including a case of Styrofoam cups with a case of lids stacked on top of the cups, and two cases of Styrofoam food containers with two cases of plastic utensils stacked on top of the containers. The floor throughout the kitchen was had a heavy coating of a sticky substance across the entire surface of the walking space of the floor that made it sticky to walk on. On 06/15/26 at 9:09 A.M., an interview with Dietary Aide (DA) #224 verified the findings in the kitchen. On 06/15/26 at 9:15 A.M., an interview with Dietary Manager (DM) #223 confirmed the findings in the kitchen. DM #223 said the two reach-in freezers were constantly in a state of defrost and she thought there was something wrong with the door seals. She said the food on the floor in dry storage was just delivered that morning and verified it sat directly on the floor. DM #223 confirmed the moldy bread and expired ricotta cheese, stating she must have missed those when she went through the kitchen cleaning it over the weekend. She verified the dark fuzzy substance throughout the walk-in cooler and stated she did not know what it was. DM #223 stated the sticky floor was a constant battle because it's a kitchen and things get spilled. Review of the facility's policy titled Environment, dated 09/2017, indicated all food preparation areas, food service areas, and dining areas would be maintained in a clean and sanitary manner. The policy indicated the dietary manager would ensure the floors, walls, ceilings, lighting, and ventilation were all maintained in a clean and sanitary manner. The dietary manager would ensure a routine cleaning schedule was in place for all cooking equipment, food storage areas, and surfaces. This deficiency represents non-compliance investigated under Complaint Numbers 2631483 and 2588125.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews, the facility failed to conduct initial tuberculosis testing upon hire for all staff, which had the potential to affect all 40 residents residing in the facility. In addition, the facility failed to ensure staff performed appropriate hand hygiene during incontinence care, affecting Resident #39, and failed to ensure staff did not handle ready-to-eat foods with bare hands while assisting Resident #37 with eating. The facility census was 40. Findings include: 1. Review of the personnel files for former Administrator #230, Certified Nursing Assistant (CNA) #220, and Registered Nurse (RN) #232 revealed there was no documented evidence tuberculosis (TB) testing was performed prior to hire. Review of the facility's TB risk assessment, dated 2026, revealed baseline TB skin testing would be performed for healthcare workers, healthcare workers would receive TB testing annually, and TB test records would be maintained by Human Resources (HR). On 06/17/26 at 12:35 P.M., an interview with the Administrator verified there were no TB test results in the personnel files for former Administrator #230, CNA #220, and RN #232. 2. On 06/16/26 at 12:04 P.M., an observation of the lunch meal in the dining room revealed CNA #225 was handling Resident #37's hamburger bun with her bare hands while cutting the hamburger into bite size pieces. CNA #225 put her bare hand on the bun multiple times during the observation. On 06/16/26 at 12:06 P.M., an interview with CNA #225 verified she handled Resident #37's food with her bare hands while cutting it up to assist with feeding. She stated she was holding the bun in place while cutting. 3. Review of the medical record for Resident #39 revealed an admission date of 01/01/20 with diagnoses that included diabetes mellitus type two, arthritis, peripheral vascular disease, kidney disease, and dementia. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #39 was cognitively impaired, did not reject care, was dependent on staff for toileting, and was incontinent of bowel and bladder. An observation on 06/16/26 at 10:21 A.M. of Resident #39 incontinence care with CNAs #200 and #205 revealed the following: CNAs #200 and #205 washed their hands and applied gloves; Resident #39 was positioned for care, CNA #200 cleansed Resident #39's genital area; Resident #39 was then turned to the side with CNA #205 assisting with holding Resident #39 in position; CNA #200 provided perineal care which included cleaning Resident #39 of a small bowel movement; and after incontinence care was completed with the same contaminated gloves CNA #200 then touched the bed linens, the bed control, and then the sink handles before finally removing her gloves and washing her hands. An interview on 06/16/26 at 10:32 A.M. with CNA #200 verified the above findings. Review of the facility policy titled Hand Hygiene, dated 2025, revealed all staff were to perform hand hygiene, staff were to perform hand hygiene as indicated, and hand hygiene is to be completed with accepted standards of practice. This deficiency represents non-compliance investigated under Complaint Number 1366180 (OH00167045).

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on review of maintenance records, observation and interviews, the facility failed to maintain kitchen equipment in proper working order. This affected all 39 residents who received food from the kitchen (except Resident #2 who was identified as having orders for nothing by mouth). The facility census was 40. Findings include: Review of the maintenance work orders revealed dietary staff reported the garbage disposal was not working on 07/21/25. The work order was set to completed on 08/29/25. Review of the repair quote dated 03/11/26 revealed the garbage disposal needed replacement. On 06/15/26 at 8:34 A.M., an observation of the kitchen revealed reach-in freezer #1 had significant ice buildup including on food products, reach-in freezer #2 had significant ice buildup including on food products, and the garbage disposal had a cover over it. On 06/15/26 at 9:09 A.M., an interview with Dietary Aide #224 verified the ice buildup in the freezers and the cover on the garbage disposal. Dietary Aide #224 stated the garbage disposal had been broken for a year, and the facility did not want to pay to fix it. On 06/15/26 at 9:15 A.M., an interview with Dietary Manager #223 verified the ice buildup in the freezers. Dietary Manager #223 said the two reach-in freezers were constantly in a state of defrost, and she thought there was something wrong with the door seals. On 06/16/26 at 8:06 A.M., an interview with Maintenance Director #206 confirmed the garbage disposal needed replacement. He stated they got a quote and it was not approved until 06/15/26. Maintenance Director #206 stated things were taking a while to get approved because the facility was being sold. This deficiency represents non-compliance investigated under Complaint Number 2631483.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility maintenance records, and interviews, the facility failed to ensure the physical environment was maintained in a safe, sanitary condition. The facility did not address ongoing water intrusion and resulting deterioration of ceiling tiles in multiple resident^use and common areas. This had the potential to affect all 40 residents residing in the facility. Findings include: Review of the maintenance work orders revealed staff reported a moldy ceiling tile in room [ROOM NUMBER] on 06/30/25 and ceiling tiles were wet and black in room [ROOM NUMBER] on 08/15/25. On 06/15/26 at 11:45 A.M., an observation of the facility revealed multiple ceiling tiles with visible brown colored water damage. In addition, several ceiling tiles had black discoloration including in hallway outside the Administrator's office, in hallway outside the business office, in hallway by room [ROOM NUMBER], and in hallway by room [ROOM NUMBER]. On 06/15/26 at 11:59 A.M., an interview with the Director of Nursing (DON) verified ceiling damage, stating the pipes in the ceiling sweat and that leaks onto the tiles. On 06/15/26 at 12:00 P.M., an interview with Maintenance Director #206 verified the water damaged ceiling tiles and stated he had to replace the ceiling tiles every two to three weeks due to the water damage. He denied that the black discoloration was mold. On 06/22/26 at 10:50 A.M., an interview with the contracted repairman who was observed installing new insulation on pipes in ceiling stated there was mold throughout the ceiling and metal parts were rusted through and falling out while he was trying to install the insulation. This deficiency represents non-compliance investigated under Complaint Numbers 2631483, 2588125, and 1366180 (OH00167045).