STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365570	A. Building B. Wing	12/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Care Center	328 West Vine Street Edgerton, OH 43517

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record review, review of cleaning procedures, and review of Resident Council meeting minutes, the facility failed to ensure resident rooms were routinely cleaned and maintained. This affected three (#29, #54, and #56) of nine residents reviewed for room cleanliness. The facility census was 62.Findings include:1. Review of the medical record for Resident #29 revealed an admission date of 07/14/23 with diagnoses including hypertension, pulmonary fibrosis, and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 had intact cognition, and required substantial/maximal assistance for toileting hygiene and partial/moderate assistance to toilet transfers.Observation on 12/23/25 at 9:31 A.M. of Resident #29's bathroom revealed it had what appeared to be red discolored water stains all the way around the bowl coming from under the rim of the toilet. Additionally, a grey ring was around the water line. Concurrent interview with Resident #29 revealed she felt the toilet was always dirty, but had been told the discoloration in her toilet was rust. Resident #29 said somebody came in earlier in the morning and scrubbed it. Resident #29 stated she had not gone into the bathroom to look at it. Interview on 12/23/25 at 9:48 A.M. with Certified Nursing Assistant (CNA) #101 confirmed residents, including Resident #29, complained about the cleanliness of their toilets. CNA #101 stated she had reported her concerns to housekeepers and nurses.Observation on 12/23/25 at 11:55 A.M., and concurrent interview with Housekeeping Manager (HM) #400 revealed Resident #29's toilet bowl had discolored hard water stains coming down inside the bowl from under the rim to the water line, approximately every two inches all the way around the bowl. Additionally, the stains on the right side of the bowl were more orange/red while the remaining stains were off-white/yellow. A grey ring was around the water line. HM #400 confirmed the observations. HM #400 stated she cleaned the toilet earlier using just a rag, and wasn't able to get the hard water stains out of the toilet.Subsequent interview on 12/23/25 at 12:15 P.M. with HM #400 revealed she used a pumice stone to clean the inside of Resident #29's toilet and was able to remove the stains. HM #400 stated she did not realize the stains could be removed and had not previously attempted to use the pumice stone to clean the bowl.Observation on 12/23/25 at approximately 12:55 P.M. revealed Resident #29's toilet was free of hard water build-up and no ring was around the water line.Interview on 12/23/25 at 3:23 P.M. with the Director of Nursing (DON) revealed she heard complaints about unclean toilets. The DON stated when she reported her concerns to the housekeeping department, and the concerns were always addressed. The DON confirmed Resident #29 used their restroom.2. Review of the medical record for Resident #54 revealed an admission date of 11/18/14 with diagnoses including anxiety, hypertension, and chronic kidney disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #54 had intact cognition. Observation on 12/23/25 at 9:18 A.M., and concurrent interview with Licensed Practical Nurse (LPN) #201 revealed Resident #54's bathroom had brown substance, approximately two inches in length on the exterior front of the toilet, and a darker brown speckled substance on the back wall of the interior bowl, approximately two inches in diameter. LPN #201 confirmed these observations. LPN #201 stated residents complained about the lack of cleanliness, particularly in the bathrooms.Observation on 12/23/25 at 2:44 P.M., and concurrent interview with Housekeeping Manager (HM) #400, revealed Resident #54's toilet had a brown substance on the front exterior of the bowl, and a brown speckled substance on the back of the interior bowl. HM #400 confirmed these observations. HM #400 confirmed Housekeeper #401 was assigned to clean and restock Resident #54's room, including the bathroom. Interview on 12/23/25 at 3:23 P.M. with the Director of Nursing (DON) revealed she heard complaints about unclean toilets. The DON stated when she reported her concerns to the housekeeping department, and the concerns were always addressed. The DON confirmed Resident #54 used their restroom.3. Review of the medical record for Resident #56 revealed an admission date of 11/18/24 with diagnoses including schizoaffective disorder, depression, and auditory hallucinations. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #56 had intact cognition. Interview on 12/23/25 at 10:05 A.M. with Certified Nursing Assistant (CNA) #102 confirmed some residents complained about bathrooms and toilets not being cleaned.Interview on 12/23/25 at 11:21 A.M. with Infection Preventionist (IP) #301 revealed staff and residents have reported concerns to her regarding cleanliness and infection control. IP #301 stated these concerns have been reported since approximately early November 2025. IP #301 stated she reported the concerns to the Administrator.Interview on 12/23/25 at 11:32 A.M. with

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, staff interview, review of Resident Council meeting minutes, review of Centers for Disease Control and Prevention (CDC) guidance, and policy review, the facility failed to ensure staff wore appropriate personal protective equipment (PPE) during a COVID-19 outbreak. This had the potential to affect all residents in the facility except 10 residents (#11, #13, #21, #25, #31, #58, #65, #68, #71, and #72) who were identified with a current COVID-19 infection. The facility census was 62.Findings include:Interview on 12/23/25 at 8:42 A.M. with Infection Preventionist (IP) #301 revealed the facility was in COVID-19 outbreak and identified ten residents with COVID-19 (#11, #13, #21, #25, #31, #58, #65, #68, #71, and #72). IP #301 reported no residents on the Memory Care Unit were diagnosed with COVID-19. Observation on 12/23/25 at 12:10 P.M. revealed signage posted outside Resident #11's door indicating Resident #11 was in droplet precautions for COVID-19. Housekeeping Manager (HM) #400 was in Resident #11's bathroom cleaning her toilet. HM #400 was not wearing a disposable gown or eye protection. Interview on 12/23/25 at 12:15 P.M. with HM #400 confirmed Resident #11 was in COVID-19 isolation and staff should wear PPE, including a gown, N95 mask, eye protection, and gloves while in the room. HM #400 confirmed she went into Resident #11's room to clean her toilet bowl and only wore the N95 mask she had on. Further observation revealed HM #400 wore a distinct striped mask. There were no striped masks observed in the PPE cart outside Resident #13's room.Further observation on 12/23/25 at 12:20 P.M. revealed signage posted outside the room shared by Resident #12 and Resident #13 indicating the residents were in droplet precautions for COVID-19. HM #400 donned a gown and gloves before entering the room shared by Resident #12 and Resident #13 and did not change her N95 mask. HM #400 did not put on eye protection before she walked past both residents in the room and entered the bathroom.Interview on 12/23/25 at 11:32 A.M. with HM #400 revealed she worked on the floor as a housekeeper and had completed all room cleanings for the day, including rooms for Resident #11, Resident #13, Resident #21, Resident #25, and Resident #31, who were identified to be in COVID-19 precautions.Interview on 12/23/25 at 12:29 P.M. with HM #400 and Housekeeper #401 stated they both do not change their N95 masks throughout the day. HM #400 and Housekeeper #401 stated they were unaware they were expected to discard their N95 mask before exiting a resident's room who was in COVID-19 droplet precautions. HM #400 confirmed she cleaned all 24 rooms on her assignment, including five rooms identified to be in COVID-19 precautions without changing her N95 mask.Follow-up interview on 12/23/25 at 3:35 P.M. with IP #301 revealed all staff should be wearing gown, gloves, N95 masks, and eye protection before entering rooms in COVID-19 precautions. IP #301 confirmed N95 masks should be changed upon exiting COVID-19 rooms. Additionally, IP #301 confirmed the facility had a COVID-19 outbreak during November 2025 and explained it was 29 days between the end of the previous outbreak and the current outbreak.Review of the Resident Council meeting minutes dated 11/18/25 revealed housekeeping staff were not using PPE in COVID-19 rooms before going into other rooms.Review of the facility's undated document Special Respiratory Precautions revealed staff were expected to wear goggles or face shield, an N95 mask, a gown, and a pair of clean gloves before entering a room in COVID-19 precautions.Review of CDC guidance titled Transmission-Based Precautions dated 04/03/24 and found at https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html revealed droplet precautions included everyone must make sure their eyes, nose, and mouth are fully covered before room entry and make sure to remove face protection before room exit.This was an incidental finding during the complaint survey completed 12/24/25.