

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365758	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2025
NAME OF PROVIDER OR SUPPLIER Parma Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5553 Broadview Rd Parma, OH 44134	
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and facility policy review, the facility failed to ensure food was served at an appetizing temperature. This had the potential to affect 84 residents receiving meals from the kitchen. The facility identified one resident (#6) as receiving nothing by mouth (NPO). The facility census was 85. Findings include: Observation of lunch meal temperatures prior to service on 07/23/25 at 11:38 A.M. with [NAME] #214 using the facility digital thermometer revealed the two trays of breaded chicken patties temperatures were 165.2 degrees Fahrenheit (F) and 167.0 F and the rice temperature was 200.0 F. Observation of lunch tray line service on 07/23/25 from 11:45 A.M. to 12:42 P.M. revealed the facility completed tray line pass. The cook was observed to run out of plates and began using divided dishes for the last three trays served. A test tray was served on the final cart. Observation of lunch test tray on 07/23/25 at 12:54 A.M. following completion of resident tray pass revealed temperatures were taken using the facility digital thermometer by Mobile Dietary Manager (DM) #299. The test tray was served on a divided dish with a heated base and dome lid. The temperatures of the breaded chicken patty on a bun was 102.8 F and the rice was 110.2 F. A taste test revealed the temperatures of the breaded chicken patty on a bun and rice were lukewarm. Interview on 07/23/25 at 12:54 A.M. with Mobile DM #299 revealed Mobile DM #299 also tasted the breaded chicken patty on a bun and rice and confirmed the temperature was not palatable and indicated she would microwave the meal. Review of the undated facility policy Food Temperatures revealed hot foods would be held at 135.0 F or greater throughout the service process.		

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 facility policy review, the facility failed to maintain a clean and sanitary kitchen area. This had the potential to affect 84 residents receiving meals from the kitchen. The facility identified one resident (#6) as receiving nothing by mouth (NPO). The facility census was 85. Findings include: Observations of the facility kitchen on 07/21/25 from 8:32 A.M. to 9:00 A.M. with Dietary Manager (DM) #245 revealed the following concerns: a. There was a prep table for juice and coffee machines which included a sink built into the table. The plumbing under the sink was leaking into a plastic container on the floor. b. Observation in the dry storage room revealed various debris under racks including a pen and a package of instant coffee. c. The floors throughout the kitchen area were sticky and had various debris and crumbs. d. Spilled thickener powder was observed on a prep table holding the mixer. e. Additional prep tables had food debris and crumbs on the bottom shelves that held various supplies. f. Dried food splatter was noted on the kitchen equipment including the convection oven, steamer, two range tops, and a sink under kitchen hood. g. The sink faucet under the kitchen hood was dripping down its side. h. The dish machine area revealed there was scale build up on the outside of the dish machine. i. The three dish machine cycle revealed the dish machine did not reach required temperatures for sanitation. The wash cycle temperature was 150 degrees F and the rinse cycle was 176 degrees F. j. Multiple dead bugs were noted in the light fixtures on ceiling. k. The floors were sticky with various food debris and there was steel wool on floor under dish machine. l. Leftover food debris was noted in the dirty side of the dish machine, which included tomato sauce, corn, and elbow noodles. m. The plastic cart holding the breakfast dishes had dried food splatter and various debris on the three levels of the cart. n. There was a plastic cart of dishes left over from the previous night with food including carrots, biscuits, and fried chicken. o. There was a plastic bin with sugar and artificial sweetener packets sitting on a table with chemicals including floor cleaner. Interview on 07/21/25 at 9:00 A.M. with DM #245 confirmed the above findings. DM #245 indicated he had only been employed at the facility for a month and a half. DM #245 indicated there were no written cleaning schedules and he would make a list for the staff when things needed done. DM #245 indicated the kitchen sanitation was unacceptable, and he would address his staff. Review of the undated facility policy General Sanitation of the Kitchen revealed staff would maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. Review of the undated facility policy titled Dishwashing revealed the final rinse temperature for a high temperature machine was 180.0 degrees Fahrenheit (F) to 194.0 F. Review of the facility policy Food Storage dated 2023 revealed foods would be stored in an area that is clean, dry, and free of contamination. Chemicals were required to be clearly labeled and stored away from food. The racks and storage surfaces should be clean and protected from splashes.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, review of pest control company invoices, and facility policy review, the facility failed to effectively manage pests in the kitchen area. This had the potential to affect 84 residents receiving meals from the kitchen. The facility identified one resident (#6) as receiving nothing by mouth (NPO). The facility census was 85. Findings include: Observations of the facility kitchen on 07/21/25 from 8:32 A.M. to 9:00 A.M. with Dietary Manager (DM) #245 revealed multiple flies throughout the kitchen area and dish machine areas. Interview on 07/21/25 at 9:00 A.M. with DM #245 confirmed the presence of multiple flies throughout the kitchen area. Review of the pest control company invoice dated 06/05/25 revealed the kitchen, dishwashing area, and dry goods storage area, received a general pest treatment, but it did not include house flies or fruit flies. Review of facility policy Pest Control dated March 2023 revealed pests would be controlled in and around all buildings to reduce any potential human health hazard. Common pests included flies. Review of the facility policy Food Storage dated 2023 revealed the storage areas would be free from rodent and insect infestation. The kitchen would be treated for pests and vermin on a regular schedule.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the facility failed to ensure a call light was in reach for resident use to call for assistance. This affected one resident (Resident #91) of one resident sampled for call light placement. The facility census was 85. Findings include: A review of medical record for Resident #91 revealed an original admission date of 04/13/21 and a readmission date of 05/22/23. Significant diagnoses included diabetes mellitus type two, unspecified dementia, generalized anxiety, major depressive disorder, cirrhosis of the liver, chronic hepatitis C, clostridium difficile, and chronic obstructive pulmonary disease. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 13 indicating the resident was cognitively intact. The MDS also revealed Resident #91 required substantial to maximum assistance with toileting, substantial to maximum assistance with showers and partial to moderate assistance for dressing. The MDS revealed Resident #91 to be occasionally incontinent of bowel and bladder. A care plan dated 06/19/25 revealed Resident #91 had behavioral symptoms. Interventions included encourage to place the call light in reach or off the floor and place a clip on the call light and clip it to the sheets or bed. On 07/21/25 at 9:39 A.M. an observation of Resident #91 revealed her lying in bed. The call light was on the floor on the right side of the bed. On 07/21/25 at 9:39 A.M. an interview with Housekeeping Supervisor #298 verified Resident #91's the call light was on the floor. On 07/22/25 at 4:09 P.M. an observation of Resident #91 revealed her lying in bed. The call light was on the floor on the right side of the bed. On 07/22/25 at 4:09 P.M. an interview with Certified Nurse Aide #212 verified Resident #91's the call light was on the floor. The review of the policy titled; Resident Call System dated March 2023 revealed the staff will provide an environment to assist in meeting the needs of residents and to provide an environment which supports and enhances each residents quality of life, providing the necessary care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being, consistent with the residence comprehensive assessment and plan of care. The policy also revealed, in subpoint 8, when leaving the room, be sure the call light is placed within the residents reach.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interviews, the facility failed to ensure that Resident #6 received oral care and was shaved per his preference. This affected one resident (#6) out of five residents reviewed for activities of daily living (ADLs). The facility census was 85. Findings include: Review of the medical record for Resident #6 revealed an admission date of 12/20/24 with diagnosis including Huntington's disease, major depressive disorder, muscle weakness, and unspecified lack of coordination. Review of the care plan for Resident #6 dated 03/27/25 revealed a goal he would be clean, dry, dressed, groomed and free of odors. Further review of the care plan revealed Resident #6 had a preference to be clean shaven. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #6 was rarely or never understood, had short-term and long-term memory impairment, and was dependent upon staff for all ADLs. An interview on 07/21/2025 at 3:17 P.M. with a family member of Resident #6 revealed the resident was often unshaven and his teeth not brushed. Additionally, the family member shared that prior to Resident #6 being dependent upon the facility staff for ADL completion, he was meticulous about his hygiene and was always clean shaven. An observation on 07/23/25 at 9:00 A.M. revealed Resident #6 was in bed and dressed in a hospital gown. He had a full, short beard with a full moustache. An observation on 07/23/25 at 9:51 A.M. of Resident #6 revealed that his teeth were covered with a thick film and his lips had visible dry crust. An interview with Licensed Practical Nurse (LPN) #213 at the time of observation verified Resident #6 needed oral care performed and shared that oral care was expected to be done every shift. An interview on 07/23/25 at 3:00 P.M. with Certified Nursing Assistant (CNA) #292 verified Resident #6 had a full, short beard and a full moustache. CNA #292 stated nursing staff did not shave Resident #6, and that he went to the beauty shop to be shaved. An interview on 07/23/25 at 4:00 P.M. with Beautician #302 revealed she used clippers on Resident #6's head and face to trim as close as she could, but she does not shave him. The beautician shared that it was not safe for her to shave Resident #6 because he did not sit still enough. Beautician #302 additionally shared that nursing was to shave Resident #6 after she trimmed his beard down. An interview on 07/24/25 at 9:15 A.M. with the Director of Nursing (DON) revealed it was expected that residents would be shaved per their preference. The DON shared the facility had an CNA on light duty who was assigned to shave and perform nail care for residents. The DON further shared that activity staff and CNAs could shave residents with an electric razor. The DON stated she believed Resident #6 was shaved by Beautician #302 last Wednesday and was not aware Resident #6 had not been shaved. Review of the facility policy bathing and personal care dated 08/2022 revealed oral care would be offered twice a day, after meals and as needed, with special attention given to residents receiving tube feeding or that were nothing by mouth. The policy further stated that shaving would be offered daily as part of the routine bathing process.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on medical record review, observation, interview, and review of the facility policy, the facility failed to ensure a smoking assessment was completed for a resident who was smoking on the facility premises. This affected one (Resident #54) of one reviewed for smoking. The facility census was 85. Findings Include: Review of the medical record for Resident #54 revealed an admission date of 07/14/25. Diagnoses included but were not limited to hemarthrosis of the right knee, type two diabetes mellitus with chronic kidney disease, end stage renal disease and dependence upon renal dialysis. Further review of Resident #54's medical record revealed no documented evidence that a smoking assessment was completed to determine the resident's capabilities and deficits to determine whether or not supervision was required. Review of the 07/14/25 admission Minimum Data Set (MDS) 3.0 for Resident #54 revealed intact cognition. Resident #54 was noted to use a wheelchair, required supervision for mobility and moderate assistance with dressing, toileting and bathing. Review of the 07/14/25 care plan for Resident #54 revealed no care plan related to smoking. Review of the nursing progress note dated 07/15/25 timed at 2:02 P.M. for Resident #54 revealed the Social Services Designee (SSD) #203 spoke with Resident #54 about the facility being a non-smoking facility and provided education about the smoking policy. Resident #54 stated he was aware he must sign-out each time he went out to smoke and must go off the facility property to smoke. Observation and interview on 07/21/25 at 9:15 A.M. revealed Resident #54 was smoking outside on the facility bench across from the facility entrance. There was no ash tray observed and there was a sign near the entrance door that stated, 'No Smoking'. Interview at the time of the observation with the Administrator confirmed the facility was a non-smoking facility and Resident #54 was not supposed to be smoking on the facility grounds. Interview on 07/22/25 at 2:23 P.M. with Licensed Practical Nurse (LPN) #266 confirmed Resident #54 was aware prior to admission that the facility was not a smoking facility. LPN #266 confirmed a smoking plan should have been in place following the 07/15/25 smoking incident. Interview on 07/22/25 at 2:28 P.M. with the Director of Nursing (DON) and the Administrator confirmed Resident #54 was caught smoking outside on 07/15/25 and a smoking assessment was not completed following the incident. Review of the August 2024 facility policy titled, Non-Smoking and Non-Vaping revealed smoking, including the use of tobacco, was strictly prohibited on the premises, both indoors and outdoors.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and observation, the facility failed to ensure that infection control guidelines were followed during incontinence care for Resident #6. This affected one (Resident #6) out one resident observed for incontinence care. The facility census was 85. Findings include:Review of the medical record for Resident #6 revealed an original admission date of 03/14/23 and a re-admission date of 12/20/24. Medical diagnoses included Huntington's disease, major depressive disorder, muscle weakness, and unspecified lack of coordination.Review of Resident #6's care plan dated 04/17/24 revealed the resident required enhanced barrier precautions to reduce the transmission of multidrug-resistant organisms related to the use of a feeding tube. Interventions included to ensure thorough cleaning and disinfection of surfaces and equipment, perform hand hygiene before and after glove use, regularly reinforce education to maintain compliance, use disposable gowns and gloves during high contact care activities, and remove gowns and gloves promptly after care activities and dispose of them in the proper receptacle.Review of the quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 was rarely or never understood, had short- and long-term memory impairment, was dependent upon staff for all activities of daily living and was always incontinent of bowel and bladder.Review of Resident #6's physician's orders revealed an order dated 07/26/25 for enhanced barrier precautions to be used while providing care.An observation on 07/21/25 at 10:45 A.M. revealed Certified Nursing Assistant (CNA) #292 and CNA #229 preformed incontinence care for Resident #6. CNA #292 cleansed Resident #6's buttocks and groin area and did not remove her gloves after. CNA #292 then touched multiple clean items with contaminated gloves including clean bed linens, the privacy curtain and Resident #6's overbed table. CNA #229 removed the soiled linen and adult brief from under Resident #6 and put it on the floor.An interview on 07/21/25 at 11:15 A.M. with CNA #292 and CNA #229 confirmed that CNA #292 did not remove her gloves after incontinence care and that CNA #229 placed the soiled linens on the floor. The CNA's further verified that the linens should have been placed in a bag once removed from Resident #6's bed.Review of the undated facility policy titled, Bathing - Personal Care, revealed residents of the health care facility will receive personal care in the facility according to the resident's plan of care to promote dignity cleanliness and general well-being.		