

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365997	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER Parkvue Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3800 Boardwalk Blvd Sandusky, OH 44870	

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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033</p> <p>Based on observation, staff interview, and policy review, the facility failed to maintain the satellite kitchens on each unit in a sanitary manner. This had the potential to affect all residents. The facility census was 77.</p> <p>Findings include:</p> <p>1. Observation on 10/28/24 at 8:43 A.M. in the Ogontz satellite kitchen revealed in the freezer there was an undated package of frozen pancakes with ice buildup, and an undated partially frozen drink with a straw inside the cup. In the refrigerator there was an undated cup of fruit and undated cheese. Inside the bottom of the freezer there was a buildup of food and spills of food on the bottom of the freezer. There were drips of food on the outside of the refrigerator/freezer unit. Further observations revealed the handwashing sink faucet handles would not move or turn on. There were hardwater stains on on the outside of the dishwasher. Continued observation revealed the microwave had a build up of dried food on the sides and inside top of the microwave.</p> <p>Interview on 10/28/24 at 8:43 A.M., Dietary Aide #416 verified the unlabeled and undated food items in the refrigerator and freezer. Dietary Aide #416 verified the microwave had not been cleaned and should be cleaned daily. Dietary Aide #416 verified the inside bottom of the freezer, outside of the freezer, and the outside of the dishwasher had not been cleaned. Dietary Aide #416 revealed the hand washing sink had not worked for a long time and staff used the main kitchen sink.</p> <p>49742</p> <p>2. Observation on 10/28/24 at 9:11 A.M. of the satellite kitchen located on the [NAME] unit revealed:</p> <p>A six-quart container of Fruit Loops cereal that was approximately two-thirds full that was undated and unlabeled.</p> <p>A six-quart container of Raisin Bran that was approximately one-half to two-thirds full that was undated and unlabeled.</p> <p>A 35-ounce bag of Corn Flakes that was approximately one-half full that was undated.</p> <p>(continued on next page)</p>

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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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A two-quart container of Corn Flakes that was approximately one-half full that was undated and unlabeled.</p> <p>A 10.8-ounce box of Honey Nut Cheerios that was approximately two-thirds full with no date.</p> <p>A 36-ounce box of iodized salt that was approximately one-eighth full with no date.</p> <p>Shelves inside of the servery cabinets, where clean dishes are stored to be used for meal service for residents, were lined with placemats. The placemats and shelves were soiled with an unidentified dark brown substance.</p> <p>The wall surrounding the sink by the dishwasher has peeling paint, peeling caulk, peeling backsplash, and there is a dark brown to black substance growing around the quarter-round trim and caulk.</p> <p>A six-quart container of brown sugar that was approximately one-half full that was undated and unlabeled with two spoons stored inside.</p> <p>Two 20-ounce containers of ketchup, both open and approximately one-half to two-thirds full, with no date.</p> <p>Two 12 ounce containers of mustard, both open and approximately one-half to two-thirds full, with no date.</p> <p>The Formica covering the drawer and cabinet door under the ice machine was lifting and exposed the particle board under it.</p> <p>Interview on 10/28/24 at 9:20 A.M. with Dining Services Assistant (DSA) #409 verified these findings.</p> <p>44454</p> <p>3. Observation on 10/28/24 at 9:00 A.M. of the satellite kitchen located on the Boeckling unit revealed the microwave had a substance splattered on the inside door, top, back, and sides of the microwave. The dishwasher and garbage disposal located in the kitchen had buildup and grime on them.</p> <p>An interview at the time of observation with Dietary Aide #399 verified the buildup and splatter.</p> <p>4. Observation on 10/28/24 at 9:18 A.M. of the satellite kitchen located on the [NAME] unit revealed there was buildup and splatter on the front and left side of the dishwasher, on the front and inside of a cupboard located to the left of the dishwasher, on the cupboard located above the aforementioned cupboard, on a garbage disposal located below the sink, and on the metal sliding doors located below the ice machine.</p> <p>An interview at the time of observation with Dietary Aide #401 verified the buildup and splatter.</p> <p>Review of the facility policy titled, Sanitation of Food Service Department, dated 2005, revealed the food service staff would maintain the sanitation of the food service department.</p>		

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<p>F 0920</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture.</p> <p>44454</p> <p>Based on dining observations, staff interview, and review of the facility census, the facility failed to ensure there was adequate space in the dining room for 17 residents (#8, #18, #24, #31, #37, #39, #41, #47, #48, #49, #51, #52, #55, #59, #63, #70, and #178) currently residing on the secured unit. The facility census was 77.</p> <p>Findings include:</p> <p>Observation on 10/28/24 at 12:13 P.M. during the lunch meal revealed there were 15 residents seated in the dining room located on the secured unit. The dining room contained four square tables, one of which was up against a wall/counter. There were no open seats left in the dining room.</p> <p>Further observation during the lunch meal revealed Resident #41 was seated at a table designated for residents who required assistance with feeding and was actively being fed by State tested Nursing Assistant (STNA) #338. STNA #351 then brought a 16th resident (Resident #18) to the dining area. STNA #338 moved Resident #41 to a sitting area while Resident #18 sat in Resident #41's place at the table. STNA #338 proceeded to feed Resident #41 in the sitting area, where there were no other residents.</p> <p>Further observation on 10/28/24 at 12:34 P.M. revealed STNA #338 finished feeding Resident #41 a cup of flavored gelatin and then left the sitting area. Resident #41 remained in the sitting area with no interaction until the rest of their lunch arrived at 12:39 P.M. Resident #41's plate was placed on a bedside table and Resident #41 was assisted with eating the rest of the lunch meal in the sitting area.</p> <p>An interview on 10/18/24 at 1:00 P.M. with STNA #338 verified STNA #338 moved Resident #41 to the sitting area for the lunch meal because there was not enough room for everyone in the dining area. STNA #338 also verified Resident #41 ate the lunch meal off of a bedside table located in the sitting area, where there were no other residents.</p> <p>An additional observation on 10/28/24 at 5:16 P.M. during the dinner meal revealed residents who were facing back-to-back had a small amount of space between the backs of their wheelchairs. STNA #314 stated aloud that they needed to find a spot for Resident #49 to sit. STNA #314 stated they would need to move Resident #41 in order for Resident #49 to fit through the middle passageway. STNA #314 moved Resident #41 away from their table (via wheelchair), assisted Resident #49 to a table, and then moved Resident #41 back to their table. STNA #314 then stated I had to move Resident #41 out so that I could get Resident #49 in.</p> <p>Review of the facility census on 10/28/24 revealed there were currently 17 residents residing on the secured unit.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>35033</p> <p>Based on observation, staff interview, and policy review, the facility failed to ensure carpets were maintained in a clean and sanitary manner throughout the facility. This affected all residents. The facility census was 77.</p> <p>Findings include:</p> <p>Observations on 10/28/24 beginning at 7:45 A.M. revealed the carpets throughout the halls and common areas on all four units were heavily stained in multiple spots throughout all four of the units.</p> <p>Interview on 10/29/24 at 3:54 P.M., the Director of Environmental Services (DES) #491 revealed the carpets were cleaned professionally once per year and were last cleaned in September of 2024. DES #491 revealed the facility cleaned spots on the carpet everyday. DES #491 verified there were multiple stains throughout the four units that kept coming back even after the area was cleaned. DES #491 revealed the facility planned to replace the carpet on one of the four units.</p> <p>Interview on 10/29/24 at 4:48 P.M., the Administrator verified the numerous carpet stains. The Administrator stated the facility had planned to replace the carpet with vinyl planks on one of the four units but had no start date for the project. Further interview on 10/31/24 at 9:37 A.M. the Administrator revealed the facility had now been approved to replace all the carpet in the facility. The Administrator revealed the carpet replacement would begin in December and take about six months to complete.</p> <p>Review of the undated policy, Carpet Cleaning Procedure revealed an outside cleaning contracted company would deep clean the facility carpets areas annually. Spot cleaning would be completed as needed and repeated if necessary.</p>