STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365997	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkvue Health Care Center	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)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, medical record review, and staff interview, the facility failed to ensure a splint was worn as ordered. This affected one (#3) of one resident reviewed for splints. The facility census was 74.Findings include:Review of the medical record for Resident #3 revealed an admission date of 08/12/25. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, major depressive disorder, and anxiety disorder.Review of the quarterly Minimum Data Set (MDS) 03/04/26 revealed Resident #3 was cognitively intact. Further review of the MDS revealed Resident #3 had an impairment on the right side and was dependent on staff for activities of daily living (ADLs).Review of the care plan dated 08/13/25 revealed Resident #3 had an ADL self-care performance deficit related to hemiplegia. Interventions included for the resident to wear a right hand splint as ordered, to monitor skin when donning and doffing the splint. Further review of the care plan revealed Resident #3 had left cerebral vascular accident (CVA) with right side hemiplegia. Interventions included for a right hand splint to be applied in the morning and removed at bedtime, and as needed for resident comfort, by the nurse.Review of the current physician orders revealed an order dated 09/29/25 to apply hand splint to the right hand in the morning, and to remove the splint in the evening.Review of the Medication Administration Record (MAR) from 03/01/26 through 03/23/26 revealed the nurse signed that the hand splint to right hand was in place in the morning and removed in the evening.Observation on 03/23/26 at 8:54 A.M. revealed Resident #3 was up in her wheelchair eating breakfast in the dining room. There was not a splint on the right hand.Observation on 03/23/26 at 9:46 A.M. revealed Resident #3 was up in her wheelchair in the common area. Resident #3 did not have a splint on the right hand.Interview on 03/23/26 at 9:46 A.M. with Resident #3 revealed the staff does not always put the splint on the resident's right hand. Resident #3 verified the staff had not applied the splint that morning. Resident #3 stated the splint was to be applied in the morning, and that the aides were usually the ones that applied and removed the splint. Interview on 03/23/26 at 9:50 A.M. with Licensed Practical Nurse (LPN) #218 confirmed Resident #3 was to wear a splint on the right hand, and further confirmed the splint was currently not on Resident #3. LPN #218 stated the splint should be applied in the morning, adding the aide typically applies Resident #3's splint after getting up in the wheelchair.Interview on 03/23/26 at 2:45 P.M. with LPN Unit Manager #302 revealed the order was for the nurse to apply Resident #3's splint to the right hand. LPN Unit Manager #302 stated the nurse was to chart the splint being applied in the MAR. LPN Unit Manager #302 further verified the MAR showed the splint as being applied on 03/23/26 in the morning.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365997	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkvue Health Care Center	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)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interview, the facility failed to ensure call lights functioned properly. This affected one (#13) of one resident reviewed for call lights. The facility census was 74.Findings include:Review of the medical record for Resident #13 revealed an admission date of 07/10/25. Diagnoses included chronic obstructive pulmonary disease (COPD), schizoaffective disorder, and anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 had intact cognition. Further review of the MDS revealed Resident #13 required supervision with toileting and transferring. Review of the care plan dated 07/11/25 revealed Resident #13 was at risk for falls related to impaired mobility. Interventions included encouraging non-skid footwear when out of bed and keeping frequently needed items within reach. Further review of the care plan revealed Resident #13 had an activity of daily living (ADL) self-care performance deficit related to generalized weakness. Interventions included one to two staff assist with toileting.Observation on 03/23/26 at 10:01 A.M. of Resident #13's call light revealed when the resident pressed the call light button the call light did not turn on.Interview on 03/23/26 at 10:01 A.M. with Resident #13 revealed the call light stopped working during the night shift and was reported to the Certified Nursing Assistant (CNA). When asked how Resident #13 called for help, Resident #13 stated, I wait for someone to walk by and yell out.Interview with Licensed Practical Nurse (LPN) Supervisor #302 confirmed that Resident #13's call light was not working. Upon investigating, LPN #302 noted the battery was out of the call light. LPN #302 attempted to replace the battery without success. LPN #302 stated the battery may be bad, she obtained a new battery, placed the battery in the call light and the call light functioned properly. Interview on 03/24/26 at 9:32 A.M. with Administrator revealed the call system had alerted that the call light for Resident #13 was not working starting on 03/22/26 at 1:59 A.M. The message in the system read pull cord not detected, check pull cord. The Administrator further confirmed the staff should have immediately investigated the reason why the call light was not functioning and if they were unable to repair they should have reported the issue.