

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366081	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER Parkview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1406 Oak Harbor Rd Fremont, OH 43420	

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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033</p> <p>Based on observation, review of medical records, review of self-reported incidents (SRI), review of witness statements, interviews with staff, residents, and family, and policy review, the facility failed to ensure one cognitively impaired resident (#03) was free from resident-to-resident sexual abuse. This resulted in Immediate Jeopardy and the potential for serious physical, mental and/or psychosocial negative outcomes for two residents (#03 and #21) when the facility failed to recognize and respond to Resident #02's increased sexual behavior. State tested Nursing Assistant (STNA) #112 reported on 04/20/24, Resident #02 had pulled his genitalia out in front of Resident #03. STNA #112 reported the incident to a nurse. On 04/26/24, Resident #02 was found with Resident #21 with his pants unfastened and was putting away his genitalia. On 04/26/24, Licensed Practical Nurse (LPN) #230 was approached by staff stating Resident #02 had exposed himself to Resident #03 in the dining room. Resident #02's care plan was never updated to reflect his increased sexual behaviors towards other residents, nor any new interventions put in place for staff to implement to address these behaviors. The physician was notified and ordered a urinalysis, which was not completed due to the resident's refusal and no other interventions were put in place except increased monitoring. The facility failed to incorporate effective interventions to prevent further abuse from happening. On 04/29/24, Resident #02 was found with his hands down Resident #03's pants. Resident #03 was not physically assessed until six days later when a skin assessment was completed. The facility did not initiate one-on-one monitoring for Resident #02 until 05/06/24. Consequently, this continued inappropriate, unwanted sexual behavior/contact resulted in Resident #03 experiencing a change in condition and negative psychosocial outcomes manifested as self-isolation in her room, including eating her meals, expressions of fearfulness, and no longer attending many activities of interest, since the incidents. Additionally, a reasonable person in the resident's position would potentially have experienced severe psychosocial harm such as dehumanization as a negative outcome resulting from having been treated as an inanimate object or as having no emotions or feelings, and/or humiliation as a result of a feeling of shame due to being embarrassed, disgraced, or depreciated by being subjected to sexual abuse/assault. This affected two (#03 and #21) of four residents reviewed for abuse. The facility census was 28.</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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 05/07/24 at 2:44 P.M., the Administrator, the Director of Nursing (DON), Regional Director of Operations (RDO) #40, Senior Administrator (SA) #41, Administrator-In-Training (AIT) #42, and Quality Assurance Registered Nurse (QARN) #43 were notified Immediate Jeopardy began on 04/26/24 after STNA #112 stated around 04/20/24, Resident #02 pulled his genitalia out in front of Resident #03. STNA #112 reported the incident to Registered Nurse (RN) #200. On 04/26/24 around 12:28 A.M., Resident #02 was found in the dining room with Resident #21 with his pants unfastened and was putting away his genitalia. On 04/26/24 around 12:56 P.M., LPN #230 was approached by staff stating Resident #02 had exposed himself to Resident #03 in the dining room. Resident #02's care plan was never updated to reflect the increased sexual behaviors nor were any new interventions put in place for staff to implement to address those behaviors. The physician was notified and ordered a urinalysis which was not completed due to resident refusal and no other interventions were put in place except increased monitoring. The facility failed to incorporate effective interventions to prevent further abuse from happening. On 04/29/24, Resident #02 was found with his hands down Resident #03's pants. Resident #03 had no skin assessment until six days later. The facility did not initiate one-to-one staff monitoring for Resident #02 until 05/06/24. Since the incident, Resident #03, who used to attend many activities and was social, now self-isolates in her room, even to eat meals, and has expressed feeling scared to come out of her room and fearful of Resident #02. Resident #03 was no longer attending many activities of interest.</p> <p>The Immediate Jeopardy was removed on 05/08/24 when the facility implemented the following corrective actions:</p> <p>On 05/07/24, Resident #03 was assessed by the DON for ill effects. Physician #400 was notified with a new order dated 05/07/24 for a psychiatric evaluation. Resident #03's care plan was updated by Regional Minimum Data Set Registered Nurse (RMDSRN) #49 on 05/07/24 with interventions for maintaining safety, a room change, and psychosocial well-being intervention to allow resident time to answer questions and to verbalize feelings, perceptions, and fears as indicated.</p> <p>On 05/07/24, Resident #02's care plan was updated by RMDSRN #49 for sexually inappropriate behaviors with interventions including intervening as necessary to protect the rights and safety of others, divert attention and remove resident to alternative location as needed, and monitoring behavior episodes, determine cause, and document. Resident #02's intervention of one-to-one supervision was effective 05/06/24 pending psychiatric evaluation which is scheduled for 05/10/24. Resident #02's interventions include: psychiatric evaluation, one-to-one monitoring, urinalysis STAT (immediately) and urinalysis with culture and sensitivity ordered by Physician #400.</p> <p>On 05/07/24, RMDSRN #49 updated the care plan for Resident #21 identified with sexually inappropriate behavior.</p> <p>On 05/07/24, the DON and QARN #43 completed a facility-wide audit to ensure accuracy of residents at risk for abuse were safe with no issues. The DON to complete audits weekly during clinical rounds and morning clinical meetings.</p> <p>On 05/07/24, the facility immediately implemented the following measures to assure this alleged deficiency does not recur:</p> <ol style="list-style-type: none"> 1. On 05/07/24, the Administrator and DON provided the abuse policy education to all staff. <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of a nurse's note dated 04/29/24 at 8:28 P.M. revealed staff saw Resident #02 with his hands in Resident #03's pants. When Resident #02 saw staff, he quickly removed his hands and tried to move tables. When asked what was going on he said nothing. Resident #03 said Resident #02 was touching her private area. The residents were removed from around each other and asked to write statements. Resident #02 refused, saying he had not done anything he needs to write a statement for, so he was not going to write one. Residents separated from being on the same halls. Staff and residents asked to write statements. The residents' families, the unit manager, and the on-call administrator were contacted, awaiting a call back from the on-call.</p> <p>Review of a facility SRI dated 04/29/24 at 9:22 P.M. revealed on 04/29/24 around 8:20 P.M., Resident #02 was found to have his hand down Resident #03's pants outside of the pull up brief, as both were sitting in the dining room. Both residents had impaired cognition. Resident #02 stated he did not do anything, and Resident #03 stated he was touching her private area.</p> <p>Review of a staff statement dated 04/29/24 by STNA #161 revealed she walked into the dining area and caught Resident #02 with his hands on Resident #03's private area. As soon as the residents were asked what they were doing, Resident #02 moved. Resident #03 was redirected to the nurse's station. Resident #03 stated Resident #02 was touching her private area.</p> <p>Review of a staff statement dated 04/29/24 by LPN #250 revealed staff reported around 7:40 P.M. they observed Resident #02 with his hands down Resident #03's pants. Resident #03 reported to LPN #250 that Resident #02 had touched her private area and she had not told him that was okay. Resident #02 told LPN #250 he had not done anything. Resident #03 was shaking and looked scared and sat with staff until she calmed down. Resident #03's room was moved.</p> <p>Review of a nurse's note dated 04/30/24 at 6:37 A.M. revealed Resident #02 was wandering the hallways attempting to go inside resident rooms. Staff redirected the resident throughout the night.</p> <p>Review of a nurse's note dated 04/30/24 at 9:18 P.M. revealed a police officer arrived and asked to speak with Resident #02 about a situation that occurred yesterday between him and another resident. Resident #02 agreed to speak with the officer, and they spoke privately. The police officer stated Resident #02 had not remembered anything happening.</p> <p>Review of a nurses note dated 05/06/24 at 12:03 P.M. revealed Nurse Practitioner (NP) #50 was informed of Resident #02 being placed on one-on-one monitoring due to increased inappropriate behaviors. No new orders at this time.</p> <p>Review of the medical record for Resident #03 revealed an admitted [DATE]. Diagnoses included schizoaffective disorder, bipolar disorder, chronic kidney disease stage three, anxiety, major depressive disorder, type two diabetes mellitus, borderline intellectual functioning, obsessive compulsive disorder, and bilateral conductive hearing loss.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed the resident had impaired cognition. Resident #03 required supervision with transfers and ambulation.</p> <p>Review of the nurse's notes for Resident #03 revealed there was no nursing documentation of the incident with Resident #02 on 04/26/24.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of a nurses note dated 04/29/24 at 8:20 P.M. revealed staff walked into the dining room and Resident #02's hands were down Resident #03's pants. Resident #03 stated the resident was touching her private area. All staff and residents were asked to make a statement. The resident's families were notified, and the on-call administrator was notified. Resident #02 and Resident #03 were separated. Resident #03 was moved to a room on another hall.</p> <p>Review of a nurse's note dated 04/30/24 at 9:05 P.M. revealed the police talked to Resident #03 about the incident yesterday and over the weekend with Resident #02. The nurse went with the officer to talk to the resident. Resident #03 told the police officer, the man put his hands down her pants and touched her and she asked him to stop. Resident #03 stated the man also pulled out his penis and asked her to touch it and she said no.</p> <p>Review of a police report revealed on 04/20/24 at 8:12 P.M., an employee from the facility called the police anonymously fearing retaliation from the facility. The anonymous employee reported on 04/25/24, Resident #02 placed his genitals in Resident #03's face in an attempt for oral sex while in the common area. The anonymous employee revealed no interventions were put in place and Resident #02 resided across the hall from Resident #03. The anonymous employee reported on 04/29/24 Resident #02 was caught by staff with his hand down Resident #03's pants and Resident #03 was anxious and upset. The anonymous employee reported the Director of Nursing was on vacation and the Assistant Director of Nursing called off today due to this incident believing she was attempting to sweep this incident under the rug. Further review of the police report revealed the officer responded to the facility and Licensed Practical Nurse (LPN) #250 was on duty. LPN #250 advised Resident #02 had displayed his genitals to multiple people at different occasions. LPN #250 reported Resident #03's room had been moved and she appeared upset. Resident #03 confirmed to Officer #77 she had not provided consent for Resident #02 to touch her, but he had placed his hands down her pants but had not penetrated her. Officer #77 also spoke with Resident #02 who was unsure what the officer was talking</p> <p>about. LPN #250 reported to Officer #77 that she believed Resident #02 knew what the officer was talking about.</p> <p>Review of a skin assessment dated [DATE] at 6:38 P.M. revealed the resident had no skin issues prior to the incident with Resident #02. Review of a skin assessment dated [DATE] at 2:46 P.M. revealed the resident had a rash to the bilateral lower legs and the top of the bilateral feet and a scab on the right scapula.</p> <p>Review of Resident #03's care plan revealed no psychosocial interventions had been initiated related to the incidents with Resident #02. Further review of the care plan revealed the resident was independent for meeting emotional, intellectual, physical, and social needs. The resident enjoyed puzzles, playing cards, reading, gardening, bingo and snack time. The resident had a membership at the YMCA for exercise and socialization.</p> <p>Further review of Resident #03's nurses notes from 02/01/24 through 05/06/24 revealed the resident used to participate in activities such socializing with other residents and playing cards, and since the incidents with Resident #02 there was documentation, the resident had only participated in one activity on 05/01/24.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observations on 05/06/24 at 8:22 A.M. revealed Resident #03 was in bed with her eyes closed. Observation on 10:23 A.M. revealed Resident #03 was in her room in bed. Observation on 05/06/24 at 2:41 P.M. revealed Resident #03 remained in her room in bed. Observation on 05/06/24 at 5:27 P.M. revealed the resident was eating dinner in her room. There were no observations of Resident #03 outside her room on 05/06/24.</p> <p>Interview on 05/06/24 at 9:05 A.M., Resident #02 denied exposing himself or touching another resident.</p> <p>Interview on 05/06/24 at 10:23 A.M., Resident #03 stated she had not wanted to talk about the incident with Resident #02. Resident #03 revealed she was scared to come out of her room, had not wanted to go to activities and had not wanted to go to the dining room. Further interview on 05/07/24 at 3:33 P.M., Resident #03 stated Resident #02 touched her skin under her brief in her private area and she told him to stop. Resident #03 looked fearful as she stated she was upset and scared of Resident #02.</p> <p>Interview on 05/06/24 at 11:03 A.M., the DON stated she was not notified of anything that happened over the weekend prior to the incident on 04/26/24 regarding Resident #02 and Resident #03. The DON verified no SRIs were submitted regarding the incidents with Resident #02, Resident #03, and Resident #21 that occurred on 04/26/24. Further interview at 3:19 P.M., the DON verified no resident interviews or skin assessments on cognitively impaired residents were completed for the incidents on 04/26/24. The DON revealed the nurses had not completed incident reports for the two incidents on 04/26/24 and the incident on 04/29/24. The DON</p> <p>revealed Resident #02, Resident #21, and Resident #03 were not followed up with after the incidents by the social worker because the social worker had resigned a week prior. The DON revealed the affected residents also had not been assessed by psychiatry since the incidents occurred. The DON believed the incident with Resident #21 and Resident #02 was an over exaggeration and nothing actually happened. The DON revealed a urinalysis was ordered for Resident #02, but he had refused. The DON revealed there were no further interventions put in place except increased monitoring. The DON revealed a skin check on Resident #03 was completed just before the incident on 04/29/24 and the resident's skin was not checked again until a routine weekly skin assessment was completed on 05/06/24. The DON revealed she was unaware if staff had notified the police regarding the incident between Resident #02 and Resident #21 on 04/26/24. Interview on 05/06/24 at 4:10 P.M., the DON revealed she had no witness statements for the incident a nursing assistant alleged had occurred around 04/20/24. The DON revealed Resident #02's sexual behaviors had not been reported to her until 04/26/24.</p> <p>Interview on 05/06/24 at 1:24 P.M., STNA #112 revealed around 04/20/24, she witnessed Resident #02 exposing himself to Resident #03. STNA #112 said she reported the incident to the nurse she thought was RN #200 or maybe another nurse. STNA #112 revealed she had heard of other times Resident #02 had been sexually inappropriate on night shift. STNA #112 revealed Resident #03 was no longer coming out of her room because she was just leery about it. STNA #112 revealed Resident #03 also does not participate in activities like she used to.</p> <p>Interview on 05/06/24 at 1:37 P.M., Resident #21 was confused, not oriented to date, time, or location. Resident #21 revealed another resident had exposed himself to her but was unable to name the resident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 05/06/24 at 1:46 P.M., STNA #161 revealed she witnessed Resident #02 touch Resident #03. STNA #161 revealed she had not asked the resident what happened. STNA #161 thought Resident #02 had touched Resident #03 on the outside of her pants. STNA #161 revealed she reported the incident to LPN #250.</p> <p>Interview on 05/06/24 at 2:01 P.M., LPN #250 revealed she worked on 04/29/24. LPN #250 revealed Resident #02 put his hands down Resident #03's pants. LPN #250 revealed she had not notified law enforcement. LPN #250 revealed there was no instructions from management except to move Resident #03 to a different room. LPN #250 revealed the resident later told the police Resident #02 had touched the skin in her private area. LPN #250 revealed she had not completed a skin assessment on Resident #03. LPN #250 revealed Resident #03 was really upset and shaking and wanted to stay at the nurse's station with the nurse. LPN #250 further revealed the following day the resident would not leave her room. LPN #250 revealed she was not aware of the previous incidents with Resident #02 exposing himself to Resident #03 and Resident #21 until she went to put in a nurse's note for Resident #03. LPN #250 confirmed there were no interventions in place for Resident #02 after the incidents.</p> <p>Interview on 05/06/24 at 2:32 P.M. with Resident #03's Family Member (FM) #500 revealed the facility notified her of the incident but the Administrator was supposed to call her back and had not. FM #500 revealed it was not Resident #03's normal behavior to stay in her room. FM #500 revealed she had not visited the resident since the incident occurred. FM #500 revealed Resident #03 liked to sleep longer in the morning, then have lunch and dinner in the dining room. FM #500 revealed the resident liked to go to bible study, play cards, bingo, and be social with other residents.</p> <p>Interview on 05/07/24 at 7:34 A.M., ADON #55 revealed staff witnessed inappropriate sexual behavior when Resident #02 had his hand in the pants of Resident #03. ADON #55 revealed she instructed the staff to get statements from other residents in the dining room, notify the family, the physician and to move Resident #03. ADON #55 revealed she called and notified the DON. ADON #55 revealed prior to this incident Resident #02 had sexual behaviors with Resident #21. ADON #55 revealed staff were also instructed to get statements regarding the incident. ADON #55 revealed Resident #02 and Resident #21's rooms were not near each other. ADON #55 revealed no other interventions were put in place. ADON #55 revealed the DON thought the sexual behavior between Resident #21 and Resident #02 was consensual. ADON #55 revealed per nursing judgement Resident #21 was not alert and oriented enough to provide consent as she had a significant decline since admission due to her condition.</p> <p>Interview on 05/07/24 at 8:05 A.M., RN #200 revealed she received in report from the prior shift nurse on 04/26/24 that Resident #02 was having sexual behaviors toward Resident #21. RN #200 revealed she notified hospice. RN #200 revealed Resident #21 was often confused and thought RN #200 was her daughter. RN #200 revealed Resident #21 was not aware of what was going on around her most of the time.</p> <p>Interview on 05/07/24 at 9:44 A.M., Nurse Practitioner (NP) #50 revealed she briefly talked to Resident #02 and Resident #03 after the incident on 04/29/24. NP #50 revealed she had not completed a skin assessment of Resident #03's perineal area. NP #50 further revealed neither resident recalled the incident. NP #50 verified she had not documented the encounter with the two residents. NP #50 revealed she gave an order on 05/06/24 for a psychiatric consult for Resident #02 and an order for one-on-one monitoring for Resident #02.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 05/07/24 at 10:47 A.M., the DON stated the resident should have been placed on one-on-one after the incident with Resident #03. The DON stated psychiatric services had been contacted to see both residents.</p> <p>Interview on 05/07/24 at 12:13 P.M., LPN #230 revealed on 04/26/24 two housekeepers came and got her saying Resident #02 had exposed himself to Resident #03. LPN #230 revealed she asked Resident #03 if Resident #02 had exposed himself, and Resident #03 said yes. LPN #230 revealed Resident #02 denied the incident. LPN #230 revealed the DON and Administrator were in the office building next door. LPN #230 revealed texting the DON. LPN #230 revealed the DON asked her if Resident #21 was also out there because there was some kind of interaction</p> <p>with them the day prior. LPN #230 stated she gathered handwritten staff statements and put them in the DON's mailbox. LPN #230 revealed when she arrived at work on 04/26/24 and during report with the previous shift's nurse, she was informed Resident #02 had previous sexual behavior with Resident #21. LPN #230 revealed she put in a nurse's note regarding the incident, but the DON told her to cross out her nurse's note as nothing had happened.</p> <p>Interview on 05/07/24 at 2:55 P.M., Housekeeping Supervisor (HS) #70 revealed on 04/26/24 she was at the closet near the dining room with Housekeeper (HSKP) #71 who was looking into the dining room and watched Resident #02 undo his robe and undo his pants in front of Resident #03. HS #70 revealed they removed Resident #03 from the dining room. Resident #03 revealed Resident #02 had exposed himself to her. HS #70 revealed the incident was reported to the nurse. HS #70 revealed in the morning prior to this incident she heard Resident #02 had also been sexually inappropriate with Resident #21 in the dining room.</p> <p>Interview on 05/07/24 at 3:24 P.M., RN #200 revealed they were finally able to get Resident #03 to leave her room today. RN #200 revealed a reasonable person would not want another resident exposing themselves or touching themselves inappropriately. RN #200 revealed no staff had reported to her any incident between Resident #02 and Resident #03 occurring around 04/20/24.</p> <p>Interview on 05/07/24 at 3:27 P.M., STNA #160 revealed as a reasonable person she would feel traumatized, shocked, and humiliated if someone exposed themselves or put their hands down her pants.</p> <p>Interview on 05/07/24 at 3:29 P.M., STNA #161 revealed as a reasonable person she would be traumatized and humiliated if a man exposed himself to her or put his hands down her pants. STNA #160 stated Resident #02's behavior shocked her.</p> <p>Interview on 05/07/24 at 4:16 P.M., LPN #240 revealed on 04/26/24, she went to give Resident #21 medications in the dining room. LPN #240 revealed Resident #02 was on the left side of Resident #21 with his pants undone and was trying to put his genitals back in his pants. LPN #240 revealed Resident #21 stated being naughty when asked what they were doing. LPN #240 revealed Resident #02 and Resident #21 were separated. LPN #240 stated she kept Resident #21 by the nurse's station. LPN #240 revealed a nursing assistant would check on Resident #02 when completing rounds. LPN #240 was not aware of any interventions put in place for Resident #02. LPN #240 stated she was instructed by ADON #55 to get witness statements. LPN #240 stated she got witness statements from herself and two nursing assistants and placed them in the DON's mailbox.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 05/07/24 at 5:19 P.M., the DON revealed she was unable to locate the original written statements for the incident on 04/26/24 with Resident #02 and Resident #21.</p> <p>Interview on 05/07/24 at 5:42 P.M., Law Enforcement Officer (Officer) #77 revealed he gathered from his interviews that on 04/29/24, Resident #02 had placed his hands down Resident #03's pants but had not penetrated. Officer #77 revealed prior to this incident Resident #02 had exposed his genitals to the face of Resident #03 and Resident #21. Officer #77 revealed when he spoke with Resident #03 on 04/30/24, the resident was shaking and scared. Officer #77 revealed Resident #02 seems to know nothing about the incident.</p> <p>Interview on 05/08/24 at 7:51 A.M., HSKP #71 revealed on 04/26/24 Resident #03 was in the dining room as was Resident #02. HSKP #71 revealed Resident #02 got up in front of Resident #03 and opened his robe and undid his pants. HSKP #71 revealed she went and removed Resident #03 and the resident told her Resident #02 had shown her his private area.</p> <p>Review of the policy, Residents Rights to Freedom for Abuse, Neglect, and Exploitation Policy and Procedure, dated 2020, revealed the facility would ensure residents were free from abuse, neglect, misappropriation of their property, and exploitation.</p> <p>Review of the policy, Abuse Investigation and Reporting, revised 07/2017, revealed the Administrator would ensure that any further potential abuse, neglect, exploitation, or mistreatment would be prevented.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153518.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033</p> <p>Based on review of Self-Reported Incidents (SRIs), review of the medical record, interview, and policy review, the facility failed to report allegations of sexual abuse. This affected three (Residents #21, #02, #03) of four residents reviewed for abuse. The facility census was 28.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #21 revealed an admitted [DATE]. Diagnoses included malignant neoplasm of left breast, secondary malignant neoplasm of brain, secondary neoplasm of right lung, chronic obstructive pulmonary disease, bipolar disorder, anxiety disorder, and type two diabetes mellitus.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident was not ambulating.</p> <p>Review of the plan of care initiated 04/04/24 for Resident #21 revealed the resident had a behavior problem fidgeting with medical equipment and sexually inappropriate comments related to cognitive decline and confusion. Interventions included administering medications as ordered and monitoring of behavior episodes and attempting to determine underlying cause.</p> <p>Review of physician orders dated 03/30/24 revealed the resident was admitted to hospice for a terminal diagnosis of malignant neoplasm of breast.</p> <p>Review of a nurse's note dated 04/26/24 at 12:28 A.M. revealed the nurse walked into dining areas to give the resident medication and Resident #02 was standing to the left of the resident with his pants unfastened trying to put his genitals back in his pants. The nurse came around to the right side of the resident and asked what they were doing and Resident #21 stated, being naughty. The residents were separated and notification was made to the assistant director of nursing.</p> <p>2. Review of the medical record for Resident #02 revealed an admitted [DATE]. Diagnoses included dementia, hypertension, benign prostatic hyperplasia, and chronic kidney disease.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed the resident had impaired cognition. The resident was independent with transfers and ambulation.</p> <p>Review of a nurse's note dated 04/26/24 at 12:16 A.M. revealed the nurse went to administer medication for Resident #21 and Resident #02 was standing to the left of the resident with his pants unfastened trying to put his genitals back in his pants. When asked, Resident #21 stated they were being naughty. The residents were separated and notification was made to the assistant director of nursing.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a crossed-out nurse's note dated 04/26/24 at 12:56 P.M. revealed LPN #230 was approached by staff stating the resident exposed himself to Resident #03, a female resident. Resident #03 confirmed Resident #02 had exposed himself to her in the dining room. Resident #02 was asked if he exposed himself and he stated that he had not. The DON was notified.</p> <p>3. Review of the medical record for Resident #03 revealed an admitted [DATE]. Diagnoses included schizoaffective disorder, bipolar disorder, chronic kidney disease stage three, anxiety, major depressive disorder, type two diabetes mellitus, borderline intellectual functioning, obsessive compulsive disorder, and bilateral conductive hearing loss.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed the resident had impaired cognition. Resident #03 required supervision with transfers and ambulation.</p> <p>Review of the nurse's notes for Resident #03 revealed there was no nursing documentation of the incident with Resident #02 on 04/26/24.</p> <p>Review of the facility's Self-Reported Incidents (SRIs) revealed the incidents on 04/26/24 between Resident #21 Resident #02 and Resident #03 and Resident #02 had not been reported.</p> <p>Interview on 05/06/24 at 9:05 A.M., Resident #02 denied exposing himself and denied touching another female resident.</p> <p>Interview on 05/06/24 at 1:37 P.M., Resident #21 was not aware of the current date, current time, or current location. The resident stated another resident had exposed himself to her but she could not recall the name of the resident.</p> <p>Interview on 05/07/24 at 11:03 A.M., the Director of Nursing (DON) revealed the incident with Resident #21 was blown out of proportion by an agency nurse. The DON verified SRIs were not filed with the state agency for the incidents on 04/26/24 with Resident #02 and Resident #03 and Resident #03 and Resident #21. The DON verified SRIs should have been filed due to the information provided at the time of the incident. The DON verified the incident was not investigated until beginning on 05/06/24 when she began gathering statements.</p> <p>Interview on 05/07/24 at 12:13 P.M., Licensed Practical Nurse (LPN) #230 revealed on 04/26/24 two housekeepers came and got her saying Resident #02 had exposed himself to Resident #03. LPN #230 revealed she asked Resident #03 if Resident #02 had exposed himself and Resident #03 said yes. LPN #230 revealed Resident #02 denied the incident. LPN #230 revealed the DON and Administrator were in the office building next door. LPN #230 revealed texting the DON. LPN #230 revealed the DON asked her if Resident #21 was also out there because there was some kind of interaction with them the day prior. LPN #230 stated she gathered handwritten staff statements and put them in the DON's mailbox. LPN #230 revealed when she arrived at work on 04/26/24, during report with the previous shift's nurse she was informed Resident #02 had a previous sexual behavior with Resident #21. LPN #230 revealed she put in a nurse's note regarding the incident but the DON told her to cross out her nurse's note as nothing had happened.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/07/24 at 2:55 P.M. Housekeeping Supervisor (HSKP) #70 revealed on 04/26/24 she was at the closet near the dining room with HSKP #71 who was looking into the dining room and watched Resident #02 undo his robe and undo his pants in front of Resident #03. HSKP #70 revealed they removed Resident #03 from the dining room. Resident #03 revealed Resident #02 had exposed himself to her. HSKP #70 revealed the incident was reported to the nurse. HSKP #70 revealed in the morning prior to this incident she heard Resident #02 had also been sexually inappropriate with Resident #21 in the dining room.</p> <p>Interview on 05/08/24 at 7:51 A.M., HSKP #71 revealed on 04/26/24 Resident #03 was in the dining room as was Resident #02. HSKP #71 revealed Resident #02 got up and in front of Resident #03 and opened his robe and undid his pants, exposing himself. HSKP #71 revealed she went and removed Resident #03 and the resident told her Resident #02 had shown her his private area.</p> <p>Interview on 05/07/24 at 4:16 P.M., LPN #240 revealed on 04/26/24 she went to give Resident #21 medications in the dining room. LPN #240 revealed Resident #02 was on the left side of Resident #21 with his pants undone and was trying to put his genitals back in his pants. LPN #240 revealed Resident #21 stated being naughty when asked what they were doing. LPN #240 revealed Resident #02 and Resident #21 were separated. LPN #240 stated she kept Resident #21 by the nurse's station. LPN #240 revealed a nursing assistant would check on Resident #02 when completing rounds. LPN #240 was not aware of any interventions put in place for Resident #02. LPN #240 stated she was instructed by the Assistant Director of Nursing to get witness statements. LPN #240 stated she got witness statements from herself and two nursing assistants and placed them in the DON's mailbox.</p> <p>Review of the policy, Abuse Investigation and Reporting, last revised 07/2017 revealed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management. Findings of abuse investigation would also be reported.</p> <p>This was an incidental finding found over the course of the complaint investigation.</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033</p> <p>Based on review of the medical record, observation, interview, and policy review, the facility failed to ensure nutritional supplements were provided per physician orders. This affected two (#25, #19) of three residents reviewed for nutrition. The facility census was 28.</p> <p>Findings include</p> <p>1. Review of the medical record for Resident #25 revealed an admitted [DATE]. Diagnoses included bipolar disorder, dementia, diabetes mellitus type two, protein calorie malnutrition, chronic kidney disease, and hypertension.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment, required set up assistance for meals, and had significant weight loss of five percent in one month or ten percent in six months.</p> <p>Review of the physician orders for Resident #25 revealed orders dated 08/23/22 for a regular diet, with regular texture and thin liquids. On 01/16/24, the resident was ordered a house shake twice daily related to protein-calorie malnutrition. On 03/29/24, the resident was ordered a magic cup nutritional supplement with meals.</p> <p>Review of the care plan revealed the resident had potential for nutritional problems related to advanced age, low BMI, significant weight loss, no teeth, weight fluctuations related to fluid shifts. The resident was noted with eating behaviors with many food preferences. The resident's family provided food weekly. Interventions included administering medication as ordered, provide, and serve supplements as ordered, serve diet as ordered and record intakes, dietician to evaluate and make diet changes recommendations as needed.</p> <p>Review of the Medication Administration Record (MAR) revealed the resident had varied supplement intakes.</p> <p>Observation on 05/06/24 at 12:05 P.M. revealed Resident #25 was in the dining room eating noodles for lunch. The resident was not provided the magic cup nutritional supplement as ordered.</p> <p>Interview on 05/06/24 at 12:10 P.M., Dietary Staff (DS) #100 verified the resident was not provided the magic cup and proceeded to get the resident a magic cup.</p> <p>2. Review of the medical record for Resident #19 revealed an admitted [DATE]. Diagnoses included schizophrenia, adult failure to thrive, severe protein-calorie malnutrition, cachexia, anemia, history of malignant neoplasm of stomach and esophagus with history of partial stomach removal.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition. The resident was independent with eating meals. The resident had significant weight loss of five percent in the last month or ten percent in the last six months.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the physician orders revealed on 10/27/23 the resident was ordered a regular diet with regular texture and thin liquids. On 01/03/24, the resident was ordered a house shake three times a day for nutritional support, may have with meals. On 04/12/24, the resident was ordered megestrol acetate suspension 800 milligrams/20 milliliters twice daily for poor appetite related to adult failure to thrive and cachexia.</p> <p>Review of the care plan revealed the resident had potential for alteration in nutrition and hydration related to history of stomach cancer, partial stomach removal, history of protein calorie malnutrition, low body weight, history of fear of food and eating. Interventions included to encourage family to bring in favorite foods, honor food preferences, monitor intake, and provide supplements as ordered.</p> <p>Observation on 05/06/24 from 8:22 A.M. through 8:53 A.M. revealed the resident was not provided the nutritional shake supplement.</p> <p>Interview on 05/06/24 at 8:55 A.M., Registered Nurse (RN) #200 verified the resident was not provided the nutritional supplement and notified dietary staff who then provided the nutritional supplement for the resident.</p> <p>Review of the policy, Food and Nutrition Services, last revised 10/2017, revealed food and nutrition services staff would inspect food trays to ensure the correct meal was provided to each resident.</p> <p>This was an incidental finding found over the course of the complaint investigation.</p>		

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033</p> <p>Based on review of the medical record, review of nurse practitioner progress notes and physician progress notes, interview, and policy review, the facility failed to ensure the physician and nurse practitioner were alternating resident visits. This affected five (#17, #19, #03, #02, #11) of six residents reviewed for physician visits. The facility census was 28.</p> <p>Findings include</p> <p>1. Review of the medical records revealed Resident #17 had an admitted [DATE]. Diagnoses included dementia, diabetes mellitus type two, epilepsy, hypertension, depressive disorder, and anxiety.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition.</p> <p>Review of the Nurse Practitioner (NP) progress notes revealed the NP had visits with the resident on 02/21/23, 03/09/23, 04/11/23, 05/02/23, 05/04/23, 06/01/23, 07/07/23, 08/10/23, 08/24/23, 09/07/23, 10/12/23, 11/16/23, 12/07/23, 01/04/23, 03/14/23, 04/04/24, and 05/01/24. The NP electronically signed each progress note.</p> <p>Review of the physician progress notes revealed there was only one signed physician progress note dated 02/08/24 during the timeframe of 02/21/23 through 05/01/24.</p> <p>2. Review of the medical record for Resident #19 revealed an admitted [DATE]. Diagnoses included schizophrenia, protein-calorie malnutrition, cachexia, anemia, and a history of malignant neoplasm of the stomach and esophagus.</p> <p>Review of the quarterly MDS assessment revealed Resident #19 had impaired cognition.</p> <p>Review of the NP progress notes revealed the NP had visited Resident #19 on 11/02/23, 11/09/23, 11/16/23, 11/22/23, 11/30/23, 12/07/23, 01/11/24, 01/25/24, 02/15/24, 02/22/24, 03/07/24, 04/04/24, 04/11/24, 04/25/24. The NP electronically signed each progress note.</p> <p>Review of the physician progress notes revealed there was only one signed physician progress note dated 10/28/23 from 10/28/23 through 04/25/24.</p> <p>3. Review of the medical record for Resident #03 revealed an admitted [DATE]. Diagnoses included schizoaffective disorder, bipolar disorder, chronic kidney disease, anxiety, major depressive disorder, type two diabetes mellitus, and borderline intellectual functioning.</p> <p>Review of the quarterly MDS dated [DATE] revealed Resident #03 had impaired cognition.</p> <p>Review of the NP progress notes revealed a NP had visited Resident #03 on 02/09/23, 03/07/23, 03/23/23, 04/04/23, 05/02/23, 06/01/23, 06/13/23, 08/04/23, 09/07/23, 09/14/23, 10/12/23, 11/02/23, 12/14/23, 01/18/24, 03/14/24, 04/04/24, and 04/25/24. The NP electronically signed each note.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366081	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER Parkview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1406 Oak Harbor Rd Fremont, OH 43420	
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 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the physician progress notes revealed there was only one signed physician progress note dated 02/01/24 from 02/09/23 through 04/25/24.</p> <p>4. Review of the medical record for Resident #02 revealed an admitted d of 07/15/22. Diagnoses included chronic obstructive pulmonary disease, dementia, hypertension, and chronic kidney disease.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed the resident had impaired cognition.</p> <p>Review of the NP progress notes revealed a NP had visited Resident #02 on 02/21/23, 04/13/23, 05/02/23, 06/06/23, 07/11/23, 08/03/23, 08/17/23, 09/07/23, 09/14/23, 10/19/23, 11/16/23, 12/28/23, 01/11/24, 03/21/24 and 04/04/24. The NP electronically signed each note.</p> <p>Review of the physician progress notes revealed there was only one signed physician progress note dated 02/01/24 from 02/21/23 through 04/04/24.</p> <p>5. Review of the medical record for Resident #11 revealed an admitted [DATE]. Diagnoses included diabetes mellitus type two, schizoaffective disorder, chronic kidney disease, anxiety and depression.</p> <p>Review of the quarterly MDS completed on 03/15/24 revealed the resident had intact cognition.</p> <p>Review of the NP progress notes revealed a NP had visited Resident #11 on 03/14/23, 04/13/23, 04/18/23, 04/25/23, 05/18/23, 06/06/23, 06/23/23, 07/14/23, 07/25/23, 07/28/23, 08/10/23, 08/17/23, 10/05/23, 10/12/23, 11/30/23, 01/25/24, 03/14/24, 04/04/24, and 04/25/24. The NP had electronically signed each progress note.</p> <p>Review of the physician progress notes revealed there was only one signed physician progress note dated 04/04/23 from 03/14/23 through 04/25/24.</p> <p>Review of the NP notes for the residents revealed the NP writes on every note the resident was seen in collaboration with the physician.</p> <p>Interview on 05/08/24 at 8:31 A.M., Resident #11 revealed she had only seen the physician one time since she has been here.</p> <p>Interview on 05/08/24 at 2:12 P.M. the Director of Nursing (DON) verified there was one signed physician History and Physical (H&P) progress note for each of the five residents, indicating the physician and NP were not alternating visits.</p> <p>Review of the policy, Physician Services, last revised 04/2013, revealed the physician would visit the resident at appropriate intervals and ensure adequate alternative coverage.</p> <p>This was an incidental finding found over the course of the complaint investigation.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>35033</p> <p>Based of review of quarterly Quality Assessment and Assurance (QAA) meeting sign in sheets, interview, and policy review, the facility failed to ensure quarterly QAA meetings were completed as required. This had the potential to affect all residents. The facility census was 28.</p> <p>Findings include</p> <p>Review of the quarterly QAA meeting sign in sheets revealed the facility had no documentation a quarterly QAA meeting was held with all the required members for the second and third quarter of 2023.</p> <p>Interview on 05/08/24 at 1:10 P.M., the Director of Nursing (DON) verified there were no sign in sheets for the quarterly meetings for the second quarter and third quarter of 2023. The DON revealed a former administrator was in charge of the sign in sheets.</p> <p>Review of the policy, Quality Assurance and Performance Improvement (QAPI), dated 2024, revealed the QAA committee would meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program.</p> <p>This was an incidental finding found over the course of the complaint investigation.</p>