

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  10/30/2024
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816</b></p> <p>Based on observation, and staff interview the facility failed to ensure resident heating and air conditioning equipment was operational inside resident rooms. This affected one (Resident #2) of four residents reviewed for environmental heating, ventilation and cooling in the facility. The total facility was census of 34.</p> <p>Findings include:</p> <p>Resident #2 admitted to the facility on [DATE] with the diagnoses including Alzheimer's disease, multiple sclerosis, dementia, mood disturbance, anxiety disorder, and hypertension. According to the minimum data set assessment dated [DATE] Resident #2 was assessed with intact cognition, required supervision and touch assistance with activities of daily living and utilized a wheelchair for mobility.</p> <p>Review of facility census information Resident #2 was moved to the current room on 09/03/24.</p> <p>According to physician orders on 10/21/24 Resident #2 was placed into SARS-CoV-2 (COVID-19) COVID isolation.</p> <p>Observation on 10/29/24 at 11:40 A.M. located Resident #2 inside a single occupancy room with the door closed. The ambient air temperature was recorded at 72 degrees Fahrenheit. Resident #2 was in bed covered with multiple blankets. No heating ventilation air conditioning (HVAC) duct work was installed inside the room. A Packaged Terminal Air Conditioner (PTAC) unit was identified as the single HVAC source. The PTAC unit was unplugged from the electrical outlet. Resident #2 stated heat and cooling was not operational since being placed into the room and at times requested additional blankets.</p> <p>On 10/29/24 at 1:10 P.M. interview with Maintenance Director (MD) #1 confirmed the PTAC unit inside Resident #2 room had not been operational for an undetermined time. The facility was attempting to obtain a replacement. MD #1 stated when room temperatures were obtained, readings included Resident #2 room and temperatures were recorded between 71-81 degrees Fahrenheit. MD#1 also verified Resident #2 would not be able to adjust the room temperature due to no additional source of heat or cooling installed inside the room.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 10/30/24 at 9:20 A.M. noted Resident #2 remained in the room. The PTAC unit remained unplugged from the electrical outlet. Resident #2's room temperature was recorded at 73.2 degrees Fahrenheit.</p> <p>On 10/30/24 at 9:27 A.M. interview with the Administrator in person and Maintenance Director #1 via phone confirmed Resident #2's room was noted to be equipped with a PTAC unit as the sole source of heating and cooling. Maintenance Director #1 was unable to indicated the period of time the PTAC unit was not operational. The Administrator also confirmed facility COVID-19 infection control protocol is to keep resident room doors closed when in isolation.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157897.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>15816</p> <p>Based on observation, and staff interview the facility failed to maintain medical equipment and supplies in a sanitary manner. This affected all 34 residents residing in the facility.</p> <p>Findings include:</p> <p>On 10/29/24 at 7:50 A.M. observation with Maintenance Director #1 during tour of the facility medical supply rooms located in the facility basement discovered the following:</p> <ol style="list-style-type: none"> <li>1. Small medical storage room identified an open box containing 16 indwelling urinary catheter insertion trays soiled with a brown substance. Posted on the exterior of the catheter tray noted the instruction, Warning Avoid storage in direct sunlight/florescent lighting and keep area cool, dry, and well ventilated. Contents STERILE in unopened, undamaged package.</li> <li>2. Small medical storage room noted a closed case of tracheostomy care kits containing 20 kits. The box was discovered with a yellow brown substance and moisture stain penetrating the box.</li> <li>3. Located inside the large medical storage room noted heavy amount of debris on the floor including individual packages of incontinence briefs, open SARS-CoV-2 (COVID-19) test kits, specimen sample containers, wound treatment dressing packages.</li> <li>4. Observation of large storage room shelving discovered individual boxes of latex exam/surgical/treatment gloves. Count revealed 96 boxes of medium latex gloves were fused together due to moisture infiltration.</li> </ol> <p>On 10/29/24 at 7:58 A.M. interview with Licensed Practical Nurse (LPN) #200 revealed nursing staff currently utilize the medical storage supplies located in the two basement medical storage rooms.</p> <p>On 10/29/24 at 8:25 A.M. interview with the Director of Nursing (DON) during tour of the two medical storage rooms confirmed the soiled and compromised medical supplies. DON confirmed no current procedure or policy was in place to ensure medical supplies were maintained and stored in a sanitary manner. The DON identified one resident (#3) with an indwelling urinary catheter and one resident (#4) with a tracheostomy.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157897.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>15816</p> <p>Based on observation, and staff interview the facility failed to ensure the physical environment was maintained free of damage or hazardous conditions. This affected one (Resident #1) of four residents rooms observed for environmental conditions in the facility. The total facility census was 34.</p> <p>Findings include:</p> <p>On 10/29/24 at 9:13 A.M. observation discovered Resident #1 in bed with the bed located next to an exterior window. The window fixture was equipped with a single pane glass storm window containing two windows. One window pane was broken with three fractures in the glass extending across the entire pane. No additional windows were installed in the fixture to prevent exterior air movement from entering the room. Further tour of the room noted three electrical receptacles with electronic devices plugged to the outlets. The outlets were discovered to be extremely loose in the electrical junction boxes. One of the three outlets were discovered to be dislodged with approximately a one foot diameter section of drywall broken way from the wall.</p> <p>On 10/30/24 at 2:25 P.M. observation with Maintenance Director #1 confirmed the broken window, loosely installed electrical outlets and broken drywall. Maintenance Director #1 stated he was unaware of the environmental concerns identified in Resident #1 room.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00158565 and Complaint Number OH00157897.</p>