STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366081	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Care Center	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of Minimum Data Set (MDS) admission assessments, staff interview, and policy review, the facility failed to ensure an admission MDS skin condition assessment was accurate. This affected one (#2) of three residents reviewed for MDS admission assessments. The facility census was 36. Findings include: Review of the medical record for Resident #2 revealed an admission date of 09/19/25. Diagnoses included surgical aftercare, colostomy status, pulmonary embolism, and malignant neoplasm of the colon. Review of the hospital documentation revealed upon discharge Resident #2 had a right buttock wound and a left buttock deep tissue injury. Review of the admission wound assessment dated [DATE] at 3:39 P.M., completed by the Director of Nursing (DON), revealed Resident #2 had a surgical incision to the abdomen and a stage two pressure ulcer of the left axilla. There was no documentation of wounds to the right or left buttock. Review of the admission MDS assessment dated [DATE] revealed the resident had intact cognition. Further review of Section M of the admission MDS revealed Resident #2 had one surgical wound, one stage two pressure ulcer, and one unstagable deep tissue injury. Interview on 10/08/25 at 11:26 A.M., MDS Registered Nurse (MDS) #264 verified Resident #2's admission skin assessment included a clinical assessment. MDS #264 revealed she had not assessed the resident. MDS #264 revealed she documented in Section M of the admission MDS the resident had a stage two pressure ulcer and a deep tissue injury. MDS #264 revealed this information was obtained from the hospital documentation. MDS #264 was asked what should be documented when the hospital documentation and the clinical assessment were not in agreement. MDS #264 revealed she was unsure what should have been documented as she was still in training. Observation on 10/08/25 at 1:06 P.M. of Resident #2 with the DON revealed the resident had a surgical wound to the abdomen and a scabbed area to the left axilla. Further observation revealed the resident had no pressure areas on the bilateral buttocks. Interview on 10/08/25 at 1:06 P.M., the DON verified completing the resident's admission wound assessment. The DON revealed the resident had no pressure ulcer or deep tissue injury to the bilateral buttocks upon admission. Interview on 10/08/25 at 2:52 P. M., Regional MDS Nurse #266 revealed Resident #2's admission MDS assessment was incorrect and the discrepancy between the hospital documentation and the clinical assessment should have been addressed prior to completing Section M. Regional MDS Nurse #266 revealed a modification of the admission assessment would be completed. Review of the facility policy titled Resident Assessments, revised 11/2019, revealed all members of the care team would be asked to participate in the resident assessment process. The resident assessment coordinator was responsible for ensuring the interdisciplinary team conducts timely and appropriate resident assessments and reviews.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, resident interview, staff interview, and policy review, the facility failed to ensure colostomy drainage bag changes were completed per physician orders. This affected one (#2) of two residents reviewed for ostomy care. The facility identified two residents with colostomies. The facility census was 36.Findings include: Review of the medical record for Resident #2 revealed an admission date of 09/19/25. Diagnoses included surgical aftercare, colostomy status, pulmonary embolism, and malignant neoplasm of the colon. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Review of the physician orders dated 09/19/25 revealed an order to change ostomy bag every three days and as needed. Review of the treatment administration record from 09/19/25 through 10/08/25 revealed no documentation Resident #2's colostomy bag changes had been completed per physician orders. Interview on 10/08/25 8:17 A.M., Resident #2 revealed her colostomy bag had burst a couple times when she had rolled over in bed onto it. Resident #2 could not recall how often staff were changing the colostomy bag. Interview on 10/09/25 at 11:10 A.M., [NAME] President of Clinical Services (VPCS) #300 verified there was no documentation the resident's colostomy drainage bag had been changed every three days per physician orders. Interview on 10/09/25 at 1:38 P.M., the Director of Nursing (DON) revealed the order to change the colostomy bag appeared on the top of the treatment administration record but was not entered correctly so staff could not document when the bag changes had been completed. The DON verified there was no documentation the colostomy bag changes had been completed every three days and as needed per physician orders. Review of the facility policy Colostomy/Ileostomy Care, revised 10/2010, revealed staff would document the date and time the colostomy/ileostomy care was provided. This deficiency represents non-compliance investigated under Complaint Number 2627398.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of available facility medications, staff interview, and policy review, the facility failed to ensure a resident was free from a significant medication error. This affected one (#2) of three residents reviewed for medications. The facility census was 36. Findings include: Review of the medical record for Resident #2 revealed an admission date of 09/19/25. Diagnoses included surgical aftercare, colostomy status, pulmonary embolism, and malignant neoplasm of the colon. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Review of the hospital discharge physician orders revealed the resident had orders for apixaban five milligrams (mg) twice daily by mouth, dronabinol 2.5 mg capsule twice daily for 30 days, folic acid one mg daily in morning by mouth, and oxycodone five mg every eight hours as needed for pain for up to 15 doses. Review of the physician orders dated 09/19/25 revealed orders for apixaban five milligrams twice daily, dronabinol 2.5 mg twice daily for 30 days for nausea and vomiting, oxycodone 5 milligrams every eight hours as needed for pain, and folic acid one mg daily. Review of the medication administration records from 09/19/25 through 09/30/25 revealed the resident was not administered the apixaban five mg at night on 09/19/25 and 09/20/25. Review of the facility on-hand medications log revealed apixaban was available in the facility automated medication dispensing machine. Review of pharmacy receipt records revealed the resident's medications were delivered on 09/20/25.Interview on 10/08/25 at 10:22 A.M., Licensed Practical Nurse (LPN) #162 revealed Resident #2 admitted to the facility on [DATE] around 5:35 P.M. LPN #162 revealed she had assessed the resident but had not had time to enter her physician medication orders prior to the end of the shift.Interview on 10/08/25 at 11:09 A.M., the Director of Nursing (DON) revealed the resident had not received the evening dose of the apixaban on 09/19/25 and 09/20/25 and the physician was not notified. Interview on 10/08/25 at 1:59 P.M., LPN #174 revealed she told Resident #2 her medications probably would not arrive until the middle of the night. LPN #174 revealed she was the only nurse in the building on the 12-hour third shift and she was never provided authorized access to the automated medication dispensing machine to pull any medications for the resident. LPN #174 stated she had not notified the physician the medications would not be administered. Further interview on 10/08/25 at 3:12 P.M., the DON verified LPN #174 had not been authorized to pull medications from the automated medication machine. The DON revealed the nurse could have notified her and she would have came into the facility to get the medication for the resident. Interview on 10/08/25 at 1:35 P.M., LPN #160 verified apixaban was available in the automated medication distribution machine. Review of the facility policy titled Administering Oral Medications, revised 10/2010, revealed to administer medications per physician orders. There were no guidelines for notification of the physician for unavailable medications. This deficiency represents non-compliance investigated under Complaint Number 2627398.