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	11/20/2025

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of hospital records, staff interview, and review of facility policy, the facility failed to ensure physician orders were in place and care was provided for a peripherally inserted central catheter (PICC line - used for long term intravenous [IV] access). This affected one (#5) of one resident reviewed for PICC line care. The facility identified one resident with a PICC line. The facility census was 36. Findings include:Review of the medical record for Resident #5 revealed an admission of 07/31/25 and a readmission date of 09/28/25. Diagnoses included multiple sclerosis (MS), neuromuscular dysfunction of the bladder, and Crohn's disease of the large intestine.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had intact cognition and required staff assistance for Activities of Daily Living (ADLs).Review of a hospital After Visit Summary (AVS) dated 10/11/25 revealed Resident #5 was seen in the emergency room for painful urination and was given a diagnosis of urinary tract infection (UTI) without hematuria. A PICC line was placed in the upper left chest and a new order for vancomycin IV solution 1000 milligrams (mg) per 200 milliliters (ml), use 1000 mg IV every twelve hours for UTI for six days.Review of the care plan, revised on 11/12/25, revealed Resident #5 required the use of an IV for antibiotics. Interventions included administer antibiotics as ordered and monitor for adverse reactions, evaluate the site for leakage/bleeding/signs of infection, monitor dressing and change as ordered, and monitor tubing and change as ordered. Review of the October 2025 physician orders revealed no orders for monitoring, flushing, or dressing changes for Resident #5's PICC line until 10/26/25 (15 days after the PICC line was placed). Review of the Treatment Administration Record (TAR) for October 2025 revealed no evidence Resident #5's PICC line was flushed, monitored, or had dressing changes completed from 10/11/25 until 10/26/25. Interview on 11/19/25 at 9:18 A.M. with the Director of Nursing (DON) verified there were no orders from 10/11/25 until 10/26/25 for PICC line site dressing changes, monitoring of the site for bleeding/leakage/signs of infection every shift, and normal saline flushes every eight hours for line patency and before and after each medication dose and there should have been physician orders in place for the care of Resident #5's PICC line. Review of the facility policy titled, Peripheral and Midline IV Catheter Flushing and Locking, revised June 2025, revealed for short and long midline catheters used for intermittent infusions, flush the catheter and aspirate for blood return prior to each infusion and at least every 24 hours to assess catheter function, lock following each use. Document the procedure in the TAR, note location of catheter, condition of insertion site, and dressing in the nurse's notes. This was an incidental finding discovered during the complaint investigation.

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
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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of hospital records, staff interview, and review of the facility policy, the facility failed to ensure qualified staff were available to administer medication through a Peripherally Inserted Central Catheter (PICC) line. This affected one (#5) of one resident reviewed for intravenous (IV) medication administration. The facility identified one resident who receive IV medications. The facility census was 36. Findings include:Review of the medical record for Resident #5 revealed an admission of 07/31/25 and a readmission date of 09/28/25. Diagnoses included multiple sclerosis (MS), neuromuscular dysfunction of the bladder, and Crohn's disease of the large intestine.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had intact cognition and required staff assistance for Activities of Daily Living (ADLs).Review of a hospital After Visit Summary (AVS) dated 10/11/25 revealed Resident #5 was seen in the emergency room for painful urination and was given a diagnosis of urinary tract infection (UTI) without hematuria. A PICC line was placed in the upper left chest and a new order for vancomycin IV solution 1000 milligrams (mg) per 200 milliliters (ml), use 1000 mg IV every twelve hours for UTI for six days. Further review revealed vancomycin was administered in the hospital on [DATE] at 5:47 P. M.Review of the care plan, revised on 11/12/25, revealed Resident #5 required the use of an IV for antibiotics. Interventions included administer antibiotics as ordered and monitor for adverse reactions, evaluate the site for leakage/bleeding/signs of infection, monitor dressing and change as ordered, and monitor tubing and change as ordered. Review of a physician order, dated 10/11/25 at 10:20 P.M., revealed Resident #5 was ordered vancomycin IV solution 1000 mg/200 ml, give 1000mg intravenously every 12 hours for UTI for six days.Review of the pharmacy delivery receipt signed 10/12/25 at 5:30 A.M. revealed vancomycin 1 gram (gm) per 250 ml was delivered to the facility for Resident #5. Review of the Medication Administration Record (MAR) for October 2025 revealed vancomycin was not administered to Resident #5 until 10/13/25 at 9:00 A.M. Review of the nursing progress note dated 10/12/25 at 8:17 P.M. revealed the nurse informed the Director of Nursing (DON) and Assistant Director of Nursing (ADON) #400 that Resident #5 needed medication ran through a PICC line. The nurse was informed that it would not be able to be completed and was asked to call the doctor to hold the medication until 9:00 A.M. on 10/13/25. The doctor was called and stated he did not feel comfortable holding the medication due to it being ordered on 10/11/25. Further review revealed a nursing progress note dated 10/12/25 at 9:54 P.M. that stated vancomycin was not infused due to Resident #5 having a chest port (PICC line) and (the medication) needed to be ran by a Registered Nurse (RN). The DON and ADON were made aware of the situation and the on-call doctor did not give an order to hold the medication. Interview on 11/19/25 at 9:18 A.M. with the DON confirmed Resident #5's doses of vancomycin were not administered on 10/12/25 at 9:00 A.M. and 10/12/25 at 9:00 P. M. due to an RN not being available to initiate the medication. The DON stated the ADON was no longer employed at the facility and she was the only RN. Review of the facility policy titled, Administering Medications, revised April 2019, revealed staffing schedules were arranged to ensure that medication was administered without unnecessary interruptions. Medications were administered in accordance with prescriber orders, including any required time frame. This deficiency represents non-compliance investigated under Complaint Number 2641971.