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	12/23/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, and policy review, the facility failed to ensure a resident's representative was notified of changes in condition. This affected one (#31) of three residents reviewed for changes in condition. The facility census was 30. Findings include: Review of the medical record for Resident #31 revealed an admission dated of 11/11/25 and a discharge date d of 12/04/25. Diagnoses included acute respiratory failure with hypoxia, non-pressure chronic ulcer of buttock, adjustment disorder, vitamin D deficiency, muscle weakness, dysphagia, hypertension, pneumonia, Parkinson's disease, mass of right lung, and severe protein calorie malnutrition. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. The resident required set-up assistance for meals. The resident had no admission weight documented on the admission MDS assessment. Review of hospital documentation dated 10/30/25 through 11/10/25 revealed the resident reported a 45-pound weight loss in three months which was intentional. The resident's hospital weight on 11/11/25 was noted as 159 pounds. Review of a physician order dated 11/13/25 revealed an order for weekly weights for four weeks then complete monthly weights unless otherwise indicated. Review of the resident's weights and vitals summary revealed the resident's weight was not documented upon admission on [DATE]. On 11/19/25 the resident weighed 148 pounds. On 11/24/25 the resident weighed 145 pounds. There was no documentation of weights from 11/25/25 through discharge on [DATE]. Review of a dietary progress note dated 11/24/25 at 7:56 A.M., revealed the dietician was notified of the resident's weight loss. The resident was noted with meal intakes of 75 percent to 100 percent with an occasional meal intake of less than 75 percent. The dietician recommended a health shake and frozen nutritional supplement to increase the resident's protein and calories. Review of the physician orders dated 11/24/25 revealed the resident had orders for a house shake (nutritional supplement) twice daily, and a protein supplement 30 milliliters (ml) daily. Also, on 11/24/25 the resident received new orders to upgrade his diet from mechanical soft consistency to a regular diet with regular texture with nectar thickened fluids. There were no physician orders for the frozen nutritional supplement. Review of the nurses' notes revealed no documentation the resident's representative was notified of the weight loss, recommended interventions, and new physician orders. Interview on 12/23/25 at 12/23/25 at 6:17 A.M., Regional Clinical Registered Nurse (RCRN) #120 verified there was no documentation Resident #31's representative was notified of the resident's weight loss, and new dietary orders. Review of the facility policy Change in a Resident's Condition or Status, revised 02/2021, revealed the resident's representative would be notified of changes in the resident's physical condition and the need to alter the resident's medical treatment. This deficiency represents noncompliance investigated under Complaint Number 2677988.

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, and policy review, the facility failed to ensure resident weights were obtained per physician orders and failed to ensure monitoring of nutritional interventions. This affected one (#31) of three residents reviewed for nutrition. The facility census was 30. Findings include: Review of the medical record for Resident #31 revealed an admission dated of 11/11/25 and a discharge date d of 12/04/25. Diagnoses included acute respiratory failure with hypoxia, non-pressure chronic ulcer of buttock, adjustment disorder, vitamin D deficiency, muscle weakness, dysphagia, hypertension, pneumonia, Parkinson's disease, mass on right lung, and severe protein calorie malnutrition. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. The resident required set-up assistance for meals. The resident had no admission weight documented on the admission MDS assessment. Review of hospital documentation dated 10/30/25 through 11/10/25 revealed the resident reported a 45-pound weight loss in three months which was intentional. The resident's hospital weight on 11/11/25 was noted as 159 pounds. Review of a physician order dated 11/13/25 revealed an order for weekly weights for four weeks then complete monthly weights unless otherwise indicated. Review of the resident's weights and vitals summary revealed the resident's weight was not documented upon admission on [DATE]. On 11/19/25 the resident weighed 148 pounds. On 11/24/25 the resident weighed 145 pounds. There was no documentation of weights from 11/25/25 through discharge on [DATE]. Review of a dietary progress note dated 11/24/25 at 7:56 A.M., revealed the dietician was notified of the resident's weight loss. The resident was noted with meal intakes of 75 percent to 100 percent with an occasional meal intake of less than 75 percent. The dietician recommended a health shake and frozen nutritional supplement to increase the resident's protein and calories. Review of the physician orders dated 11/24/25 revealed the resident had orders for a house shake (nutritional supplement) twice daily, and a protein supplement 30 milliliters (ml) daily. Also, on 11/24/25 the resident received new orders to upgrade his diet from mechanical soft consistency to a regular diet with regular texture with nectar thickened fluids. There were no physician orders for the frozen nutritional supplement. Review of the Medication Administration Record (MAR) from 11/24/25 through 12/04/25 revealed the resident was administered the nutritional supplement and protein supplement per physician orders. There was no documentation the resident had been given the frozen nutritional supplement per the dietician recommendations. Interview on 12/23/25 at 6:17 A.M., Regional Clinical Registered Nurse (RCRN) #120 verified Resident #31's weight was not assessed upon admission. Further interview on 12/23/25 at 8:47 A.M., RCRN #120 revealed the frozen nutritional supplement had been added to the resident' meal ticket. RCRN #120 verified there was no documentation the frozen nutritional supplement had been received. RCRN #120 revealed going forward the Registered Dietitian would be required to notify her on all nutritional communications. Review of the facility policy Weight Assessment and Intervention, revised 03/2022, revealed resident weights would be monitored for undesirable or unintended weight loss or gain. Resident would be weighed upon admission and at intervals established by the interdisciplinary team. Review of the facility policy Nutrition (Impaired)/Unplanned Weight Loss Clinical Protocol, revised 09/2012, revealed the nursing staff would monitor and document the weight and dietary intake of residents in a format which permits readily available comparisons over time. This deficiency represents noncompliance investigated under Complaint Number 2677988.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations, staff interview, and review of a job description, the facility failed to ensure resident rooms were maintained in a safe and sanitary condition. This affected three (#31, #3 and #30) of six resident rooms observed during the survey. The facility census was 30. Findings include: Observation on 12/22/25 at 10:25 A.M. in Resident #30's room revealed the two floor ventilation air vents had rust spots with the many areas of missing paint finish. Observation on 12/22/25 at 11:00 A.M. in Resident #3's room revealed the floor ventilation air vent was bent in the middle with rust spots. Observation on 12/22/25 at 3:00 P.M. in the room of former Resident #31 revealed the two ventilation floor air vents had rust spots, and missing finish. Further observations revealed the ventilation vents had a large build up of dust inside the floor vent. Additional observation revealed a missing piece of trim along side the bed in the former room of Resident #31. Observation and subsequent interview on 12/22/25 from 3:31 P.M. through 3:38 P.M., the Director of Maintenance (DOM) #180 verified the degraded condition of the ventilation vents in the rooms of Resident #3, Resident #30, and former room of Resident #31. DOM #180 also verified the missing piece of trim next to the bed with a nail sticking out of the wall in the former room of Resident #31. DOM #180 revealed the facility staff had not notified him of the condition of the ventilation vents or the missing trim. Interview on 12/23/25 at 11:45 A.M., Regional Risk Registered Nurse (RRRN) #135 revealed the facility had no policy regarding maintaining the condition of resident rooms. Review of the job description dated 04/23/12 for the Director of Environmental Services revealed the Director of Environmental Services was responsible to conduct periodic inspections of the building, correcting all damages to hallways, walls, ceilings, floors, roof, and resident rooms. This deficiency represents noncompliance investigated under Complaint Number 2677988.