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	01/13/2026

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 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on employee personnel file review, review of the facility criminal background log, review of the facility daily timecard activity, staff interview, and policy review, the facility failed to ensure nursing staff with disqualifying legal convictions were not employed by the facility. This affected all 31 residents residing in the facility.Findings include:Review of the personnel file revealed Licensed Practical Nurse (LPN) #200 was hired on 10/28/25.Review of the facility criminal background log noted LPN #200's criminal background investigation was submitted on 10/27/25 and returned on 11/20/25.According to facility daily timecard activity noted LPN #200 worked a scheduled shift on 01/06/26 between 6:53 A.M. and 7:36 P.M.Interview on 01/08/26 at 7:50 A.M., the Administrator revealed LPN #200 was charged and found guilty of domestic violence. Upon hire LPN #200 had not disclosed the guilty conviction. When LPN #200's criminal background check was returned the acting human resources staff had not discovered the conviction and recorded the Bureau of Criminal Investigation (BCI) results as acceptable for employment. The Administrator stated the facility would not have hired LPN #200 due to the disqualifying code and related legal conviction. On 01/08/26 at 8:40 A.M. interview with Business Office Manager/Human Resource (BOM) #402 designee revealed during the hiring process LPN #200 had not divulged any legal conviction. On 11/20/25 when the fingerprint results were returned and the BOM noted a code of A on the result. The BOM #402 stated she was unaware the code disqualified LPN #200 from employment. Review of the employment disqualifying offences with the BOM #402 revealed the code indicated domestic violence was the conviction against LPN #200.Review of the facility policy titled Resident Right to Freedom from Abuse, Neglect, and Exploitation, dated 2025. The facility will not employ or otherwise engage in individuals who: Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law. This deficiency represents Substandard Quality of Care.This deficiency represents non-compliance investigated under Complaint Number 2702722.

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and staff and resident interview, the facility failed to ensure interventions to manage lower extremity edema were implemented in accordance with physician orders. This affected two (#05 and #06) of six residents reviewed for physician prescribed treatment applications. The facility census was 31.Findings include:1. Review of the medical record revealed Resident #05 was admitted to the facility on [DATE]. Diagnoses included lymphedema, major depression, cellulitis, chronic venous hypertension with lower extremity ulcer, chronic peripheral venous insufficiency, morbid obesity, epilepsy, cellulitis on right toe, and history of transient ischemic attack. Review of the most current Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #05 had moderately impaired cognition, delusions, no behaviors, required setup or clean-up assistance with activities of daily living, at risk for pressure ulcer development, received an antidepressant, a diuretic, an antiplatelet, and anticonvulsant medications.Review of the 11/30/23 nursing plan of care was revised to address Resident #05's risk for impaired skin integrity due to a history of cellulitis and edema. Interventions included follow facility protocols for treatment of injury, identify/document potential causative factors and eliminate/resolve where possible, keep skin clean and dry, use lotion on dry skin, monitor/document location, size and treatment of skin injury, report abnormalities, failure to heal, signs and symptoms of infection, maceration, and the resident needs pressure relieving/reducing mattress to protect the skin while in bed.On 12/26/25 at 7:00 P.M., a physician order for Resident #05 was implemented for the application to bilateral lower extremities. Instructions included wash pat dry, apply UNNA boot dressing from the toes to below the knee, cover with Coban (wrap). Change on Monday, Wednesday and Friday and as needed (PRN). May apply triad paste and wrap with roll gauze, cover with Coban if UNNA boot was unavailable.Observation on 01/07/25 at 11:27 A.M. Resident #05 was observed in bed with no treatment of pressure relief boots in place. The residents heels were resting on the mattress. Observation and interview on 01/07/26 at 12:47 P.M., Registered Nurse (RN) #300 verified Resident #05 was without pressure relief boots or wraps in place. RN #300 assessed Resident #05 who had plus three edema to bilateral lower extremities.2. Review of the medical record revealed Resident #06 was admitted to the facility on [DATE]. Diagnoses included intracerebral hemorrhage, right sided hemiplegia, seizure disorder, anxiety disorder, deep vein thrombosis and embolism right lower extremity, chronic respiratory, tracheostomy, gastrostomy, and anemia. Review of the most current MDS assessment dated [DATE] assessed Resident #06 with intact cognition, no behaviors, required substantial to maximal assistance with activities of daily living, medications included an anticoagulant and a diuretic.Review of the 08/27/25 nursing plan of care was revised to address Resident #06's functional abilities, impaired/self-care, and mobility deficit. Resident #06 was at risk for decline in functional ability and usual performance associated complications. Interventions included the application of ace wraps to the right lower leg from toes to knee.Review of Resident #06' physician orders revealed on 01/01/26 at 7:00 P.M. an order for the application of ace wraps to the right lower leg from the toes to the knee each shift as tolerated for edema.Observation on 01/07/26 at 11:24 A.M., Resident #06 was seated at the bedside with feet to the floor. No wraps were applied to the lower extremities.Observation and interview on 01/07/26 at 11:32 A.M., Licensed Practical Nurse (LPN) #202 verified the resident without the leg wraps in place. LPN #202 assessed Resident #06 with plus three edema to the right lower extremity. Resident #06 stated the wraps had not been applied for the past three days.This deficiency represents non-compliance investigated under Complaint Number 2702722.

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, facility policy review, and manufacturer user manual, the facility failed to ensure pressure relieving interventions were implemented to promote healing and prevent the development of pressure ulcers. Actual Harm occurred when Resident #02 was placed on a faulty alternating air mattress without standard wound or equipment assessment which resulted in the deterioration of an existing stage IV pressure ulcer (full-thickness loss with exposed bone/muscle/tendon) and the development of three in-house acquired unstageable (obscured by sloth/eschar) deep tissue injuries (purple/maroon discoloration, intact or blistered skin) to the back and buttock. This affected one (#02) of four residents reviewed for pressure ulcers. The facility census was 31.Findings include:Review of the medical record revealed Resident #02 was admitted to the facility on [DATE]. Diagnoses included multiple sclerosis, sepsis, hypertension, non-pressure chronic ulcer of the buttock, anemia, severe protein calorie malnutrition, depression, anxiety disorder, myocardial infarction, neuromuscular dysfunction of bladder, chronic respiratory failure, Crohn's disease, colostomy, stage IV left buttock pressure ulcer, and confined to the bed. On 08/04/25, a non-compliance care plan was implemented with intervention to document educational attempts made with resident in relation to compliance. Explain all procedures prior to starting them and the benefits of the procedure. Notify the physician/certified nurse practitioner of non-compliance.On 11/07/25, a nursing plan of care was revised to address Resident #02's behavior problem making false claims and resistance to care. Interventions included administer medications as ordered and monitor effectiveness. Anticipate and meet resident's needs; however, there were no interventions listed on the care plan to address how the resident needs would be met. On 12/23/25, the nursing plan of care was revised to address Resident #02's stage IV pressure ulcer located on the left buttock. Interventions included administer treatment as ordered and monitor effectiveness. Educate resident/family/caregivers as to the cause of the breakdown, including transfer/positioning requirements, importance of taking care during ambulating/mobility, good nutrition and frequent repositioning, float bilateral heels in the bed as tolerated, follow facility policies/protocols for prevention/treatment of skin breakdown, and low air loss relieving mattress to the bed. Check the function of setting every shift. Change the mattress as needed (PRN). Monitor/document/report as needed (PRN) any changes in skin status, appearance, color, wound healing, signs or symptoms of infection, wound size (length by width by depth), and the stage. Teach the resident/family the importance of changing positions for prevention of pressure ulcers. Encourage small frequent position changes. The resident needed monitoring/reminding/assistance to turn/reposition side to side at least every two hours, more often as needed or requested. On 12/23/25, there was a physician order for the placement of a Low Air loss (LAL) relieving mattress to the bed. Check function of setting every shift for bed monitoring. There was no documentation or instruction indicated or prescribed for the low air loss mattress settings. Review of the wound specialist physician assessment completed on 12/24/25 revealed Resident #02 was assessed with a stage IV pressure ulcer to the left superior buttocks measuring 8.0 centimeters (cm) long by 4.0 cm wide by 0.3 cm deep with heavy serosanguinous drainage. Interventions included reposition per facility protocol, off-load wounds, and turn side to side in bed.Review of the nursing progress notes revealed on 12/27/25 at 11:55 A.M. Resident #02 experienced mental status changes and was subsequently sent to the hospital for evaluation. Review of the hospital community referral documentation dated 01/02/26 identified pressure ulcers noted on left buttock stage one measuring 8.0 cm by 2.0 cm and a stage II (partial skin loss, exposed dermis) of the left buttock measuring 4 cm by 5.5 cm. The wounds were described as moist, bleeding, excoriated, (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	painful and red. The physician wound treatment included cleanse the wound with mild soap and water and apply a thin layer of TRIAD as barrier and autolytic debridement, no cover (open to air). Review of the readmission nursing assessment dated [DATE] revealed Resident #02 returned to the facility following hospitalization. Resident #02 was assessed as alert and cognitively intact, utilized a urinary indwelling catheter and colostomy for elimination, area of skin breakdown to buttocks, bedfast all or most of the time, upper and lower bilateral extremity range of motion impairment, and dependent on staff for the completion of activities of daily living (ADL). Additional review of the nursing readmission assessment dated [DATE] identified an area of skin breakdown to the buttocks; however, no wound description or measurements were documented. The medical record lacked documentation indicating the type of skin breakdown, interventions placed to the residents' bed, or assessment of a low air loss mattress for proper fit and/or operation.Review of the medical record, including treatment administration records lacked documentation indicating the function of the alternating air mattress was monitored each shift between 01/02/26 and 01/05/26.On 01/02/26 at 6:00 P.M., the clinical admission progress notes document Resident #02 with a stage IV pressure ulcer to the left buttock. No further skin breakdown, wound descriptions or measurements were documented. No treatment applications, including TRIAD barrier/autolytic debridement, were documented in the medical record between 01/02/26 and 01/04/26 at 7:00 P.M.Review of the physician orders on 01/04/26 at 7:00 P.M., the buttock wound dressing was changed to include cleansing with normal saline, pat dry, apply calcium alginate, cut to fit, and cover with dry dressing twice daily.On 01/04/26 at 7:21 P.M., a skin check evaluation was completed and noted a left buttock wound measuring approximately 11.0 cm by 6.0 cm with bloody drainage. Review of the nurses' notes dated 01/05/26 at 5:00 P.M., revealed nursing discussed with Resident #02 getting transferred into a wheelchair while the bed mattress was being worked on. The resident stated earlier in the day her family would be in to transfer her into her wheelchair. Family was in to visit but had not transferred the resident to the wheelchair. The writer asked the resident if a mechanical lift could be used as ordered to work on the mattress. The resident refused to be transferred. The resident stated she would be okay in bed as is until the next time her family came and visited to transfer her. There was no further documentation contained in the medical record regarding attempts to replace the faulty mattress, or additional interventions to decrease pressure and prevent associated skin breakdown. The medical record lacked documentation indicating attempts to reposition the resident or resident refusal of repositioning, nor off-loading attempts or positioning side to side between 01/02/26 and 01/07/26. There was no physician or certified nurse practitioner notification of the refusal contained in the medical record.Review of the Plan of Care (POC) response history task resident turn and reposition while in bed documentation revealed there was no documented evidence of repositioning between 01/02/26 and 01/03/26 until 4:52 A.M. on 01/03/26. On 01/03/26, repositioning occurred at 4:52 A.M., 8:46 A.M., 4:27 P.M., and 5:40 P.M.; on 01/04/26 at 9:29 A.M., 12:05 P.M., 5:09 P.M., and 11:17 P.M.; on 01/05/26 at 2:10 A.M., 6:08 A.M., 4:25 P.M., 4:26 P.M., 4:30 P.M., 4:31 P.M., and 5:10 P.M.; on 01/06/26 at 4:15 A.M., 4:16 A.M., 1:06 P.M., 5:24 P.M., 5:25 P.M., 8:00 P.M., and10:00 P.M.; and on 01/07/26 at 12:00 A.M. 2:00 A.M., 4:00 A.M., 6:00 A.M., and 1:17 P.M. There was no documented evidence in the medical record indicating Resident #02 refused repositioning between 01/02/26 and 01/07/26. Observation on 01/07/26 at 8:32 A.M. noted Resident #02 positioned on her back with the head of the bed elevated. A low air loss mattress was applied to the bed and the air pump located on the foot board had an active visual alarm (indicator light flashing) indicating alternate failure. The audible alarm was muted. Resident #02 was positioned at the head of the air mattress, and her feet were positioned extending over the foot of the mattress. Two pillows (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	were noted under her lower extremities filling a gap between the foot board and the bottom of mattress measuring approximately 18 inches. Resident #02 stated the air mattress was not properly inflated and she was sitting on the metal bed frame underneath her. Resident #02 stated the same low air loss mattress was in place since before she went to the hospital most recently.Interview and observation on 01/07/26 at 8:43 A.M., Licensed Practical Nurse (LPN) #202 verified assuming care of Resident #02 at 7:00 A.M. LPN #202 proceeded to Resident #02's room and was unaware Resident #02's low air loss mattress was malfunctioning or had an active alarm. LPN #202 verified the alternate alarm was active. LPN #202 went on to state she was unaware how to verify the alternating air mattress was operating as designed. LPN #202 would check the sides of the air mattress and would not check to see if the mattress was properly inflated under the resident. LPN #202 went on to verify Resident #02 was sitting with direct pressure on the metal bedframe to the residents' buttocks.According to the alternating air mattress user manual (undated) the mattress audible/visible alarm turns on after one minute when there is low pressure, power failure or alternate failure. To mute audible alarm, press the alarm mute button. The visible alarm indicator will flash till problem is solved. If the mattress stops alternating or alternate abnormally, the audible alarm will be activated, and the alternate failure indicator will flash. For nursing and caring convenience, press the max firm button to automatically inflate the mattresses to maximum level for about 20 minutes. The pressure will return to alternate mode after 20 minutes. Observation on 01/07/26 at 12:20 P.M., a skin evaluation was completed with the wound specialist physician and Registered Nurse (RN) #300. Resident #02 was assessed with the following skin impairments: left superior buttock full thickness stage IV pressure wound with duration greater than 443 days, measuring 17 cm by 10 cm by 0.1 cm with heavy serosanguinous exudate (drainage); the right buttock unstageable deep tissue injury, etiology pressure duration greater than one day, measured 3.5 cm by 4.5 cm, skin intact with purple/maroon discoloration; right upper back unstageable deep tissue injury, etiology pressure duration greater than one day, measured 1.1 cm by 2.8 cm, skin intact with purple/maroon discoloration; and the right lower back unstageable deep tissue injury, etiology pressure duration greater than one day, measured 0.8 cm by 1.2 cm, skin intact with purple/maroon discoloration.Review of the facility policy titled Pressure Ulcers/Skin Breakdown Clinical Protocol, revised April 2018 revealed the staff, and practitioners will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings, and application of topical agents. Current approaches should be reviewed for whether they remain pertinent to the resident/patient's medical conditions, are affected by factors influencing wound development or healing, and the impact or specific treatment choices made by the resident patient or a substitute decision-maker.Interview on 01/08/26 at 6:05 A.M., with Regional Registered Nurse #400 and Interim Director of Nursing #201 during the review of Resident #02's medical record verified wound measurements and descriptions were not obtained at the time of admission and not until 01/07/26 when evaluated by the wound specialist physician. Furthermore, following Resident #02's refusal on 01/05/26 to change the air mattress, the medical record lacked attempts to reapproach, determine underlying cause for refusal, or additional interventions to promote skin integrity.This deficiency represents non-compliance investigated under Complaint Number 2702722.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, staff interview, review of the control substance inventory sheet, and policy review, the facility failed to ensure controlled substances and narcotic medications were correctly handled, and inventoried. This affected eight (#07, #15, #06, #16, #23, #22, #09 and #21) of eight residents identified by the facility who received narcotic medications. In addition, the facility failed to ensure narcotic medications were reconciled at the point of administration. This affected one (#07) of eight residents who received narcotic medication. The facility census was 31. Findings include:Observation on 01/08/26 at 3:14 A.M. noted pharmaceuticals delivered to the facility by pharmacy delivery staff. Licensed Practical Nurse (LPN) #201 was handed a package containing medications from the pharmacy delivery staff. No attempt to count the medications or review the contents of the package and pharmacy delivery staff immediately exited the facility.At 3:17 A.M., LPN #201 was observed placing medication cards which included controlled substances/narcotic medications in the two facility medication carts. No additional staff was observed to monitor the placement of the medications on the carts.On 01/08/26 at 3:25 A.M., a reconciliation count of narcotic medications contained in the front medication cart discovered a medication control monitoring inventory sheet of Oxycodone (opioid/narcotic pain medication) 5-325 milligrams (mg) prescribed to Resident #07 with a total inventory of 23 tablets. Observation of the Oxycodone 5-325 mg medication card containing the tablets was noted to equal 22 tablets.Interview with LPN #201 at the time of the observation verified the medication reconciliation count was not accurate. LPN #201 stated she previously administered the medication to Resident #07. But had not made the removal of the narcotic on the medication control monitoring inventory sheet at the time of the removal. LPN #201 verified the medication should have been recorded as removed at the time of administration.Review of the policy titled Controlled Substances, revised November 2022 revealed controlled substances are counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count all controlled substances together. Both individuals sign the designated controlled substance record. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. Nursing staff count controlled medication inventory at the end of each shift. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services.Interview on 01/12/26 at 7:30 A.M., Regional Registered Nurse #400 provided a list of eight current residents identified who received narcotics/controlled medications on 01/08/26. The list included Residents (#07, #15, #06, #16, #23, #22, #09 and #21). A follow-up interview at 1:30 P.M., the Regional Registered Nurse #400 verified medication delivery required the receiving nurse and the delivery personnel to count the delivery including when narcotics are delivered.This deficiency represents non-compliance investigated under Complaint Number 2702722.