STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366093	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Village Health Care Center Inc	1525 Crater Avenue Dover, OH 44622

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on closed record review, hospice record review, interview, review of a contract between the facility and an outside hospice agency, and facility policy review, the facility failed to effectively communicate with Resident #83's hospice agency as per the written agreement to ensure the resident's need for medication administration was met. This affected one resident (#83) of four residents reviewed for hospice care. The facility census was 76.Findings include: Review of the closed medical record for Resident #83 revealed an admission date of 03/03/25. Diagnoses included muscle weakness, anxiety disorder, major depressive disorder, hypertension, and vascular dementia, unspecified. Resident #83 passed away at the facility on 05/29/25. Review of a care plan for Resident #83, updated on 05/28/25, revealed the resident was admitted to hospice care. Interventions included administering medications as ordered by hospice and maintaining resident's safety and comfort.Review of Resident #83's physician orders revealed Hospice Medical Director (HMD) #900 provided orders dated 05/29/25 for the resident to receive Ativan (a controlled anti-anxiety medication) 0.5 milligrams (mg) two tablets (totaling 1 mg) by mouth every three hours scheduled on a routine basis. The order began on 05/29/25 at 3:00 A.M. Resident #83 additionally had an order dated 05/29/25 for Dilaudid (a narcotic analgesic) 4 mg every two hours for pain scheduled on a routine basis to begin on 05/29/25 at 2:00 A.M.Review of Resident #83's Medication Administration Record (MAR) for May 2025 revealed the resident's Ativan was recorded as administered as ordered on 05/29/25 at 3:00 A.M., 6:00 A.M., and 9:00 A.M. The 12:00 P.M. dose and the 3:00 P.M. doses of Ativan were not recorded as administered. Continued review of the MAR revealed the resident's Dilaudid was recorded as administered as ordered on 05/29/25 at 2:00 A.M., 4:00 A.M., 6:00 A.M., and 8:00 A.M. The 10:00 A.M. and 12:00 P.M. doses of Dilaudid were not recorded as administered, despite the MAR referencing the resident had a recorded pain level of one at 10:00 A.M. and a pain level of two at 12:00 P.M. Continued review of Resident #83's medical record revealed no evidence of communication between Registered Nurse (RN) #442 and the resident's hospice agency to indicate the reason for holding the medication. An interview on 04/22/26 with Licensed Practical Nurse (LPN) #452 confirmed Resident #83's medical record contained no indication or rationale as to why the resident's Avitan and Dilaudid doses were held on 05/29/25. Review of Resident #83's hospice records dated 05/29/25 revealed no communication between or with the facility of any reported change in condition or to collaborate on Resident #83's medication regimen.The record failed to reveal communication between RN #442 and the hospice agency to indicate the reason for holding the ordered medication. This was confirmed by interview on 04/22/26 with Licensed Practical Nurse (LPN) #452. Review of the hospice record for Resident #83 also failed to reveal any communication with the facility with report of a change in condition requiring a change in the ordered doses or frequency of medications.Continued review of the hospice medical record revealed a note dated 05/29/25 authored by Hospice LPN #901 which revealed she arrived at the facility on 05/29/25 for a visit related to Resident #83 experiencing periods of apnea (temporary cessation or pausing of breathing, lasting from a few seconds to minutes). Hospice LPN #901 noted the resident was unresponsive to verbal and tactile stimuli and was receiving scheduled Ativan and Dilaudid. The note referenced RN #442 had (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	held doses (of the Ativan and Dilaudid) due to her judgement of not feeling the resident needed the medications. Per hospice staff that have been present at the bedside, Resident #83 had been very restless and agitated throughout the night and would not leave his gown on. Hospice LPN #901 discussed with the resident's daughter about medication administration and whether she wanted staff to hold medications or if she preferred the medications be administered as scheduled. The daughter reported to the nurse she preferred to do what hospice staff felt was best and she wanted the resident kept comfortable. Hospice LPN #901 recommended administering the resident the scheduled medications as ordered, rather than risking medications wearing off and the resident beginning to show signs of discomfort again to which the daughter agreed. Hospice LPN #901 discussed with RN #442 the family's wishes for medication and RN #442 was very upset as she felt the resident did not need the medications and, per her judgement, she would not give. RN #442 informed and discussed with the facility's Director of Nursing (DON). Hospice LPN #901 discussed Resident #83's medications with the DON who voiced understanding to the family's request for medication administration. The DON informed Hospice LPN #901 that she, the DON, would plan to administer the resident's ordered medication as RN #442 still did not feel comfortable administering medications as ordered and as the family wished. Further review of Resident #83's MAR revealed at 1:52 P.M., Resident #83 was administered his scheduled Dilaudid (due at 2:00 P.M.) by the DON.On 04/21/26 at 9:32 A.M. an interview with the Administrator revealed communication with hospice was based on Interdisciplinary Team (IDT) recommendations. If a facility nurse had a concern about medication or order, there would be a discussion with [Director of Nursing (DON)] and she would advise what further steps should be taken. He agreed calling the physician would be necessary to determine a medication concern or discrepancy, not the DON. Interview with LPN #452 on 04/22/26 at 4:55 P.M. revealed if there were concerns regarding a hospice resident, a change in condition, a family concern, or a concern with medications, it must be relayed to the hospice nurse for further orders. She confirmed a nurse from the facility should never administer a different dose than ordered without first talking to hospice for further orders or directions.Review of a policy titled Nursing Services Policy and General Guidelines revised 03/25, revealed all medications were to be administered by the method, time, and dosage as prescribed by the attending physician. Review of a document titled 2026 Quality Assurance Performance Improvement Plan for Park Village Dover revealed the facility provided supervision and collaborated with the medical and nursing team at Park Village by reviewing, dispensing, and monitoring medication effectiveness to ensure therapeutic goals were maintained for each and every resident. Review of a facility contract with Resident #83's hospice agency, dated 04/25/23, revealed each party was responsible for documenting communications in the clinical record to ensure the needs of Hospice patients were met 24 hours a day. The facility would not make any modifications to the plan of care without first consulting with hospice. Hospice retained the sole authority for determining the appropriate level of hospice care provided to each patient. The facility should immediately inform hospice of any change in condition of the patient. Further, if there were physician orders that were inconsistent with the plan of care or Hospice protocols, a RN with the facility should notify hospice. An authorized representative of Hospice would resolve the differences directly with the physician and secure the necessary orders.This deficiency represents non-compliance investigated under Complaint Number 1394812 (OH00166707).