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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview with staff, and review of the recommendations of the US Department of Agriculture, the facility failed to store and serve food in a manner to prevent foodborne illness. This had the potential to affect 75 of 76 residents who received meals from the facility kitchen. The facility census was 76.Findings include: Observation and interview on 04/19/26 between 9:05 A.M. and 9:24 A.M. during the initial kitchen tour revealed four full loaves and one half loaf of [NAME] sandwich bread with use by date of 04/14/26 on the bread rack used for meal service on 04/19/26. This was verified at the time of observation by Dietary [NAME] (DC) #513 who removed the bread and discarded it in the trash. Observation on 04/21/26 at 11:20 A.M. of food and drink temperature checks for the lunch meal revealed drinks cups containing water, juices, and white and chocolate milk lined up on the counter for lunch meal services. The cups did not have any lids or coverings. There was no ice bath or device/means to keep the fluids cold. Further observation revealed the temperature check of the milk from two different cups was 47 degrees Fahrenheit (F) and 50 degrees F. Temperature check of the apple juice revealed a temperature reading of 44 degrees F. These observations were verified at the time of observation by Dietary Manager (DM) #408.Observation on 04/21/26 at 12:25 P.M. of the tray line for the lunch meal revealed a dietary staff member carrying three cups containing juice, milk, and water to place on a tray for lunch service. The dietary staff member was carrying all three cups by the top rims, and her fingers were inside of the rim of two of the cups. This was verified by DM #408 who immediately directed the dietary staff member to throw the drinks out and get new ones. Review of the United States Department of Agriculture (USDA) website for recommendations for safe handling, Danger Zone (40 F - 140 F) | Food Safety and Inspection Service, revealed cold foods should be kept at or below 40 degrees Fahrenheit, and place food on ice. Further review revealed the danger zone of foods left at temperatures between 40-140 degrees Fahrenheit for as little as 20 minutes can lead to doubling of bacterial growth leading to food borne illness.

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, policy review, and staff interview, the facility failed to ensure the Pre-admission Screening and Resident Review (PASARR) document reflected accurate medical diagnoses. This affected two (Resident #9 and #69) of two residents reviewed for PASARR documents. The facility census was 76.Findings include: Medical record review revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, dementia, anxiety, delusional disorders, and depression.Review of Resident #9's most recent PASARR document, dated 05/14/25, revealed Section E: Indications of Serious Mental Illness did not indicate the diagnoses of and was not revised/updated to include diagnoses of hallucinations, delusions, depression, and anxiety.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 02/25/26, revealed the resident had a severe cognitive impairment.Interview on 04/21/26 at 9:36 A.M. with Social Service Director (SSD) #404 confirmed Resident #9's PASARR, dated 05/14/25, did not include the diagnoses of hallucinations, delusions, depression, and anxiety.2. Medical record review revealed Resident #69 was admitted to the facility on [DATE] with diagnoses including severe dementia, delusional disorder, anxiety disorder, major depressive disorder, and heart failure.Review of Resident #69's most recent PASARR document, dated 02/19/26, revealed Section D did not indicate the diagnosis of dementia; and Section E did not indicate the diagnosis of delusional disorder.Review of the admission Minimum Data Set (MDS) 3.0 assessment, dated 03/04/26, revealed the resident had a moderate cognitive impairment.Interview on 04/21/26 at 9:40 A.M. with SSD #404 confirmed Resident #69's PASARR, dated 02/19/26, did not accurately reflect the resident's diagnoses of dementia and delusional disorder. Review of the facility policy titled PASARR Policy dated 03/24/25 revealed a PASARR will be completed by the social service designee for all residents prior to admission to the facility, with the exception of residents with a hospital exemption. Any resident who requires a level two screen will be considered part of the PASARR population. A new resident review will be completed following a significant change of condition for the resident. Any resident who has a clean level one screen will be considered part of the non-PASARR population. A new resident review will be completed following admission to psychiatric hospital or upon the addition of a new psychiatric diagnosis and/or medication.

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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 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 (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, review of Centers for Disease Control (CDC) guidelines, and facility policy review, the facility failed to provide routine cleaning and disinfection of resident care equipment including equipment shared among residents (blood pressure cuff and pulse oximeters). This affected two residents (#7 and #67) of seven residents observed for infection control during medication administration. Further, the facility failed to ensure staff demonstrated the proper use of gloves with hand hygiene during incontinence care. This affected one resident (#71) of three residents reviewed for incontinence care. The facility identified 63 incontinent residents. The facility census was 76.Findings include:1.Observation on 04/20/26 at 8:19 A.M., during medication pass, revealed Registered Nurse (RN) #442 take the blood pressure (BP) of Resident #67 with a wrist BP cuff prior to administering medications. After obtaining the BP reading, the RN placed the BP cuff back onto the medication cart and did not sanitize it before using the cuff on another resident. This was confirmed by RN #442 during an interview on 04/20/26 at 9:26 A.M.Continued observation on 04/20/26 at 9:05 A.M., during medication pass, observed RN #442 check the heart rate of Resident #7 with a pulse oximeter (device used to check oxygen level and heart rate) prior to administering medication. RN #442 did not disinfect the pulse oximeter prior to or after use. The device was placed back into a basket holding several other pulse oximeters on the medication cart. This was confirmed by RN #442 during an interview on 04/20/26 at 9:26 A.M.On 04/20/26 at 9:26 A.M., an interview with RN #442 confirmed she had not disinfected manual BP cuff or pulse oximeter prior to or after use on residents. She indicated she did not disinfect equipment as a general practice and would welcome recommendations on how to disinfect the equipment between resident usages.The facility failed to provide a policy for disinfecting resident care equipment shared between residents.Review of Center for Disease Control (CDC) guidelines revealed it was required to disinfect shared noncritical resident equipment (stethoscopes, blood pressure cuffs, etc.) with an EPA (Environmental Protection Agency) registered hospital disinfectant after each use. 2. On 04/22/26 at 2:00 P.M., an observation of Certified Nursing Assistant (CNA) #478 and CNA #501 performing incontinence care on Resident #71 was completed. During the observation, the aides sanitized their hands and donned gloves prior to beginning care. The aides removed the resident's soiled brief, cleaned the resident's perineal area, applied a new brief, replaced her bed clothes, straightened the room, and took out the trash. The two CNAs did not wash their hands or change their gloves at any point during care. Once care and room tidying was completed, the aides removed their gloves and washed their hands. This was confirmed by CNAs #478 and #501 immediately following the observation. On 04/22/26 at 2:30 P.M., an interview with the Director of Nursing revealed the expectation would be to follow the facility policy. The policy indicated hand washing and glove changes should take place prior to care, after removing soiled clothing and briefs, and after completing resident care. She provided the facility policy.Review of a facility policy titled incontinence care policy, revised 08/24/22, revealed the policy was to prevent skin breakdown from moisture and fecal waste on the skin due to incontinence and to promote resident dignity. The procedure stated staff were to put on gloves, remove wet or soiled undergarment, cleanse the perineal area and place soiled linens in appropriate receptacles. The staff should then remove gloves, wash hands with either water or antibacterial hand sanitizer, and dry hands. The staff would then apply clean gloves, assist with applying a clean brief, and adjusting clothing. The staff should then remove gloves, sanitize hands, and settle the resident into bed or chair. Soiled linens and trash would then be taken to the appropriate receptacle, and hands would again be sanitized.