

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366392	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026
NAME OF PROVIDER OR SUPPLIER Burbank Parke Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 14976 Burbank Road Burbank, OH 44214	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on medical record review, observation, resident interview, and staff interview, the facility failed to ensure staff provided the appropriate level of supervision during mealtimes for residents at risk for choking. This affected one (Resident #49) of three residents observed for change in condition. Based on observation, staff interview, and review of the facility policy, the facility also failed to ensure medications were stored in a safe and secure manner. This had the potential to affect eight facility-identified cognitively impaired and independently mobile (Residents #18, #45, #57, #59, #61, #77, #78, #80.) The facility census was 74 residents. Findings include: 1. Review of the medical record for Resident #49 revealed an admission date of 04/16/24 with diagnoses including unspecified dementia, cerebral infarction, and acute and chronic respiratory failure. Review of the care plan for Resident #49 dated 10/06/25 revealed the resident had the potential for altered nutritional status. Interventions included following: monitoring eating ability, cut up meats, encourage resident to eat in main dining room for all meals every day and evening shift for choking risk. Review of the progress note for Resident #49 dated 01/08/26 at 1:02 P.M. per Licensed Social Worker (LSW) #303 revealed a care conference was completed which included Resident #49's two daughters. Resident #49's family requested a possible diet order change to a softer texture related to the resident's numerous missing teeth. Review of the physician's orders for Resident #49 revealed an dated 01/09/26 for carb controlled diet with cut up meats. Review of the Minimum Data Set (MDS) assessment for Resident #49 dated 04/24/26 revealed the resident was cognitively intact and required staff assistance with activities of daily living (ADLs.) Review of the progress note for Resident #49 dated 06/05/26 at 3:16 P.M. per Licensed Practical Nurse (LPN) #331 revealed the resident was eating in her room, came out to desk and stated that she was coughing while eating with no choking noted. LPN #331 received a new order to encourage the resident to eat in the main dining room for all meals. Review of the Speech Therapy (ST) evaluation for Resident #49 dated 06/09/26 at 6:37 P.M. per Speech Therapist (ST) #481 revealed the resident's risk factors included documented physical impairments and associated functional deficits which caused the resident to be at increased risk for aspiration. Recommendations included supervision for oral intake including distant supervision. To facilitate safety and efficiency, it was recommended the patient use the following strategies and or maneuvers during oral intake: lingual sweep/swallow, alternation of liquid/solids, bolus sized modifications, upright position during meals. Observation on 06/10/2026 at 11:25 A.M. revealed Resident #49 was in her chair in her room alone eating her lunch and had completed about 50 percent (%) of the meal. Interview on 06/10/26 at 11:26 A.M. with Resident #49 confirmed the staff delivered her lunch tray, left the room, and had not returned. Resident #49 stated she had eaten breakfast earlier in the day in her bed without supervision. Phone interview on 06/10/26 at 1:34 P.M. with ST #481 confirmed she evaluated Resident #49 on 06/09/26 and recommended distant supervision during meals. ST #481 (continued on next page)		

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 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. Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to ensure staff notified the physician promptly of a change in resident condition. This affected one (Resident #56) of three residents reviewed for change in condition. The facility census was 74 residents. Findings include: Review of the medical record for Resident #56 revealed an admission date 11/29/22 with diagnoses including congestive heart failure, visual hallucinations and lack of coordination. Review of Minimum Data Set (MDS) assessment for Resident #56 dated 05/20/26 revealed the resident was cognitively impaired and required substantial/maximal assistance with personal hygiene. Review of the progress notes for Resident #56 dated 06/02/26 through 06/10/26 revealed they did not include documentation of drainage or redness to the resident's left eye. Observation on 06/08/26 at 10:00 A.M. of Resident #56 revealed the resident's left eye was red and droopy. Interview on 06/08/26 at 10:01 A.M. of Resident #56 confirmed the resident complained of occasion itching to the left eye. Observation on 06/09/26 11:28 A.M. of revealed Resident #56's left eye was red and the lashes had dried crust on the upper and lower lids. Interview on 06/09/26 at 11:30 A.M. with Licensed Practical Nurse (LPN) #339 confirmed Resident #56 received eye drops three times a day for dry eyes, and she would assess Resident #56's left eye for redness and drainage. Interview on 06/10/26 at 8:16 A.M. with Physician #425 confirmed he was not notified about the redness and drainage to Resident #56's left eye. Interview on 06/10/26 10:39 A.M. with LPN #339 confirmed she had taken a wet washcloth and cleaned Resident #56's eye to see if the redness and drainage would resolve on its own. LPN #339 verified she had not notified Resident #56's provider of the resident's left eye being red and crusty. LPN #339 stated if a change in condition was noted, she normally will give it a day to see if she should notify the physician. Interview on 06/10/26 10:56 A.M. with the Director of Nursing (DON) confirmed if there was a change of condition with a resident she would expect the nurse to call her or text her. The DON verified staff should notify the physician when a change of condition was identified. Review of the facility policy titled Change in a Resident's Condition or Status dated 2001 revealed nurses will notify the resident, resident's attending physician or provider and the resident representative of changes in the resident's condition and/or status.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to provide timely incontinence care for dependent residents. This affected one (Resident #69) of The facility census was 74 residents. Findings include: Review of the medical record for Resident #69 revealed an admission date of 11/09/18 with diagnoses including Parkinson's disease and dementia. Review of the care plan for Resident #69 initiated 11/13/18 and updated 05/26/26 revealed Resident #69 had a potential for alteration in skin integrity related to immobility, diagnosis of diabetes mellitus, anemia and bowel and bladder incontinence. Interventions included the following: provide treatments per the physician's order, weekly skin assessment for skin irritation, redness, bruises, scratches, open areas, check every two hours and as needed for incontinence. Review of the Minimum Data Set (MDS) assessment for Resident #69 dated 05/15/26 revealed the resident was severely cognitively impaired, was always incontinent of bowel and bladder, required assistance with toileting and personal hygiene. Observation on 06/09/26 at 2:50 P.M. of incontinence care for Resident #69 per Certified Nursing Assistants (CNAs) #351 and #356 revealed the resident's incontinence brief was saturated with urine and stool and an open area to the resident's coccyx was covered with stool. Interview on 06/09/26 at 3:21 P.M. with CNA #351 confirmed she was Resident #69's primary aide and she had laid the resident down to change her incontinence brief at 10:00 A.M. when she started the shift. CNA #351 stated Resident #69 had a open area to her coccyx and she noted there was no dressing present to the wound. CNA #351 further confirmed she did not notify the nurse there was no dressing present to the wound nor had she checked or changed the resident between 10:00 A.M. and 2:50 P.M. because the resident required two people for incontinence care and there was not enough staff. Review of the facility policy titled Wound Prevention undated revealed staff would provide skin hygiene daily with cleanser, rinse and dry thoroughly as needed to keep local areas of skin clean, dry and free of body wastes such as urine, feces, perspiration and wound drainage.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on medical record review, observation, staff interview, and review of the facility policy, the failed to provide appropriate care and treatment to a resident with a pressure ulcer. This affected one (Resident #69) of two residents reviewed for pressure ulcers. The facility census was 74 residents. Findings include: Review of the medical record for Resident #69 revealed an admission date of 11/09/18 with diagnoses including Parkinson's disease and dementia. Review of the care plan for Resident #69 initiated 11/13/18 and updated 05/26/26 revealed Resident #69 had a potential for alteration in skin integrity related to immobility, diagnosis of diabetes mellitus, anemia and bowel and bladder incontinence. Interventions included the following: provide treatments per the physician's order, weekly skin assessment for skin irritation, redness, bruises, scratches, open areas, check every two hours and as needed for incontinence. Review of the Minimum Data Set (MDS) assessment for Resident #69 dated 05/15/26 revealed the resident was severely cognitively impaired, was always incontinent of bowel and bladder, required assistance with activities of daily living (ADLs), was at risk for developing pressure ulcers, and had no wounds. Review of the pressure ulcer risk assessment for Resident #69 dated 05/15/26 completed by Registered Nurse (RN) #306 revealed the resident was at high risk for the development of pressure ulcers. Review of the physician's orders for Resident #69 revealed an order dated 05/27/26 to cleanse the area to the coccyx with normal saline, pat dry, apply Medihoney and cover with dry dressing three times weekly on Tuesday, Thursday, and Saturday and as needed. Review of the weekly skin wound note for Resident #69 dated 06/03/26 at 3:13 P.M. per Wound Care Nurse Licensed Practical Nurse (WCN/LPN) #480 revealed the resident had an open area to her buttocks first identified on 05/26/26 which measured 1.2 (centimeters (cm) in length by 0.8 cm in width by 0.1 cm in depth. An order was obtained to cleanse the area with normal saline, pat dry, apply Medihoney, and cover with a dry dressing three times per week and as needed. Review of the Treatment Administration Record (TAR) for Resident #69 dated June 2026 revealed the order to cleanse the open area to the resident's coccyx with normal saline, pat dry, apply Medihoney, and dry dressing was due to be completed on 06/09/26 but had not been signed off. The last time the dressing was signed off as completed was on 06/06/26. Observation on 06/09/26 at 2:50 P.M. of incontinence care for Resident #69 per Certified Nursing Assistants (CNAs) #351 and #356 revealed the resident's incontinence brief was saturated with urine and stool and there was no dressing to the resident's coccyx wound nor was a dressing present in the brief. The wound was covered with stool. As the CNAs were finishing completion of incontinence care LPN # 339 and WCNLPN #480 entered the room. WCN LPN #480 measured the wound to the resident's coccyx and noted it measured 0.5 cm in length by 0.3 cm in width by 0.2 cm in depth with inflamed surrounding tissue measuring 0.3 cm. Interview on 06/09/26 at 3:01 P.M. with LPN #339 confirmed Resident #69 had an order for a dressing to the coccyx wound but there was no dressing present to the wound. Interview on 06/09/26 at 3:01 P.M. with WCN/LPN #480 verified the open area to Resident #69's coccyx was a pressure ulcer which should have been covered with a dressing, and she was unsure why the dressing was not present. WCN/LPN #480 stated maybe the dressing had fallen off and no one had notified the nurse. Interview on 06/09/26 at 3:21 P.M. with CNA #351 confirmed she was Resident #69's primary aide and she had started her shift at 10:00 A.M. CNA #351 stated at 10:00 A.M. when she laid Resident #69 down to change the resident's brief she noted there was no dressing present to the wound on the resident's coccyx. CNA #351 further confirmed she did not notify the nurse there was no dressing present to the wound nor had she checked or changed the resident between 10:00 A.M. and 2:50 P.M. Review of the facility policy titled Wound Prevention undated revealed the facility would provide care, services and (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation related to the occurrence, treatment, and prevention of pressure and non-pressure related wounds. During daily routine care the CNA will observe the resident's skin. When abnormalities were noted this would be communicated to the licensed nurse. Staff would provide skin hygiene daily with cleanser, rinse and dry thoroughly as needed to keep local areas of skin clean, dry and free of body wastes such as urine, feces, perspiration and wound drainage.		

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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 medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to don appropriate personal protective equipment (PPE) during care activities for residents with orders for enhanced barrier precautions (EBP.) The affected two (Residents #6 and #69) of the residents reviewed for EBP. The facility census was 74 residents. Findings include: 1. Review of the medical record for Resident #6 revealed an admission date of 02/21/25 with diagnosis including chronic kidney disease and obstructive and reflux uropathy. Review of the care plan for Resident #6 dated 10/18/24 revealed the resident was at increased risk for infection and or trauma related to use of foley catheter due to history of prostate cancer and recurrent urinary tract infections. Interventions included an indwelling catheter and EBP. Review of the physician's orders for Resident #6 revealed an order dated 11/19/25 for a foley catheter and EBP. Review of the Minimum Data Set (MDS) assessment for Resident #6 dated 04/27/26 revealed the resident was cognitively intact and had an indwelling catheter. Interview on 06/08/26 at 11:26 A.M. with Resident #6 confirmed staff did not wear PPE when they emptied his catheter. Observation on 06/09/26 at 11:11 A.M. of catheter care for Resident #6 per Certified Nursing Assistant (CNA) #383 revealed the aide did not don a gown prior to entering the resident's room to provide care. There was a sign posted on Resident #6's doorway indicating the resident was on EBP. Interview on 06/09/26 at 11:15 A.M. with CNA #383 confirmed Resident #6 had a sign on the door indicating he was on EBP. CNA #383 stated she did not wear a gown during catheter care for Resident #6. 2. Review of the medical record for Resident #69 revealed an admission date of 11/09/18 with diagnoses included Parkinson's disease and dementia. Review of the MDS assessment for Resident #69 dated 05/15/26 revealed the resident was severely cognitively impaired and required assistance with activities of daily living. Observation on 06/09/26 at 2:50 P.M. of incontinence care for Resident 69 per CNAs #351 and #356 revealed the resident did not have a sign on the door indicating her was on EBP nor were isolation gowns available outside the room. CNAs #351 and #356 did not don gowns while providing care. Observation of incontinence care revealed Resident #69 had an open wound to the coccyx. Licensed Practical Nurses (LPNs) #339 and #480 then entered Resident #69's room to measure the wound and complete wound care. LPNs #339 and #480 did not don gowns while providing care. Interviews on 06/09/26 at 3:10 P.M. with LPNs #339 and #480 confirmed Resident #69 had a pressure ulcer to the coccyx first identified 05/26/26. LPNs #339 and #480 confirmed they had not donned gowns while providing wound care to Resident #69. Observation on 06/11/26 at 9:28 A.M. with the Director of Nursing (DON) revealed there was no EBP sign on or near the doorway to Resident #69's room nor was there PPE readily available for staff to use. Interview on 06/11/26 at 9:30 A.M. with the DON confirmed Resident #69 should be on EBP and staff should don appropriate PPE when providing care. Review of the facility policy titled Enhanced Barrier Precautions undated revealed EBP were used as an infection prevention and control intervention to reduce the transmission of multi drug resistant organisms (MDRO's) to residents. EBP's employed targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions did not otherwise apply. Gloves and gowns are applied prior to performing the high contact resident care activity. Examples of high contact resident care activities requiring the use of gown and gloves for residents on EBP included the following: transferring, providing hygiene, changing briefs or assisting with toileting, device care or use (including urinary catheter), wound care.		