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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165234	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Manor	516 Thirteenth Street Wellman, IA 52356

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26529 Based on observation, clinical record review, and staff interviews, the facility failed to administer medications as ordered for 1 of 5 residents reviewed (Resident #1). The facility's failure resulted in Resident #1's increased agitation and escalation of physical behaviors that resulted in aggressive physical contact between Resident #1 and another resident (Resident #2). In addition, a staff member, Staff A, Certified Nurse Aide (CNA), got injured from an encounter with Resident #1. The facility reported a census of 55 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] listed his admitted as 5/30/24 from an inpatient psychiatric hospital. Resident #1 could make himself understood, and usually understood others. The MDS reflected Resident #1 had a Level II PreAdmission Screening and Resident Review (PASRR) initated for severe mental illness. The MDS indicated he had delusions, physical, and verbal behaviors directed towards others that occurred from 1 to 3 days of the 7 days that preceded the assessment the behaviors put Resident #1 at increased risk for physical illness or injury, significantly interfered with Resident #1's care and participation in activities/social interaction, put others at risk for significant injury, was significantly intrusive on the privacy or activities of others, and significantly disrupted the care or living environment. The MDS indentified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. Resident #1 required limited staff assistance/supervision for eating, dressing the upper body and personal hygiene. He required moderate staff assistance for transfers from chair to bed or toilet, dressing his lower body and bathing. He didn't walk and used a wheel chair for his primary mode of transportation. A hospitalization Summary Report dated 5/28/24 indicated Resident #1 stayed in the hospital since 5/13/24 at the inpatient psychiatric unit following an episode of physical aggression at a his Assisted Living (AL) facility. They reported he had aggressive behaviors ongoing for the past several months, and consistent with major neurocognitive disorder with behavioral disturbance. Resident #1 would benefit from medication optimization. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Level II PASRR dated 5/24/24 reflected Resident #1 had diagnoses that included major neurocognitive disorder, major depressive disorder, generalized anxiety disorder, gambling disorder, and alcohol abuse in remission. The PASRR identified Resident #1 met the criteria and determined appropriate for long term care facility placement. The assessment indicated he required specialized services that included ongoing psychiatric medication management by a psychiatrist or a psychiatric Advanced Registered Nurse Practitioner (ARNP) to evaluate his response and effectiveness of the psychotropic medications on target symptoms, modify medication orders, and evaluate ongoing need for additional behavioral health services. Resident #1's Medication orders listed on the hospital discharge summary dated 5/30/24 included: a. Trazodone (anti-depressant and can be used as a sedative) 50 milligram (mg) administered by mouth (oral) twice daily at 12:00 p.m. and 5:00 p.m. b. Trazodone 25 mg administered oral twice daily as needed (PRN) for prolonged agitation, with notation 1st line (first treatment of choice for resident agitation). c. Quetiapine (anti-psychotic) 50 mg administered oral daily. d. Quetiapine 75 mg administered oral daily at 6:30 p.m. A Nursing Progress Note transcribed by Staff B, Registered Nurse (RN), on 5/30/24 at 4:13 p.m. reflected Resident #1 arrived to facility at approximately 2:45 p.m. via a wheelchair van. He appeared alert and oriented, however he had a new diagnosis of dementia with a history of sundowners (increased agitation and confusion around sunset hours), intermittent confusion, speech clear, and appropriate. Resident #1 visited with the other residents in common area and appeared to adjust well. The clinical record review revealed the Director of Nursing (DON) entered Resident #1's medication orders in the electronic record on 5/30/24 at the following times: a. Trazodone 50 mg oral tablet, give 50 mg by mouth daily in the afternoon, entered at 6:00 p.m. - The medication order said to start on 5/31/24 at 11:00 a.m. b. Trazodone 50 mg oral tablet, give 50 mg by mouth daily in the evening, entered at 6:00 p.m. - The medication order directed to start on 5/31/24 at 4:00 p.m. c. Trazodone 50 mg oral tablet, give 25 mg by mouth as needed (0.5 tab) 2 times a day for agitation, entered at 5:30 p.m. - The medication order directed to start on 5/30/24 at 5:30 p.m. d. Quetiapine 25 mg oral tablet, give 50 mg by mouth in the morning, entered at 6:00 p.m. - The medication order directed to start on 5/31/24 at 6:00 a.m. e. Quetiapine 25 mg oral tablet, give 75 mg by mouth in the evening, entered at 6:00 p.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The medication order directed to start on 5/31/24 at 4:00 p.m. Nursing Progress Note entries by Staff C, Licensed Practical Nurse (LPN) revealed: a. On 5/30/24 at 7:16 p.m. Resident actively attempted to exit, stating he had a doctor appointment and needed to leave. Staff provided multiple redirects from the front door. b. On 5/30/24 at 7:45 p.m., 8:28 p.m., 9:28 p.m., 9:48 p.m., 10:17 p.m., 10:48 p.m., 11:03 p.m. and 11:36 p.m. described Resident #1 continued his exit seeking behavior that required mulitple redirects by staff. c. On 5/31/24 at 12:17 a.m., 1:43 a.m. and 2:05 a.m. described Resident #1 required 1 to 1 staff supervision in the common area due to his exit seeking behavior. d. On 5/31/24 at 3:00 a.m., Resident #1 actively attempted to exit, stating he had a doctor appointment and needed to leave. Staff C informed him that its still night time and they could figure it out in the morning. Resident #1 became very aggressive, stood up from his wheelchair, declared he is going to leave, and no one is going to stop him! He expressed being very angry for being locked up in the facility. e. Additional entries by Staff C on 5/31/24 at 4:00 a.m. and 4:30 a.m. described Resident #1's continued exit seeking behavior. f. On 5/31/24 at 6:45 a.m. Resident #1 went through kitchen and set off the east dining room door alarm, he reported looking for the night nurse. Staff C redirected him back over to the lounge area. The facility's Nurse Practitioner (NP), an adult and geriatric specialty NP, assessed Resident #1 on 5/31/24 at 2:23 p.m. and ordered Resident #1 to receive lorazepam (anti-anxiety medication) 0.5 mg by mouth daily at bedtime (HS) and 0.5 mg by mouth as needed for anxiety. A Nursing Progress Note transcribed by Staff D, RN, on 5/31/24 at 10:42 p.m. indicated around 9:15 p.m., upon reaching the nurses station Resident #1 sat in his wheelchair, hitting and attempting to kick a CNA. The CNA reported Resident #1 went in Resident #2's room, hitting and pushing that resident. The CNA stepped in and assisted Resident #1 back to the nurses station. During that time Resident #1 kept screaming and attempting to either hit or kick the CNA and Staff D while trying to ask what happened. Staff D notified the DON, Administrator and Nurse Practitioner (NP). They received an order to transport Resident #1 to the hospital emergency room (ER) for psychiatric evaluation. Staff D called 911 dispatch, the county sheriff and ambulance arrived around 9:25 p.m. to 9:30 p.m Review of Resident #1's May, 2024 Medication Administration Record (MAR) revealed Resident #1 didn't receive the following medications as ordered: a. Trazodone 50 mg tablet ordered daily at 5:00 p.m. on 5/30/24 b. Quetiapine 75 mg ordered daily at 6:30 p.m. on 5/30/24. c. Trazodone ordered as needed, the 1st line for agitation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Resident #1 did receive lorazepam as ordered at HS on 5/31/24. A Hospital ER Progress Note and Psychiatrist Physician assessment dated [DATE] stated: Patient had past psychiatric history of major depressive disorder and dementia who presented to the emergency department for violent behaviors at care facility. Dementia is a chronic and progressive disease that cannot be cured, and often times comes with agitation. At this time, patient wouldn't benefit from psychiatric admission as he previously was admitted and subsequently had violent behaviors immediately after discharge. Furthermore, patients with major neurocognitive disorders can often decompensate and become even more confused with the change to setting, worsening their behaviors. In terms of agitation, lorazepam as needed will often disinhibit elderly patients and make agitation worse. In order to decrease harm from known risks of benzodiazepines (group of sedative medication that includes lorazepam) in elderly patients, recommend changing as needed lorazepam to trazodone. A Nursing Progress Note transcribed by Staff E, LPN, on 6/3/24 at 1:22 p.m. indicated they sent a message to the NP regarding the as needed order for lorazepam. The facility's NP made additional psychiatric medication order changes that included: a. Lorazepam 0.5 mg administer oral daily at 1:00 p.m., ordered 6/1/24. b. Haldoperidol (anti-psychotic) administer 2 mg tablet oral twice a day as needed, ordered 6/2/24. c. Lorazepam 0.5 mg administer oral daily at 1:00 p.m. discontinued 6/3/24 at 2:35 p.m. d. Lorazepam 0.5 mg administer oral as needed (ordered on 5/31/24) discontinued 6/3/24 at 2:35 p.m. e. Lorazepam 0.5 mg administer by intramuscular injection (a shot) daily as needed, ordered 6/5/24. f. Haldoperidol 4 mg administer oral 4 times a day as needed, ordered 6/5/24. g. Trazodone dose increased to 75 mg administer oral twice daily, ordered 6/5/24. The clinical record did not reveal, and the facility couldn't provide documentation the facility NP consulted or coordinated Resident #1's psychiatric medication orders with a psychiatrist or psychiatric nurse practitioner. A Nursing Progress Note transcribed by Staff C on 6/18/24 at 8:50 p.m. stated: Resident #1 assaulted a CNA as they provided 1:1 while in room. The staff stated Resident #1 hit her in the arm and face, bit her left hand, twisted her hand causing her nails to break, and drew blood. The nurse notified the Administrator immediately, who gave instructions to call 911, request ambulance with escort to send Resident #1 to the ER. 9:05 p.m.: DON (Director of Nursing) at the facility. 9:15 p.m.: EMS (Emergency Medical Services) and Sheriff at the facility. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9:30 p.m.: County paramedics at the facility. 9:37 p.m.: Resident left the facility with EMS. Review of Resident #1's June 2024 MAR revealed: a. Trazodone 50 mg administered oral daily at 12:00 administered from 6/2/24 through 6/5/24. b. Trazodone 50 mg administered oral daily at 5:00 p.m. administered 6/2/24 through 6/5/24. c. Trazodone 75 mg administered oral daily at 12:00 p.m. not administered on 6/7/24, recorded by Staff F, Certified Medication Aide (CMA). d. Trazodone 75 mg administered oral daily at 5:00 p.m. administered from 6/6/24 through 6/17/24. e. Quetiapine 50 mg administered oral daily in the morning not administered on 6/1/24 as resident was not in the facility, and not administered on 6/7/24 and 6/14/24, documented by Staff F, CMA. f. Quetiapine 75 mg administered oral daily at 6:30 p.m. not administered on 6/1/24 as resident was not in the facility, and not administered on 6/7/24 recorded by Staff F, CMA, 6/8/24 recorded by Staff H, CMA, 6/9/24 recorded by Staff I, CMA, 6/10/24 and 6/11/24 recorded by Staff G, CMA, 6/12/24 recorded by Staff J, CMA, 6/13/24 recorded by Staff F, CMA, and 6/14/24 recorded by Staff H, CMA. g. Trazodone 25 mg administered oral 2 times daily as needed administered 5 times. Observations: On 6/20/24 at 11:19 a.m. Staff L, MDS Nurse, revealed 2 automated medication dispensing machines located in a locked medication room. An inventory list of medications available through the system included both trazodone and quetiapine, in various prescription strengths that provided availability for a wide range of medication orders, including coverage if the facility couldn't find Resident #1's medications due to getting lost or misplaced. On 6/20/24 at 1:14 p.m. in the Administrator's office, with the Administrator and DON, there were 3 cardboard boxes, approximate size 14 inches by 18 inches by 10 inches high, each held a large clear plastic bag that contained multiple prescription bottles of medications and bulk over-the-counter medication supplies from the Veteran's Administration (VA) pharmacy for Resident #1. In addition, they had a large clear plastic bag with multiple prescription bottles and pharmacy supplies provided by the VA pharmcy for Resident #1. All together, they had at least 70 prescription medication bottles between the 4 bags for Resident #1. Count of Resident #1's trazodone and quetiapine medications issued by the VA pharmacy at that time revealed: a. Trazadone 50 milligram (mg) tablets, 90 tablets dispensed 5/30/24, instructions on the bottle directed 1 tablet administered oral daily at noon, 1 tablet administered oral daily in the evening at 5:00 p.m., and 1/2 tablet administered oral as needed twice daily, 88 whole tablets and 1 half tablet remained in the bottle. (continued on next page)

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

b. Seroquel (brand name for quetiapine) 25 mg tablets, 150 tablets dispensed 5/30/24, instructions on the bottle directed 2 tablets administered oral daily in the morning and 3 tablets administered oral daily in the evening at 6:30 p.m., 141 tablets remained in the bottle.

c. Trazodone 50 mg tablets, 45 dispensed on 2/12/24, instructions on the bottle directed 1 tablet administered oral daily and a half tablet administered once daily as needed, 6 whole tablets and a half tablet remained in the bottle.

d. Trazodone 50 mg tablets, 60 dispensed on 4/15/24, instructions on the bottle directed 1 tablet administered oral daily at hour of sleep (HS), and 1/2 tablet administered oral twice a day as needed, 33 whole tablets and a half tablet remained in the bottle.

A medication dispensing card sent by the facility's pharmacy (not the VA) revealed 28 trazodone 75 mg doses (each were 1/2 of a 150 mg trazodone pill) dispensed on 6/6/24, the label on the card instructed take one-half tablet (75 mg) by mouth every afternoon and every evening, 8 doses (1/2 tablets) remained in the dispensing card on 6/20/24.

The facility provided documentation Assisted Living (AL) staff picked up a prescription bottle of quetiapine 25 mg tablets from the VA pharmacy, 30 tablets dispensed on 5/10/24, the bottle label directed 1 tablet administered oral daily in the evening. The prescription bottle was not in Resident #1's supply of VA meds inspected on 6/20/24, staff would have discarded the bottle when empty. Documentation of medication administration from AL revealed the medication was not administered on 5/10/24 and 1 dose administered at HS on 5/11/24.

Per facility records, Resident #1 received:

a. Trazodone

i. 50 mg dose - 11 documented administrations

ii. 75 mg dose - 24 documented administrations

iii. 25 mg as needed - 5 documented administrations

- The review determined Resident #1 should have received 19 and 1/2 tablets from the supply on hand

- Resident #1 only had 1 and 1/2 tablets removed from the bottle, leaving at least 18 doses not administered.

b. Quetiapine

i. 50 mg dose - 16 documented administrations

ii. 75 mg dose - 9 documented administrations

- The review determined Resident #1 had 59 of the 25 mg tablets administered from the supply on hand, 29 from the bottle dispensed on 5/10/24 and the other 30 from the 5/30/24 bottle.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- However, the bottle dispensed on 5/30/24 only had 9 tablets removed from the bottle, indicating 11 doses not administered. The facility's Equipment and Supplies for Administering Medications policy revised August, 2014, directed staff: a. The facility maintains equipment and supplies necessary for preparation and administration of medications. b. The charge nurse is notified if supplies are inadequate or equipment fails to work properly. The charge nurse reports equipment and supply deficiencies to the DON. The facility's Medication Administration General Guidelines policy revised August, 2014, directed staff: a. Medications are administered as prescribed in accordance with good nursing principles and practices. b. If a medication with a current, active order cannot be located in the medication cart, medication room,and facility, the pharmacy is contacted or medication removed from the emergency medication kit. c. Medications are administered in accordance with written orders of the prescribe. d. Residents may actively refuse medications. Medication refusal must be reported to the prescriber based upon facility guidelines. e. If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time, the space provided on the MAR for that dosage administration is initialed and circled. Documentation of the event is required in the record. The facility's Emergency Pharmacy Service and Emergency Kits policy, revised August 2014, listed the emergency pharmacy service is available on a 24 hour basis. Emergency needs for medication are met by using the facility's approved emergency medication supply or by special order from the provider pharmacy. The provider pharmacy supplies emergency medications including emergency drugs, antibiotics, controlled substances, products for infusion in the automated dispensing unit and/or electronic medication cabinet. Staff Interviews On 6/20/24 at 1:28 p.m., the Administrator stated when Resident #1 admitted on [DATE] to the facility, he had all of his prescription medications issued from the VA pharmacy with him. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/24 at 2:25 p.m. Staff C stated she worked the 6:00 p.m. to 6:00 am shift through agency at the facility. Seh explained the CMA's had the responsiblility to provide the medication administration on the evening shift (6:00 p.m. to 10:00 p.m.). She worked from 6:00 p.m. on 5/30/24 through 6:00 a.m. on 5/31/24. Resident #1 acted more like he experienced sundowning, she could talk to him and redirect him to calm him down. He pretty much required 1 to 1 with him that night. She did not administer the as needed trazodone because she could redirect him from the exit seeking behaviors. On 6/19/24 at 2:41 p.m. Staff A stated she worked the evening shift on 5/31/24, as she walked a different resident in the hall she observed Resident #1 push Resident #2 into her room. He had a hold of her wrists and wouldn't let go as he yelled at the resident to go lay down. Staff A stated she had to get the resident she ambulated safely seated before she could intervene, yelled for help and got to Resident #2's room as quickly as she could. She attempted to separate Resident #1 from Resident #2. Staff M, CNA, also responded and helped to separate the residents, Staff M stayed with Resident #2 as Staff A got Resident #1 out of her room. She took him towards the Nurse's Station and Resident #1 kicked her in the stomach, but not hard enough to cause injury. The facility assigned her to work 1:1 with Resident #1 on the 6/18/24 evening shift. Resident #1 demanded to see her papers, because he saw his name on the clipboard. She let him see the clipboard and he became more agitated, he struck her on the chin with his hand, she raised her left arm to protect herself and he bit her on that hand, twisted her hand hard and pulled her fingers back which caused 2 of her fingernails to break off and fractured the distal end of her finger. Staff A reported she had an evaluation, where they treated her injuries on the morning of 6/19/24. On 6/25/24 at 3:32 p.m. Staff F, Certified Medication Aide (CMA), stated Resident #1 had times he would take his medication fine, other times he said he didn't need it and wouldn't take it. Sometimes the facility didn't have the medication available and had to get it from the automated dispensing machine at the facility. She told the nurse if Resident #1 refused, and she would try to offer the medication at another time, but she didn't document that. Staff F documented an H for held when she was responsible for medication administration on 6/7/24 for the 12:00 p.m. Trazodone dose and the morning and 6:30 p.m. Quetiapine doses, the 6:30 p.m. Quetiapine dose on 6/13/24, and the morning Quetiapine dose on 6/14/24. On 6/25/24 at 3:01 p.m. Staff G, CMA, stated she marked Resident #1's MAR with NA for not administered when she couldn't find the bottle for the medication, and they didn't have the correct dose for him in the automated medication dispensing machine. Later she realized she could have gave 2 pills for a dose, so she could have gave him the correct dosage from the dispenser. She didn't remember if she told the nurse about the missed dose because she didn't think the nurse could get the correct dose from the dispenser. Staff G recorded NA for the 6:30 p.m. quetiapine dose on 6/11/24, and did not administer the dose on 6/10/24 documented as a circle around her initials on the MAR. Staff G stated she suspected the other staff didn't administer Resident #1's VA medications, but she had no proof and didn't report it to anyone. On 6/25/24 at 4:35 p.m. Staff H, CMA, stated when she administered Resident #1's medications on the 6/8/24 evening shift, she found an empty bottle of quetiapine in the med cart, and documented NA for not available. She realized afterward she should have told the nurse to pull the medication from the automated dispenser, but did not. She recorded an R when Resident #1 refused the quetiapine 6:30 p.m. dose on 6/14/24, and did not tell the nurse he refused the medication, she added Resident #1 usually took his medications pretty good. (continued on next page)

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