

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/27/2025
NAME OF PROVIDER OR SUPPLIER  Parkview Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>35434</p> <p>Based on clinical record review, facility policy review, staff and resident interviews, the facility failed to ensure staff treated residents with dignity and respect while providing incontinence cares for 2 of 6 residents reviewed for dignity(Residents #2 and #7). The facility reported a census of 49 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set(MDS) assessment tool, dated 2/4/25, listed diagnoses for Resident #2 which included non-Alzheimer's dementia, multiple sclerosis (a disease which causes impairment in the nerves), and diabetes. The MDS stated the resident required partial/moderate assistance with toileting hygiene and listed her Brief Interview for Mental Status (BIMS) score as 5 out of 15, indicating severely impaired cognition.</p> <p>The facility policy Resident Rights reviewed 4/26/23, stated the facility would treat residents with kindness, respect, and dignity.</p> <p>Review of Care Plan, dated 7/3/24, revealed a Focus area to address [Name redacted] has a psychosocial well-being problem due to past trauma in her life Anxiety. Interventions included, in part: Allow [name redacted] time to answer questions and to verbalize feelings, perceptions, and fears.</p> <p>Review of the Care Plan, dated 7/15/24 revealed a Focus area to address [Name redacted] is ADL self-care performance deficit. Interventions included, in part TOILET USE; partial, needs cueing and reminders to toilet and help with incontinence care, date initiated: 7/15/24.</p> <p>A 3/9/25 Nurses Note stated Resident #2 and her roommate reported that the Certified Nursing Assistant (CNA) was very rough and mean when she entered the room to help the resident. The resident stated she just pulled my pants down and pushed me over. The resident was very distraught and the nurse informed her she would speak with the CNA and pass the information along to management. Both residents stated they did not want the CNA to return to their room. After speaking with the CNA, the nurse heard her in the same resident room trying to turn off the call light speaking in a snippy and hostile manner.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/25/25 at 9:45 a.m., Resident #3 (Resident #2's roommate) stated Staff A came into the resident's room in the middle of the night and Resident #2 was asleep and she could hear her snoring. Resident #3 stated Staff A flipped the blankets down and pulled Resident #2's pants down. Resident #2 told Staff A no and she swatted her hand at Staff A and said oww. Resident #3 stated that Staff A then said that we all had to do things we didn't want to do. Staff A then placed the brief on Resident #2 and Resident #2 told her to get out and she left the room.</p> <p>Review of Staff A's Time Card documented she punched in on 3/8/25 at 10:00 p.m. and punched out at 6:00 a.m.</p> <p>During an interview on 3/25/25 at 3:47 p.m., Staff D Licensed Practical Nurse (LPN) stated she was called into Resident #2's room by her roommate and they both said they did not appreciate how the CNA behaved towards Resident #2. They stated she did not warn her before rolling her and was harsh with her wording. She said both residents were not happy and did not want her to return. She stated later in the shift she heard Staff A in Resident #2 and #3's room and she was speaking in a short manner and not using proper bedside manner right after she had spoken to her about it. She said she could not make out the words she was saying. Staff D stated she texted the Director of Nursing(DON) towards the end of her shift regarding Staff A.</p> <p>2. The MDS assessment tool, dated 2/12/25, listed diagnoses for Resident #7 which included morbid (severe) obesity, anxiety, and depression. The MDS stated the resident required partial/moderate assistance rolling left and right and substantial/maximal assistance with toileting hygiene. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition.</p> <p>A 9/14/22 Care Plan entry directed staff to assist the resident with cleansing after each incontinent episode.</p> <p>During an interview on 3/25/25 at 3:02 p.m., Resident #7 stated Staff A came into her room and asked her to roll over. She stated she felt Staff A's manner towards her was almost like she was mad. She stated she told Staff D about it and she did not have her come in her room anymore.</p> <p>During an interview on 3/26/25 at 12:47 p.m. Staff F CNA stated that Resident #7 told her that Staff A was rude and rough when rolling her and was throwing her during rolling. Staff F stated she reported this the the nurse about 2 weeks ago but was not sure which nurse.</p> <p>During an interview on 3/26/25 at 4:00 p.m., the Administrator stated if someone was mean, rude, or rough, they completed an observation of that worker. She was under the impression the concerns with Staff A were more related to cultural differences. She stated staff did not tell her she was mean or rough. Staff did not report any concerns with Resident #7. She stated if staff reported such concerns they would take it seriously. They would investigate and suspend that person and report it to the State Agency within 2 hours. She stated she did not know about the situation with Resident #2 until they were scanning over the weekend progress notes on Monday morning 3/10/25. She stated she would not have wanted Staff A to continue working(after the allegation was made).</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>35434</p> <p>Based on clinical record review, policy review, and staff and resident interviews, the facility failed to report allegations of abuse for 2 of 2 residents reviewed for abuse (Residents #2 and #7). The facility reported a census of 49 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) assessment tool, dated 2/4/25, listed diagnoses for Resident #2 which included non-Alzheimer's dementia, multiple sclerosis(a disease which causes impairment in the nerves), and diabetes. The MDS stated the resident required partial/moderate assistance with toileting hygiene and listed her Brief Interview for Mental Status (BIMS) score as 5 out of 15, indicating severely impaired cognition.</p> <p>The facility Abuse Prevention policy, dated 10/21/22, declared:</p> <p>a. The facility was committed to protecting the residents from abuse by anyone including facility staff.</p> <p>b. The facility would report alleged abuse violations to the State Survey Agency immediately but not later than 2 hours after the allegation was made.</p> <p>Review of Care Plan, dated 7/3/24, revealed a Focus area to address [Name redacted] has a psychosocial well-being problem due to past trauma in her life Anxiety. Interventions included, in part: Allow [name redacted] time to answer questions and to verbalize feelings, perceptions, and fears.</p> <p>Review of the Care Plan, dated 7/15/24 revealed a Focus area to address [Name redacted] is ADL self-care performance deficit. Interventions included, in part TOILET USE; partial, needs cueing and reminders to toilet and help with incontinence care, date initiated: 7/15/24.</p> <p>A 3/9/25 Nurses Note stated Resident #2 and her roommate reported that the Certified Nursing Assistant (CNA) was very rough and mean when she entered the room to help the resident. The resident stated she just pulled my pants down and pushed me over. The resident was very distraught and the nurse informed her she would speak with the CNA and pass the information along to management. Both residents stated they did not want the CNA to return to their room. After speaking with the CNA, the nurse heard her in the same resident room trying to turn off the call light speaking in a snippy and hostile manner.</p> <p>During an interview on 3/25/25 at 9:45 a.m., Resident #3 (Resident #2's roommate) stated Staff A came into the resident's room in the middle of the night and Resident #2 was asleep and she could hear her snoring. Resident #3 stated Staff A flipped the blankets down and pulled Resident #2's pants down. Resident #2 told Staff A no and she swatted her hand at Staff A and said oww. Resident #3 stated that Staff A then said that we all had to do things we didn't want to do. Staff A then placed the brief on Resident #2 and Resident #2 told her to get out and she left the room.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Staff A's Time Card documented she punched in on 3/8/25 at 10:00 p.m. and punched out at 6:00 a.m.</p> <p>The facility lacked documentation they reported the allegation to the State Agency (SA) prior to 3/10/25.</p> <p>During an interview on 3/25/25 at 3:47 p.m., Staff D Licensed Practical Nurse (LPN) stated she was called into Resident #2's room by her roommate and they both said they did not appreciate how the CNA behaved towards Resident #2. They stated she did not warn her before rolling her and was harsh with her wording. She said both residents were not happy and did not want her to return. She stated later in the shift she heard Staff A in Resident #2 and #3's room and she was speaking in a short manner and not using proper bedside manner right after she had spoken to her about it. She said she could not make out the words she was saying. Staff D stated she texted the Director of Nursing (DON) towards the end of her shift regarding Staff A.</p> <p>2. The MDS assessment tool, dated 2/12/25, listed diagnoses for Resident #7 which included morbid(severe) obesity, anxiety, and depression. The MDS stated the resident required partial/moderate assistance rolling left and right and substantial/maximal assistance with toileting hygiene. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition.</p> <p>A 9/14/22 Care Plan entry directed staff to assist the resident with cleansing after each incontinent episode.</p> <p>During an interview on 3/25/25 at 3:02 p.m., Resident #7 stated Staff A came into her room and asked her to roll over. She stated she felt Staff A's manner towards her was almost like she was mad. She stated she told Staff D about it and she did not have her come in her room anymore.</p> <p>During an interview on 3/26/25 at 12:47 p.m. Staff F CNA stated that Resident #7 told her that Staff A was rude and rough when rolling her and was throwing her during rolling. Staff F stated she reported this the the nurse about 2 weeks ago but was not sure which nurse.</p> <p>The facility lacked documentation they reported the allegation to the State Agency.</p> <p>During an interview on 3/26/25 at 4:00 p.m., the Administrator stated if someone was mean, rude, or rough, they completed an observation of that worker. She was under the impression the concerns with Staff A were more related to cultural differences. She stated staff did not tell her she was mean or rough. Staff did not report any concerns with Resident #7. She stated if staff reported such concerns they would take it seriously. They would investigate and suspend that person and report it to the State Agency within 2 hours. She stated she did not know about the situation with Resident #2 until they were scanning over the weekend progress notes on Monday morning 3/10/25. She stated she would not have wanted Staff A to continue working (after the allegation was made).</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>35434</p> <p>Based on clinical record review, policy review, and staff and resident interviews, the facility failed to investigate allegations of abuse and failed to ensure separation between the alleged perpetrator of abuse and residents for 2 of 2 residents reviewed for abuse(Residents #2 and #7). The facility reported a census of 49 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set(MDS) assessment tool, dated 2/4/25, listed diagnoses for Resident #2 which included non-Alzheimer's dementia, multiple sclerosis(a disease which causes impairment in the nerves), and diabetes. The MDS stated the resident required partial/moderate assistance with toileting hygiene and listed her Brief Interview for Mental Status(BIMS) score as 5 out of 15, indicating severely impaired cognition.</p> <p>The facility Abuse Prevention policy, dated 10/21/22, stated the facility was committed to protecting the residents from abuse by anyone including facility staff. The policy stated the facility would investigate allegations of abuse and suspend employees accused of abuse during the investigation.</p> <p>Review of Care Plan, dated 7/3/24, revealed a Focus area to address [Name redacted] has a psychosocial well-being problem due to past trauma in her life Anxiety. Interventions included, in part: Allow [name redacted] time to answer questions and to verbalize feelings, perceptions, and fears.</p> <p>Review of the Care Plan, dated 7/15/24 revealed a Focus area to address [Name redacted] is ADL self-care performance deficit. Interventions included, in part TOILET USE; partial, needs cueing and reminders to toilet and help with incontinence care, date initiated: 7/15/24.</p> <p>A 3/9/25 Nurses Note stated Resident #2 and her roommate reported that the Certified Nursing Assistant(CNA) was very rough and mean when she entered the room to help the resident. The resident stated she just pulled my pants down and pushed me over. The resident was very distraught and the nurse informed her she would speak with the CNA and pass the information along to management. Both residents stated they did not want the CNA to return to their room. After speaking with the CNA, the nurse heard her in the same resident room trying to turn off the call light speaking in a snippy and hostile manner.</p> <p>During an interview on 3/25/25 at 9:45 a.m., Resident #3(Resident #2's roommate) stated Staff A came into the resident's room in the middle of the night and Resident #2 was asleep and she could hear her snoring. Resident #3 stated Staff A flipped the blankets down and pulled Resident #2's pants down. Resident #2 told Staff A no and she swatted her hand at Staff A and said oww. Resident #3 stated that Staff A then said that we all had to do things we didn't want to do. Staff A then placed the brief on Resident #2 and Resident #2 told her to get out and she left the room.</p> <p>Staff A's Time Card documented she punched in on 3/8/25 at 10:00 p.m. and punched out at 6:00 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility lacked documentation of an investigation initiated prior to 3/10/25 and lacked documentation Staff A was separated from residents from the time of the allegation to the end of her shift on 3/9/25.</p> <p>During an interview on 3/25/25 at 3:47 p.m., Staff D Licensed Practical Nurse (LPN) stated she was called into Resident #2's room by her roommate and they both said they did not appreciate how the CNA behaved towards Resident #2. They stated she did not warn her before rolling her and was harsh with her wording. She said both residents were not happy and did not want her to return. She stated later in the shift she heard Staff A in Resident #2 and #3's room and she was speaking in a short manner and not using proper bedside manner right after she had spoken to her about it. She said she could not make out the words she was saying. Staff D stated she texted the Director of Nursing(DON) towards the end of her shift regarding Staff A.</p> <p>2. The MDS assessment tool, dated 2/12/25, listed diagnoses for Resident #7 which included morbid(severe) obesity, anxiety, and depression. The MDS stated the resident required partial/moderate assistance rolling left and right and substantial/maximal assistance with toileting hygiene. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition.</p> <p>A 9/14/22 Care Plan entry directed staff to assist the resident with cleansing after each incontinent episode.</p> <p>During an interview on 3/25/25 at 3:02 p.m., Resident #7 stated Staff A came into her room and asked her to roll over. She stated she felt Staff A's manner towards her was almost like she was mad. She stated she told Staff D about it and she did not have her come in her room anymore.</p> <p>During an interview on 3/26/25 at 12:47 p.m. Staff F CNA stated that Resident #7 told her that Staff A was rude and rough when rolling her and was throwing her during rolling. Staff F stated she reported this the the nurse about 2 weeks ago but was not sure which nurse.</p> <p>The facility lacked documentation of an investigation initiated regarding Resident #7's allegation and lacked documentation Staff A was separated from residents at the time of the allegation.</p> <p>During an interview on 3/26/25 at 4:00 p.m., the Administrator stated if someone was mean, rude, or rough, they completed an observation of that worker. She was under the impression the concerns with Staff A were more related to cultural differences. She stated staff did not tell her she was mean or rough. Staff did not report any concerns with Resident #7. She stated if staff reported such concerns they would take it seriously. They would investigate and suspend that person and report it to the State Agency within 2 hours. She stated she did not know about the situation with Resident #2 until they were scanning over the weekend progress notes on Monday morning 3/10/25. She stated she would not have wanted Staff A to continue working(after the allegation was made).</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>35434</p> <p>Based on clinical record review, policy review, and staff interview, the facility failed to notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for 1 of 1 discharges reviewed (Resident #8). The facility reported a census of 49 residents.</p> <p>Findings included:</p> <p>1. The Minimum Data Set (MDS) assessment tool, dated 1/17/25, listed diagnoses for Resident #8 which included bipolar disorder, anxiety, and depression and listed the resident's Brief Interview for Mental Status (BIMS) score as 14 out of 15, indicating intact cognition.</p> <p>A 2/4/25 Health Status Note stated the resident had increasing behaviors and the facility sent him to the hospital for evaluation.</p> <p>The facility lacked documentation of resident representative and ombudsman notification of discharge.</p> <p>On 3/27/25 at 10:21 a.m., via email, the Administrator stated the facility did not notify the ombudsman of the resident's discharge.</p> <p>The facility policy Notification of Transfer and Discharge, dated 3/17/25, stated the facility would provide the resident and resident representative notice of an impending transfer or discharge. The facility would notify the resident and resident representative(s) of the impending transfer or discharge and the reasons for the move in writing and in a language and manner they would understand. The facility would also send a copy of the notice to a representative of the Office of the State Long Term Care Ombudsman.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>35434</p> <p>Based on clinical record review, policy review, and staff interview, the facility failed to provide the resident and/or the resident's representative(s) a notice of bed-hold policy for 1 of 1 discharges reviewed (Resident #8). The facility reported a census of 49 residents.</p> <p>Findings included:</p> <p>The Minimum Data Set (MDS) assessment tool, dated 1/17/25, listed diagnoses for Resident #8 which included bipolar disorder, anxiety, and depression and listed the resident's Brief Interview for Mental Status (BIMS) score as 14 out of 15, indicating intact cognition.</p> <p>The facility policy Resident Bed Hold, dated 11/15/22, stated the facility would provide written information to the resident and/or the resident representative regarding the bed hold policy prior to transferring the resident to the hospital. The facility would provide written information about these policies prior to and upon transfer for such absences.</p> <p>A 2/4/25 Health Status note stated the facility planned to transfer the resident to the hospital. The note lacked documentation of family notification of the transfer or bed hold information provided to the family.</p> <p>The 2/4/25 Discharge Evaluation lacked documentation regarding bed hold.</p> <p>The facility lacked documentation they provided the resident and/or the resident's representative(s) a notice of bed-hold policy at the time of the resident's discharge.</p> <p>On 3/27/25 at 10:42 a.m. via email, the Administrator stated it was her understanding the nurse on duty communicated with the family regarding the resident's discharge to the hospital and this would have included bed hold information.</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>35434</p> <p>Based on clinical record review, policy review, and staff interview, the facility failed to ensure the completion of proper notices and documentation after they did not allow a resident to return to the facility after a hospitalization for 1 of 1 discharged residents reviewed(Resident #8). The facility reported a census of 49 residents.</p> <p>Findings included:</p> <p>The Minimum Data Set (MDS) assessment tool, dated 1/17/25, listed diagnoses for Resident #8 which included bipolar disorder, anxiety, and depression and listed the resident's Brief Interview for Mental Status (BIMS) score as 14 out of 15, indicating intact cognition. The MDS stated the resident had no behaviors during the review period.</p> <p>The facility policy Notification of Transfer and Discharge, dated 3/17/25, stated the facility would provide the resident and resident representative notice of an impending transfer or discharge which would include the reason for discharge and information regarding appeal rights.</p> <p>A 10/24/24 Nurses Notes stated the resident admitted to the facility and was pleasant and cooperative.</p> <p>A 12/14/24 Behavior Note stated the resident's family member stated the resident sounded depressed. The Director of Nursing (DON) spoke to the resident and he stated he had no plan to harm himself but did not feel like himself.</p> <p>The facility lacked documentation of any further behaviors displayed by the resident from his admission until 2/2/25.</p> <p>A 2/2/25 Nurses Note stated the resident had increased behaviors.</p> <p>A 2/4/25 8:37 a.m. Health Status note documented the resident was behaviorally different from baseline after his electroconvulsive therapy (ECT) treatment yesterday. Throughout the evening and overnight, the resident's behaviors became increasingly erratic and included, urinating on the floor, and taking all of his clothes off. The facility obtained an order to send him to the hospital for evaluation.</p> <p>The resident's clinical record lacked the following:</p> <ul style="list-style-type: none"> <li>a. documentation related to the clinical decision making process regarding the resident's inability to return to the facility.</li> <li>b. documentation of provider consultation in the decision making to not allow the resident to return.</li> <li>c. documentation of which specific needs the facility could not provide the resident.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>d. documentation that the facility provided the family with information regarding appeal rights including the name, address(mailing and email), and telephone number of the entity which received such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request.</p> <p>During an interview on 3/25/25 at 1:51 p.m. Staff B, Licensed Practical Nurse (LPN) stated prior to the night the resident had his change in condition, they did not have problems with him. She stated after he came back from his ECT appointment, he couldn't move his legs and he was in a wheelchair. She stated he lost it and was not in the same mental status. He threw his shoes and needed to have one on one supervision. She stated he was very out of character and they had to provide individual supervision to keep him from falling.</p> <p>On 3/25/25 at 2:09 p.m., Staff C, Certified Nursing Assistant (CNA) stated normally Resident #8 would joke around and seemed like a regular person. He stated the day before he discharged from the facility, he went to the hospital for a treatment and when he came back he said he felt drunk but had not been drinking. Staff C stated he became more loud and obnoxious and unaware of what was going on. Staff C stated he had to lead him out of another resident's room and he undressed himself in the dining room. Staff C stated this was not like him.</p> <p>During an interview on 3/25/25 at 3:47 p.m., Staff D, LPN stated Resident #8 did not need a whole lot of help and she never had problems with him or observed behavioral issues.</p> <p>On 3/26/25 at 12:47 p.m. Staff F CNA stated she loved Resident #8 and he was usually so relaxed and calm. She said he was friends with another resident and played cards at night. She stated however that the last night he was at the facility he was not himself. He was in the hallway and had his shorts off and threw them across the hallway. She stated this was very odd for him and her jaw dropped. She stated she had to sit with him for an hour because he kept getting up. She stated the nurse took his vitals and they were fine and they didn't think they could send him out in the middle of the night based solely on his behaviors. She stated the kitchen staff arrived and made him an early breakfast because he said he was hungry but he then refused the meal and threw the food items.</p> <p>During an interview 3/26/25 at 3:36 p.m., the Social Worker stated it was difficult to have the resident in the facility because they could not carry out one on one supervision. She stated they had a meeting with the family and told them if something else happened they did not know if they could bring him back.</p> <p>On 3/26/25 at 4:00 p.m., the Administrator stated the made the decision they were not going to take the resident back and stated the company's regional consultant gave them specific reasons but she did not have documentation of those reasons.</p> <p>During an interview on 3/27/25 at 1:18 p.m., the Administrator stated she did not have documentation related to the decision making process with regard to Resident #1 not being allowed to return to the facility. She stated she thought that the paperwork including appeal notices did not need to be completed if the resident was out of the facility more than 10 days.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/27/2025
NAME OF PROVIDER OR SUPPLIER  Parkview Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0713</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or arrange emergency care by a doctor 24 hours a day.</p> <p>35434</p> <p>Based on clinical record review, policy review, and staff interview, the facility failed to provide emergency services in a timely manner (Resident #8). The facility reported a census of 49 residents.</p> <p>Findings included:</p> <p>The Minimum Data Set (MDS) assessment tool, dated 1/17/25, listed diagnoses for Resident #8 which included bipolar disorder, anxiety, and depression and listed the resident's Brief Interview for Mental Status (BIMS) score as 14 out of 15, indicating intact cognition. The MDS stated the resident had no behaviors during the review period.</p> <p>The facility policy Notification of a Change in Condition, revised 4/26/23, stated the facility would notify the provider of a resident's change in condition including unusual behavior.</p> <p>A 2/2/25 Nurses Note stated the resident had increased behaviors.</p> <p>A 2/4/25 8:37 a.m. Health Status note stated the resident was behaviorally different from baseline after his electroconvulsive therapy (ECT) treatment yesterday. Throughout the evening and overnight, the resident's behaviors became increasingly erratic and included, urinating on the floor and taking all of his clothes off. The facility obtained an order to send him to the hospital for evaluation.</p> <p>On 3/25/25 at 2:09 p.m., Staff C CNA stated normally Resident #8 would joke around and seemed like a regular person. He stated the day before he discharged from the facility, he went to the hospital for a treatment and when he came back he said he felt drunk but had not been drinking. Staff C stated he became more loud and obnoxious and unaware of what was going on. Staff C stated he had to lead him out of another resident's room and he undressed himself in the dining room. Staff C stated this was not like him.</p> <p>On 3/25/25 at 3:47 p.m., Staff D LPN stated Resident #8 did not need a whole lot of help and she never had problems with him or observed behavioral issues.</p> <p>On 3/26/25 at 12:47 p.m. Staff F CNA stated she loved Resident #8 and he was usually so relaxed and calm. She said he was friends with another resident and played cards at night. She stated however that the last night he was at the facility he was not himself. He was in the hallway and had his shorts off and threw them across the hallway. She stated this was very odd for him and her jaw dropped. She stated she had to sit with him for an hour because he kept getting up. She stated the nurse took his vitals and they were fine and they didn't think they could send him out in the middle of the night based solely on his behaviors. She stated the kitchen staff arrived and made him an early breakfast because he said he was hungry but he then refused the meal and threw the food items.</p> <p>The facility lacked documentation of an assessment carried out or physician notification when staff identified a change in mentation in the middle of the night on 2/3/25 to 2/4/25. The facility lacked documentation of physician notification of the changes prior to 2/4/25 at 8:27 a.m.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/27/2025
NAME OF PROVIDER OR SUPPLIER  Parkview Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  516 Thirteenth Street Wellman, IA 52356	

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<p>F 0713</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/27/25 at 10:45 a.m., the Director of Nursing (DON) stated if a resident had a change in mental status, nurses should notify the provider immediately and have them sent out if there was a complete change from baseline.</p>