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	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Manor	516 13th 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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and resident and staff interviews, the facility failed to prevent a resident-to-resident incident that resulted in an injury. Resident #1 hit Resident #2 with a walker which resulted in a nasal fracture. The facility reported a census of 56. Findings include:1. Review of the Minimum Data Set (MDS), dated [DATE] identified Resident #1 as severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 3 out of 15. The MDS list of diagnoses included metabolic encephalopathy, seizure disorder and age-related cognitive decline. The MDS identified Resident #1 walked independently up to 150 feet, and utilized a walker for mobility. Review of the Care Plan, date initiated: 3/24/25, revealed a Focus area to address [name redacted, Resident #1] has a history/potential of Sundowning (a worsening of symptoms like confusion, anxiety and agitation in the individuals with dementia that occurs in the late afternoon and evening) in the early-late afternoon. Interventions identified, included, in part:a. Anticipate and attempt to meet needs. Date Initiated: 9/19/25.b. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner Divert attention. Remove from situation and take to alternate location as needed. Date Initiated: 9/19/25.The Care Plan, date initiated: 5/30/25, included a Focus area to address [name redacted] has potential/history of being physically aggressive r/t dx (diagnosis) of Dementia and he has poor impulse control. Physically aggressive toward another resident 10/12 and causing serious injury. Interventions included, in part:a. Administer medications as ordered. Monitor for side effects and effectiveness. Date Initiated: 5/30/25.b. Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. Date Initiated: 5/30/25.c. Assess and address for contributing sensory deficits. Date Initiated: 5/30/25.d. Assess and anticipate needs: foods, thirst, toileting needs, comfort level, body positioning, pain, etc. Date Initiated: 5/30/25.e. COMMUNICATION: provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated. Date Initiated: 5/30/25.f. Modify environment: Adjust room temperature to comfortable level, Reduce noise, dim lights, place familiar objects in room, keep door closed, etc. Date Initiated: 5/30/25A review of the progress notes revealed the following Nurses Note entered on 6/13/25 at 11:30 PM, CNA (Certified Nursing Assistant) stated resident [Resident #1] fell after he made an attempt to hit another resident. The resident [Resident #1] stated the other resident involved in verbal altercation was talking bad to the female residents that were also sitting near the nurse's station. Review of the Facility Incident Report, Submission Date: 10/16/25 at 9:36 AM [State Agency notified of incident by phone on 10/12/25 at 5:20 PM] Incident Summary: [Name redacted, Resident #1].with the following diagnosis: Metabolic Encephalopathy, Type 2 Diabetes Mellitus Without Complications, Age-Related Cognitive Decline, Cognitive Communication Deficit, Muscle Weakness, Difficulty in Walking, Not Elsewhere Classified, Not Elsewhere Classified BIMS-03. Name redacted, Resident #2].with the following diagnosis: Senile Degeneration of Brain, Not Elsewhere Classified, Other Giant Cell Arteritis, Polymyalgia Rheumatica, Inflammatory Liver Disease, Unspecified, Nontoxic Multinodular Goiter, Other Specified Symptoms and Signs Involving the Circulatory and Respiratory Systems BIMS-08. On October 12, 2025, at approximately 4:52 PM, [name redacted] Director of Nursing, reported to me, [name redacted], Administrator, that [name redacted Resident #1] had used his walker to strike [name redacted, Resident #2] in the face. It was reported that [name redacted], Dietary Aide, witnessed the incident. Staff immediately intervened, separating from the residents. [Name redacted, Resident #2] was assessed by the nursing staff and transported by ambulance to [name of hospital redacted]. Family/POA/Guardians notified. Nurse Practitioner notified. State Agency notified via phone October 12th, 2025, at approximately 05:20pm.[Name redacted, Resident #1] was placed on 1:1 supervision for 72 hours. [Law enforcement name redacted] notified. Corrective Action Description: Following the conclusion of the investigation, On October 12, 2025, at approximately 4:35 PM, [name redacted, Resident #2] was observed seated in the dining room next to [name redacted, Resident #1] as dining service was about to begin. [Name redacted, Dietary Aide] entered the dining room from the kitchen with the drink cart and witnessed [name redacted, Resident #1] stand, pick up his walker, and strike [name redacted, Resident #2] in the face. No yelling, raised voices, or disturbances were observed prior to the incident. At the time of the incident, [name redacted], Certified Medication Aide, was stationed outside the dining room near the open doors at the medication cart. She heard [name redacted, Resident #2] cry out and immediately intervened. [Name redacted, Resident #1] was standing over