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	04/16/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, record review, and facility policy review, the facility failed to ensure allegations of verbal and physical abuse were reported to the State Agency within two hours of staff knowledge for 1 of 3 residents (Resident #1) reviewed for Resident's Rights. The facility reported a census of 50 residents. Findings include: Review of the Minimum Data Set (MDS) assessment, dated 3/17/26, revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which indicated severe cognitive impairment. The list of diagnoses included: Cerebral Vascular Accident (CVA or stroke) with weakness or decreased sensation affected the right dominant side, non-Alzheimer's dementia, aphasia (acquired communication disorder caused by brain damage that impairs speaking, understanding, reading and writing), anxiety disorder, and depression. The MDS indicated that Resident #1 used a walker to ambulate with set up assistance and required staff supervision while eating.Review of the Care Plan, revised on 3/19/26, revealed a Focus area for Resident #1 having behaviors of frequently calling out with repetitive words and instructed that when Resident #1 is calling out, staff will ensure all needs are met. Once all needs are met, staff will initiated planned ignoring to attempt to decrease unwanted behaviors and staff will praise when positive behaviors are displayed. Review of the Care Plan, revised on 3/19/26, revealed that Resident #1 was a recipient of an allegation of physical and verbal abuse. Interventions instructed the following: a. 2/28/26 incident: Social Services Designee (SSD) to complete psychosocial well-being visits weekly x4 and as needed as Resident #1 allows. Resident #1 separated from the accused (accused no longer works in facility). Psych services to assess and treat as Resident #1 allows. Assessment [skin] completed with no injuries or pain observed. Appropriate departments and Power of Attorney (POA) updated. Date initiated: 3/02/26. b. Encourage visits with SSD to promote healing and recover for Resident #1. Date initiated: 3/02/26. c. Interdisciplinary Team to identify root cause analysis to prevent reoccurrence. Date initiated: 3/02/26. d. Medication review for Resident #1 as needed. Date initiated: 3/02/26. e. Nursing to evaluate Resident #1 for any acute medical conditions as indicated. Date initiated: 3/02/26. f. Nursing and/or Social Services to notify Medical Director and resident representative of any incidents. Date initiated: 3/02/26. g. Physical exam for Resident #1 by provider if indicated. Date initiated 3/02/26. h. Psychiatric consult or referral will be completed as indicated, and only if appropriate and approved by Resident #1 and/or the resident's representative. Date initiated 3/02/26.i. Staff to assess body to identify any potential injuries to Resident #1. Date initiated: 3/02/26.Review of a General Progress Note, dated 3/01/26 at 10:00 AM, revealed the following entry in Resident #1's records: Notified by Administrator that abuse allegations were made against a nurse involving the resident in the dining room. It was witnessed by Dietary Aides that the nurse was observed grabbing resident under his right arm forcefully attempting to remove resident from the dining room due to resident yelling. Resident assessed by the Director of Nursing (DON) for injuries, no bruising or marks noted, and resident denied pain at this time. Resident able to ambulate as before and continued to watch TV with no visible distress noted. Interviews conducted with staff that were present. Alleged nurse refused to speak with the Administrator, turning her keys in and left. POA and provider were updated with the situation. State Agency notified. Social Worker notified to (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	start psychosocial visits. Review of the facility provided document, dated 3/01/26 at 10:00 AM, detailed an alleged abuse incident involving Resident #1 and Staff A, Licensed Practical Nurse (LPN) that occurred in the dining room, summarizing that it was witnessed by Dietary Aides, Staff B and Staff C, that Staff A was observed grabbing Resident #1 under his right arm forcefully attempting to remove resident from the dining room due to resident yelling. During an interview on 4/15/26 at 9:00 AM, Staff B, Dietary Aide, confirmed working on 2/28/26 in the dining room during breakfast and reported that Resident #1 was sitting in the dining room and repeatedly called out to staff, Hey man, I'm hungry!, before his breakfast was served. Staff B stated that she heard Staff A, LPN, tell Resident #1 to, shut up, more than one time, as Staff A walked past Resident #1 and delivered medications to other residents. Staff B stated she also witnessed on the morning of 2/28/26, Staff A tell Resident #1 to Come on, get up! and observed Staff A, yank Resident #1 up from his seat in the dining room, by the right upper arm, then turn him away from the table in a rough manner, and continued to hold onto Resident #1's right upper arm, as Staff A marched him out of the dining room to the common area. Staff B reported that she had heard Staff A tell Resident #1 to shut up on other occasions, before this incident, but had not witnessed any rough handling prior to 2/28/26. Staff B stated that the incident she witnessed between Staff A towards Resident #1, looked and sounded like abuse. Staff B denied telling anyone about what she had witnessed until that evening when she spoke to another kitchen staff about incident and was informed to write a statement. Staff B reported she received education and was instructed to notify her Supervisor immediately with any concerns for abuse. During an interview on 4/15/26 at 12:19 PM, Staff C, Dietary Aide, confirmed working on 2/28/26 in the dining room during breakfast. Staff C reported that he observed Resident #1 ambulating independently in and out of the dining room before breakfast was to be served Staff C stated that he witnessed Resident #1 standing in front of his dining room chair and Staff A, LPN, approached Resident #1, getting very close to him, and started yelling at him, they're not ready for you, go back out. Staff C stated he then witnessed Staff A pull on Resident #1's right forearm, which caused Resident #1's legs to cross, Resident #1 grabbed his walker, then Resident #1 sat himself down in the dining room chair, and Staff A walked away. Staff C reported that he talked to another Dietary staff that day about what he witnessed, talked to the Administrator the following day, and was instructed to write a witness statement of incident by the Administrator. Staff C stated that the way Staff A spoke to Resident #1 had been rude and said the way Staff A pulled Resident #1's arm appeared to be abusive. Staff C reported he received education and was instructed to notify his Supervisor or the Administrator immediately for any concerns of abuse. During an interview on 4/15/26 at 1:15 PM, Activities Director, reported that she worked on the morning of 2/28/26 and witnessed Resident #1 walk from common area towards the dining room and was stopped by Staff A, LPN, who stood at a medication cart that partially blocked the entrance to dining room, Activities Director heard Staff A say to Resident #1, you can't go in there because you're annoying everyone else in the dining room, if you can stop annoying everyone, you can go back in. The Activities Director stated that she then went and called the Administrator to told her what she heard Staff A say to Resident #1. The Activities Director denied seeing Staff A touch Resident #1 or handle Resident #1 in a rough manner. During an interview on 4/16/26 at 2:20 PM, the Director of Nursing (DON), reported she was notified on the morning of 3/01/26, by the facility Administrator, that there was accusation of Staff A handling Resident #1 in a rough manner on 2/28/26. The DON revealed an expectation that all staff report any concern for abuse immediately to ensure resident safety. Review of the facility investigation of self reported incident, dated 3/01/26, revealed that on 3/01/26 at approximately 8:25 AM, the facility Administrator arrived to facility to follow up regarding a report received the previous day alleging that Staff A had raised her voice at residents during her shift and was provided an envelope by kitchen staff written by Staff B, Dietary Aide. which informed that on 2/28/26, Staff A yelled, shut up at Resident #1 and that Staff A removed Resident #1 from his dining room chair, grasped his right upper arm and forcefully escorted him out of the dining room. The investigation indicated that the State Agency was (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified on 3/01/26 at approximately 9:32 AM. The investigation indicated the following steps were taken by facility related to allegation of abuse: a. Completed witness interviews and interviews of working staff. b. Staff mandatory re-education on abuse prevention and reporting procedures was initiated immediately.c. Risk Management completed. d. Psych consult/referral. e. MDS/Care Plan updated. f. The incident will be reviewed during the next Quality Assurance and Performance Improvement (QAPI) committee meeting. Review of the facility policy, titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, dated 3/18/26, directed the following: Review of the Section titled, Reporting:a. All allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the Administrator.b. All allegations of resident abuse shall be reported to the appropriate state entity not later than two (2) hours after the allegation is made.