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	08/08/2024

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 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. 35434 Based on observation, clinical record review, policy review, and staff and resident interviews, the facility failed to carry out a treatment as ordered for 1 of 3 residents reviewed(Resident #34). The facility reported a census of 53 residents. Findings include: The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Minimum Data Set(MDS) assessment tool, dated 5/26/24, listed diagnoses for Resident #34 which included diabetes, respiratory failure, and morbid obesity. The MDS stated the resident had a Stage 4 pressure ulcer and listed the resident's Brief Interview for Mental Status(BIMS) score of 14 out of 15, indicating intact cognition. The 11/15/22 Wound Management policy, dated 11/15/22, stated the facility would provide treatments in accordance with the physician orders. A 1/24/23 Care Plan entry list stated the resident had a Stage 4 pressure ulcer. A 6/15/23 Care Plan entry directed staff to treat as per the orders. The 7/30/24 Specialty Physician Wound Evaluation and Management Summary stated the resident had a Stage 4 Pressure Wound of the left ischium(the lower back hip bone) and directed staff to apply skin prep once daily for 16 days. The July and August 2024 Treatment Administration Records(TARs) listed a 6/13/24 order for skin prep to the wound on the left ischium every day shift. The 7/3/24 and 7/4/24 entries were blank and lacked initials to indicate staff completed the dressing. The 7/26/24 entry contained scribbled out initials which were illegible. The 8/5/24 entry contained the initials of Staff J Registered Nurse(RN) and the 8/6/24 entry had the initial of Staff G Licensed Practical Nurse(LPN). The TARs lacked documentation of an order for Maxorb (type of wound dressing used to treat draining wounds) to the wound. On 8/6/24 at 9:01 a.m. Resident #34 stated that staff did not carry out treatments as they should on her buttock. She stated she missed treatments. On 8/7/24 at 10:44 a.m. Staff G LPN agreed to complete the resident's wound treatment and measurements. Staff G stated that she would measure the open areas. The resident laid on her back and Staff G uncovered her and lifted up her abdominal folds. Staff G inspected under the folds and stated she was clear. Staff G then covered the resident back up. She stated she did not think the resident had an area on her bottom. Staff G rolled the resident over on her right side and she had a red open wound on her left ischium. Staff G stated she would retrieve dressing supplies and she left the room. Upon return, Staff G measured the wound which had a red wound bed with yellow slough on the top and the bottom as 3.2 centimeters(cm) x 1.3 cm x 0.3 cm(length x width x depth). She then applied Maxorb to the wound and covered it with a foam dressing. After the dressing change, Staff G stated she did not complete a treatment on 8/6/24 to the resident's ischium. When queried regarding the presence of her initials on the entry for the resident's 8/6/24 skin prep, she stated the physician carried out the treatment. On 8/7/24 at 4:06 p.m., via phone, Staff J Registered Nurse(RN) stated on 8/5/24, she signed off the resident's skin prep as complete with the intention of completing it later in the day. She stated after 2.5 hours of the shift though, the facility terminated her contract and she was unable to complete this On 8/8/24 at 10:40 a.m. the Director of Nursing(DON) stated she expected staff to carry out all treatment orders.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on observation, interview, clinical record review, and facility policy review, the facility failed to elevate the head of bed during administration of enteral feeding and failed to label supplemental formula bag with the date and time that enteral feeding had started for 1 of 2 residents (Resident #33) reviewed for enteral/tube feeding. The facility reported a census of 53 residents. Findings include: The Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating moderate cognitive impairment. Resident #33 required partial to moderate staff assistance to turn and reposition in bed and had been dependent upon staff to transfer. Diagnoses included alcohol induced acute pancreatitis without necrosis or infection, malnutrition, generalized peritonitis, sacroiliitis, autoimmune thyroiditis, and gastrostomy status. Resident #33 required feeding tube prior to and while a resident at facility, she received 25% or less proportion of total calories through tube feeing. The Care Plan, initiated 6/12/24, revealed Resident #33 had an alternative nutritional intake via tube feeding with the goal that resident will remain free of side effects or complications related to tube feeding through the review date. An intervention instructed staff to elevate the head of bed 45 degrees during and for thirty minutes after tube feed. The Order Summary, dated August 2024, revealed an active order, with the start date of 6/13/24, to change out enteral feed set (bags, formula, piston syringe, and cylinder) every 24 hours on overnight shift. This order instructed staff to label bags with time and date for gastrostomy tube (g-tube) care. The facility document titled, Visual/Bedside Kardex Report, dated 8/07/24, for Resident #33, instructed staff to elevate the head of bed to 45 degrees during and thirty minutes after tube feed. On 8/07/24 at 7:56 AM, Resident #33 laid flat in bed, the head of bed remained in lowest position, tube feeding noted to be running at 35 milliliters (mL) per hour with a water flush of 40 mL every hour. Noted label on formula bag which indicated tube feeding administration had been initiated at 12:00 AM on 8/07/24. On 08/07/24 at 8:14 AM, Staff K, Certified Nursing Assistant (CNA) informed that Resident #33 should never be flat in her bed during tube feeding due to risk for aspiration. Staff K stated that Resident #33 never refused cares or repositioning from staff that she is aware of. On 8/07/24 at 8:20 AM, Director of Nursing (DON), entered Resident #33's room, Resident #33 continued to lay flat in bed, with head of bed at lowest position, DON informed that the resident's head of bed should be up more during tube feeding administration and proceeded to elevate the head of bed to resident's preference. DON revealed the expectation that staff elevate Resident #33's head of bed to her preference or comfort and that Resident #33 should not lay flat during administration of tube feeding. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/08/24 at 8:40 AM, Resident #33 laid in bed with head of bed slightly elevated, noted tube feeding running via pump at 35mL per hour, with 40mL water flush per hour. The bag of supplemental formula that hung from the pump lacked label or identification of date and time that tube feeding administration had been initiated. On 08/08/24 at 8:43 AM, Staff G, Licensed Practical Nurse (LPN) entered Resident #33's room and had been unable to find a label with date and time to Resident #33's supplemental formula feeding being administered. On 08/08/24 at 10:42 AM, DON revealed expectation that supplemental formula hung for tube feeding administration be labeled with date and time initiated. The facility provided a document of procedures followed for enteral feedings, titled Tube Feedings, dated 2019, which instructed staff to position the patient with head of the bed elevated to at least 30 degrees or upright in a chair to prevent aspiration. The document additionally instructed staff to label the enteral administration set with the date and time that it is hung.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44512 Based on record review, resident and staff interviews, call light logs, facility policy and resident council minutes the facility staff failed to respond to call lights within a reasonable amount of time. Residents reported having to wait from 30 minutes to over an hour for the call light to be answered numerous times (Resident #10, #22, #34, & #50). The facility reported a census of 53 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #22 revealed a diagnosis of obesity and a chronic wound to the left foot therefore required the assistance of 1 for dressing and personal hygiene. Resident # 22 had a Brief Interview for Mental Status (BIM) score of 15 suggesting an intact cognition. During an interview on 8/05/24 at 9:19 AM, Resident #22 stated the staff are often slow at answering her call light, 30 mins to 2 hours. Resident #22 stated if it's longer than 45 minutes, she will call the front desk, if no answer, then she will call the social worker. Resident #22 stated she can make it to the bathroom but needed assistance in the bathroom and had waited for over an hour on the toilet and the staff told her they had forgotten she was down that hall. 2. The MDS dated [DATE] for Resident #10 revealed a diagnosis of heart failure, had a history of falls and required moderate assistance with dressing, toileting and maximal assistance with personal hygiene needs. Resident #10 had a BIM score of 13 suggesting an intact cognition. During an interview on 8/5/24 at 10:48 AM, Resident #10 stated she would put her call light on for assistance to change her clothes and it may take the staff more than a half an hour to respond. On 8/8/24 at 11:30 a.m., the Administrator stated she did not have the ability to print call light logs but stated the surveyor could view them at the computer at the nursing station. The logs included the following response times: Resident #10 On 7/30/24, the call light response time was 40 minutes, from 5:28 p.m. to 6:09 p.m. On 8/1/24, the call light response time was 23 minutes, from 4:13 p.m. to 4:37 p.m. 48888 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The MDS, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. Resident #50 required substantial to maximal staff assistance with bed mobility and transfers to and from bed. Resident #50 had frequent pain symptoms, post spinal fusion surgery, and had a documented Stage 3 pressure injuries to sacrum. Diagnoses included: multiple injuries, subsequent encounter, monoplegia of upper limb affecting left non-dominant side, necrotizing vasculopathy, post-laminectomy syndrome, and contusion of lung. The Care Plan, initiated 7/08/24, revealed Resident #50 at risk for falls, staff instructed that Resident #50 needed prompt response to all requests for assistance. On 8/06/24 at 9:31 AM, Resident #50 reported a concern with long call light wait time and stated it depended upon the staff working as some may be prompt to answer and other take 30 minutes to an hour or more to assist him when call light is pressed. On 8/8/24 at 11:30 a.m., the Administrator stated she did not have the ability to print call light logs but stated the surveyor could view them at the computer at the nursing station. The logs included the following response times: Resident #50 On 8/1/24, the call light response time was 19 minutes, from 1:44 p.m. to 2:03 p.m. On 8/4/24, the call light response time was 21 minutes, from 9:51 a.m. to 10:12 a.m. On 8/5/24, the call light response time was 19 minutes, from 2:55 p.m. to 3:14 p.m. 35434 4. The 6/26/24 Resident Council Minutes, stated the issue of call light response was not resolved. The 7/25/24 Resident Council Minutes stated the issue of call lights was resolved but stated it depends on staff. The minutes did not contain further details about the issue. 5. The MDS assessment tool, dated 5/26/24, listed diagnoses for Resident #34 which included diabetes, respiratory failure, and morbid obesity and listed the resident's Brief Interview for Mental Status(BIMS) score of 14 out of 15, indicating intact cognition. A 9/14/22 Care Plan entry stated the resident had bladder incontinence. On 8/6/24 at 9:01 a.m., Resident #34 stated call lights were terrible. She stated a lot of times one had to wait for an hour for help and this could happen any time of the day. She stated this last week she waited at least 30 minutes a couple times and used her phone to time this. She stated about a week ago, she had an incontinent episode due to the long wait time and when this happened she felt not very good. An 8/8/24 Care Plan entry encouraged staff to assist the resident to the toilet. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/08/24 at 11:30 a.m., the Administrator stated she did not have the ability to print call light logs but stated the surveyor could view them at the computer at the nursing station. The logs included the following response times: Resident #34 On 7/31/24, the call light response time was 26 minutes, from 9:40 a.m. to 10:07 a.m. On 8/1/24, the call light response time was 36 minutes, from 12:35 p.m. to 1:11 p.m. On 8/8/24 at 9:49 a.m., Staff I Certified Nursing Assistant(CNA) stated lately staffing was not as good. She stated staff were sometimes unable to answer call lights within 15 minutes when they were in a room with another resident. She stated if there were many call lights alerted, the response time could be up to 30 minutes. On 8/8/24 at 10:40 a.m., the Director of Nursing(DON) stated staff should respond to call lights within 15 minutes. On 8/8/24 at 1:59 p.m., the Administrator stated staff should answer call lights within 15 minutes. Via email correspondence on 8/8/24 at 2:40 p.m., the Administrator stated the facility did not have a policy which addressed call lights.

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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. 44512 Based on observations, staff interviews and policy review, the facility failed to practice appropriate infection control measures with the laundry, during the passing of ice water, provide environmental cleaning and disinfecting of areas between laundry and dietary and were low on Personal Protective Equipment (PPE) gloves, not readily accessible in all resident areas. The facility reported a census of 53 residents. During an observation on 8/05/24 at 11:40 AM, Staff L, Hospitality Aide passed water, filled the ice cup for resident's residing in the 200 hall and dropped the scoop back into the ice and closed the lid at each resident room. During an observation on 8/06/24 at 11:02 AM, Staff E, Laundry Aide delivered towels and washcloths to the large laundry carts in the halls. The wire basket containing the clean laundry brought up from the basement laundry room was not covered. During an observation on 8/7/24 at 7:56 AM, in the hallway by the elevator leading to laundry services and the backdoor of the kitchen, a bag of trash with brown liquid substance in a wire basket dripped a puddle onto the floor where people were walking by to go to elevator that travels to the basement laundry area. The elevator floor was dirty with brown substance and dirt. Upon entering the laundry area, three piles of laundry were on the floor between the wash machine and three vinyl baskets. Three dryers were actively drying clothes. Staff C, Laundry Aide, opened the lint doors to find all three dryers filters filled with lint. During an interview on 8/7/24 at 7:56 AM, Staff C, Laundry Aide stated the laundry staff separated the laundry on the floor this morning. Staff C stated she was providing training to the staff. Staff C stated the dryer filters get cleaned at the end of each day. Staff C stated Staff E, Laundry Aide was to have cleaned them at the end of day 8/6/24. During an interview on 8/7/24 at 8 AM, Staff D, laundry aide stated she was taught to clean the dryer filters two times a day but had not checked it this morning as she assumed that Staff E cleaned them last night. During an interview on 8/7/24 at 8:18 AM, The Administrator stated she was training a new laundry/housekeeping supervisor, the hallway to the elevator was mopped and disinfected, the laundry was picked up and the floor was disinfected, and the laundry staff will be trained in the required fire safety for the driers. During an interview on 8/7/24 at 1:18 PM Staff B, Certified Nursing Assistant (CNA) stated it was hard to find wipes and gloves as they were short in supply. During an interview on 8/07/24 at 3:26 PM, Staff A, Infection Preventionist stated the large and medium gloves were in back order, the X-large gloves were in the basement and small gloves in the supply closet. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policies provided by the Infection Preventionist failed to address Personal Protective Equipment (PPE).