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	08/14/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, resident interview and facility assessment review, the facility failed to treat residents with dignity and respect for 2 of 21 reviewed (Resident #29 and Resident #41) reviewed for dignity. The facility reported a census of 50 residents. Findings included:. 1. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #29 list of diagnoses included heart failure, dementia and anxiety. The Brief Interview for Mental Status (BIMS) score of 11 out of 15 indicated moderate cognitive impairment.Review of the Care Plan revealed a Focus area, dated 1/19/23 for Resident #29 to address self-care performance deficit, alerted needed encouragement to change clothes, needs clean clothes put out daily and she can then dress, encourage to change clothes daily, goals included to assist with facial hair and maintain resident's dignity.During an observation on 8/7/25 at 2:43 PM, Resident #29 sat in common area, wearing a thin shirt without wearing a bra, and noticeable yellowish food stains. Resident #29's hair appeared unbrushed. During an interview on 8/7/25 at 2:45 PM Resident #29 relayed was not feeling good, had a bothering rash pointed chest area. Licensed Practical Nurse (LPN) Staff C came from behind the nurse station and escorted Resident #29 to her room with a medicated powder. During an observation on 8/7/25 at 2:50 PM LPN, Staff C, LPN and Resident #29 came from residents' room, LPN Staff C escorting resident back to the common area. Resident #29 pointed to the stains on her shirt said she did not have any other short sleeve shirts. Staff C shared the rash worsened and would be contacting the provider. Staff B, LPN intervened when quired about the clothing and brought Resident B several short sleeve shirts to choose. Resident expressed gratitude.During an interview on 8/11/25 at 12:28 LPN, nurse, Staff B stated the facility had a large storage boutique downstairs from donations for residents to have as needed and felt any resident who needed clothing could be supported. 2. Review of the MDS assessment dated [DATE] identified Resident #41 list of diagnoses included cancer, renal disease, diabetes, anxiety and depression. The BIMS score of 15 out of 15 indicated intact cognition.Review of the Care Plan revealed a Focus area, dated 2/19/25 for Resident #41 to address a history of trauma and loss is at risk for psychosocial well-being concerns, a goal included to remain free of signs of distress.During an interview on 8/4/25 at 2:38 PM, Resident #41 shared an experience that caused her to be upset and did not think was handled right. She explained there was a room search and several personal items that were important were bagged up and taken, which included special scissors and tweezers, she had for over 40 years. Resident #41 stated she was told she needed to get a lock box, which her family supplied. She stated the items were lost by staff and she had to repeatedly ask, before they were found up to three weeks later. During an interview on 8/12/25 at 5:00 PM, Staff H, Social Services, stated the wide spread room search was for resident's safety. Staff H stated she had been aware of Resident #41 being upset that her scissors and tweezers were taken and misplaced by staff. Staff H explained they were eventually found and given back. Staff H stated she was aware the items were important to Resident #4 and was upset about them being lost. During an interview on 8/12/24 at 5:30 PM, the Administrator relayed the search was necessary to take items of risk for other resident safety. She explained they would have replaced the lost items had not been found.Review of the facility assessment dated [DATE], revealed Person Centered and Person Directed Care required affording people dignity compassion and respect, offering of personalized care, support or treatment.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interview and resident interview the facility failed to ensure resident call lights were within reach for 2 of 24 residents reviewed (Resident #30,Resident# 36). The facility reported the census is 50.Findings include:1. Review of the Minimum Data Set (MDS) dated [DATE] for Resident #30 revealed a Brief Interview of Mental Status (BIMS) score of 4 out of 12, which indicated a severe cognitive impairment. The list of diagnoses included dementia, diabetes, lung disease, lack of coordination, unsteadiness on feet, aphasia and dysphagia referring to difficulty with language and swallowingReview of the Care plan revealed a Focus area, initiated 11/11/24 to address Resident #30 communication problem, cognitive impairment secondary to dementia directed staff to allow time for response, ask yes/no questions, use simple, brief, consistent words and cues. The Care Plan did not address the call light for resident use. During an observation on 8/4/25 at 2:18 PM, Resident #30 lying perpendicular on his bed, with head against the wall, and feet, off the side of the bed, relayed would like help. The call light was on the floor around a nearby table leg, not within reach.During an observation on 8/5/25 at 1:55 PM, Resident #30 in his room, with the call light cord hanging on the wall at the wall connection for the cord, out of his reach. During an interview on 8/5/25 at 1:56 PM, Resident #30 acknowledged the call light was not within reach, and hung on the wall at the connection site. During an observation on 8/7/25 at 2:18 PM, Resident #30 call light continued to hang on the wall at the wall connection, not accessible to resident sitting on the bed. 2. Review of the MDS dated [DATE] for Resident #36 documented a BIMS score of 9 out of 15, which indicated a moderate cognitive impairment. The MDS documented Resident #36 needed partial/moderate assistance to sit to lye, sit to stand and for chair to bed transfers. Review of the Care Plan revealed a Focus area, initiated 2/3/25 Resident #36 to address a selfcare performance deficit, required staff assistance to turn and reposition, assist of one with walker and wheel chair, one person assist with personal hygiene toilet use and transfers. The Care Plan documented risk for falls and to be sure the call light is within reach, encourage use and needs prompt response to all requests for assistance.During an observation on 8/4/25 at 3:12 PM, Resident #36 in her room in a recliner with her head slouched down near the seat and bottom partly off the chair seat. The call light rested on a chair next to the recliner, out of the residents reach. The resident stated she wanted help to lie down in bed.During an interview [NAME] 8/4/25 at 3:13 PM, Staff B, Licensed Practical Nurse (LPN) entered Resident #36 room with visiting Nurse Practitioner, Staff A acknowledged resident could not reach the call light, proceeded to help Resident #36 to bed as requested.During an interview on 08/11/25 at 12:42 PM, the Director of Nursing stated all residents should have a call light accessible to them and the expectation is for staff to ensure call lights are accessible to all residents.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review the facility failed to accurately document resident's cardiopulmonary resuscitation (CPR) status for 1 of 24 (Resident #34) residents reviewed. Findings include:Review of Resident #34's electronic health record (EHR) revealed a profile page with indicated a status of Do not Resuscitate (DNR). Review of Resident #34's scanned EHR documents revealed a DNR IPOST for different resident. Review of Resident #34's Physician Orders, revealed a verbal order dated [DATE] stating Resident #34's DNR code status. Review of Resident #34's Care Plan dated [DATE] revealed, Resident #34 and his responsible party, requested a code status for CPR/initiate CPR.On [DATE] at 12:36 PM, a review of facility provided binder containing resident's IPOST, revealed Resident #34's IPOST indicated CPR status. Verbal consent for signature received by Resident #34's legal healthcare representative on [DATE] and signed by facility physician on [DATE]During an interview on [DATE] at 11:58 AM, Staff C, Licensed Practical Nurse (LPN), stated a resident's code status is found on their profile page, under their name in PCC and there is also a binder at the nurses station that has all the resident's IPOST. During an interview on [DATE] at 10:18 AM, Staff I, LPN, stated she checks code status on Resident's PCC profile page and there is also an IPOST binder at the nurses station. Staff I, LPN, stated depending on the situation is where she would look. If she is at a computer when she is notified of a situation, she would look there. If she was closer to the nurses station and not logged in she would find the resident's IPOST for code status. Review of the facility policy titled, Code Status (DNR)(CPR) Validation - Quick Reference Guide, dated [DATE] All Code Status orders must be validated upon admission and reviewed quarterly. Code Status orders must have the required state approved DNR form signed by all appropirate parties prior to entering a No CPR order in [name of EHR brand redaced]

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, staff interviews, and the facility housekeeping assistant job description, the facility failed to thoroughly mop the dining room floor after each meal service and clean the ceiling fans in the dining room on a routine basis. The facility reported a census of 50 residents.Findings include:During an observation on 8/11/25 at 1:58 PM, after dining service finished, the floor noted to be sticky around the walls by the baseboards near the front entrance of the dining room. Dried liquids marks under and around the dining room tables near the front entrance of the dining room. A dried pink liquid stain observed under a chair in the dining room. Two of the ceiling fans closest to the entrance door were covered in dust and had a ring of dust around the ceiling fans on the ceiling. During an observation at breakfast service on 8/12/25 at 7:58 AM, the floors remained sticky near the baseboards along the wall near the front entrance of the dining room. The floor had dried liquids stains and a pink stain on the floor in the same places as yesterday. Thick dust remained on the ceiling fans and ceiling. During an interview on 8/12/25 at 10:39 AM, Staff F, Housekeeping queried on when housekeeping mopped the dining room and Staff F stated after breakfast and lunch. Staff F stated she Staff G, Housekeeping spot mopped the dining room floor yesterday after lunch because they can't get into the dining room until 1:15 PM and then the residents played Bingo in the dining room. Staff G stated on Monday and Wednesdays housekeeping spot mopped after lunch due to activities in the afternoon. Staff F asked who cleaned the fixtures such as the ceiling fans, and Staff F stated another housekeeper cleaned the ceiling fans recently. During an interview on 8/12/25 at 10:54 AM, Staff G, Housekeeping queried when housekeeping mopped the dining room floor and Staff G stated everyday after breakfast and lunch. Staff G stated she didn't know who mopped after dinner. Staff G stated housekeeping staff spot mopped the dining room floor after lunch because the residents got out of the dining room late and played Bingo. Staff G stated if residents were not in the dining at 12:45 PM, housekeeping could fully mop the dining room floor after lunch. Staff G asked who cleaned the ceiling fans in the dining room, and Staff G stated housekeeping did them a week or two ago. During an interview on 8/12/25 at 11:01 AM, the Housekeeping Supervisor stated the dining room floor mopped three times a day. The Housekeeping Supervisor stated housekeeping mopped the dining room floor after breakfast and lunch and dietary staff cleaned after dinner service. The Housekeeping Supervisor queried on how often the ceiling fans cleaned in the dining room and the Housekeeping Supervisor stated weekly. The Housekeeping Supervisor observed the ceiling fans and the sticky floors in the dining room and stated he appreciated bringing to his attention. The Housekeeping Supervisor confirmed the ceiling fans needed cleaned and the floors sticky around the baseboards. During an interview on 8/12/25 at 3:34 PM, the Administrator informed of the sticky floors and dusty ceiling fans in the dining room and the Administrator stated the Housekeeping Supervisor already told her the fans were filthy. The Administrator stated housekeeping cleaned them and the Housekeeping Supervisor spoke with his team about the dining room floors. The Administrator stated if lunch ran late, housekeeping staff spot mopped and after dinner dietary staff spot mopped. Per email on 8/12/25 at 4:25 PM, the Administrator documented the facility didn't have a formal housekeeping policy for cleaning and sanitizing common areas. Review of the facility Job Description: Housekeeping Assistant dated 5/22 revealed, in part: Essential Functions of Housekeeping Assistant: Sweep and mop floors; Clean furniture, equipment, fixtures, and hardware

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review the facility failed to carry out provider orders for 10 of 24 residents reviewed (R#1, R#8, R#13, R#17, R#26, R#29, R#30, R#40 R#43, R#45). The facility reported a census of 50 residents.Findings include:1. The Minimum Data Set (MDS) for Resident #1 assessment, dated 7/22/25 listed diagnoses for Resident #1 included dementia, disorder of thyroid. A Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated intact cognition. The Care plan initiated 3/20/24 for Resident #1 relayed has medications listed with black box warning referring to risks and potential adverse reactions. Intervention included to obtain and report laboratory draws and result as ordered. A Clinic Note date of service 10/10/24 for Resident #1 revealed, the provider directed routine labs every six months, last labs collected in April 2024, directed to collect labs as ordered on the next lab day. During an interview on 8/12/25 at 12:49 PM, the Director of Nurses (DON) stated the labs ordered 10/10/24 were missed and that in October there was not a process. The DON explained the current process is the provider was to alert the floor nurse of orders. The nurse should have added the order to the Nurses, Medication Administration Record (MAR). The DON relayed the lab order was put on the regular MAR and a Medication Aide signed the lab as it was being completed in error. 2. The MDS dated [DATE] for Resident #30 documented diagnoses included diabetes, lung disease, lack of coordination, unsteadiness on feet, aphasia and dysphagia referring to difficulty talking and swallowing. The Care Plan focus initiated 3/6/25 for Resident #30 documented diagnoses of diabetes, with a goal of no related complications. Interventions included to take medications as ordered by the doctor, included to monitor and document side effects and effectiveness. The Care Plan directed to obtain and monitor lab, diagnostic work as ordered, report results to the provider and follow up as indicated. The Clinic Note dated 1/20/25 for Resident #30 documented lab ordered in November 2024 outstanding, will remind of outstanding labs. Review of a Clinic Note dated 3/24/25 for Resident #30 revealed collection of labs on lab day in November 2024 and again on 1/20/2025 documented reviewed labs collected, were dated 1/26/25.The Clinic Note dated 5/27/25 for Resident #30 documented last labs collected 3/2025, recheck diabetes labs in three (3) months, due by 6/30/25 added additional thyroid lab. Review of a Clinic Note dated 7/28/25 revealed the last lab work was collected 3/2025, lab orders provided in May 2025 were not completed, new orders provided included to collect the labs by the end of this week. During an interview on 8/12/25 at 1:10 PM, the DON voiced the labs ordered per the clinician visit note for Resident # 30 on 11/14/24 were not done. The DON relayed it appeared the order was again put on the standard MAR and signed off as completed in error. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The MDS dated [DATE] for Resident #43 documented diagnoses included cancer, heart disease, vascular disease, diabetes, stroke, and respiratory disease. The Care Plan initiated 7/17/24 for Resident #43 directed to obtain and report lab results as ordered by the physician or nurse practitioner, to obtain and report laboratory draws, results as ordered. The Clinic Note dated 5/27/25 for Resident #43 documented last labs collected 3/2025 and directed additional labs the week of 6/30/2025. The Clinic Note dated 7/28/25 for Resident #43 documented Last labs were collected in 03/2025. Previous lab orders provided at last visits for collection during the week of 06/30/2025 were not collected. Directed to collect by the end of the week. During an interview on 8/13/25 at 12:55 PM, the Administrator stated this resident is one that could have refused lab work and was not documented, relayed will need to get better with documentation. 4. The MDS dated [DATE] for Resident #45 documented diagnoses included diabetes and seizure disorder. The Care Plan initiated 2/14/25 for Resident #45 documented a focus for diabetes with a goal to avoid complications. Also relayed had potential for nutritional problem, directed to obtain and monitor lab/diagnostic work as ordered. Report results to the provider and follow up as indicated. The Clinic Note dated 3/17/25 for Resident #45 relayed are no recent labs available on Resident #45. Please collect on next lab day, outline of labs listed. The Clinic Note dated 4/21/25 for Resident #45 documented no recent labs available, lab orders provided last visit were not collected. Please collect the next facility lab day. In an email communication on 8/11/25 at 11:04 AM, the DON responded and explained the facility process, relayed when our providers make their weekly rounds, they look to see who needs labs and they write the orders. Lab draws are on Monday unless it’s a stat lab, needed right away. The Administrator or DON takes the lab to the hospital and they fax the results to us and to the providers. We notify the family of results and follow up with the provider to see if they want any new orders. During an interview on 8/12/25 at 1:19 PM, the DON stated she cannot explain what occurred, as to why labs were not done, relayed, labs should have been put on the Medication Administration Record (MAR) and done by the nurse on lab day Monday or Tuesday. The DON relayed would be looking into and working on a better plan regarding labs. 5. Review of Resident #8’s MDS dated [DATE] revealed a BIMS score of 15 out of 15, which indicated intact cognition. The list of diagnoses included coronary artery disease, hypertension, renal insufficiency, depression, anxiety disorder, arthritis, hip fracture, and pain in left hip. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Care Plan dated 6/25/25 revealed Resident #8 is at risk for falls with interventions including placing non-slide strips in front of her closet, ensuring Resident #8 is wearing appropriate footwear when ambulating and staff setting out gripper socks for Resident #8 each night. Resident #8 has a left displaced femur fracture related to a fall with interventions including following physician’s orders for weight bearing status and for nursing staff to see physician’s orders and/or Physical Therapy treatment plan. Review of Resident #8’s Electronic Health Record (EHR) revealed the following nursing progress notes:a. 5/26/25 at 6:30 AM Resident #8 was found on the floor sitting in front of her recliner, Resident #8 stated “I was trying to get up out of my chair and lost my balance. I fell on my left side, my arm and leg hurt a little bit but I’m able to move everything. I’m unsure if I hit my head. My head does not hurt.” Initiated neuros, called on call provider to make aware of situation and Resident #8’s status. Assessed for injury; none. Educated Resident #8 on the importance of wearing proper footwear (socks and shoes, gripper socks) while transferring and to utilize the call light if assistance is needed. b. 5/26/25 at 9:40 AM Resident #8 is complaining of increased pain in her left leg/hip since the fall. Resident #8 is able to move leg but states that it hurts when she stands on it. Call placed to on-call Physician and requested an x-ray of the left hip/leg. Physician gave the okay for x-ray service to come and perform a bedside x-ray due to advanced age and limited mobility. Resident #8 aware. c. 5/26/25 at 1:30 PM X-ray service arrived and performed an x-ray of Resident #8’s left hip and left femur. Results are as follows: right hip arthroplasty, Displaced fracture involving the greater trochanter but no obvious periprosthetic extension. The on call Physician notified of results and received an order to send Resident #8 to the ER for further evaluation and treatment. Review of Resident #8’s ER report dated 5/26/25 at 10:00 PM, revealed the on-call Orthopedics Physician reviewed further imaging and noted this fracture would typically be managed nonoperatively, weightbearing as tolerated, and Resident #8 will need to follow-up with Orthopedics. Resident #8 was admitted to the hospital for pain management. Review of Resident #8’s Hospital Discharge Summary Notes dated 5/29/25 at 9:07 AM, revealed Resident #8 is requiring narcotics as pain is still significant with ambulation. Resident #8 required scheduled oxycodone each morning to tolerate Physical Therapy. Resident #8 is stable for discharge back to facility with Physical Therapy (PT) and Occupational Therapy (OT) Services. Resident #8 requires continued assessment and treatment to establish an appropriate level of assistance and to follow-up with Orthopedics. Resident #8’s EHR revealed a Nursing Progress note dated 6/3/25 at 2:25 PM, stated, phone call received from Orthopedic Clinic, stating Resident #8’s previous Orthopedic surgeon would like Resident #8 to follow up. Passed this message along to staff with scheduling to get this appointment made. Review of Facility’s Provider Progress Note dated 6/16/25, revealed Resident #8 was seen on this day for follow-up hospitalization for a ground level fall resulting in fracture of left hip. Resident #8 reports pain is well-controlled and feeling well overall. Resident #8 is actively working with PT/OT; Resident #8's pain has been well-controlled, continue with PT/OT and follow-up visits with Orthopedics. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continued review of Resident #8’s EHR failed to reveal nursing documentation or Orthopedic Clinic notes indicating Resident #8 had been seen for a follow-up for the fracture. On 8/13/25 at 1:05 PM, documentation for Resident #8’s follow-up Orthopedic visit was requested from the Director of Nursing (DON) and Facility Administrator. On 8/13/25 at 2:07 PM, DON stated via email, A follow-up appointment was not made for Resident #8, the nurse reports putting the request under the Activity’s door for our appointment/transportation person. 6. The MDS for Resident #13 MDS dated [DATE] revealed a BIMS of 13, indicating cognitively intact and diagnoses of hypertension, hyperlipidemia, history of stroke, seizure disorder, anxiety disorder and depression. Review of Resident #13's Care Plan initiated 9/3/24, documented a focus for risk of falls due to gait/balance problems, with interventions of requesting labs including seizure medications. Review of Clinic Note dated 9/13/24 for Resident #13 documented Lipid and Dilantin levels obtained 9/2024, due for routine labs on next facility lab day. Review of Clinic Note dated 3/24/25 for Resident #13 documented last labs were collected 9/2024 and directed to collect labs as ordered on the next lab day including level for monitoring seizure medications. Review of Clinic Note dated 5/27/25 for Resident #13 documented last labs were collected 9/2024 and directed to collect labs as ordered on the next lab day including level for monitoring seizure medications, orders provided last visit. Review of Clinic Note dated 7/28/25 for Resident #13 documented last labs were collected 9/2024 and directed to collect labs as ordered on the next lab day including level for monitoring seizure medications, orders provided last visit. Review of Nursing Progress notes and Order Summary for Resident #13 dated 9/13/24 to 7/28/25 failed to provide directed labs had been ordered or collected. 7. Review of Resident #17's MDS dated [DATE] revealed BIMS of 14, indicating cognitively intact and diagnoses of heart failure, hypertension, renal insufficiency, hyperlipidemia, depression, chronic atrial fibrillation, and insomnia. Review of Resident #17's Care Plan initiated 4/13/2020 directed to obtain and monitor lab and diagnostic work as ordered, reporting results to MD and follow up as indicated. A focus dated 6/1/23 indicating Resident #17 having episodes of insomnia due to not sleeping through the night, resulting in complaints of tiredness and need for naps during the day. Review of Clinic Note dated 10/24/24 for Resident #17 documented proceed with ordered sleep study for evaluation as result of Insomnia, Snoring and Daytime Hypersomnia. Review of Resident's condition, assessment, finding and pertinent laboratory and or diagnostic tests were discussed with nursing staff, understanding voice and acceptance of proposed place of care indicated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Clinic Note dated 1/6/25 for Resident #17 documented at time of last visit on 10/24/24, an order was placed for a sleep study, will check on the status of this. Review of Resident's condition, assessment, finding and pertinent laboratory and or diagnostic tests were discussed with nursing staff, understanding voice and acceptance of proposed place of care indicated. Review of Clinic Note dated 5/5/25 for Resident #17 documented at time of visit on 10/24/24, an order was placed for a sleep study, chart review shows that scheduling has been unsuccessful at reaching facility to get this scheduled. Will have nurse reach out and see about getting this coordinated. Review of Cardiology Progress Note dated 5/14/25 documented Resident #17 does not sleep well and wakes up frequently through the night, has high blood pressure and would benefit getting a sleep study done and test has been ordered. Resident #17 will be notified of those results when received. Review of Clinic Note dated 7/7/25 for Resident #17 documented at time of visit on 10/24/24, an order was placed for a sleep study, chart review shows that scheduling has been unsuccessful at reaching facility to get this scheduled. Will have nurse reach out and see about getting this coordinated. Updated order placed. Review of Resident's condition, assessment, finding and pertinent laboratory and or diagnostic tests were discussed with nursing staff, understanding voice and acceptance of proposed place of care indicated. Review of Resident #17's Nursing Progress Notes revealed the following: 3/16/25 at 1:59 AM, Resident #17 stated she was supposed to have a sleep study two years ago and hasn't. This nurse stated the information would be pass on. 5/6/25 at 5:23 PM, Call received from Provider's office for Sleep Study order at local hospital, will call to set up Sleep Study. 7/8/25 at 9:30 AM, Received orders from Provider for Sleep Study, will call Facility with further direction. Resident aware. Review of Order Summary for Resident #17 dated 10/24/24 to 7/7/25 failed to provide directed Sleep Study had been ordered or completed. 8. The MDS dated [DATE] for Resident #26 revealed BIMS of 13, indicating cognitively intact and diagnoses of hypertension, renal insufficiency, hyperlipidemia, and hyponatremia (low sodium levels related to kidney disease and diabetes). Review of Care Plan initiated 3/31/22 for Resident #26 revealed, obtain and monitor lab/diagnostic work as ordered, report results to MD and follow up as indicated related to Resident #26's nutritional problem due to hyponatremia, hypertension, and Stage 3 chronic kidney disease. Review of Clinic Note dated 12/19/24 for Resident #26 documented, Resident #26 has had a steady weight gain since her admission in 2022, as a result of her diagnosis of Heart Failure, weight monitoring frequency should increase to daily weight checks with an order for Furosemide 20mg by mouth daily as needed for weight gain of 3lbs or greater in 24 hours or 5lbs or greater in one week. (continued on next page)

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	165234	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Manor	516 13th Street Wellman, IA 52356

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Clinic Noted dated 2/17/25 documented, Resident #26 has had a steady weight gain since her admission in 2022, as a result of her diagnosis of Heart Failure, weight monitoring frequency should increase to daily weight checks. Review of PCC in which they have not been weighing consistently on a daily basis as ordered, provided reminder. Routine labs every 6 months, please collect on next facility lab day. Review of Resident #26's weights revealed consistent daily weights were started on 2/11/25. Review of Resident #26's EHR failed to indicate as needed Furosemide was administered on the Medication Administration Record (MAR) and/or Nursing Progress Notes as ordered for weight gain of 3lbs or greater in 24 hours or 5lbs or greater in one week, for the following dates and weight changes: a. 3/22/25 169lbs, 3/23/25 172.2lbs (increase of 3lbs in 24 hours), 3/24/25 174lbs (increase of 5lbs in 48 hours) b. 4/21/25 172.6lbs, 4/22/25 176lbs (increase of 4lbs in 24 hours) c. 5/8/25 171.4lbs, 5/9/25 174lbs (increase of 3lbs in 24 hours) Review of Resident #26's labs ordered 2/17/25, collected on 3/26/25 and resulted on 3/27/25 documented, I have reviewed these results, repeat CBC with diff in 2 weeks. Review of Resident #26's Nursing Progress note created on 3/29/25 with effective date 3/27/25 revealed lab results reviewed by Facility Provider, no new orders at this time. Review of Clinic Note dated 4/21/25 for Resident #26 documented, last labs were collected 3/26/25, recommended at that time to collect repeat CBC in 2 weeks. I do not see this has been done, please collect CBC, BMP, and A1c on next facility lab day. Review of Clinic Note dated 6/3/25 for Resident #26 documented, last requested labs were collected 6/30/2025. 9. Review of MDS dated [DATE] for Resident #29 revealed BIMS of 11, indicating moderate cognitive impairment and diagnoses of hypertension, hyperlipidemia, non-Alzheimer’s dementia, chronic atrial fibrillation, and congestive heart failure. Review of Care Plan initiated 1/19/23 with focus of Resident #29's diuretic therapy with interventions to administer diuretic medications as ordered by Physician. A Clinic Note dated 10/3/24 for Resident #29 documented orders for daily weight monitoring and administer additional Furosemide 20mg with weight increase of 3lbs or more in 24-hour time period, provided to DON. A Clinic Note dated 12/12/24 for Resident #29 documented weights show trend increase, at time of last visit on 10/3/24, an order for daily weight monitoring as a result of weight increase trend with recommendation to add an additional 20mg Furosemide with weight increase of 3lbs or more in 24 hours’ time however, orders were not completed as requested. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Clinic Noted dated 2/10/25 for Resident #29 documented Provider has continued request for daily weight monitoring. At time of last visit on 10/3/24 and 12/12/24, an order for daily weight monitoring as a result of weight increase trend with recommendation to add an additional 20mg Furosemide with weight increase of 3lbs or more in 24 hours’ time however, daily weight monitoring has not been occurring. Reminded facility of the importance of this order. Review of Resident #29's EHR failed to indicate as needed Furosemide was administered on the MAR and/or Nursing Progress Notes as ordered for weight gain of 3lbs or greater in 24 hours or 5lbs or greater in one week, for the following dates and weight changes: a. 2/24/25 208lbs, 2/25/25 215lbs (increase of 7lbs in 24 hours) b. 3/1/25 210lbs, 3/2/25 215lbs (increase of 5lbs in 24 hours) c. 3/15/25 208lbs, 3/16/25 214lbs (increase of 6lbs in 24 hours) d. 3/29/25 210lbs, 3/30/25 215lbs (increase of 5lbs in 24 hours) e. 5/11/25 212lbs, 5/12/25 215lbs (increase of 3lbs in 24 hours) f. 6/2/25 212lbs, 6/3/25 215lbs (increase of 3lbs in 24 hours) g. 7/15/25 205.4lbs, 7/16/25 209lbs (increase of 4lbs in 24 hours) 10. The MDS dated [DATE] for Resident #40 revealed BIMS of 14, indicating cognitively intact and diagnoses of hypertension, renal insufficiency, diabetes mellitus, hyperlipidemia, thyroid disorder and depression. Review of Resident #40's Care plan initiated 6/28/25 documented focus on potential for nutritional problems due to Type 2 diabetes mellitus, hyperlipidemia, and chronic kidney disease with interventions to obtain and monitor labs/diagnostic work as ordered. report results to MD and follow up as indicated, Registered Dietitian to evaluate and make diet change recommendations as needed, and weigh and record weight per facility protocol. Review of Clinic Note dated 12/19/24 for Resident #40 documented weight loss noted over the last 60 days, referral to Facility Dietitian, diabetic labs ordered to be collected on next facility lab day. Review of Clinic Note dated 2/17/25 for Resident #40 documented weight loss noted over the last 60 days, weight loss was noted at time of last visit when it was recommended that Resident #40 be referred to facility Dietitian. Chart review shows this has not been done, will reach out to facility to have referral created for evaluation. Diabetic labs recommended to be obtained at time of last visit, these have not been completed, collect diabetic labs on next facility lab day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Clinic Note dated 4/21/25 for Resident #40 documented weight loss noted over last 60 days, this was noted at time of last visit 2/17/25 when it was recommended that patient be referred to facility dietitian. Chart review shows this has not been done, will reach out to facility to have referral created for evaluation. Diabetic labs collected 4/21/25, new orders provided for further labs to be collected on next facility lab day. Review of lab results dated 4/29/25 for Resident #40 documented reviewed lab results, Resident #40 would benefit from protein supplementation, previously advised dietitian referral. A Clinic Note dated 6/30/25 for Resident #40 documented previous routine labs resulted 4/21/25 reviewed, previously advised Dietitian referral, Resident #40 would benefit from protein supplementation Review of Nutritional Evaluation dated 4/30/25 for Resident #40 documented Dr's office provided Registered Dietitian referral for supplements secondary weight loss and hyponatremia, recommend liquid protein three times daily and Mighty Shakes at lunch and supper for additional calories and protein. Review of Physicians Orders for Resident #40 revealed an order dated 5/1/25 for liquid protein three times daily and Mighty Shakes at lunch and supper dated 4/30/25. In an email on 8/11/25 at 11:04 AM the DON responded and explained the facility process, relayed when our providers make their weekly rounds, they look to see who needs labs and they write the orders. Lab draws are on Monday unless it’s a stat lab, needed right away. The Administrator or DON takes the lab to the hospital and they fax the results to us and to the providers. We notify the family of results and follow up with the provider to see if they want any new orders. During an interview on 8/12/25 at 1:19 PM with the DON relayed cannot say what occurred, labs should have been put on the Medication Administration Record (MAR) and done by the nurse on lab day Monday or Tuesday. The DON relayed would be looking into and working on a better plan regarding labs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/13/25 at 12:59 PM and email communication on 8/14/25 at 12:56 PM, Facility Administrator stated when the Provider is in the facility doing rounds the DON or MDS Coordinator are with the provider, any orders or recommendations are then communicated to that person. The Provider will also write these orders on a carbon copy form, this form is given to the nurse assigned to that resident hall during this shift, once the nurse receives the orders they are responsible for transcribing and processing these orders. The Provider will dictate their visit into EPIC (hospital electronic health system), when this is completed it is expected the Medical Records Department will export these Clinic Notes into the appropriate resident's PCC. At the time of the interview the Administrator confirmed the completed dictated Clinic Notes are not reviewed by nurses to note/sign or acknowledge the Clinic Note is reviewed and orders are received. The Administrator acknowledged the missed lab orders, sleep study, Orthopedic follow-up, blood glucose monitoring, weight monitoring with as needed Diuretics, weight and nutrition concerns and stated there is a systemic issue with the Facility Providers and Facility as well as the reliance on Agency Staff in the past and the inconsistency it brings. When nursing staff are frequently changing, it can disrupt continuity of care and hinder effective communication between Providers and the team. This inconsistency can lead to delays or misinterpretations in implementing provider orders. The Administrator stated she would expect nursing staff to treat provider orders with urgency and accuracy, ensuring they are processed promptly and implemented as intended. Clear documentation, timely follow-through, and proactive communication are key. It is essential to for nurses to feel empowered to ask questions or seek clarification when needed, especially when orders are complex or require coordination across discipline. Review of facility policy titled Physician Orders Policy, reviewed 9/28/22 directed: To provide guidance and ensure Physician Orders are transcribed and implemented in accordance with Professional Standards, State & Federal Guidelines. 1.Physician Orders shall be provided by Licensed Practitioners (Physicians, Nurse Practitioners, & Physician’s Assistants) authorized to prescribe Orders.2. Orders must be Recorded in the Medical Record by the Licensed Nurse authorized to transcribe such Orders.3. Physician Orders must be documented clearly in the Medical Record. The required components of a Complete Order:a. Date and Time of Orderb. Name of Practitioner Providing Orderc. Name and Strength of Medication/Treatment d. Quantity/Durationе. Dosage/Frequency f. Route of Administrationg. Indication/Diagnosis h. Stop Date, if Indicated4. Physician Orders that are missing required components, are illegible or unclear must be clarified prior to implementation.5. Physician Order Sheet (POS) will be maintained with current Physician Orders as New Orders are received. Discontinued Orders will be marked as discontinued with the date, and all new Orders will be written in the appropriate area on the POS with the date the order was received.6. Physician Orders will be transcribed to the appropriate Administration Record (MAR/eMAR or TAR/eTAR).7. Medications will be ordered from the Pharmacy to ensure prompt delivery. Medications available from the Emergency Drug Supply (E-Kit) or Automatic Dispensing Unit (ADU) shall be utilized for the first dose until a supply arrives from Pharmacy, if available

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, clinical record review, facility policy review and staff interviews, the facility failed to store medications that required refrigeration at an appropriate temperature. The facility reported a census of 50 residents. Findings include:During an observation on 8/11/25 at 2:12 PM, the thermometer on the inside of the medication storage refrigerator revealed 50 degrees. The freezer compartment on the mini refrigerator was covered with dried ice that almost filled the entire freezer compartment except for 2 ice bags that sat on the dried ice. The refrigerator held multiple insulin pens and other medications. The Refrigerator/Freezer Temperature Record for August 2025 revealed PM temperatures: a. 8/1/25 at 46 degreesb. 8/2/25 at 48 degreesc. 8/3/25 at 47 degreesd. 8/4/25 at 50 degreese. 8/5/25 - no temp documentedf. 8/6/25- 48 degreesg. 8/7/25 at 48 degreesh. 8/8/25 no temp documentedi. 8/9/25 at 50 degreesj. 8/1/25 at 48 degreesDuring an interview on 8/11/25 at 2:22 PM, Staff E, Registered Nurse (RN) queried on what the medication storage refrigerator temperature needed to be at and Staff E stated around 40 degrees. Staff E informed the thermometer read 50 degrees and Staff E stated she would look into it.During an interview on 8/11/25 at 2:28 PM, the Director of Nursing (DON) queried on what temperature the medication storage refrigerator temperature needed kept at and the DON stated she didn't know off the top of her head but definitely below 50 degrees. The DON showed the temperature log and informed the freezer section of the refrigerator full of ice and the DON stated they would need to defrost it and they would put the medications in another refrigerator in the other medication storage room. The Facility Medication Storage in the Facility Storage of Medication Policy dated 11/18 revealed: Medications requiring refrigeration are kept in a refrigerator at temperatures between 36 degrees Fahrenheit and 46 degrees Fahrenheit with a thermometer to allow temperature monitoring.