STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165306	A. Building B. Wing	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Care Center	2237 Highway 34 Fairfield, IA 52556

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 22506 Based on facility record review, staff interviews, and hospital record review, the facility failed to ensure residents were appropriately assessed and provided interventions to maintain their optimal health and well being for 1 of 3 residents reviewed (Resident #1). The facility reported census was 44 residents. Findings include: According to a Minimum Data Set (MDS) with a reference date of 2/16/24, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating an intact cognitive status. Resident #1 had been independent with ADL's, but following a fall with fracture, was dependent on staff with transfers (Hoyer), mobility (W/C), dressing, toilet use, and personal hygiene needs. Resident #1's diagnoses included fracture right femur, myopia. A Progress Note dated 3/29/24 found Resident #1 returned from the hospital following a fall and fractured right femur. Resident #1 was placed on an opioid for pain control, and according to the VS.weight.BM document, had no recorded bowel movements since her return through 4/2/24. A Progress Note written by Staff A, Registered Nurse, on 3/29/24, indicated Resident #1 had very active bowel sounds in all 4 quadrants upon re-admission. A Progress Note written by Staff B, Registered Nurse, on 4/3/24 at 12:34 p.m. indicated Resident #1 refused to eat lunch and received a new standing order for constipation, Senna S 2 tabs twice daily and Bisacodyl suppository 10 mg rectally as needed daily. In an interview on 4/16/24 at 1:15 p.m. Staff B, Registered Nurse, stated she usually works from 6:00 a.m. to 2:00 p.m. Staff B stated she recalls on 4/3/24, Resident #1 complaining of stomach discomfort, abdominal distention and constipation. Staff B stated she updated the physician of the resident's condition and wrote a standing order for Senna and a Bisacodyl suppository. Staff B stated the Senna and Bisacodyl suppository was not in stock, so they would have to wait for the pharmacy delivery that evening. Staff B stated she informed Staff C at shift change report. Staff B stated the next day (4/4/24), Resident #1 continued to have stomach discomfort and abdominal distention. Staff recalled being informed that the suppository administered was not effective, which prompted her to obtain an order for a fleets enema, which was again not in stock and was not administered during her shift. Staff B stated she did not attempt another suppository or assess Resident #1 for impaction. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A Progress Note written by Staff C, Licensed Practical Nurse, on 4/3/24 at 5:01 p.m. indicated Resident #1's abdomen was hardened, Resident #1 had an emesis and was complaining of stomach pain. Staff C indicated Resident #1 was found to be impacted and Staff C digitally removed the impaction, noting a large amount of hardened, dark stool was removed. A Progress Note written by Staff C, Licensed Practical Nurse, on 4/3/24 at 5:54 p.m. indicated Resident #1 was delivered a room tray and Resident #1 only wanted drinks. Orange juice and prune juice were provided. A Progress Note written by Staff D, Licensed Practical Nurse, on 4/4/24 5:30 a.m. indicated Resident #1 had a large liquid brown emesis last evening and her abdomen remained distended. Staff D administered a suppository (8:00 p.m. on Medication Administration Record (MAR)) indicating only a smear resulted. In an interview on 4/16/24 at 1:00 p.m. Staff C, Licensed Practical Nurse, stated he generally works 6:00 a.m. to 6:00 p.m. and recalls Resident #1 having trouble with her bowels, stomach pain, and distention. On the evening of 4/4/24, Staff C checked Resident #1 for impaction and removed a large amount of hard stool. Staff C stated he remembered hearing in report that there was an order for Senna, but did not recall being informed of the order for a suppository. Staff C stated he had Resident #1 remain in bed during his shift. A Progress Note written by Staff B, Registered Nurse, on 4/4/24 at 8:22 a.m. indicated Resident #1 was still complaining of discomfort to abdomen and abdomen remained distended. No emesis noted at breakfast. Staff B indicated she contacted the physician's office to update on Resident #1's condition. Resident #1 was encouraged to drink fluids. A Progress Note written by Staff B, Registered Nurse, on 4/4/24 at 11:06 a.m. indicated Resident #1 had a small greenish emesis after lunch. A Progress Note written by Staff B, Registered Nurse, on 4/4/24 at 1:18 p.m. indicated new orders received for Zofran ODT 4 milligrams every six hours as needed (nausea), Miralax twice daily (laxative), and a one time order for a fleets enema. Pharmacy notified to ensure Miralax and fleets enema would be delivered on evening run. In an interview on 4/16/24 at 3:30 p.m. Staff F, Certified Medication Aide, stated she was working the evening shift on 4/4/24. Staff F stated Resident #1 was not feeling well and had reportedly vomited a couple of times that morning. Resident was complaining of her neck brace. Staff F recalls Resident #1 getting an enema, but she was not in the room. In an interview on 4/16/24 at 3:19 p.m. Staff E, Certified Nurse Aide, stated she recalls Resident #1 having bowel discomfort on 4/3/24 and 4/4/24. Resident #1 was stating she needed to have a bowel movement. Staff E stated Resident #1 was questioning things as she always does. Resident #1's abdomen was hard and distended. Staff E stated they tried pushing fluids to help her out. A Progress Note written by Staff H, Licensed Practical Nurse, on 4/4/24 at 9:15 p.m. indicated fleets enema delivered by pharmacy and administered with a moderate amount of soft stool expelled. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 4/16/24 at 4:38 p.m. Staff H, Licensed Practical Nurse, stated she was working a 6:00 p.m. to 6:00 a.m. shift on 4/4/24. Resident #1 had been sick earlier with bowel issues. Staff H indicated Resident #1 had gotten up for supper, but didn't eat much. They were able to get her to drink some prune juice. Staff H stated she received the fleets enema from pharmacy and administered it, feeling like she had good results. Resident #1 had a medium amount of soft stool expelled and her abdomen was less rigid afterwards and stated she was feeling better. Staff H stated Resident #1's bowel issues was a high priority. Staff I, Registered Nurse, stated Resident #1 had no further bowel movements that evening and seemed to sleep ok. Staff I stated she did not assess Resident #1 before leaving that morning. In an interview on 4/17/24 at 11:35 a.m. Staff G, Certified Nurse Aide, stated she worked 6:00 a.m. to 2:00 p. m. on 4/5/24 and provided care for Resident #1. Staff G stated that morning her and another aide changed and dressed Resident #1. Resident #1 had a small bowel movement. Resident #1 was awake and talkative, but mumbling and not speaking in full sentences. Staff G stated Resident #1 was not complaining of pain, but may have gotten a pain medication earlier. Resident #1 was transferred per Hoyer lift into her wheelchair and propelled to the dining room. Resident #1 took a few bites of food and drank all of her fluids. Resident #1 was having difficulties staying upright in her chair and was falling asleep, all of which was unusual. After breakfast at around 8:30 a.m. they laid Resident #1 back into bed. Staff G stated Resident #1's abdomen was very distended and hard. Staff G stated she informed the nurse, Staff A, of Resident #1's inability to stay upright and her mumbling. Staff G stated she thought Resident #1 had an enema that morning, but wasn't sure. At around 9:15 a.m. Resident #1 was playing with her call light and noticeably groggy and not making sense. Staff G stated she again reported this to their nurse, Staff A. At 10:30 a.m. Staff G checked on Resident #1, noting she remained dry, but was very warm and sweating. Staff G stated she removed Resident #1's long sleeve shirt and placed her in a gown. Staff G stated she also removed her socks and noticed her feet were slightly mottling. Staff G stated she reported Resident #1's condition to their nurse, Staff A, who agreed with Resident #1 remaining in bed for lunch. At around 11:30 a.m. Staff G stated she passed room trays. She stated she was able to get Resident #1 to eat a few bites of yogurt and dessert and a few sips of water. It was around this time the DON came in and asked how Resident #1 was doing. Staff G stated she reported her observations. At around 12:00 p.m. Staff G stated she checked on Resident #1 and she was dry and a tiny bit responsive. Her head of bed was at 45 degrees. From 12:30 p.m. to 1:30 p.m. Resident #1 remained in bed and unresponsive. A Progress Note written by Staff A, Registered Nurse, on 4/5/24 at 1:30 p.m. indicated Staff A checked on Resident #1 after she had not come to the dining room for lunch. Resident #1' s vital signs were temperature 93.9, pulse 44, respirations 26, blood pressure 111/28 and unable to get an oxygen saturation level. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 4/17/24 at 2:00 p.m. Staff A, Registered Nurse, stated she was working the day shift on 4/5/24 after being off a few days prior. Staff A stated it was reported to her that Resident #1 was having bowel issues and they had administered an enema to try and resolve the issue. Staff A stated that morning after breakfast she completed an assessment, including vital signs on Resident #1. Resident #1's abdomen was distended and hard, but not sore. Staff A stated she had no concerns and no further contact with Resident #1 until after lunch at about 11:30 a.m. It was at that time Staff A went to Resident #1's room because she did not come out for lunch. Staff A stated she checked her vital signs which were concerning and initiated oxygen, but noted Resident #1 was talkative and alert. Staff A stated the DON and Staff I also came into the room and together they dealt with Resident #1. At 2:10 p.m. the physician was notified and gave an order to send Resident #1 out for evaluation. When asked why there was a delay over a 2 hours before sending Resident #1 to the hospital, Staff A provided no explanation. A Progress Note written by Staff I, Registered Nurse, on 4/5/24 at 1:36 p.m. indicated Staff I was called to Resident #1's room by the Director of Nursing (DON). Blood pressure again checked and was 80/20. Unable to obtain an oxygen saturation level. Oxygen administered at 2 liters per minute per nasal canula with head of bed elevated. Resident #1 had audible gurgling. Physician notified and updated and family notified of Resident #1's condition. A Progress Note written by Staff A, Registered Nurse, on 4/5/24 at 2:30 p.m. indicated Resident #1's physician was updated on her condition and Resident #1 was requesting to go to the hospital. At 2:10 p.m. Staff A was given orders to send Resident #1 to the hospital. A Progress Note written by Staff A, Registered Nurse, on 4/5/24 at 2:34 p.m. indicated the ambulance arrived at 2:30 p.m. Resident #1 vital signs were obtained and Resident #1 was placed on a gurney and left just prior to 3:00 p.m. In an interview on 4/17/24 at 1:30 p.m. the Director of Nursing (DON), stated Resident #1 was not the same after her fall and fractured right femur. Resident #1 seemed more anxious and needy. The DON stated she met with Resident #1 in an attempt to relieve her anxiety. The DON stated Resident #1 had always had a pot belly, as if she was pregnant. On 4/3/24, Staff B, reported Resident #1 was constipated and having episodes of emesis. Resident #1 was encouraged to stay active, eat and drink plenty of fluids. Nothing seemed to be helping and on 4/4/24 they got an order for an enema. That evening Resident #1 was up for supper and ate a few bites. The enema was given with seemingly good results. The next morning the DON stated she spoke with Resident #1 and she seemed to be fine. The DON stated Resident #1 was having difficulties keeping her head up with her c-collar on, so she was searching for a high back wheelchair around lunch time. The DON stated Staff A reported Resident #1 was placed on oxygen and her vital signs were not good. The DON stated she got Staff I and together they checked Resident #1's blood pressure. Resident #1's feet were mottled and Staff I contacted Resident #1's son to report her condition. The son then spoke with the social worker and DON and decided he wanted his mother sent to the hospital. The DON stated when she observed the feet mottling, she felt death was imminent. In an interview on 4/17/24 at 12:30 p.m. Staff K, Certified Medication Aide, stated on the morning of 4/5/24, she passed Resident #1's morning medications. Staff K stated the medications were crushed due to Resident having difficulties swallowing. Staff K stated Resident #1 stated she was in pain and ready to go. Staff K stated she did not recall anything else about that morning. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 4/17/24 at 11:20 a.m. Staff J, Certified Nurse Aide, stated on 4/3/24 and 4/4/24 Resident #1 seemed her normal self. Resident #1 was talkative and stated her stomach felt hard and bigger. Staff J stated Resident #1's abdomen was very distended. Staff J stated Resident #1 had a medium bowel movement noted in her brief on the morning of 4/3/24 and a small bowel movement during a transfer on the morning of 4/4/24. According to the Prehospital Care Report (Emergency Medical Services (EMS) dated 4/5/24, EMS was on scene at 2:22 p.m. They were dispatched on report of a resident (Resident #1) being cold and clammy with depressed oxygen and blood pressure levels. Resident #1 was lying in bed, supine with a c-collar on. Staff report resident was alert and oriented and acting her normal self at breakfast this morning. Staff reports placing Resident #1 on oxygen at 2 liters per minute per nasal canula. Resident #1 is unresponsive, breathing normally, but oxygen saturation is at 67% when removed from oxygen. Resident #1 is cool and clammy. Hands and feet are purple in color. Resident #1 is hypotensive, eyes fixed and not responsive. Placed on a gurney and oxygen added at 10 liters per minute. According to the hospital Emergency Department (ED) Provider Note dated 4/5/24, Resident #1 was brought in for evaluation and was unresponsive and showing signs of mottling in her extremities. Resident #1 was felt to be in the dying process. Resident #1 was dramatically hypotensive, possible septic and mildly hypoxic. ED Course: It was decided given her current picture that comfort measures would be most appropriate, and these were initiated, but she ended up passing away in the ER.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22506 Based on resident and staff interviews, the facility failed to provide an effective rodent control program within the facility. The facility reported census was 44 residents. Findings include: In an interview on 4/18/24 at 10:40 a.m. Staff N, Housekeeper, stated she has worked at the facility for three months and during that time mouse infestation has been an on-going issue. Staff N stated she had observed multiple mice in resident rooms and frequently sees droppings when sweeping. Staff N stated just today she swept up mouse droppings in room [ROOM NUMBER] on B-hall. Staff N stated they are to check the glue traps daily, but noted it had been so bad the mice are chewing on the traps and don't seem to be sticking to the glue. Staff N stated the residents in room [ROOM NUMBER] and 113 on B-hall have both complained about seeing mice in their room. Staff N stated she heard an aide, Staff M, witnessed seeing a mouse on the lap of a resident in room [ROOM NUMBER] on B-hall. In an interview on 4/18/24 at 1:30 p.m. Staff M, Certified Nurse Aide, stated a couple of weeks ago, she witnessed a mouse on the lap of a resident sitting in his room. In an interview on 4/18/24 at 11:00 a.m. Staff O, Housekeeping Supervisor, stated she had worked at the facility for several years and recently returned and had never seen the mice like they have seen this year. Staff O stated in early February they began seeing mice and contacted their pest control provider. The provider placed poison on the exterior of the building and glue traps were provided for the interior. Staff O stated initially they were catching 5-7 mice a day, mostly on B-hall. It has since slowed down. Staff O stated some of the issue is related to room [ROOM NUMBER]. The resident has food brought in, trash on his floor, and will not allow housekeeping in to clean his room routinely. In an interview on 4/18/24 at 10:20 a.m. Staff P, Dietary Supervisor, stated in the last month she had a couple of dietary staff see mice in the kitchen area. Staff P stated she had also seen mouse droppings near the storage shelves and kitchen. Staff P stated about six weeks ago she saw a mouse in the break room and reported her concerns to their maintenance and housekeeping supervisor and was provided glue traps. Staff P stated she removed the food from the bottom shelf and has placed several glue traps in the kitchen area. During an observation and interview on 4/18/24 at 10:50 a.m. Resident #4 (room [ROOM NUMBER]) was sitting up in his recliner with the TV on. Resident #4 stated he sees mice in his room all of the time and the staff does nothing about it. Resident #4 was agitated. A Minimum Data Set (MDS) completed 3/8/24 noted Resident #4 with a Brief Interview for Mental Status score of 15 out of 15, indicating an intact cognitive status. During an observation and interview on 4/18/24 at 10:40 a.m. Resident #5 (room [ROOM NUMBER]) was lying on his bed. There was a noticeable odor in the room and the door was covered with trash, boxes, and belongings. Resident #5 stated he often hears and sees mice in his room. A Minimum Data Set completed 3/8/24 noted Resident #5 with a Brief Interview for Mental Status score of 13 out of 15, indicating an intact cognitive status.