

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165306	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2025
NAME OF PROVIDER OR SUPPLIER Parkview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2237 Highway 34 Fairfield, IA 52556	

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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on clinical record review, facility policy review, and staff interview, the facility failed to ensure resident code status were clear and consistent in the electronic health record as compared to the documentation kept in binder at the nurses desk for 1 of 24 residents (Resident #33) reviewed for advance directives. The facility reported a census of 49 residents. Findings include: The Minimum Data Set (MDS) assessment tool, dated 5/2/25, listed diagnoses for Resident #33 which included non-Alzheimer's dementia, anxiety disorder, and depression and listed her Brief Interview for Mental Status (BIMS) score as 0 out of 15, indicating severely impaired cognition. The facility Resuscitation Policy, effective 8/17/17, stated the facility would maintain each resident's resuscitation status in the clinical record. On 7/1/25 at 12:50 p.m., a review of Resident #33's Iowa Physician Order for Scope of Treatment, dated 1/20/23 and scanned in the electronic health record (EHR), revealed the resident was a Full Code. The resident's IPOST, dated 9/24/24, located in a book at the nursing station, stated the resident was a Do Not Resuscitate (DNR). On 7/1/25 at 12:52 p.m., Staff C Licensed Practical Nurse (LPN) stated if he needed to determine a resident's code status, he would either look in the EHR or the book at the nursing station, whichever was the fastest. On 7/1/24 at approximately 1:00 p.m., the Director of Nursing (DON) stated that code statuses should match and she would remedy the situation.</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on clinical record review, facility policy review, and staff interview, the facility failed to notify the physician of a weight gain for 1 of 3 residents reviewed for nutrition (Resident #24). The facility reported a census of 49 residents. Findings include: The Minimum Data Set (MDS) assessment tool, dated 5/30/25, listed diagnoses for Resident #24 which included edema (swelling), non-Alzheimer's dementia, and major depressive disorder. The MDS listed the resident's cognition as severely impaired. A 9/4/24 Care Plan entry stated the resident would maintain a healthy weight. Review of Resident #24's Weight Report listed the following weights: a. 5/1/25 a weight of 158 lbs. (pounds) b. 6/26/25 180 lbs., a gain of 22 lbs. or 13.92 percent. A 5/26/25 Quarterly Nutritional Assessment stated the resident had a weight gain and recommended a reduction of the resident's supplement to 60 milliliters (ml) once daily. The facility lacked documentation of provider notification of the resident's additional weight gain from 5/26/25 until 6/26/25. On 7/3/25 at 9:27 a.m. Staff D Registered Nurse (RN) stated if a resident had a 22 lbs. weight gain in two months she would check the resident for swelling and make sure the weight was correct. She stated she would notify the provider. On 7/3/25 at 9:30 a.m., the Director of Nursing (DON) stated if a resident gained 22 lbs. in two months, she would notify the Registered Dietician and the provider. She stated she expected staff to address a weight gain. Review of the undated facility policy Change in Condition revealed the facility would consult with the resident's physician when there was a significant change in condition or a need to alter treatment.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>Based on observation, clinical record review, policy review, and staff interview, the facility failed to provide an ongoing program of activities for 1 of 1 residents reviewed for activities (Resident #24). The facility reported a census of 49 residents. Findings include: The annual Minimum Data Set (MDS) assessment tool, dated 11/29/25, listed diagnoses for Resident #24 which included edema (swelling), non-Alzheimer's dementia, and major depressive disorder. The MDS listed the resident's cognition as severely impaired and stated the resident preferred the following activities: listening to music and spending time outdoors. Review of the Care Plan, dated 3/3/22, revealed the resident was at ease in joining other residents in activities. The Care Plan identified the resident enjoyed Jewish singing and visiting with friends from the meditating community. The facility Activity Services Policy, revised 7/13/23, stated the facility would plan activities based on resident interests, abilities, and needs. The facility designed activities to promote physical, mental, and social well-being. The untitled monthly activity logs revealed the resident participated in the following activities: a. April 2025: exercise - participated 22 times, refused once; one-on-one visits - participated 23 times. b. May 2025: exercise - participated 17 times, refused 5 times; one-on-one visits - participated 22 times; games - refused 1 time; pretty nails - refused 1 time; bible study - participated 1 time. c. June 2025: exercise - ball toss, walking, target toss, bean bag toss - participated 16 times, refused 2 times; one-on-one visits - participated 19 times; games - participated 1 time; church - participated 1 time; party - refused 1 time. Review of the activity calendars revealed other activity offerings included: outing, bingo, movie, cooking, crafting, coffee club, help with cleaning/folding. The facility lacked documentation these activities were offered to Resident #24. The activity calendar lacked documentation of further activities offered to the resident. Observations of Resident #24 revealed the following: a. On 6/30/25 at 1:32 p.m., the resident sat on the edge of his bed. b. On 7/1/25 at 8:51 a.m., the resident laid in bed. c. On 7/1/25 at 11:37 a.m. and 12:10 p.m., the resident sat at the dining room table. d. On 7/2/25 from 8:44 a.m. until 9:48 a.m., the resident sat on the couch in the day room and watched a TV game show. e. On 7/2/25 at 11:09 a.m. and 11:46 a.m., the resident sat at the dining room table. f. On 7/2/25 at 1:38 p.m., the resident laid in bed. g. On 7/2/25 at 3:10 p.m., the resident sat in a recliner in the day room and watched a TV game show. h. On 7/3/25 at 8:59 a.m., the resident sat in a recliner in the day room. During an interview on 7/3/25 at 9:42 a.m., the Director of Nursing (DON) agreed that resident should be kept busy and stimulated with activities. During an interview on 7/3/25 at 9:03 a.m., the Life Enrichment Coordinator stated she completed an hour of activities in the memory care unit. She stated she was responsible for transportation also so when she was doing that, she could not spend time on activities. During an interview on 7/3/25 at 9:18 a.m., the Director of Activities stated she was new at the facility but stated in her old facility she conducted activities every hour to 2 hours, around 5 activities per day. She stated she would like to carry out that schedule at this facility eventually. She stated staff could complete an activity with the residents before lunch.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, policy review, and staff interview, the facility failed to ensure medications and chemicals were secured and not accessible to 10 of 10 (which included Resident #11) cognitively impaired and independently mobile residents on the memory care unit. The facility reported a census of 49 residents. Findings include:1. The Minimum Data Set (MDS), dated [DATE], listed diagnoses for Resident #11 which included obesity, prediabetes, and a moderate intellectual disability The MDS stated the resident was independent with walking and listed her cognition as severely impaired. Review of the Care Plan, dated 10/24/24, revealed Resident #11 had cognitive loss and dementia and impaired decision making. The Care Plan directed staff to determine if her decisions would endanger her or others. The Care Plan documented the resident felt the need to touch different things and directed staff to allow this when safe to do so. During an observation on 6/30/25 at 1:47 p.m., while in the day room of the Memory Care Unit, Resident #11 pulled back the curtain covering the right-hand cubby and looked in. Other residents sat in the room but no staff were present. 2. Review of an untitled facility document revealed a list of 10 cognitively impaired, independently mobile residents in the locked Memory Care Unit. Observations on 7/2/25 revealed residents from the above list were unattended in the day room without staff at the following times: 8:52 a.m. to 8:55 a. m.; 9:02 a.m. to 9:08 a.m.; and 9:13 a.m. to 9:15 a.m.During an observation on 7/2/25 at 9:54 a.m., the right-hand cubby in the day room found to have contained the following:a. Staff B Certified Nursing Assistant's (CNAs) bag which contained an almost full bottle of ibuprofen 200 milligrams (mg)b. A spray bottle of Old English furniture polish in which the label stated it could cause eye irritationDuring an interview On 7/2/25 at 10:06 p.m., the Director of Nursing (DON) stated the resident environment should be free from medications and chemicals. She stated staff should lock up their personal items. The undated facility Hazard Communication Program stated the facility was committed to preventing chemical exposures.The undated facility policy [Facility Name Redacted] Medication Pass and Treatments directed staff to keep medications locked at all times.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on observation, record review, staff interviews, and the facility policy, the facility failed to follow the menu for 1 of 1 meals observed and 2 of 2 residents sampled for a therapeutic diet (Resident #21 and Resident #36). The facility reported a census of 49 residents. Findings include: 1. Review of the facility Spring/Summer 2025 Menu Week 1 revealed the following menu for Tuesday, July 1, 2025: a. Lemon chicken b. Garlic parmesan pastac. Roasted caesar vegetable [a substitute of California mix (generally a mixture of broccoli, cauliflower and carrots) made]d. Garlic toast</p> <p>e. Sugar cookie barsDuring an observation of the puree process on 7/1/25 at 10:47 a.m., Staff E, Dietary Cook/Aide did not prepare the puree garlic toast menu item. During an observation 7/1/25 at 11:50 a.m., the lunch meal service started. Staff E prepared plates for the residents. No garlic toast served with the prepared plates throughout the lunch meal service. During an interview on 7/1/25 12:41 a.m., Dietary Manager confirmed no bread served and stated garlic bread was supposed to have been served. During an interview on 7/2/25 at 9:54 a.m., Staff G, Dietary Aide queried if bread was served for lunch yesterday and Staff G stated no, she thought they were supposed to have garlic toast. Staff G stated she guessed they didn't have enough, but no one told her that directly. During an interview on 7/3/25 at 12:28 p.m., the Dietary Manager queried on not having the garlic toast and the Dietary Manager stated [name redacted] hadn't been getting them supplies because sometimes they run out. The Dietary Manager asked about substitutes and the Dietary Manager stated he usually tried to come up one, but didn't always.</p> <p>2. The Minimum Data Set (MDS) assessment for Resident #36, dated 3/28/25, identified the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 (indicative of severe cognitive impairment) and diagnoses of dementia and diabetes. The Care Plan for Resident #36, last revised 4/3/25, identified the resident was at risk for weight loss due to cognitive status. On 07/01/25 at 12:04 PM, dietary staff brought Resident 36's food out. The resident received mechanically ground lemon chicken with sauce, pasta, broccoli casserole. The resident ate 100 percent. The resident did not receive a piece of garlic bread per the facility menu and was not offered a bread substitute. 3. The MDS assessment for Resident #21, dated 5/2/25, identified the resident had a BIMS of 11 out of 15 (indicative of a moderate cognitive impairment) and diagnosis of cerebral vascular accident (stroke) and diabetes. The Care Plan for Resident #21, last revised 5/8/25, identified the resident received a therapeutic diet related to a diagnosis of diabetes. On 7/01/25 at 12:07 PM, dietary staff served Resident #21 her lunch which included lemon chicken with a sauce, pasta and a broccoli casserole. Resident #21 did not receive a piece of garlic bread per the facility menu and was not offered a bread substitute. The facility policy, titled Food and Nutrition Services, dated October 2017, identified the facility provided each resident with a nourishing, palatable, well-balanced diet that meets their daily nutritional and special dietary needs.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interviews, and the facility policy, the facility failed to provide a palatable vegetable for 1 of 1 meal observed. The facility reported a census of 49 residents. Findings include:1. The Facility Spring/Summer 2025 Menu Week 1 revealed the following menu for Tuesday, July 1, 2025::a. Lemon chicken b. Garlic parmesan pastac. Roasted caesar vegetable [a substitute of California mix (generally a mixture of broccoli, cauliflower and carrots) made]d. Garlic toast. Sugar cookie [NAME] 7/1/25 at 12:52 p.m., the State Agency received and tasted a lunch tray with the above menu items. The California mix sampled contained mostly broccoli pieces. The broccoli pieces were soft and mushy, and tasted and smelled like black pepper. During an interview on 7/2/25 at 8:28 a.m., Staff E, Dietary Aide/Cook queried if she followed a recipe for the menus stated she followed the recipes. Staff E stated the vegetable was a California mix. Staff E queried if the California mix had a recipe for how much seasoning to add and Staff E stated no, she didn't measure the seasoning, Staff E sprinkled the seasoning and tasted it and thought it tasted fine. Staff E stated some people said it was too spicy, but Staff E made sure she stirred it pretty good. Staff E stated she used a salt free seasoning blend in the California mix and might have had a big clump in it. During an interview on 7/3/25 at 8:43 a.m., the Dietician queried on using a salt free seasoning blend with the vegetables and she stated the cooks added the seasoning for taste. The Dietician stated if residents complained, it was a different story. She stated she wouldn't put spices on broccoli. The Dietician asked about the texture of the broccoli and she stated the broccoli should be tender and the spices withheld unless the vegetables were supposed to be spiced. During an interview on 7/3/25 at 12:28 p.m., the Dietary Manager queried on the broccoli served on 7/1/25 and he stated broccoli was difficult to hold and constantly wanted to turn pale. The Dietary Manager stated he would prefer they undercook the broccoli and let the steam table finishing cooking it, but there was no way to keep the broccoli from getting mushy. The Dietary Manager asked about the salt free seasoning blend to the vegetable dish and the Dietary Manager stated it was very possible the cook added too much.</p> <p>2. During an observation on 07/01/25 at 12:04 PM, dietary staff brought Resident 36's food out. The resident received mechanically ground lemon chicken with sauce/gravy, pasta, and broccoli casserole. Staff A, Certified Nurses Aide (CNA), and Staff C, CNA, assisted the resident with sitting at the table. The resident started to eat and talk with his tablemates. At 12:12 PM, Staff A, CNA, sat at the resident's table. Resident #36 requested salt for his food. Staff A helped to apply salt to the resident's food and then offered to pepper the resident's food. Resident #36 responded that someone had already peppered it. Resident #36 told one of his tablemates that the food had too much pepper. 3. On 6/30/25 at 2:01 PM, Resident #21 reported the food was not good. She explained that it was either undercooked or overcooked.On 7/01/25 at 12:07 PM, dietary staff served Resident #21 her lunch which included lemon chicken with a sauce, pasta and a broccoli casserole. The broccoli casserole was mushy and overcooked in appearance. The resident ate 50 percent of the meal, and did not eat the broccoli casserole. The facility policy, titled Food and Nutrition Services, dated October 2017, identified the facility provided each resident with a nourishing, palatable, well-balanced diet that meets their daily nutritional and special dietary needs.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, facility policy review and staff interviews, the facility failed to maintain a sanitary kitchen which included safe refrigerator temperatures, consist daily refrigerator temperature check documentation, target sanitization levels in the dishwasher, staff hand hygiene practices, and clean deep freeze equipment. The facility reported the census of 49 residents. Findings include: Review of the June 2025 Refrigerator Logs revealed temperatures logged during the evening shift on 6/25/25; 6/27/25; 6/28/25; 6/29/25; and 6/30/25. Review of the June 2025 Refrigerator Log for Refrigerator #2 revealed the following temperature documented during the evening shift: a. 6/25/25: 48 degrees Fahrenheit (F). b. 6/27/25: 48 degrees F. c. 6/28/25: 48 degrees F. d. 6/29/25: 48 degrees F. e. 6/30/25: 47 degrees F. During the initial kitchen observation on 6/30/25 at 10:18 a.m., the white deep freeze had a large amount of ice buildup along the inside of the freezer walls. During the initial kitchen observation on 6/30/25 at 10:38 a.m., the temperature logs on the refrigerator had a total of 5 entries for June. The Dietary Manager queried where the dishwasher logs were located and the Dietary Manager stated he didn't have them at the moment. The thermometers for two refrigerators in the main kitchen registered a temperature of 45 degrees F. The thermometer for the refrigerator on the counter by the handwashing sink log registered a temperature of 48 degrees F. During an observation on 7/1/25 at 8:52 a.m., Staff E, Dietary Aide/Cook queried where the test strips were located for the dishwasher and she stated she didn't know where they were. During an observation on 7/1/25 at 8:58 a.m., the Dietary Manager found the test strips for the dishwasher and after a cycle run for testing the strip read 25 parts per million (ppm). The color on the strip was light purple. The Dietary Manager stated [name redacted] was in a couple months ago and did some adjustments. The Dietary Manager asked about the dishwashing logs and he provided them. The Dietary Manager confirmed the refrigerator and freezers temperatures were not being completed even though he told his staff to do them. The Dietary Manager queried on providing the manufacture instructions for the dishwasher and he stated he couldn't because the dishwasher had been here longer than he was. The Dietary Manager asked if he would talk with someone about providing the manufacturer instructions and he stated yes, he would. During an observation on 7/1/25 at 11:10 a.m., Staff E temped the alternate main dish of smashed burgers. Staff E cleaned the thermometer and lifted the trash lid with her bare hands and placed the wipes in the trash can and then the lifted the trash can lid again to place another wipe in it and the side of the thermometer touched the top of the trash lid. Staff E continued to temp the smashed burgers and did not wash her hands or the clean the thermometer after it touched the trash lid. During an interview on 7/1/25 at 11:34 a.m., the Dietary Manager queried on the plan for the dishwasher and the Dietary Manager stated he placed a call to the company who fixed it and the staff would need to hand sanitize the dishes until the sanitizing up to a target 50 PPM. The Dietary Manager queried on problems with the dishwasher and he stated no, not until now. During an observation on 7/1/25 at 11:37 a.m., the thermometer for refrigerator on the corner by the handwashing sink temperature read 52 degrees F. During an observation on 7/1/25 at 11:45 a.m., the Dietary Manager used a different test strip roll and ran a dishwasher cycle and retested the sanitizer and the Dietary Manager stated the strips got darker. The color on the strip was between the 25 PPM and the 50 PPM. The Dietary Manager confirmed the test strip not dark enough and the staff would not use the dishwasher until it was fixed. During an observation on 7/1/25 at 12:10 p.m., the thermometer for the refrigerator on the counter of the kitchen by the handwashing sink temperature read 55 degrees F. During an interview on 7/1/25 12:41 p.m., Dietary Manager queried on the temperature of the refrigerator next to the handwashing sink and he stated the refrigerator settled down after meal services and he had the coils cleaned a few weeks ago. The Dietary Manager stated he instructed staff to limit their use of the refrigerator and keep the doors closed. The Dietary Manager stated he would keep an eye on it and would shuffle items to the other refrigerator. During an interview on 7/1/25 at 1:05 p.m., the Administrator notified of the dishwasher sanitizer strips not meeting the required level and the Administrator stated she would speak to the Dietary Manager and see what was going on. During an interview on 7/1/25 at 1:32 p.m., the Administrator stated the dishwasher strip was at 50 PPM and showed a picture on her phone that was close to 50 PPM on the strip. The Administrator stated the facility would use paper plates until [name redacted] came to the facility and looked at the dishwasher. During an interview on 7/1/25 at 1:45 p.m., the Dietary Manager stated he fixed the problem and the dishwasher was working, because he adjusted the tubing. During an interview on 7/1/25 at 1:53 p.m., the Dietary Manager tested a test strip on the dishwasher and the</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff interview, the facility failed to offer an annual influenza vaccine for 2 of 5 residents (Residents #11 and #24) reviewed for immunization. The facility reported a census of 49 residents. Findings include: 1. The Minimum Data Set (MDS), dated [DATE], listed diagnoses for Resident #11 which included obesity, prediabetes, and moderate intellectual disabilities and listed her cognition as severely impaired. An untitled document, dated 3/13/24, documented that the Resident #24's resident representative consented to an influenza vaccine. The facility lacked documentation the resident received an influenza vaccine during the 2024-2025 flu season. 2. The MDS assessment tool, dated 5/30/25, listed diagnoses for Resident #24 which included edema (swelling), non-Alzheimer's dementia, and major depressive disorder. The MDS listed the resident's cognition as severely impaired. An untitled document, dated 3/13/24, documented that the Resident #24's resident representative consented to an influenza vaccine. The facility lacked documentation the resident received an influenza vaccine during the 2024-2025 flu season. The undated facility Policy for Provision of Influenza and Pneumococcal Vaccines, stated the facility would screen residents to determine if they were current on their immunizations. The policy stated the facility would offer all residents the influenza vaccines. On 7/3/25 at 9:39 a.m., the Director of Nursing(DON) stated she was not sure how the facility missed the above resident's annual influenza shots.</p>		