STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165343	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Rehabilitation Center	601 Park Avenue Sac City, IA 50583

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based record review and staff interview, the facility failed to notify the resident's representative of a change in condition for 1 of 4 residents reviewed (Resident #1). The facility reported a census of 43 residents. Findings include:According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #1 demonstrated long and short term memory problems and severely impaired cognitive skills for daily decision making. The resident had diagnoses including a stroke with hemiplegia of the right dominant side.The Care Plan identified the resident at risk for alteration in skin integrity related to immobility, right sided weakness Status Post (S/P) stroke, anticoagulant and antiplatelet usage. On 7/30/25 pressure ulcer right buttock, and 8/15/25 pressure ulcer left buttock. A Concern Form dated 8/29/25 documented Resident #1's family member gave a verbal in person report. She felt the facility had not notified her of the resident's wound worsening.The Progress Notes dated 8/21/25 at 3:54 p.m. documented the weekly skin assessment revealed a reddish-purplish colored area remained on the left upper buttock with some yellow slough and measured 2.7 cm x 2 cm. She also had an open area measuring 8 cm x 10.5 cm that had deteriorated on her right buttock, with yellow slough around the edges and brown discolored skin in the center. The fax with the above information returned by the Primary Care Provider on 8/22/25 showed physician notification. The clinical record lacked documentation the resident representative received notification of the change in the wound.On 9/3/25 at 12:20 p.m. Staff C Licensed Practical Nurse (LPN) stated she normally did wound assessments on Thursdays and then she would fax the doctors with the results. She said the resident's wounds had been deteriorating.The facility Notification for Change of Condition policy revised 6/2023 identified the facility would provide care to residents and provide notification of resident change in status. The facility must immediately inform the resident; consult with the resident's physician, and notify the resident's representative when there was a significant change in the resident's physical, mental, or psychosocial status.

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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(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. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 of 3 resident's reviewed (Resident #1). The facility reported a census of 43 residents. Resident #1 had wounds that were deteriorating. The resident was seen in the wound center. The facility sent the assessment of the wound in a fax to the PCP on 8/21/25 and wrote the resident would be seen in the wound center 8/22/25. The PCP replied okay. The PCP was not the wound center provider. The resident did not have an appointment on 8/22/25. The facility did not follow up until 8/27/25 with an assessment. The fax notified the wound center physician that the wound deteriorated and had a foul odor. The physician ordered a different treatment until seen on 8/29/25. The nurse who did the assessment had hoped he would want to see her sooner, but did not convey that in the fax. The resident admitted to the hospital 8/28/25 in respiratory distress, with fever and a large buttock ulcer, which likely caused her symptoms. The resident became septic (a life threatening complication of an infection). Findings include:According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #1 demonstrated long and short term memory problems and severely impaired cognitive skills for daily decision making. The resident had diagnoses including a stroke with hemiplegia (paralysis of 1 side of the body) of the right dominant side.The Care Plan identified the resident at risk for alteration in skin integrity related to immobility, right sided weakness Status Post (S/P) stroke, anticoagulant and antiplatelet usage. On 7/30 pressure ulcer R buttock, and 8/15 pressure ulcer L buttock. Interventions included: Administering medications as ordered, administering treatment per physician orders, barrier cream to peri area/buttocks as needed, educating the resident and/or family/caregiver as to causes of skin breakdown, including transfers/positioning requirements, encouraging good nutrition and hydration in order to promote healthier skin, encouraging to reposition, following facility policies/protocols for the prevention/treatment of skin breakdown, observing skin condition with care, pressure reducing device on bed, pressure reducing device on chair, providing preventative skin care, using pillows/positioning devices as needed.The Progress Notes documented the following: a. On 7/31/25 at 9:32 a.m. a reddish-purplish colored area remained on the resident's left upper buttock due to Moisture Associated Skin Damage (MASD). The skin was peeling over this area with yellowish colored drainage and the Mepilex saturated. They used a Mepilex dressing to this area for protection on bath days. They questioned changing the Mepilex dressing daily to this area, start Vitamin C 500 mg, Zinc 50 mg daily, and 4 oz of supplement 2 times a day, to promote wound healing. b. On 7/31/25 at 4:01 p.m. a fax received from the Primary Care Provider (PCP) regarding the compromised area on the left upper buttock. New orders included changing the Mepilex dressing daily to the area, and starting Vitamin C, Zinc, and supplement. c. On 8/4/25 at 10:51 a.m. the open area to the resident's left buttock was purple, with blisters, appearing to turn into a pressure area. A moderate amount of drainage to the area, and the Mepilex saturated this a.m. The resident had pain when touched the area. Asked for an order to have the resident seen at the wound clinic. d. On 8/4/25 at 3:46 p.m. the fax returned regarding an order for the resident to be seen at the wound clinic for the open area to her buttock. The physician responded yes. e. On 8/7/25 at 11:33 a.m. a weekly skin assessment revealed a reddish-purplish colored area remained on the left upper buttock. The skin was peeling over the area with serous drainage. The area had deteriorated and measured 8.2 cm x 8 cm. They used a Mepilex dressing to the area daily. She also had a red 1.2 cm x 1.3 cm blanchable area on her left buttock with intact skin. Moisture barrier cream applied to the area. She would be seen in the wound clinic the next day. They would continue to monitor the area. f. On 8/7/25 at 9:19 p.m. received a fax regarding the resident's weekly skin assessment. The physician responded agree. g. On 8/8/25 at 11:25 a.m. the resident returned from the wound care appointment with a new order for Santyl ointment to the right buttock wound and cover with Mepilex 3 times per week. h. On 8/14/25 at 9:01 a.m. the weekly skin assessment revealed a reddish-purplish colored area remained on the left upper buttock with the skin peeling, serous drainage, and some yellow slough. The area remained the same and measured 8.2 cm x 8 cm. She also has a reddish-purple 2.2 cm x 2.2 cm area that had deteriorated on her left buttock with intact skin. Moisture barrier cream applied to the area. She would be seen in the wound clinic the following day. They would continue to monitor the area. i. On 8/15/25 at 12:36 p.m. the resident went to the wound clinic with orders for Santyl & Mepilex to the right buttock and sacrum 3 times a week and as needed (prn). Aquacel AG/small Mepilex border to the left buttock 3 times a week and prn. Follow up appointment 8/29/25

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to ensure a resident received adequate supervision to prevent accidents for 1 of 3 residents reviewed (Resident #2). Resident #1 fell on 7/10/25 fracturing his right elbow that would require surgical repair, and a laceration near his right eye requiring 7 sutures. The resident had a pressure alarm that did not sound to alert staff the resident was getting up without assistance. Staff failed to determine why the alarm did not sound. On 7/11/25 the resident fell again fracturing his left elbow, also requiring surgical repair. The resident's pressure alarm again failed to sound to alert staff the resident was getting up. The facility reported a census of 43 residents. Findings include:The Care Plan documented Resident #2 admitted to the facility on [DATE]. The Care Plan identified the resident had impaired cognitive function, and at risk for falls, on 7/10/25 at 10:30 a.m. fall with no injury, on 7/10/25 at 2:07 p.m. fall with right eyebrow laceration, fracture right elbow, on 7/11/25 at 6:10 a.m. fall with left elbow fracture, left eyebrow laceration, pain in left wrist. On 7/10/25 door alarm initiated and moved to a closer room to the nurse's station.The Progress Notes documented the following: a. On 7/10/25 at 10:30 a.m. the aides summoned the nurse when the resident was found in a sitting position in the opposite room. The resident went to the emergency room for evaluation. b. On 7/10/25 at 2:07 p.m. the resident was found in a sitting position in the room across the hall. The resident was unable to move his right upper extremity. The resident's eye lid on the right side (swelling hemorrhaging). Certified Nursing Assistants (CNA's) held a cold washcloth to the site of his face. Relevant interventions in place at the time of the incident: included a bed alarm.Preliminary Recommendations, if any, for consideration as further preventative measures was a door alarm. c. On 7/10/25 at 2:59 p.m. received a call from hospital. The nurse reported resident had a laceration to his right eyebrow that was sutured. The resident had 7 sutures needing removal in one week. Suture care instructions being sent back with resident. Nurse also reports the resident broke his right elbow in multiple locations and would need surgery. Prior to surgery, the resident needed cardiac clearance. Appointment set up with cardiology for July 16th at 8:45 a.m. They called to schedule a surgery appointment on July 17th. The nurse at the hospital reported the resident had splint and sling in place, the elbow would need to be kept at 90 degrees. The resident could continue same medications, and able to return to the facility at that time. d. On 7/10/25 at 3:13 p.m. received paperwork upon resident's return. Suture instructions: keep wound clean and dry, use hydrogen peroxide and water soaked gauze to wipe clean every day. The goal of each cleaning was to get it back to just stitches and skin, not letting a scab form. They should dress the laceration with antibiotic ointment, and cover with bandages if it could get dirty. No prolonged soaks until healed, quick showers were okay, patting dry afterwards. Stitches out in 7 days, monitor for infection. Tylenol if needed for temp or discomfort. No instructions for splint care. e. On 7/11/25 at 8:03 a.m. the nurse was called into the resident's room at 6:10 a.m.by the CNAs while they were doing physical rounds and saw the resident on the floor face down. No alarm sounded. The fall was not witnessed. It took 2 staff with a gait belt to assist the resident up and into his recliner with a walker. The resident had a slow, unsteady gait. The resident wore his gripper socks. It appeared the resident used his walker at the time of the incident. The floor was dry other than the blood that came from the resident's injures after the fall. The resident was last checked at 4 a.m. and was not incontinent of bowel and the catheter emptied. The resident stated he tried to hold himself up when asked what he was attempting to do. The resident bled from the previous injury to his right eye brow and a new injury to the left eyebrow. The nurse had previously laid eyes on the resident at 5:50 a.m. and he rested in bed. The resident had full range of motion (ROM) to his extremities other than his right arm that had a previous injury to his elbow. He did not complain of discomfort while having resident do ROM other than slight discomfort in his left wrist. Neuros initiated and pupils sluggish. The resident complained of pain in his nose, lower back, and left wrist. The resident got a laceration to his left eyebrow. Made resident comfortable and cleaned blood off. The resident had a pressure alarm under him while in bed. This alarm did not sound. The resident had a history of turning his alarms off and/or moving them. Preliminary Recommendations, if any, for consideration as further preventative measures was a bed alarm that attached to the resident and sounded when the resident tried to get up. f. On 7/11/25 at 11:15 a.m. called the hospital to check the status of the resident. The ER nurse informed the resident had fractured his left elbow. g. On 7/11/25 at 5:55 p.m. a hospital nurse called and stated the resident admitted with possible return 7/12 or 7/13/25. h. On 7/13/25 at 10:30a.m. the resident returned to the facility. Both arms were in splints with ace wrap form his hands to the