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	01/08/2026

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and family interview, the facility failed to allow a resident representative/Power of Attorney (POA) assist a cognitively impaired resident with decision making for 1 resident reviewed (Resident #4). The facility reported a census of 47 residents.Findings include:According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #4 scored 10 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. Diagnoses included atrial fibrillation, cirrhosis, arthritis, and repeated falls.The Progress Noes dated 9/14/25 at 12:29 p.m. documented Resident #4 was alert to person, and to place. The resident was confused.The Progress Notes dated 9/15/25 at 10:32 a.m. documented the resident was alert to person. The resident was confused and forgetful.The Progress Notes dated 9/16/25 at 1:10 p.m. documented the resident was alert to person. The resident was confused and forgetful.The Progress Notes dated 9/17/25 at 1:48 p.m. documented the resident was alert to person. The resident was confused and forgetful.The Progress Notes dated 9/17/25 at 10:20 a.m. documented the Social Services Director (SSD) spent some time with the resident this morning going over the Medicaid application. He was knowledgeable about the information and what each insurance company was for. Reviewed with the resident's family member for accuracy.An undated and unsigned note in the resident's EHR read life insurance policy for the resident $15,000. Would need to call company at time of death with the policy number and phone number. Would need a copy of the death certificate sent to the company.An email dated 9/29/25 at 3:46 p.m. documented the SSD wanted to email the POA so it was in writing and a visual for her. The SSD had been working on gathering all of the resident's items for the Medicaid application with him. The things they discovered included a final expense policy with a cash value of an estimated $3,277.81, and a face value of $15,000 (would likely need to be cashed out to get him below resources). The SSD waited on documents including the life insurance. Once she had them she should be able submit the Medicaid application. The resident was okay with cashing out the final expense plan, if the POA was as well. It would take a little bit of time for the transaction to be completed.The POA responded asking what the SSD meant cashing out his policy, as she needed to do this.In an email from the SSD to the resident's POA regarding a Medicaid application update on 9/30/25 at 10 a.m. the SSD wrote the resident must be below $2,000 in assets in order to submit. The SSD could assist the resident with it, just wanted the POA aware. The POA thought it was a supplemental policy. When they called it was a final expense policy.An insurance company Request for Cash Surrender Value of Policy contained the resident's signature, and the SSD signature for the witness dated 10/15/25.The clinical record lacked documentation of the resident's cognitive status when he signed the cash surrender policy.On 1/7/25 at 12:23 p.m. the SSD stated she had contact with the resident's daughter via email and in person about the resident's life insurance policy. She thought when they talked, the POA was okay with him cashing out the insurance policy. The resident was ok with it. They needed to spend down if he wanted to get on Medicaid. She said the resident's BIMS was in the (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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	moderately impaired category, but in the upper end. She said when his daughter came in she was very upset with her about doing this. The SSD said she had no documentation of how she proceeded. She did not document dates or times when she talked to the resident's POA. On 1/8/25 at 10:05 a.m. the resident's POA stated the resident did not want to cancel his life insurance policy. The POA said when the SSD said they needed to do this, she told her to wait until she could get in touch with the insurance company to see what they could do. She said the insurance company would not give her the information until they had the POA papers. She faxed them, then she had to send them via certified mail. She said she found out the insurance was cancelled from the company. She was very upset. There were other options. She said the resident's mental status had declined and he was not in a condition to make that decision. She said if the resident had understood what it meant, he would not have signed the paper.On 1/8/25 at 12:50 p.m. the corporate Medicaid Service Coordinator stated when spending assets down to under $2,000 they had to look at everything. She said there were several options for life insurance; cashing out the policy, buyout of the policy with a different owner, and an irrevocable burial fund. It was her understanding the resident had a high enough BIMS and was able to make this decision himself.On 1/8/25 at 2:30 p.m. during the exit conference the SSD stated not being aware of the buyout option. She said the POA had applied a CD to the burial fund.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed ensure an As Needed (PRN) psychotropic medication was only continued after 14 days with a provider written rationale and end date for 1 of 3 residents reviewed (Resident #4). The facility reported a census of 47 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #4 scored 10 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. Diagnoses included atrial fibrillation, cirrhosis, arthritis, and repeated falls. A New Prescription Summary dated 9/25/25 documented an order for Lorazepam/Ativan 0.25 mg by mouth every 4 hours PRN for anxiety.An order dated 10/2/25 changed the Lorazepam 0.25 mg, from every 4 hours PRN, to every 2 hours PRN with no rationale for continuing and no end date.The Medication Administration Record for October showed the PRN Lorazepam 0.25 mg administered 19 times through the 28th, and 11 of those times were ineffective.On 1/7/25 at 8:46 a.m. the Director of Nursing (DON) said family didn't want the resident on the psych meds. She said they tried all the non-pharmacological interventions before administering meds because that was what the family wanted. The DON stated she did not think they gave a rationale or end date to continue the PRN Lorazepam.The facility policy, Usage for Psychotropic Medications Guidance, revised 3/25, documented PRN use of psychotropics (excluding antipsychotics) to 14 days unless extended by the attending physician with a documented rationale.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure interventions were in place to prevent falls, and failed to ensure the completion of neuro assessments after falls for 1 of 3 resident's reviewed (Resident #4). The facility reported a census of 47 residents.Findings include:1.According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #4 scored 10 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident required partial/moderate assist with oral hygiene, toileting hygiene, showering/bathing, lower body dressing, personal hygiene, sit to stand, and chair/bed-to-chair transfer. Diagnoses included atrial fibrillation, cirrhosis, arthritis, and repeated falls. The Care Plan with a goal target date of 1/4/26 identified the resident at risk for falls related to impaired cognition and recent falls. The resident's goal to minimize the risk for falls. Interventions included the resident to wear gripper socks in bed.The Progress Notes dated 10/16/25 at 8:05 p.m. documented Resident #4 was in bed with the bed in lowest position. Resident with grippy socks on and was noted as staff walked by laying on the floor between the bed and the wall. The resident gripped the curtains. The resident answered simple questions of yes or no, but not able to verbalize what he attempted to do. Relevant interventions in place at the time of the incident included the resident had on grippy socks on. The Progress Notes dated 10/19/25 at 1:55 a.m. documented the nurse was called into the room. The resident in the room by his dresser, on the floor leaning on his left arm, holding himself up. The resident stated he did not hit his head, but his left arm hurt. The nurse noted a skin tear on his left arm near his elbow 4x3 cm. It took 3 staff to get the resident up with a gait belt into the wheelchair. Education given to staff, that the resident needed to wear proper footwear, grippy socks or shoes at all times, even in bed. 2. The Progress Notes dated 10/16/25 at 8:05 p.m. documented Resident #4 laid on the floor between the bed and the wall. The resident gripped the curtains. The resident answered simple questions of yes or no, but not able to verbalize what he attempted to do. A Neurological Evaluation Flow Sheet (Double Sided) initiated 10/16/25 at 8 p.m. documented results of the post fall assessments for Resident #4. The flowsheet lacked completed assessments on 10/17/25 at 12 a.m., 1 a.m. 4 a.m., and 5 a.m. indicating the resident sleeping. An entry for 10/17/25 2-10, and 10-6 documented sleeping but included vital signs, and the 2-10 column included pupil size and reaction while the resident slept.The Progress Notes dated 11/19/25 at 6:45 p.m. documented the ADON summoned the nurse. Upon approaching, observed the resident sitting on his buttocks on the floor, facing the med room door. The resident's bilateral lower extremities (BLE) flexed out in front of him and bilateral upper extremities (BUE) flexed at his sides. The resident's wheel chair sat behind him. A Neurological Evaluation Flow Sheet initiated 11/19/25 at 6:45 p.m. documented results of the post fall assessments for Resident #4. The flow sheet lacked completed assessments on 11/21/25 at 12:45 a.m., and 11/22/25 at 12:45 a.m. indicating the resident sleeping. On 1/7/25 at 1:32 p.m. the Director of Nursing (DON) stated the neuro sheets needed to be filled out completely. At times hospice may ask a resident be allowed to sleep through the neuros, but they did not do that for this resident that they she knew of. The facility Fall Occurrence policy revised 2/2024 documented the procedure included an incident would be completed each time a resident had a fall. Neurological assessments would be initiated for unwitnessed falls and/or falls that were witnessed and the resident hit their head (neuros completed as directed on neuro flowsheet). Documentation and monitoring to be completed for 72 hours post fall. Complete neurological evaluation with vital signs initially, then every 30 minutes X 4, then every hour X 4, then every 8 hours X 9 (72 hours). More frequent evaluations may be necessary. Complete (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	episodic charting for at least 72 hours including any pertinent evaluation findings related to the neurological evaluation. Review the most recent evaluation on the medical record and notify the Physician of any changes from the previous evaluation.