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	06/10/2026

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 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 on record review and staff interviews, the facility failed to ensure that the resident's physician and responsible party were notified regarding the failure to administer prescribed, scheduled medications including a high-risk medications for 2 of 3 residents reviewed (Resident #1 and #2). The facility reported a census of 42 residents.Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented diagnoses of malignant neoplasm of anal canal, renal insufficiency and malnutrition. The MDS showed the Brief Interview for Mental Status (BIMS) score of 13, which indicated no cognitive impairment. Review of the April 2026 Medication Administration Record (MAR) for Resident #1 showed the Director of Nursing (DON) indicated by documentation on the MAR the following evening mediations were not administered on 4/21/26:Clonidine for hypertensionMetoprolol for hypertensionSertraline for depressionCefuroxine Axetil for abnormal findings in the lung fieldKlor-Con for low potassium 2. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 documented diagnoses of blood clot, depression, and dementia. The MDS showed the Brief Interview for Mental Status (BIMS) score of 00, which indicated severe cognitive impairment. Review of the April 2026 Medication Administration Record (MAR) for Resident #2 showed the Director of Nursing (DON) indicated by documentation on the MAR the following evening mediations were not administered on 4/21/26:Trazodone for depressionEliquis for history of blood clot in lungMemantine for Alzheimer's DiseaseRisperidone for behavioral disturbances Tylenol for generalized pain During an interview on 6/4/26 at 4:15 PM, the DON confirmed that Resident #1 and Resident #2 missed their scheduled evening medications on 4/21/26. Although the DON acknowledged Eliquis is a high-risk medication, the physician and the residents' families were not notified of the missed doses, which the DON admitted should have occurred. The DON stated, we usually do but it didn't happen this time. Review of the facility policy concerning notification of change in condition revealed the document failed to provide necessary guidance for personnel regarding the failure to administer prescribed medications, particularly those categorized as high-risk. During an interview on 6/10/26 at 2:46 PM, the Administrator admitted that notification to the physician should have occurred and indicated they would search for a corresponding facility policy.

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and staff interviews, the facility failed to ensure that only licensed staff administered medications. Additionally, the facility failed to ensure that narcotics were counted only by qualified personnel authorized to manage controlled substances, and that licensed nursing staff completed the shift-to-shift narcotic count together. These failures allowed an unlicensed staff member (CNA) to attempt medication administration and perform narcotic counts, both beyond their scope of practice. The facility reported a census of 42 residents. Findings include: 1. During an interview on 6/10/26 at 10:23 AM, Staff B, CNA, stated that agency nurse Staff C, Licensed Practical Nurse (LPN), asked if she attended nursing school. Staff B confirmed she had and would graduate if she passed her final test in May. Later, Staff C informed Staff B that Resident #3 would not take her medications. Staff B reported that Staff C stood in the doorway and pressured her to help administer the medications to Resident #3. Staff B stated, I hate confrontation. Staff C handed me her med cup, he put it in my hand and said 'here.' When Staff B asked, Are you sure? after realizing the request was wrong, Staff C replied, Ya, I couldn't get her to take them. Staff B stated, I don't argue with the nurses, I was always taught not to. The nurses are the boss. When asked if she administered the medications to Resident #3, Staff B replied, I went and tried, with Staff C in the door way, I tried but she wouldn't take them. When asked if she used a spoon, Staff B stated, Yes, with a spoon. When asked if the medications were crushed, Staff B stated, they were not. I told Staff C that Resident #3 is not taking them. Staff B noted that Staff C then asked her to crush the medications; Staff B replied, I guess. Staff B recounted, But then Staff C put the medications in the crusher, crushed them and gave them to me and walked away. Staff B did not attempt to administer the medication again, noting Resident #3 was actively passing. Staff B returned the medications to Staff C, informed him Resident #3 refused them, and walked away. Staff B stated that Staff E, CNA, was also present in the room. Staff C reported she received disciplinary action that included suspension without pay. During an interview on 6/10/26 at 11:33 AM, Staff E, CNA, reported that Staff C, LPN, entered Resident #3's room and asked, 'Do you guys know this resident?' Staff E replied that the resident had slept most of the day and refused medications for the shift. Staff C asked if Staff B, CNA was a nurse; both Staff B and Staff E replied she was not. Staff C, LPN told Staff B, CNA 'You give this,' and watched from the doorway as Staff C attempted to administer the medications; however, Resident #3 refused. When asked whether staff crushed the medications, Staff E stated, 'I don't remember the details. I think so, I do know that Resident #3 wouldn't take them.' 2. During an interview on 6/10/26 at 9:02 AM, Staff A, Certified Medication Aide (CMA), stated on 4/21/26 she received a report from Staff B, CNA that two nurses, Staff C, LPN, and Staff D, LPN were not getting along. Staff A observed Staff B, CNA performing a narcotic medication count with Staff C. When asked if she observed Staff B performing a narcotic count, Staff A replied, I did see that Staff B, CNA and Staff C were doing the narc count; they even asked me a question about it, but I don't remember what the question was. Staff A immediately contacted the Assistant Director of Nursing (ADON) and asked, Is Staff B a med aide? Because she's doing narc count. The ADON responded, No. When asked if they discussed anything else, Staff A stated, Nothing; we hung up. During an interview on 6/10/26 at 10:23 AM, Staff B, CNA stated that, at the end of the shift on 4/21/26, Staff C, LPN did not answer the call light or walkie. Staff B then observed Staff D, LPN exchanging a loud conversation with Staff C near the [NAME] 3 Hall, which caused staff to run from the hall to ensure none of the residents fell. Staff C demanded that Staff B count narcotics with him, claiming the ADON directed him to do so. Staff B stated, I said what the heck, I said no and he said that the ADON said that I had to. I said that I didn't have a license and that I couldn't. She added, I know it was wrong but he said I had to. Staff B reported that after she completed a narcotic medication count with Staff C, she completed a separate count with Staff D. She confirmed the nurses did not complete the count together as the ADON had directed. Staff B (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated, I said that I didn't have a license and that I couldn't count. I know it was wrong but Staff C, LPN said I had to. Then I counted with him then with Staff D, LPN and she said that I was doing it all wrong. The CNA's were caught in the middle. I counted with each of them but not together. When asked if she documented completing the narcotic count, Staff B replied, Yes, Staff C said I had to sign the sheet. During an interview on 6/10/26 at 2:03 PM, Staff D, LPN, reported on 4/21/26 she witnessed Staff B, CNA perform a narcotic medication count and received a resident nurse report from Staff C, LPN. Staff D reported that Staff B holds neither a medication aide certification nor a nursing license. Staff D stated, Staff B should have never been put in a position to count narcotics, receive a nurse report and be left with the cart keys. The Narcotic and Controlled Substance form dated April 2026 showed Staff B, CNA signed her initials on 4/21/26. During an interview on 6/10/26 at 1:49 PM, The DON reported that a CNA must never work beyond their scope of practice. The DON reported that no CNA should perform a narcotic count or administer medication. The DON reported the CNA received education and disciplinary action. During an interview on 6/10/26 at 2:46 PM, the Administrator reported that only nurses are permitted to administer medications. The Administrator also reported that she remained unaware the nurses failed to complete the narcotic medication count together. The Administrator stated that nurses must count the narcotics together at the end of every shift. The Administrator reported the facility lacked a specific policy and instead followed the Iowa code for scope of practice.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interviews and record review, the facility failed to ensure residents remained free from significant medication errors. On 4/21/26, staff failed to administer scheduled evening medications for 2 of 3 resident reviewed (Resident #1 and #2). Instead, the medications were found in envelopes stapled to the residents' respective medication bubble packs. The facility reported a census of 42 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented diagnoses of malignant neoplasm of anal canal, renal insufficiency and malnutrition. The MDS showed the Brief Interview for Mental Status (BIMS) score of 13, which indicated no cognitive impairment. Review of the April 2026 Medication Administration Record (MAR) for Resident #1 showed the Director of Nursing (DON) indicated by documentation on the MAR the following evening mediations were not administered on 4/21/26:Clonidine for hypertensionMetoprolol for hypertensionSertraline for depressionCefuroxine Axetil for abnormal findings in the lung fieldKlor-Con for low potassium During an interview on 6/10/26 at 1:04 PM, Resident #1 reported that she did not receive any of her medications on a night in April. When asked to remember the nurse, Resident #1 replied, it was a gentleman. Resident #1 could not recall his name and answered, I never did know it but he was an agency nurse. Resident #1 stated that someone spoke to her about the incident the next morning. When asked if she had any complications related to the missing medication pass, the resident stated, 'No, I don't believe so.' 2. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 documented diagnoses of blood clot, depression, and dementia. The MDS showed the Brief Interview for Mental Status (BIMS) score of 00, which indicated severe cognitive impairment. Review of the April 2026 Medication Administration Record (MAR) for Resident #2 showed the Director of Nursing (DON) indicated by documentation on the MAR the following evening mediations were not administered on 4/21/26:Trazodone for depressionEliquis for history of blood clot in lungMemantine for Alzheimer's DiseaseRisperidone for behavioral disturbances Tylenol for generalized pain During an interview on 6/10/26 at 9:02 AM, Staff A, Certified Medication Aide (CMA), stated, Staff D, Licensed Practical Nurse (LPN) showed me bubble packs that had the envelopes used for crushing meds stapled to the bubble pack. It looked like a full med pass was in there. Staff A identified the medications as belonging to Resident #1 and Resident #2. During an interview on 6/10/26 at 10:23 AM, Staff B, Certified Nursing Assistant (CNA), reported that when Staff D, LPN reviewed the medication cart for Staff C, LPN Staff D found bubble packs with envelopes with medications taped to the bubble packs. Staff B further stated, Staff D showed me, maybe there were 3 but I don't know which residents they were for. During an interview on 6/10/26 at 2:03 PM, Staff D, LPN corroborated that Resident #1 and #2 missed their medication pass on the evening of 4/21/26. Staff D noted that although the medications were indicated as administered by Staff C, LPN, she discovered an envelope containing medications stapled to the medication bubble cards for both residents. During an interview on 6/4/26 at 4:15 PM, the Director of Nursing (DON) reported that staff alerted her to medications found in envelopes (the clear medication envelopes used for crushing medications) attached to medication bubble cards. The DON's investigation determined that on 4/21/26, two residents missed the evening medication pass, and she found the medications stapled to a medication bubble pack for each of the two residents. The DON noted the medications were signed off as administered on the Medication Administration Record (MAR). The DON identified the residents as Resident #1 and Resident #2. The DON and the Assistant Director of Nursing (ADON) reviewed the medications, compared the medication, and confirmed the scheduled evening medications were present within the envelopes. The DON noted that the practice of stapling medication envelopes to bubble packs had never occurred prior to that night. The DON reported staff is expected to leave medications in the bubble packs unless administered. If medications cannot be administered once removed from the bubble packs, the medications should be destroyed. When the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON followed up with the agency nurse, Staff C, LPN reported that he felt flustered during the shift due to the events that occurred and never returned to passing the medications. When asked if the investigation showed complications related to the missed medication pass for either resident, the DON stated, no. When asked if the physician was notified, the DON stated, no. When asked if she considered any of the medication to be a high risk medication, the DON acknowledged Eliquis as a high risk medication. When asked if the provider and family should have been notified, the DON stated, yes, we usually do but it didn't happen this time. During an interview on 6/10/26 at 2:46 PM, the Administrator stated her expectation that facility personnel adhere to the six rights of medication administration. Upon requesting the pertinent policy, the Administrator indicated the facility utilizes the National Standard as their guiding protocol for the six rights of medication administration.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 staff interviews, the facility failed to ensure that medication cart keys were secured and handled exclusively by qualified personnel, allowing a Certified Nursing Assistant (CNA), who is unauthorized to manage controlled substances, to possess the keys and conduct narcotic counts. The facility reported a census of 42 residents. Findings Include: During an interview on 6/10/26 at 10:23 AM, Staff B, CNA, admitted she performed narcotic counts with Staff C, Licensed Practical Nurse (LPN), and Staff D, LPN, separately, rather than together as directed by the Assistant Director of Nursing (ADON). Although Staff B stated she lacked the licensure to conduct counts, she claimed Staff C, LPN, insisted she participate and sign the documentation. Staff B noted she performed counts with each nurse individually, remarking that the CNAs were caught in the middle. During an interview on 6/10/26 at 2:03 PM, Staff D, LPN, reported that on 4/21/26, she witnessed Staff B, CNA, perform a narcotic medication count and receive a resident nurse report from Staff C, LPN. Staff D reported that Staff B holds neither a medication aide certification nor a nursing license. Staff D stated, Staff B should have never been put in a position to count narcotics, receive a nurse report and be left with the cart keys. During a follow-up interview on 6/10/26 at 2:10 PM, Staff B confirmed that Staff C, LPN, left the medication cart keys in her possession upon exiting the facility. Staff B noted she was given no choice in the matter and held the keys for an undetermined period before transferring them to Staff D, LPN, following the completion of the count. During an interview on 6/10/26 at 2:19 PM, the Director of Nursing (DON) stated that a CNA must never work beyond their scope of practice and that no CNA should possess medication cart keys. The DON reported that the CNA received educational and disciplinary action. During an interview on 6/10/26 at 2:46 PM, the Administrator acknowledged being unaware that the CNA had possession of the medication cart keys. The Administrator confirmed the facility lacked a policy regarding the safe handling of medication cart keys, despite adhering to CMS and pharmacy standards.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the record review and interviews with facility staff, the facility failed to maintain accurate documentation of medication administration as not administered on 4/21/26 for 2 of 3 residents reviewed (Residents #1 and #2). The facility reported a census of 42 residents.Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented diagnoses of malignant neoplasm of anal canal, renal insufficiency and malnutrition. The MDS showed the Brief Interview for Mental Status (BIMS) score of 13, which indicated no cognitive impairment. Review of the April 2026 Medication Administration Record (MAR) for Resident #1 showed the following medications as administered. The Director of Nursing (DON) indicated by documentation on the MAR the following evening mediations were confirmed as not administered on 4/21/26:Clonidine for hypertensionMetoprolol for hypertensionSertraline for depressionCefuroxine Axetil for abnormal findings in the lung fieldKlor-Con for low potassium 2. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 documented diagnoses of blood clot, depression, and dementia. The MDS showed the Brief Interview for Mental Status (BIMS) score of 00, which indicated severe cognitive impairment. Review of the April 2026 Medication Administration Record (MAR) for Resident #2 showed the following medications as administered. The Director of Nursing (DON) indicated by documentation on the MAR the following evening mediations were confirmed as not administered on 4/21/26:Trazodone for depressionEliquis for history of blood clot in lungMemantine for Alzheimer's DiseaseRisperidone for behavioral disturbances Tylenol for generalized pain During an interview on 6/10/26 at 9:02 AM, Staff A reported, Staff D, Licensed Practical Nurse (LPN) showed me bubble packs that had the envelopes used for crushing meds stapled to the bubble pack. Staff A indicated the medications belonged to Resident #1 and Resident #2. Staff A stated It looked like a full med pass was in there. Staff A reported although the medications were not administered, Staff C, Licensed Practical Nurse signed the medication as administered on the MAR. During an interview on 6/10/26 at 2:03 PM, Staff D, LPN corroborated that Resident #1 and #2 missed their medication pass on the evening of 4/21/26. Staff D noted that although the medications were indicated as administered by Staff C, LPN, she discovered an envelope containing medications stapled to the medication bubble cards for both residents.During an interview on 6/4/26 at 4:15 PM, the Director of Nursing (DON) stated she was notified by facility staff regarding medications discovered in clear crushing envelopes which remained attached to bubble cards. The DON reported her subsequent investigation revealed that Resident #1 and Resident #2 did not receive their evening medication pass on 4/21/26. The DON confirmed finding medications stapled to a bubble pack for each resident, despite the Medication Administration Record (MAR) showing the medications as administered. The DON and the Assistant Director of Nursing (ADON) conducted a comparison of the drugs and confirmed that the envelopes contained the scheduled evening medications. The DON reported staff is expected to leave medications in the bubble packs unless administered. If medications cannot be administered once removed from the bubble packs, the medications should be destroyed. During an interview on 6/10/26 at 2:46 PM, the Administrator stated her expectation that facility personnel adhere to the six rights of medication administration. Upon requesting the pertinent policy, the Administrator indicated the facility utilizes the National Standard as their guiding protocol for the six rights of medication administration.