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	03/06/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49628 Based on observation, resident and staff interviews, clinical record review, and policy review, the facility failed to develop and implement a Comprehensive Care Plan for 4 of 12 residents reviewed (Resident #4, #15, #16, #22). The Care Plans failed to identify target behaviors related to the use of psychotropic, antianxiety, and antidepressant medications, and non-pharmalogical interventions. The facility reported a census of 38 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #4 dated 12/13/24 identified a Brief Interview for Mental Status (BIMS) score of 10/15 indicating moderate cognitive impairment. The MDS included diagnoses of anxiety, depression, and Non-Alzheimer's Dementia. The document identified little interest or pleasure in doing things 2-6 days in the reporting period, rarely lonely or isolated from those around. The MDS identified Resident #4 took antipsychotic and antidepressant medications during the last 7 days of the assessment period. Review of Resident #4's Electronic Medical Record (EMR) Physician Orders dated 3/6/25 identified the resident was prescribed; a.) Quetiapine Fumarate 25 mg - .5 tablet once daily for dementia in other diseases classified elsewhere, unspecified severity with other behavioral disturbance, b.) Lexapro 5 mg - 2.5 mg once daily for depression unspecified. The Physician Orders did not identify target behaviors related to the medications prescribed. An EMR Progress Note dated 7/17/24 identified refusal of care. Resident #4's Care Plan initiated 9/14/23 identified a focus area related to utilization of a psychotropic medication in the category of antipsychotic and antidepressant. The document identified interventions including side effects, monitor behaviors per facility protocol, monitor for changes in cognition, mood and behaviors. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan failed to identify target behaviors related to the use of psychotropic medications, non-pharmalogical interventions, and the side effects of medications. The Care Plan failed to have a focus area with goal(s), and interventions related to the diagnosis of dementia. 2. The MDS for Resident #15 dated 1/22/25 identified a BIMS score of 15/15 indicating normal cognition. The MDS included diagnoses of Alzheimer's, Non-Alzheimer's Dementia, anxiety, and depression. The document identified no signs/symptoms of feeling down, depressed or hopeless, social isolation, delusions, hallucinations, rejection of care or wandering. The MDS identified Resident #15 took antipsychotic and antidepressant medications during the last 7 days of the assessment period. Review of Resident #15's EMR Physician Orders dated 3/5/25 identified the resident was prescribed; a.) Buspirone HCl 10 mg 1 time/day for anxiety disorder, unspecified and major depressive disorder, single episode unspecified, b.) Buspirone HCl 15 mg 3 times/day for anxiety, c.) Lexapro 30 mg 1 time/day for major depressive disorder, single episode unspecified, d.) Bupropion HCl ER (XL) 24 hour 300 mg 1 time/day for depression, e.) Trazodone HCl 50 mg .5 tablet 1 time/day for major depressive disorder, single episode unspecified, f.) Abilify 1 mg 1 time/day for major depressive disorder, single episode unspecified, The Physician Orders did not identify target behaviors related to the medications prescribed. The EMR Progress Notes dated 5/1/24 to 3/5/25 revealed Resident #15 displayed behaviors of complaints of not getting what she wants related to smoking, ignoring staff when attempting to assist, history of frequent complaints and anger with staff, refusal of assessment, and yelling at staff. Resident #15's Care Plan identified the use of a psychotropic medication in the category of antipsychotic/ antidepressant, and anti-anxiety related to anxiety and depression diagnoses. Interventions for staff to follow revealed medications as ordered, side effects and complications, ensuring the diagnosis corresponds with medication prescribed, non-pharmalogical interventions, monitor behaviors per facility protocol, cognition, mood, and behavior. The Care Plan failed to identify the target behaviors related to the use of antipsychotic medications and anxiety. 3. The MDS for Resident #16 dated 1/22/25 identified a BIMS score of 15/15 indicating normal cognition. The MDS included diagnoses of anxiety disorder, depression, schizophrenia, and post traumatic stress disorder. The document identified the resident feeling down, depressed or hopeless during the previous 7-11 days, poor appetite or overeating 7-11 days, feeling bad about oneself 2-6 days, sometimes feeling lonely or isolated from others. The document revealed no behaviors, rejection of care or wandering. The MDS identified Resident #16 took antipsychotic and antidepressant medications during the last 7 days of the assessment period. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #16's EMR Physician Orders dated 3/5/25 identified Resident #16 was prescribed a.) Sertraline 50 mg 1 tablet day related to major depressive disorder, b.) Lamotrigine 200 mg 1 tablet day related to schizoaffective disorder, bipolar type, c.) Invega Oral Tablet Extended Release 24 hour 6 mg 1 tablet day related to schizoaffective disorder, bipolar type The Physician Orders did not identify target behaviors related to the medications prescribed. The EMR Progress Notes dated 1/25/25 to 3/5/25 revealed Resident #16 displayed no behaviors. Resident #16's Care Plan revealed the utilization of psychotropic medication in the category of antipsychotic/antidepressant related to schizoaffective disorder, depression. The Care Plan revealed interventions for staff included side effects, use of non-pharmalogical interventions, and monitoring behaviors per facility protocol. The facility failed to identify target behaviors related to the use of psychotropic medications and schizoaffective and depression diagnoses in the Care Plan. 4. The MDS for Resident #22 dated 12/20/24 identified a BIMS score of 13/15 indicating normal cognition. The MDS included diagnoses of anxiety, depression, bipolar, and psychotic disorder. The document identified no signs/symptoms of feeling down, depressed or hopeless, social isolation, delusions, hallucinations, rejection of care or wandering. The MDS identified Resident #22 took antipsychotic and antidepressant medications during the last 7 days of the assessment period. Review of the EMR Physician Orders dated 3/5/25 identified Resident #22 was prescribed; a.) Seroquel 25 mg 1 tab at bedtime for generalized anxiety disorder, delusional disorder, b.) Amitriptyline HCl 50 mg one time day for depression, c.) Duloxetine HCl 60 mg one time/day for depression. The Physician Orders did not identify target behaviors related to the medications prescribed. The EMR Progress Notes dated 5/1/24 to 3/5/25 revealed Resident #22 had 2 episodes of depression without the symptoms of depression. The Progress Notes did not identify target behaviors. Resident #22's Care Plan revealed the utilization of psychotropic medication in the category of antipsychotic/antidepressant related to depression and anxiety. The Care Plan revealed the interventions for staff included side effects, monitoring behaviors per facility protocol, and monitoring for changes in mood, cognition, and behavior. The facility failed to identify target behaviors related to the use of psychotropic medications with anxiety and depression diagnoses in the Care Plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/6/25 at 8:07 AM the Administrator and the Director of Nursing (DON) stated some residents have Behavior Management Plans that were developed by the Social Worker with the assistance of the psych provider if necessary. The Administrator stated however not every resident had a Behavior Management Plan. The Administrator stated the plans were located in the Narc Book on the medication carts. The Administrator stated those individuals with a Behavior Management Plan also had a sheet that staff mark what behaviors happened during the day. The DON and Administrator acknowledged neither target behaviors nor non-pharmalogical interventions were identified on all the Care Plans. On 3/6/25 at 11:36 AM the Administrator was unable to provide details regarding the statement monitor behaviors per facility protocol identified on the Care Plans. On 3/6/25 at 12:00 PM the Regional Nurse Consultant stated the monitor behaviors per facility protocol was a general statement used by the previous corporation, and the facility was in the process of updating Care Plans to provide more individualized focus areas, goals and interventions. The facility policy, Baseline Care Plan Guidelines V2, Rev 121018, revealed the Care Plan should provide the information needed to safely care for a new resident. The document revealed the interventions needed to match the resident's current needs. The facility policy, Antipsychotic Drug Use, Revised 10/99, revealed the facility would identify the symptoms of the diagnosis requiring antipsychotic,antidepressant drug intervention. The document revealed the Care Plan should be reviewed and updated for interventions related to identified behaviors or symptoms of the diagnosis.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49628 Based on observations, staff interviews, clinical record reviews, and policy reviews the facility failed to review and revise the Care Plan interventions for 2 of 12 residents reviewed (#4, #17). The facility failed to revise Care Plan interventions for a resident who had a change in oxygen use and changed from weight gain to weight loss, and a resident who had a new intervention for fall prevention. Findings include: 1. The Minimum Data Set (MDS) for Resident #4 dated 12/13/24 identified a Brief Interview for Mental Status (BIMS) score of 10/15 indicating moderate cognitive impairment. The MDS included diagnoses of anxiety, depression, Non-Alzheimer's Dementia, and congestive heart failure (CHF). The MDS identified Resident #4 took antipsychotic and antidepressant medications. The document revealed the resident did not have a weight loss or gain of 5% or more in the past month or loss or gain of 10% or more in the last 6 months. The document revealed the resident did utilize oxygen (O2). a.) The Electronic Medical Record (EMR) Progress Notes 5/1/24 to 3/5/25 revealed on 2/19/25 the Dietitian noted the resident weighed 162.4# triggering for a loss of 19# (10%) since 1/19 weight of 183#, and from 8/23/24 weight of 183#. The entry questioned the accuracy of the 1/19 weight as weights before and after were in the 169-173# range. However the 180 day (6 month) look back revealed a significant weight loss. The entry further revealed notification to the primary care provider (PCP), the resident's BMI was 27 indicating overweight, and the resident had been ill. An entry on 7/23/24 identified a weight warning for weight gain with the resident retaining fluid and requesting small servings during meals. Additionally the resident was triggered for a weight gain on 5/15/24 with the initiation of a diuretic related to CHF. The EMR Weights revealed Resident #4 had daily weights until 2/24 then weights decreased gradually to monthly or twice monthly. The EMR Clinical Physician Orders revealed an order for daily weight for one time a day for edema initiated on 10/10/23 and discontinued on 2/1/24. Resident #4's Care Plan revealed a focus area identifying unplanned/unexpected weight gain related to CHF, bilateral lower extremity (BLE) edema with a creation date of 9/20/23 and revision date of 11/20/24. An intervention for staff to follow included weight daily per PCP order created on 12/20/23 and revised on 11/20/24. The facility failed to update the Care Plan to reflect Resident #4's change from unexpected weight gain to weight loss, and discontinuation of daily weights on 2/1/24. On 3/6/25 at 8:12 AM the Administrator and Director of Nursing (DON) acknowledged the resident's Care Plan neither reflected the current interventions for weighing the resident nor the documentation by the Dietitian in the Progress Notes of the resident having a significant weight loss rather than a weight gain. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b.) The EMR Progress Notes 5/1/24 to 3/5/25 revealed Resident #4's use of O2. An entry on 10/23/24 revealed O2 at 2-4 liters(L) per nasal cannula (NC) every shift for titrated O2 to keep sats equal to or greater than 90%. Entry dated 6/22/24 revealed communication with the PCP to increase O2 use to 2-4 L per NC. The EMR Clinical Physician Orders dated 3/6/25 revealed an order for O2 at 2L-4L per NC every shift for titrate O2 to keep saturations equal to or greater than 90% confirmed on 6/22/24. Resident #4's Care Plan revealed a focus area related to CHF with an intervention of continuous humidified O2 on at 2L/NC. The facility failed to update the Care Plan to reflect Resident #4's change of O2 use from continuous 2L to O2 at 2L-4L every shift for titrate to keep saturations equal to or greater than 90%. Observation on 3/3/25 revealed Resident #4 with humidified O2 via NC at 3L while seated in her recliner. Observation on 3/4/25 revealed Resident #4 at the beauty salon with humidified O2 via NC at 3L. On 3/4/25 at 1:08 PM Staff B, Certified Nursing Assistant (CNA)/Bath Aide, stated Resident #4 utilized O2 at all times and staff could turn the concentrator off and on to transport the resident. On 3/4/25 at 1:51 PM Staff C, Registered Nurse (RN), stated the resident used oxygen at all times. However when the staff confirmed with the Clinical Physician Orders, the staff stated the orders reflected titrated oxygen not continuous to keep sats above 90%. On 3/6/25 at 8:15 AM the DON stated the order allowed the nurses to raise the oxygen if necessary to 4L to keep the resident's saturations above 90%. The DON acknowledged the Care Plan did not reflect the order for titration to 4L. 2. The MDS for Resident #17 dated 1/24/25 identified a BIMS score of 4/15 indicating severe cognitive impairment. The MDS included diagnoses of hypertension (high blood pressure) anxiety, Non-Alzheimer's Dementia, and history of falling. The MDS identified Resident #4 took antipsychotic and antiplatelet medications. The document revealed the resident had 1 fall with no injury and 1 fall with injury (except major) since the prior assessment. The document revealed the resident utilized a bed alarm and chair alarm both used daily. On 3/3/25 at 12:32 PM observed Resident #17 in a low bed with a bed pad alarm and bed rails; w/c alarm present on w/c. On 3/4/25 at 1:01 PM observed Resident #17 in a low bed with a bed pad alarm, bed rails, and call light within reach. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #17's Care Plan dated 12/2/20 identified a focus area related to not thinking clearly related to back pain with an intervention of an alarm at all times due to attempts to self transfer. The document revealed a focus area related to fall at home sustaining a closed compression fracture and risk for falls related to weakness and restless leg syndrome. Interventions for this focus area included appropriate footwear, self propelling wheelchair (w/c) with leg rests out of way, Dycem to recliner. The document revealed a focus area related to use of grab bars on the bed with the intervention of use of grab bars for impaired mobility and transfer ability. The facility failed to revise the Care Plan to reflect the use of a low bed as a fall intervention. On 3/4/25 at 1:08 PM Staff B stated when the resident goes to bed, it is moved to the low position. The staff were told to lower the bed by nurses, and it was on the Communications Board, part of the EMR. Staff B stated the resident had been utilizing the low bed for awhile. On 3/4/25 at 1:51 PM Staff C stated she would look at the Care Plan for all of Resident #17's fall interventions. When the staff was reviewing the Care Plan, she stated the resident required a low bed for some time, but acknowledged it was not on the Care Plan. Staff C updated the Care Plan during the interview. On 3/4/25 at 3:37 PM Staff D stated fall interventions for Resident #17 included a pressure pad alarm, w/c alarm, and the bed lowered to the floor. On 3/6/25 at 8:17 AM the DON stated Care Plan focus areas and interventions should be added to the Care Plan as they are needed to reflect the resident's current needs and level of care. The DON expected if a new fall intervention was put into place it would be added to the Care Plan at that time. On 3/6/25 at 8:20 AM the Administrator stated she expected the Care Plans to provide interventions that reflected the residents' needs. The Administrator acknowledged that some Care Plans might need updates as there had been a change in staffing and the DON had been covering multiple areas. The facility did not have a policy related to Care Plan revisions. The Administrator indicated the facility followed the Resident Assessment Instrument (RAI) manual for Care Plan updates.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056 Based on observations, record review, staff interviews, the facility failed to have an emergency tracheostomy kit with obturator at bedside for 1 of 1 residents reviewed (Resident #24). The facility reported a census of 38. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #24 documented diagnoses of coronary artery disease, acute respiratory distress, depression, and pneumonia. The MDS showed the Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented Resident #24 had a tracheostomy (surgical opening in neck to provide for obstruction of breathing) and required oxygen. Review of the Care Plan with a target date of 5/15/25 revealed Resident #24 has a tracheostomy in place related to malignant neoplasm of the larynx. The Care Plan revealed that the facility would maintain a spare trach at the bedside. The Care Plan failed to have documentation that Resident #24 would fiddle with the emergency trach kit while it was in the room. Review of the facility provided tracheostomy guidelines for Resident #24 that are kept in the narcotic binder at the nurses medication cart titled Tube Out Procedures revealed that the extra tracheostomy tube and obturator will be kept at bedside. Observations of the residents room on 3/3/25 at 1:00 PM and 3/6/25 at 12:05 PM revealed no emergency tracheostomy set with an obturator kept in the room. Interview on 3/6/25 at 12:05 PM, Staff A, License Practical Nurse (LPN) stated the facility keeps the extra tracheostomy set up at the nurses station. When asked about the agency nurses and how they would know where to locate it if there was an emergency, Staff A responded that she would report where it was kept during nurse to nurse report. Interview on 3/6/25 at 12:15 PM with the DON, acknowledged they don't keep the emergency trach kit in the room because Resident #24 is independent with ambulation and is able to get up and fiddles with items throughout his room and it wouldn't stay clean. Interview on 3/5/25 at 11:20 AM with the Administrator stated the facility does not have a tracheostomy policy.