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	03/12/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident council meetings, Electronic Health Record (EHR)review, document review, resident interview, and staff interview the facility failed to provide nursing staff to assure residents safety by not responding to call lights in a timely manner for 4 of 6 residents reviewed (Resident #27, #53, #11 and #15). The facility reported a census of 45 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #27 had a Brief Interview for Mental Status (BIMS) of 13 indicating no cognitive impairment. The MDS also documented Resident #27 was dependent on staff for toileting hygiene, lower body dressing, and taking off footwear. On 3/9/26 at 12:28 PM Resident #27 stated he has had to wait up to 45 minutes in the last week or two for his call light to be answered. Review of Resident #27's EHR documented Resident #27 resided in room [ROOM NUMBER]. Review of facility provided call light log for Resident #27 in room [ROOM NUMBER] from 3/4/26 - 3/11/26 revealed call lights that had longer than a 15 minute response time on: 3/5/26 at 5:04 AM 19 minutes and 53 seconds. 3/5/26 at 6:57 PM 22 minutes and 24 seconds. 3/8/26 at 6:49 AM 38 minutes and 26 seconds. 3/10/26 at 5:36 AM 19 minutes and 40 seconds. 3/10/26 at 3:35 PM 30 minutes and 56 seconds. 3/10/26 at 7:42 PM 26 minutes and 8 seconds. 2. The MDS for Resident #53 had not had a completed cognitive section for the MDS because Resident #53 had entered the facility on 3/6/26. Review of Resident #53's EHR documented an admission date of 3/6/26. On 3/9/26 at 1:31 PM Resident #53 stated he had not stayed at the facility long, just 2 or 3 days. Resident #53 explained it had taken up to an hour to have his call light answered. Resident #53 stated at one time he wanted a bed pan and was incontinent of stool because he had to wait so long. Resident #53 explained he had to wait while sitting on a bed pan for 45 minutes. Resident #53 (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

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	03/12/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	explained he had sores on his buttocks but the sores originated from the hospital. Resident #53 stated it was embarrassing to be incontinent of stool because he had to wait and he was continent of his bowels. Review of EHR dated 3/9/26 at 1:37 PM titled, Progress Notes documented Resident #53 was alert to person, place, time and staff names and faces. Review of Resident #53's EHR documented Resident #53 resided in room [ROOM NUMBER]. Review of facility provided call light log for Resident #53 in room [ROOM NUMBER] from 3/6/26 - 3/11/26 revealed call lights that had longer than a 15 minute response time on: 3/7/26 at 10:47 AM 29 minutes and 25 seconds. 3/7/26 at 12:42 PM 25 minutes 16 seconds. 3/7/26 at 5:56 PM 16 minutes and 57 seconds. 3/8/26 at 3:30 AM 32 minutes and 56 seconds. 3/8/26 at 6:10 AM 1 hour, 1 minute and 38 seconds. 3/8/26 at 8:16 AM 15 minutes and 5 seconds. 3/8/26 at 9:38 AM 25 minutes and 16 seconds. 3/8/26 at 10:17 AM 24 minutes and 49 seconds. 3/8/26 at 12:59 PM 40 minutes and 6 seconds. 3/8/26 at 2:11 PM 26 minutes and 8 seconds. 3/8/26 at 3:02 PM 18 minutes and 42 seconds. 3/8/26 at 5:35 PM 30 minutes and 15 seconds. 3/8/26 at 8:00 PM 26 minutes and 46 seconds. 3/9/26 at 4:47 AM 18 minutes and 55 seconds. 3/9/26 at 5:34 AM 19 minutes and 30 seconds. 3/9/26 at 6:06 AM 18 minutes and 25 seconds. 3/9/26 at 9:42 PM 16 minutes and 49 seconds. 3/10/26 at 12:18 AM 25 minutes and 16 seconds 3/10/26 at 7:38 AM 17 minutes and 27 seconds. (continued on next page)

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	03/12/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/10/26 at 8:55 AM 24 minutes and 4 seconds. 3/10/26 at 11:04 AM 16 minutes and 17 seconds. 3/10/26 at 4:22 PM 18 minutes and 23 seconds. 3/10/26 at 5:19 PM 17 minutes and 45 seconds. 3/10/26 at 7:45 PM 23 minutes and 31 seconds. 3/11/26 at 4:37 AM 32 minutes and 20 seconds. 3/11/26 at 1:19 PM 16 minutes and 19 seconds. 3/11/26 at 4:49 PM 22 minutes and 49 seconds. On 3/11/26 at 3:50 PM Staff I, CNA stated she had noticed call lights had taken longer than 15 minutes to be responded to. Staff I explained that usually several call lights were on at once and it took longer than 10 minutes to put the initial resident to bed. Staff I explained that staff filled slips out to explain the reason there are call lights longer than 15 minutes. 3. Review of Resident #11's MDS dated [DATE] revealed a BIMS score of 14 indicating intact cognitive functioning. The MDS further revealed Resident #11 required two plus physical assistance with sitting to standing, chair/bed-to chair transfers, and transferring to the toilet. Interview on 3/10/26 at 8:39 AM with Resident #11 revealed that call lights take forever, and are up to 30 minutes sometimes. Resident #11 further revealed that she watches the clock and can tell how long it takes. 4. Review of Resident #15's MDS dated [DATE] revealed a BIMS score of 14 indicating intact cognitive functioning. The MDS further revealed Resident #15 required two plus physical assistance with sitting to standing, chair/bed-to chair transfers, and transferring to the toilet. Interview on 3/10/26 at 9:18 AM with Resident #15 revealed that call lights often take longer than 15 minutes to be answered, and at times she has waited almost 30 minutes to be helped. Resident #15 revealed that she watches the clock. Interview on 3/11/26 at 1:02 PM with Staff C Registered Nurse (RN) revealed residents wear a pendant and when pushed go to tablets and pagers that CNA's carry around. Staff C then revealed that the call lights above the doors do not actually light up. Staff C further revealed that he feels the teams are pretty good, and answer call lights pretty quickly. Staff C disclosed that he is unaware of any call light audits being completed. Interview on 3/11/26 at 1:08 PM with Staff D CNA revealed that the call lights above the doors for residents' rooms do not go on when a call light is turned on. Staff D revealed the residents have pendants. Staff D further disclosed staff are supposed to fill out a paper if they realize call lights are on longer than 15 minutes. Interview on 3/11/26 at 1:11 PM with Staff F CNA revealed that she carries a pager that shows when (continued on next page)

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	03/12/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	call lights are on, and how long that they are on for. Staff F then revealed that call lights do go longer than 15 minutes on occasion. Staff F then disclosed that she notices it more when agency staff are at the facility, as they do not get the pager at the beginning of their shift. Staff F revealed that if call lights go longer than 15 minutes the staff are to fill out a paper as to why the call light took longer than 15 minutes to answer. Interview on 3/11/26 at 1:22 PM with Staff E CNA revealed that call lights above the doors do not function, and that the residents' have pendants on necklaces. Staff E then revealed that she carries a pager system that she picks up when her shift starts, and this will be alerted as to when a call light is on and how long a resident has been waiting. Staff E then disclosed that call lights have taken longer than 15 minutes to answer. Staff E revealed that in the main nurses hub there is a big screen that has all the call lights, and it also notifies staff as to what call lights are on and how long they have been on as well or if there are low batteries in the pendants. Interview on 3/12/26 at 8:25 AM with the Director of Nursing (DON) revealed that she has heard that call lights have lasted longer than 15 minutes ,and staff fill out slips. The DON further revealed that she has heard of agency staff not picking up the pagers for the call light system. The DON further revealed that call lights should be answered in 15 minutes or less. The DON then disclosed that call lights are a concern. Review of facility provided documents titled, Past Calls 3/4/36-3/11/26 revealed call light logs with several call lights lasting longer than 15 minutes. Upon review of the documents there were several instances of times ranging from 16 minutes up to 1 hour and 8 minutes. Review of a facility provided document titled, Call Light Policy with a revised dated of 9/2023 revealed: a. Facility shall answer call lights in a timely manner.

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	03/12/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview and policy review the facility failed to prepare food in accordance with professional standards by not completing appropriate hand hygiene during meal service to prevent cross contamination, not dating open food items and not disposing of expired food items. The facility reported a census of 45 residents.Findings include:Observation on 3/9/26 at 10:10 AM of a 2 door refrigerator revealed these food items open and undated 16 oz. container of parmesan cheese and a bag of diced chicken.Observation on 3/9/26 at 10:14 AM of a 2 door freezer revealed a large bag of bacon bits and a large bag of chicken cordon bleu both open and undated.Observation on 3/9/26 at 10:16 AM of a 3 door freezer revealed a plastic container containing about 10 biscuits and a large bag of cinnamon rolls open and undated. A box of pre-cooked hamburgers with bag open and box top cut away with food items on the shelf above and a box of pre-cooked omelets with the bag open and box top cut away with the hamburger box on the shelf above. Observation on 3/9/26 at 10:20 AM of dry storage revealed 3 cans of chili beans with an best by date of 1/25, 1 can of butter beans with a best by date of 6/25, 1 can of tomato paste with a best buy date of 9/25 and a glass jar of pizza sauce with a best by date of 9/25.On 3/9/26 at 11:17 AM Staff N, Certified Dietary Manager (CDM) stated she would expect the food items that were open to have an open date. The CDM stated she would expect the food items that would have a best by date that was prior to today's date would have been discarded and not served to residents. An observation during the lunch meal service revealed Staff N obtained container of butter, obtained loaf of bread, obtained bag of sliced meat from the refrigerator, applied gloves to both hands, opened bread bag with both hands, removed a slice of bread from inside the bag with right hand, placed slice of bread on the plate, left hand used to hold bread in place, right hand used to hold the knife and butter the slice of bread, right hand used to open sealed bag of deli sliced meat, left hand held bag of meat, right hand reached in to remove several slices of meat, some slices of removed meat placed on bread, a couple slices of meat placed back in the bag of sliced meat, knife used to cut the slice of bread in half, each slice of bread with meat picked up and folded together into a sandwich, gloves removed and plated sandwich taken to dining room. Review of a facility provided policy revised 10/23 titled, Food Handling documented the purpose of the policy was to adhere to the food safety standards described in the local Food Code and as per CMS food safety standards for long-term care. Employees must perform hand hygiene prior to handling food and maintain safe food handling practices. All foods prepared in operation must be covered and labeled with date of preparation prior to storage in refrigerators and freezers. A use-by date should be specified. Upon receiving, check products for condition, possible contamination, and temperature. Reject any product that is questionable or damaged. Store refrigerated and frozen foods first and date products to ensure first in-first out process.

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	03/12/2026

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review, staff interview, and policy review the facility failed to have the necessary required members attend quarterly quality assurance meetings. The facility reported a census of 45 residents.Findings include:Review of facility provided documents titled, Quality Assurance and Performance Improvement Committee Attendance Record for the months of August 2025 through February 2026 revealed there was no Infection Preventionist (IP) that attended the Quality Assurance (QA) meetings. Interview on 3/12/26 at 8:51 AM with the Administrator revealed that the facility did not have an IP until the new Director of Nursing (DON) came to the facility to work. Follow up interview on 3/12/26 11:13 AM with the Administrator confirmed the IP was not present at the meetings from August of last year to February of this year. The Administrator then revealed her expectation would be to have an IP at the meetings per expectations.Review of a facility provided document titled, QAPI Policy with a revision date 10/2023 revealed:a. The members of the QAPI committee must meet at least quarterly.

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	03/12/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Records (EHR) review, Medication Administration Records - Treatment Administration Records (MAR-TAR), resident interviews, staff interviews, and policy review the facility failed to provide an opportunity for bath or shower and failed to apply edema wear as ordered by the physician to 3 of 3 residents reviewed (Resident #4, #27 and #11). The facility reported a census of 45 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] for Resident #4 documented a Brief Interview for Mental Status (BIMS) of 13 indicating no cognitive impairment. The MDS also documented Resident #4 required partial / moderate assistance to shower/bathe self with staff doing less than half the effort. On 3/10/26 at 9:28 AM Resident #4 said she was supposed to receive baths on Tuesdays and Thursdays. Resident #4 explained she would like a shower twice a week. Resident #4 said she was supposed to wear edema socks but has not had them in a couple of months. On 3/10/26 at 9:44 AM an observation in Resident #4's bathroom revealed no compression socks present. Resident #4 wearing thick black socks just over the ankle. On 3/11/26 at 10:14 AM an observation in Resident #4's bathroom revealed no compression socks present. Resident #4 wearing thick black socks just over the ankle. Review of Resident #4's EHR titled, Orders documented a physician's order with a start date of 12/9/25 to apply edema wear in the morning and remove in the evening. Review of Resident #4's MAR-TAR documented a physician's order with a start date of 12/9/25 to apply edema wear in the morning and remove in the evening. Review of Resident #4's EHR titled, Baths for the last 30 days revealed a bath was given on 2/11, 2/17, 2/19, 2/24, 3/4, 3/5, 3/10. No refusals had been documented. Review of Resident #4's EHR titled, Tasks documented Resident #4 prefers a shower 3 times a week and as needed. Review of Resident #4's EHR titled, Care Plan documented an intervention to assist Resident #4 with shower/bathing per schedule. On 3/11/26 at 3:50 PM Staff I, Certified Nurse Assistant (CNA) stated she does work with Resident #4 and was currently working with Resident #4 that morning. Staff I explained Resident #4 was fairly independent. Staff I explained she had never taken edema wear off of Resident #4 and it was never passed on to her by anyone at the facility that Resident #4 required edema wear. On 3/11/26 at 4:03 PM Staff J, Registered Nurse (RN) acknowledged she worked with Resident #4 frequently. Staff J stated she had taken Resident #4's edema wear off and had taken them off this week. Staff J explained that she had taken the edema wear off the night of 3/10/26 or 3/9/26. On 3/11/26 at 3:54 PM Staff K, CNA acknowledged she had been working on Resident #4's hall for the last month. Staff K stated had periodically checked on Resident #4 to ensure she was safe. Staff K explained Resident #4 was fairly independent. Staff K stated Resident #4 had not had edema socks (continued on next page)

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	03/12/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that she was aware of. On 3/11/26 at 4:23 PM the Director of Nursing (DON) stated she expected the nurse would document if they put the edema wear on and would make an observation that the edema wear is in place. The DON also stated she expected a nurse would ensure the edema wear was removed in the evening in accordance with the physician's orders. 2. The MDS dated [DATE] documented Resident #27 had a BIMS of 13 indicating no cognitive impairment. The MDS also documented Resident #27 was dependent on staff for toileting hygiene, lower body dressing, and taking off footwear. On 3/9/26 at 12:28 PM Resident #27 explained he was supposed to get 2 showers a week but only usually received one. Resident #27 stated he was supposed to receive showers on Monday and Thursday each week but mostly got them only on Thursday. Review of Resident #27 EHR titled, Tasks documented baths were given on 2/12, 2/16, 2/19, 2/23, 3/2, 3/9. Bath missed on 3/2 and 2/26. No refusals documented. On 3/11/26 at 9:07 AM Staff D, Certified Nurse Assistant (CNA) / Certified Medication Assistant (CMA) / Bathaide stated someone will fill in when she is not at the facility. Staff D acknowledged residents did not receive baths as they are supposed to a minimum of twice a week. Staff D explained she was pulled to the floor frequently and unable to complete the baths appropriately. On 3/11/26 9:17 AM Staff L, CNA and Restorative Aide explained she would complete baths when Staff D was not at the facility or was pulled to the floor. Staff L stated it had been rough lately and she got pulled to the floor quite a bit. Staff L stated in the past 3 weeks one either Staff D or herself are pulled daily. 3. Review of Resident #11's MDS dated [DATE] revealed a BIMS score of 14 indicating intact cognitive functioning. The MDS further revealed Resident #11 required two plus physical assistance with sitting to standing, chair/bed-to chair transfers, transferring to the toilet, and transferring to the bath/shower. Interview 3/10/26 at 8:44 AM Resident #11 revealed that she has only been receiving one shower a week, and it should be twice a week. Resident #11 further revealed that the facility is short of staff, and constantly pulls the bath aide to the floor and baths/showers aren't getting completed. Review of Resident #11's Care plan with a revision with a date of 2/14/26 revealed an intervention to assist Resident #11 with shower/bathing per schedule. Review of a document titled, Documentation Survey Report with a date of February 2026 revealed Resident #11 had a shower on the 4th, 18th, and 25th. Review of the Documentation Survey Report for the month of March 2026 revealed Resident #11 had refused 1 time with no other showers documented. Interview on 3/11/26 at 8:15 AM with Staff D CNA disclosed residents get baths 2-3 times a week. Staff D then revealed the bathtub had been broken for about a year and parts had been ordered. Staff D then revealed the facility did order a part, but it was too small and had to be sent back. Staff D revealed if residents refuse a bath then it is charted in the electronic health record. Staff D further (continued on next page)

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	03/12/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disclosed that she has been pulled a lot to the floor. Staff D then confirmed bathing is not being completed twice a week. Interview on 3/11/26 at 9:47 AM with the Director of Nursing (DON) revealed baths should be completed twice a week, and if there are refusals then they should be documented. The DON stated bed baths should be offered, and if they do not get a bath/shower it should be moved to the next day. Interview on 3/11/26 at 10:05 AM with the Administrator revealed that she would expect baths/showers to be given at the appropriate times, and according to the resident's requests. Review of a facility document titled, Hygiene-Bathing/Shower with a revision date of 3/24 indicated staff need to document in the Electronic Healthcare Record (EHR) when baths/showers are completed.

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	03/12/2026

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, resident interview, staff interview, and policy review the facility failed to provide range of motion (ROM) services to a resident with limited ROM to prevent further decrease in range of motion or development of contractures for 2 of 3 residents reviewed (Resident #4 and #9). The facility reported a census of 45.Findings include:1. The Minimum Data Set (MDS) dated [DATE] for Resident #4 documented a Brief Interview for Mental Status (BIMS) of 13 indicating no cognitive impairment. The MDS also documented Resident #4 required partial / moderate assistance to shower/bathe self with staff doing less than half the effort.On 3/10/26 at 9:39 AM Resident #4 stated when she came in she had therapy and then it stopped. Resident #4 stated she could walk down the hall with a walker and did not need a wheelchair when she was in therapy. Resident #4 explained she used a walker now. Resident #4 stated she would like to have some therapy and had spoken to someone about therapy. Resident #4 stated she did not know who she had spoken with but thought they would get back to her about therapy. Review of Resident #4's EHR titled, Task documented restorative 3 times a week, nu-step for 10 minutes, seat 9, arms 11, laying down exercises lower left extremity and right lower extremity for 15 reps each, ball under the knee then kick up foot, heel slides, hip abduct and adduct, straight leg raise 3 times a week. Review of Task documented Resident #4 had no refusals. Task documented Resident #4 had utilized nu-step 4 times for 15 minutes. Review of Resident #4's EHR titled, Survey Report V2 for month of February documented Resident #4 completed restorative on 2/25 and 2/27.Review of Resident #4's EHR titled, Survey Report V2 for month of March documented Resident #4 completed restorative on 3/2, 3/4 and 3/9.2. The MDS dated [DATE] documented Resident #9 had a BIMS of 14 indicating no cognitive impairment. The MDS also documented Resident #9 was dependent on staff for toileting hygiene, shower/bathe, lower body dressing and taking off footwear.On 3/10/26 at 8:49 AM Resident #9 stated when there was someone available they were pulled to the floor frequently. Review of Resident #9's EHR titled, Task documented under the restorative task manual resist leg press for 10 - 15 reps each leg. Nu-step 5 - 10 minutes as tolerated. The restorative task documented Resident #9 refused 2/24 and 2/27. The restorative task documented Resident #9 did not refuse 2/11, 2/12, 2/13, 2/16, 2/17, 2/18, 2/19, 2/23, 2/25, 2/26, 3/2, 3/3, 3/4, 3/5, 3/6, 3/9, 3/10 and 3/11. The restorative task documented 0 on 2/11, 2/17, 2/19, 2/23, 2/26, 3/3,3/6, 3/9 and 3/10.Review of Resident #9's EHR titled, Care Plan documented an intervention that Resident #9 was in a restorative nursing program to help achieve and maintain optimal physical, mental, and psychosocial skills. Care Plan also documented as an intervention to educate Resident #9 of restorative program needs and participation schedule, encourage Resident #9 to participate in restorative programs and follow therapy recommendations as applicable.On 3/11/26 at 9:07 AM Staff D, Certified Nurse Assistant (CNA) / Certified Medication Assistant (CMA) / Bath aide stated she would fill in for Staff L when she was off. Staff D acknowledged she was unable to complete restorative with the residents appropriately because she would be pulled to work as a CNA frequently.On 3/11/26 at 9:17 AM Staff L, CNA / Restorative Aide stated she had been in restorative since September or October. Staff L explained it had been rough lately because she was pulled to the floor quite a bit to work as a CNA. Staff L explained in the past 3 weeks either Staff D or herself are pulled daily. Staff L explained when she documented 0 on the restorative task that indicated she was pulled to work as a CNA and was unable to complete the restorative task for the resident. Staff L acknowledged that restorative task for Resident #4 and #9 did not have the restorative task completed as it was written.On 3/11/2026 1:12 PM Staff M, Regional Director of Operations (RDO)/Physical Therapist Assistant (PTA) stated Staff L got pulled to the floor at times. Staff M explained the restorative task documentation did not appear to have been charted that it was completed according to how the restorative task was (continued on next page)

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	03/12/2026

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	written.On 3/11/26 at 2:51 PM the Director of Nursing (DON) acknowledged the Bath Aide and Restorative Aide get pulled frequently but not both together a lot. The DON acknowledged after review of restorative task for Resident #4 and #9 the restorative was not charted as completed appropriately. The DON stated she expected the restorative program would be followed as written. Review of policy revised 5/25 titled, Nursing Rehabilitation / Restorative Care documented upon the completion of a comprehensive assessment of a resident, the facility should attempt to incorporate restorative programs that will assist a resident to maintain or improve their physical functioning. It is recognized that this will not be possible in all cases. Residents who are candidates for restorative nursing care shall be appropriately assessed, care planned and evaluated for progress. The need for rehabilitation/restorative care will be determined through a comprehensive assessment and/or skilled evaluation. The rehabilitation/restorative plan will be determined through nursing assessment with therapy intervention if deemed appropriate. The care plan should include goals, interventions, special instructions & frequency of the restorative program. This information is to be communicated to the caregivers responsible for carrying out the tasks as outlined by the plan of care, documented in the task and available on the Kardex. The Restorative program Evaluation Quarterly will be documented with the following criteria: Review of the current plan of care for implementation, appropriateness of goals & interventions and tolerance/intolerance to current program.

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	03/12/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and staff interview, the facility failed to implement appropriate infection prevention and control practices to prevent the spread of infection. Specifically, the facility failed to clean equipment between resident use for 1 of 5 residents reviewed (Resident #15). The facility also failed to follow Transmission-Based Precautions (TBP) when delivering a meal tray to a resident with COVID-19 for 1 of 2 residents reviewed (Resident #37). Additionally, the facility failed to follow current Centers for Disease Control and Prevention (CDC) guidelines by not implementing Enhanced Barrier Precautions (EBP) during a wound care dressing change to prevent the spread of multidrug-resistant organisms (MDROs) for 1 of 3 residents reviewed (Resident #11). The facility reported a census of 45 residents.Findings Include: 1. Observation on 3/9/26 at 12:12 PM showed Staff A, Dietary Aide, failed to don personal protective equipment (PPE) prior to entering Resident #37's room while the resident was on Transmission-Based Precautions. Staff A entered the room, placed the meal tray on the bedside table within reach of the resident, exited the room, and then used hand sanitizer. Staff A did not don PPE prior to entering the resident's room. During an interview on 3/9/26 at 12:26 PM, the Director of Nursing (DON) reported that Resident #37 tested positive for COVID-19 on 2/28/26 and would remain on Transmission-Based Precautions until 3/10/26. During an interview on 3/11/26 at 10:14 AM, the Administrator reported all staff should wear PPE when entering a room where a resident is COVID-19 positive. The Administrator further reported Staff A had been off work prior to the resident testing positive for COVID-19 and had missed the PPE refresher training provided to staff. The Administrator reported she would follow up with dietary staff to ensure Transmission-Based Precautions were followed. 2. Observation on 3/09/26 at 12:05 PM noted Staff B came out of covid positive Resident #15's room, and brought out the sit to stand mechanical lift. Staff B Certified Nursing Assistant (CNA) was observed not cleaning the lift after use, and took the lift to the end of south hall and placed the lift in the living area. On 3/11/26 at 9:47 AM interview with the DON confirmed that mechanical lifts should be cleaned after use in a room requiring PPE. Interview on 3/11/26 at 10:05 AM with the Administrator revealed that mechanical lifts should be cleansed after use in rooms requiring PPE. 3. The Minimum Data Set (MDS) dated [DATE] for Resident #11 documented a Brief Interview for Mental Status (BIMS) of 14 indicating no cognitive impairment. The MDS also documented an active diagnosis of Multidrug-Resistant Organism (MDRO). MDS also documented Resident #11 an infection of the foot and other open lesion(s) on the foot. Review of Resident #11's Electronic Health Record (EHR) titled, Orders documented a physician's order with a start date of 2/17/26 for a dressing change to right ankle and right lower shin to cleanse with normal saline, apply aquacel ag and cover with mepilex border 3 times per week until healed. (continued on next page)

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	03/12/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #11's EHR titled, Medication Administration Record - Treatment Administration Records (MAR-TAR) documented a physician's order with a start date of 2/17/26 for a dressing change to right ankle and right lower shin to cleanse with normal saline, apply aquacel ag and cover with mepilex border 3 times per week until healed. On 3/11/26 at 9:35 AM an observation of Resident #11's wounds provided by the Assistant Director of Nursing (ADON) revealed the ADON knocked on the door, entered the room, completed hand hygiene, applied gloves, did not apply gown, explained to Resident #11 procedure, pulled right sock down, right lateral outside aspect of right lower extremity had a 1.5 inch by about 3/4 of an inch wound with pink wound bed, no active drainage of bleeding, ADON pulled right leg pant leg up over knee, revealed a dark brown / black scab 1.5 inches x about 1 inch, no redness noted around the area, removed gloves, completed hand hygiene. On 3/11/26 at 9:40 AM the ADON stated had Resident #11 had both wounds since admission to the facility. On 3/11/26 at 9:32 AM an observation outside of Resident #11's room revealed no Enhanced Barrier Precautions (EBP) sign posted outside the door. Review of Resident #11's EHR titled, Care Plan documented no focus, goal and interventions for EBP. On 3/11/26 at 2:51 PM the Director of Nursing (DON) / Infection Preventionist (IP) acknowledged Resident #11 was not currently on EBP. The DON stated typically the EBP is only in place with residents who have a wound that had an infection and/or a MRDO. The DON stated if the wound did not have an infection present or a history of an infection then EBP was not required. The DON stated she uses her knowledge of infections to determine what residents required EBP. The DON stated if she had any other questions she would reach out to Staff G, Regional Nurse Consultant (RNC) with any questions but does not refer to the CDC for guidance. On 3/11/26 at 2:51 PM Staff G acknowledged Resident #11 should have EBP in place related to her wounds. Review of the facility's Infection Control Manual dated September 2023 indicated staff are required to don appropriate PPE prior to entering the room of a resident on Transmission-Based Precautions. Review of a facility provided policy titled, Infection Control Manual Surveillance with a revision date of September 2023 indicated staff are to perform terminal cleaning and disinfection of patient's/resident's room and reusable medical equipment. Review of facility provided policy revised 3/24 titled, Enhanced Barrier Precautions documented the purpose of the policy was to minimize risk of transmission of novel or targeted Muli-Drug Resistant Organisms (MDROs) during high contact resident care activities for residents requiring enhanced barrier precautions (EBP). EBP will be used in conjunction with standard precautions for residents with any of the following (if/when Contact Precaution requirements are not in place): Infection or colonization with a CDC-targeted MDRO when contact precautions do not otherwise apply and wounds and/or indwelling medical devices (even if the resident is not known to be infected or colonized with a targeted MDRO). For residents whom EBP are indicated; gowns and gloves should be used during high contact resident care activities that provide opportunity for MDROs to be transferred to staff hands and clothing. High contact resident care activities include: Wounds care: any skin opening requiring a dressing and dressing.