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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165522 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/10/2024 |
| NAME OF PROVIDER OR SUPPLIER Parkview Manor Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1009 Third Street Reinbeck, IA 50669 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35438</p> <p>Based on observation, clinical record review, and staff interviews, the facility failed to ensure that 1 of 3 residents reviewed were treated with dignity and respect (Resident #1). On 3/23/24 Staff A, Certified Nursing Assistant (CNA) yelled at Resident #1 in a disrespectful and undignified manner using foul language The facility reported a census of 28 residents.</p> <p>Findings include:</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 4 out of 15, indicating severely impaired cognition. The MDS further documented the resident required set up or clean up, and totally dependent for chair/bed to chair transfer. The MDS further identified diagnoses that included: atrial fibrillation, non-Alzheimer ' s dementia, and anxiety.</p> <p>Review of an Alleged Abuse Facility Incident Report prepared on 3/23/24 at 5:30 p.m. by the Director of Nursing (DON) revealed: On 3/23/24 between 4:45 p.m. and 5:10 p.m. Staff B, CNA and Staff C, CNA were assisting Resident #1 up for supper. They were in the process of hooking the last two loops of the mechanical lift sling to the machine when Staff A, CNA entered the room. Staff A was alleged to have taken over and hooked up the sling. When Resident #2 told Staff A to leave the room, it was alleged she responded, hit me, I ' m not afraid of you, you are so f***ing disrespectful to me and I ' m here with you every day. Resident was questioned and didn ' t recall anything about the incident.</p> <p>The Care Plan dated as initiated on 8/26/22 identified a focus area related to a communication problem and directed staff to be extra patient with resident at times when his dementia causes him to say and do things that he would normally not do.</p> <p>In an observation on 4/9/24 at 1:25 p.m. Resident #2 was transferred with 2 staff assist and a full mechanical lift from his wheelchair. The sling was noted to be a full body 3 point sling. Resident was compliant with instructions to cross his arms. Arms noted to have protective sleeves covering the top part of the back of the hand.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>In an interview on 4/10/24 at 9:50 a.m. Staff B, CNA reported that Staff A had entered the room and shoved her out of the way and hooked the top hook of the sling. Staff B described that Staff A was moving way too fast for the resident and had not informed him of what she was doing. Staff B stated that it was just too much for the resident and he became agitated. Staff B stated Resident #2 told Staff A that he was going to punch her, she responded that she wasn't afraid of him. As Staff A started to leave, Staff A was reported to say, you are so f**king disrespectful to me and that she was there everyday to care for him.</p> <p>In an interview on 4/10/24 at 12:03 p.m. Staff C, CNA stated she had been assisting Staff B, CNA transfer Resident #1 on 3/23/24 when Staff A, CNA had entered the room. Staff B verified that she witnessed Staff A yell at the resident, hit me. I'm not afraid of you. You're f**king disrespectful to me, and I take care of you every day. Staff C stated that Staff A was very rude and used disrespectful and foul language that should never be used when interacting with a resident.</p> <p>In an interview on 4/9/24 at 3:00 p.m. Staff D, Licensed Practical Nurse (LPN) stated that she had assessed the resident after the reported incident. Staff D verified that there was no injury and the resident had not mentioned anything about the incident.</p> <p>In an interview on 4/9/24 at 2:30 p.m., the DON verified that she had completed the investigation. The facility had suspended Staff A during the investigation. Upon completion of the investigation the facility had terminated Staff A for violating the abuse policy and because her language and treatment of Resident #1 was not the kind of treatment that is tolerated by the facility.</p> <p>Review of facility Abuse Prevention, Identification, Investigation and Reporting Policy dated as reviews 12/21/16 included: the expectation that all residents have the right to be from abuse. Definition of verbal abuse included: oral, written or gestured language that willfully include disparaging and derogatory terms to residents, or within their hearing distance.</p> | | |