STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165522	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Manor Care Center	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441 Based on clinical record review, personnel record review, staff interviews, and policy review, the facility failed to protect a resident from verbal abuse by a staff member for 1 of 13 residents reviewed for abuse (Resident #9). The facility reported a census of 28 residents. Findings include: Resident #9's Minimum Data Set (MDS) assessment dated [DATE] indicated they had clear speech. The MDS reflected they had physical behavioral symptoms and rejected care for 1 to 3 days during the 7-day lookback period. The MDS identified a Brief Interview for Mental Status (BIMS) of 9, indicating moderately impaired cognition. Resident #9 required total assistance from staff with toileting. The MDS listed Resident #9 as always incontinent. The MDS included diagnoses of Alzheimer's disease and unspecified severity dementia with behavioral disturbances. The Care Plan Focuses revised 7/9/24 reflected Resident #9 had a. an activities of daily living (ADL) self-care performance deficit related to Alzheimer's disease. The Interventions listed Resident #9 as dependent on 1 staff for toileting hygiene. b. frequent bowel and bladder incontinence related to advanced Alzheimer's disease. The Interventions directed staff to use disposable briefs, check routinely, and as needed. Staff A's, Certified Nurse Aide (CNA), Personnel Record reviewed on 9/3/24 at 10:10 AM, reflected she told Resident #9 fuck you too after changing his incontinence brief. During an interview on 9/25/24 at 3:17 PM, Staff B, CNA, reported on 8/30/24 during the first rounds Staff A stood on one side of Resident #9's bed and Staff B, CNA stood on the other side. As they changed his incontinence brief, he became combative and tried to bite Staff A. When Resident #9 said fuck you to Staff A, she responded fuck you too. During an interview on 9/30/24 at 11:00 AM, Staff A admitted she told Resident #9 fuck you too after changing his incontinence brief while walking past the foot of his bed the night of 8/30/24. (continued on next page)

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
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled, Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy revised November 2023 documented all residents have the right to be free from abuse. Residents must not be subjected to abuse by anyone, including facility staff. Verbal abuse may be considered a type of mental abuse. Verbal abuse includes the use of oral communication to residents within hearing distance, regardless of age, ability to comprehend or disability. During an interview on 9/26/24 at 11:57 AM, the Director of Nursing (DON), verified Staff A acknowledged told Resident #9 fuck you too. She added they suspended Staff A on 9/3/24 pending the investigation.

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441 Based on staff interview, facility investigation review, clinical record review, and policy review, the facility failed to notify the Department of Inspections, Appeals and Licensing (DIAL) of alleged physical and verbal abuse that occurred on 8/30/24 around 11:30 PM in a timely manner. The Certified Nursing Aide (CNA) reported the alleged incident after first rounds on 8/30/24 to a Licensed Practical Nurse (LPN). The facility didn't start their investigation for the alleged abuse until 9/3/24 for 1 of 13 residents reviewed for abuse (Resident #9). The facility reported the incident to DIAL at approximately 1:00 PM on 9/3/24. The Department notified the facility of the immediate jeopardy (IJ) on 9/24/24, that began on 8/30/24. The facility removed the immediacy on 9/24/24 after completing the following: a. On 9/3/24 the facility disciplined and educated the nurse about their requirement to separate the employee from the resident and report to the Director of Nursing (DON) and/or Administrator immediately. b. Starting on 9/4/24 the facility began education to all staff regarding timeliness of reporting potential abuse of a resident by a staff. c. On 9/24/24 the Director of Nursing (DON) called the remaining staff to review abuse education. The scope and severity lowered from the immediate potential harm level J to a D after ensuring the facility implemented education about their policy and procedure. The facility reported a census of 28 residents. Findings include: Resident #9's Minimum Data Set (MDS) assessment dated [DATE] indicated they had clear speech. The MDS reflected they had physical behavioral symptoms and rejected care for 1 to 3 days during the 7-day lookback period. The MDS identified a Brief Interview for Mental Status (BIMS) of 9, indicating moderately impaired cognition. Resident #9 required total assistance from staff with toileting. The MDS listed Resident #9 as always incontinent. The MDS included diagnoses of Alzheimer's disease and unspecified severity dementia with behavioral disturbances. The Care Plan Focuses revised 7/9/24 reflected Resident #9 had a. an activities of daily living (ADL) self-care performance deficit related to Alzheimer's disease. The Interventions listed Resident #9 as dependent on 1 staff for toileting hygiene. b. frequent bowel and bladder incontinence related to advanced Alzheimer's disease. The Interventions directed staff to use disposable briefs, check routinely, and as needed. (continued on next page)

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/24/24 at 11:40 AM, Staff C, Licensed Practical Nurse (LPN), reported Staff B, CNA, told her she had concerns around 3:00 AM or 4:00 AM the morning of 8/31/24. Staff B reported Resident #9 went to hit or slap Staff E, CNA, and she blocked the resident. Staff C reported Resident #9 could be combative and you would need to stop something if you could see it coming so he didn't hit you. Staff C denied having knowledge of Staff E being verbally or physically abusive with any other residents. Staff C revealed she planned to speak with the Administrator on Monday 9/2/24, when they returned from vacation about the incident. However, Staff B reported it to someone else before she had a chance to notify the Administrator. Staff C remarked she didn't even think of telling the DON of the allegation in the Administrator's absence. During the notification of the immediate jeopardy on 9/24/24 at 5:15 PM, the Director of Nursing (DON) verbalized frustration in regards to the lack of timely notification from the staff of the incident, as she had been at the facility and worked the weekend following the alleged incident. During an interview on 9/25/24 at 3:17 PM, Staff B reported on 8/30/24 before midnight as they just started first rounds, Staff E came out of Resident #9's room requesting Staff B's assistance with him. Staff B reported they often started assisting Resident #9 with 1 person and see how it went. Then sometimes they needed a second person depending on his behaviors. Staff B stated she stood on one side of the bed and Staff E stood on the other side. As they changed his incontinence brief, Resident #9 started hitting, being combative, and tried to bite Staff E. Resident #9 told them fuck you, and Staff E replied fuck you too back him. Staff E then called Resident #9 an asshole when he hit and kicked Staff E. She then pushed his arm down to avoid getting hit and when he became calm, Staff E slapped his forearm with an open hand. Staff B described Resident #9 as calm as they finished his care. Staff E slapped Resident #9 on, she thought, his right leg with an open hand and again he didn't respond, he remained quiet. Staff B stated after they finished doing cares, Staff E left the room with the garbage and Staff B made sure Resident #9 was comfortable. Staff B stated she told Staff C step by step about the incident around 12:45 AM 1:00 AM on 8/31/24 after they finished first rounds. Staff B reported Staff C acknowledged that wasn't right and that she would let the Administrator know. Staff B reported the next time she worked, she saw Staff E still working, so she told Staff D, LPN, about the incident as she knew they would report it. During an interview on 9/26/24 at 10:20 AM, Staff D reported Staff B asked her over the weekend what to do in regards to a situation she witnessed with Staff E and Resident #9. Staff D told Staff B to turn the information in to her supervisor. Staff B reported they did that when she told Staff C after it happened. Staff D reported when she came into work the morning of Tuesday 9/3/24 after the alleged incident, she saw Staff E walking out of the facility. Staff C reported she approached Staff B who also worked that night, took her aside, and asked her why Staff E was still working as she had assumed the situation had been taken care of. In which Staff B replied she had no idea why Staff E was still working. Staff D stated she reported the information Staff B told Staff C to the DON when she arrived at work the morning of 9/3/24 around 8:00 AM. Then the facility handled the situation from there. During an interview on 9/26/24 at 11:57 AM, the DON explained on Tuesday morning, 9/3/24 shortly before 8:00 AM, right as she arrived to work, Staff D asked her if she knew anything about what happened with Resident #9 and Staff E. She responded she hadn't heard anything. Staff D shared the information Staff B reported to her and then the DON reported she immediately contacted the Network Support Administrator as the provisional Administrator was on vacation. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/30/24 at 11:00 AM, Staff A admitted she told Resident #9 fuck you too after changing his incontinence brief while walking past the foot of his bed the night of 8/30/24. Review of facility policy titled, Nursing Facility Abuse Prevention, Identification, Investigation and Reporting policy, revised November 2023 directed to report all allegations of resident abuse immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative. All allegations of abuse shall be reported to the Iowa Department of Inspections and Appeals no later than 2 hours after the allegation is made. On 9/26/24 at 10:39 AM the Administrator said they expected the facility to report the alleged abuse to the Administrator and Director of Nursing immediately and turned it into the Department of Inspections, Appeals and Licensing (DIAL) within 2 hours.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441 Based on staff interview, facility investigation review, time card detail, and policy review, the facility failed to separate a staff member from dependent residents accused of alleged physical and verbal abuse that occurred on 8/30/24 around 11:30 PM in a timely manner for 1 of 13 residents reviewed for abuse (Resident #9). The staff member not only continued to work the rest of her shift on 8/30/24, they worked full shifts on 8/31/24, 9/1/24, and 9/2/24. Due to the facility failing to separate the alleged abuser from the alleged victim and/or other vulnerable residents, this resulted in an immediate jeopardy situation. The facility didn't initiate an investigation for the alleged abuse until 9/3/24. The Department notified the facility of the immediate jeopardy (IJ) on 9/24/24, that began on 8/30/24. The facility removed the immediacy on 9/24/24 after implementing the following: a. On 9/4/24 the facility began and completed education for all charge nurses to send the alleged abuser home immediately upon receiving information of alleged abuse. The staff member will remain off work until incident is investigated. b. On 9/5/24 the facility terminated the alleged abuser/employee. The scope and severity lowered from the immediate potential harm level L to a F after ensuring the facility implemented education about their policy and procedure. The facility reported a census of 28 residents. Findings include: Resident #9's Minimum Data Set (MDS) assessment dated [DATE] indicated they had clear speech. The MDS reflected they had physical behavioral symptoms and rejected care for 1 to 3 days during the 7-day lookback period. The MDS identified a Brief Interview for Mental Status (BIMS) of 9, indicating moderately impaired cognition. Resident #9 required total assistance from staff with toileting. The MDS listed Resident #9 as always incontinent. The MDS included diagnoses of Alzheimer's disease and unspecified severity dementia with behavioral disturbances. The Care Plan Focuses revised 7/9/24 reflected Resident #9 had a. an activities of daily living (ADL) self-care performance deficit related to Alzheimer's disease. The Interventions listed Resident #9 as dependent on 1 staff for toileting hygiene. b. frequent bowel and bladder incontinence related to advanced Alzheimer's disease. The Interventions directed staff to use disposable briefs, check routinely, and as needed. (continued on next page)

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 9/24/24 at 11:40 AM, Staff C, Licensed Practical Nurse (LPN), reported Staff B, CNA, told her she had concerns around 3:00 AM or 4:00 AM the morning of 8/31/24. Staff B reported Resident #9 went to hit or slap Staff E, CNA, and she blocked the resident. Staff C reported Resident #9 could be combative and you would need to stop something if you could see it coming so he didn't hit you. Staff C denied having knowledge of Staff E being verbally or physically abusive with any other residents. Staff C revealed she planned to speak with the Administrator on Monday 9/2/24, when they returned from vacation about the incident. However, Staff B reported it to someone else before she had a chance to notify the Administrator. Staff C remarked she didn't even think of telling the DON of the allegation in the Administrator's absence. During an interview on 9/25/24 at 3:17 PM, Staff B reported on 8/30/24 before midnight as they just started first rounds, Staff E came out of Resident #9's room requesting Staff B's assistance with him. Staff B reported they often started assisting Resident #9 with 1 person and see how it went. Then sometimes they needed a second person depending on his behaviors. Staff B stated she stood on one side of the bed and Staff E stood on the other side. As they changed his incontinence brief, Resident #9 started hitting, being combative, and tried to bite Staff E. Resident #9 told them fuck you, and Staff E replied fuck you too back him. Staff E then called Resident #9 an asshole when he hit and kicked Staff E. She then pushed his arm down to avoid getting hit and when he became calm, Staff E slapped his forearm with an open hand. Staff B described Resident #9 as calm as they finished his care. Staff E slapped Resident #9 on, she thought, his right leg with an open hand and again he didn't respond, he remained quiet. Staff B stated after they finished doing cares, Staff E left the room with the garbage and Staff B made sure Resident #9 was comfortable. Staff B stated she told Staff C step by step about the incident around 12:45 AM 1:00 AM on 8/31/24 after they finished first rounds. Staff B reported Staff C acknowledged that wasn't right and that she would let the Administrator know. Staff B reported the next time she worked, she saw Staff E still working, so she told Staff D, LPN, about the incident as she knew they would report it. During an interview on 9/26/24 at 10:20 AM, Staff D reported Staff B asked her over the weekend what to do in regards to a situation she witnessed with Staff E and Resident #9. Staff D told Staff B to turn the information in to her supervisor. Staff B reported they did that when she told Staff C after it happened. Staff D reported when she came into work the morning of Tuesday 9/3/24 after the alleged incident, she saw Staff E walking out of the facility. Staff C reported she approached Staff B who also worked that night, took her aside, and asked her why Staff E was still working as she had assumed the situation had been taken care of. In which Staff B replied she had no idea why Staff E was still working. Staff D stated she reported the information Staff B told Staff C to the DON when she arrived at work the morning of 9/3/24 around 8:00 AM. Then the facility handled the situation from there. During an interview on 9/26/24 at 11:57 AM, the DON explained on Tuesday morning, 9/3/24 shortly before 8:00 AM, right as she arrived to work, Staff D asked her if she knew anything about what happened with Resident #9 and Staff E. She responded she hadn't heard anything. Staff D shared the information Staff B reported to her and then the DON reported she immediately contacted the Network Support Administrator as the provisional Administrator was on vacation. Review of Staff E's time card detail listed they worked the following dates and times and wasn't separated from residents following the alleged incident on 8/30/24: a. 8/30/24: 10:19 PM 6:08 AM (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	b. 8/31/24: 9:56 PM 6:21 AM c. 9/1/24: 9:59 PM 6:15 AM d. 9/2/24: 10:03 PM 6:07 AM Review of facility policy titled, Nursing Facility Abuse Prevention, Identification, Investigation and Reporting policy, revised November 2023 instructed all allegations of resident abuse should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative. Upon receiving a report of an allegation of abuse, the facility shall immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. If this involves evaluation of abuse by an employee, this will be accomplished by separating the employee accused of abuse from all other residents through the following or a combination of the following, if practicable: (1) suspending the employee; (2) segregating the employee by moving the employee to an area of the facility where there will be no contact with any resident of the facility; and in rare instances (3) separating the employee accused of abuse from the resident alleged to have been abused, but allowing the employee to care for and have contact with other residents only if there is a second employee who remains with and accompanies the employee accused at all time to supervise all contacts and interactions with the residents. On 9/26/24 at 10:39 AM the Administrator reported they expected the staff to separate potential abusers from the resident immediately. They should send them home immediately and then check the resident for injury. They would be on suspension until the facility and the Department of Inspection, Appeals, and Licensing (DIAL) completed the investigation of the incident and potentially have their employment terminated. The Administrator added the facility should report it to the Administrator and Director of Nursing immediately and turned into DIAL within 2 hours.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review, staff interviews, observations, hospital record review, and policy review, the facility failed to provide adequate nursing supervision to prevent accidents and injuries for 1 of 3 residents reviewed (Resident #21). On 9/17/24 Resident #21 attempted suicide by wrapping the bed remote cord around his neck twice which resulted in transfer to the hospital for a psychiatric evaluation and medication changes at the facility. Following his return, the facility gave him back his television, but failed to secure the television cords, cable cords, and a power cord under the bed to prevent access. Due to Resident #21's recent incident with wrapping a cord around his neck, this resulted in an immediate jeopardy situation. The State Agency informed the facility of the Immediate Jeopardy that began on 9/24/24 at 5:15 PM. The Facility Staff removed the Immediate Jeopardy on 9/24/24 through the following actions: - On 9/17/24, Resident #21 was seen at the Hospital Emergency Department. At that time, the Physician documented Not suicidal. No emergent medical condition. - On 9/24/24 at 5:30 PM, the Director of Nursing (DON), Provisional Administration and Administrator in training (AIT) entered Resident #21's room, secured the bed electrical cord, the cable cords and television cords with zip ties. They repositioned the television, moved Resident #21's recliner across the room away from the television, and removed the bed remote. The scope lowered from a J to a D at the time of the survey after ensuring the facility secured the cords in Resident #21's room. The facility identified a census of 26 residents. Findings include: Resident #21's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. The MDS identified Resident #21 as independent with bed mobility and required partial/moderate assistance with transfers. The MDS indicated Resident #21 used a manual wheelchair and required partial/moderate assistance with locomotion. Resident #21's MDS included diagnoses of atrial fibrillation (abnormal heart rate), hypertension (high blood pressure), heart failure (inability of the heart to pump blood well), renal disease (kidney), benign prostatic hyperplasia (BPH enlarged prostate), stroke, and non Alzheimer's dementia. The Care Plan Focuses initiated 9/19/24 described Resident #21 as a new admission to the facility and had difficulty adjusting to the new surroundings/routine. Resident #21 wrapped a cord around his neck and told staff that he wanted to kill himself. The Care Plan directed the following interventions: 9/17/24: Send to the emergency room (ER) for an evaluation (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9/17/24: Psych Advance Registered Nurse Practitioner (ARNP) started clonazepam and lorazepam (anti anxiety medication) 9/19/24: Ensure cords, sharp objects, curtains and anything else that could be harmful are removed from Resident #21 room or zip tied together so it can't be used to harm himself. The eMAR - Medication Administration Note dated 9/14/24 at 3:50 PM documented Resident #21 yelled out the first two hours of the second shift, requesting staff to call his wife so she could take him out of the facility. Resident #21 got the call light necklace/cord wrapped around his neck. The staff removed the call light necklace and replaced it with a band for his wrist. The Health Status Note dated 9/17/24 at 8:15 AM documented a CNA (certified nursing assistant) entered Resident #21's room and observed him with blankets over his head. When the CNA removed the blanket, they found Resident #21 with the cord to the bed remote wrapped around his neck twice. The CNA removed the cord and Resident #21 didn't show any signs of respiratory distress. His didn't have marks or redness noted. The CNA assisted Resident #21 to the bathroom and then reported the incident to the nurse. When the nurse went to Resident #21's room, he reported he did it to kill himself. When asked why he wanted to kill himself he replied because she tried to give him a shower early at 6:15 AM that morning, who takes a shower that early. Resident #21 requested to get up, go to the bathroom, and the CNA asked him if he wanted to get up, take a shower, then go to breakfast. Resident #21 began to yell at the CNA, he requested to go back to bed, and have his clothes hanged up in the closet. Once back in bed, Resident #21 began yelling over and over for someone to get him up. The CNA moved on to assist another resident. The staff informed Resident #21 he would have to wait for the CNA to finish and then they would come back. When the CNA returned to Resident #21's room, she walked into the incident documented in the note. The staff assisted Resident #21 with care and brought him out to the dining room after the completion of his vital signs. The staff informed the kitchen Resident #21 couldn't have objects that he could use as a self-harm object. At the time, the DON and Administrator were present in the building. The DON sat with Resident #21 at the dining room table. The facility received new orders to send Resident #21 to the ER for an evaluation. The facility notified Resident #21's wife of the situation, who agreed with the transfer. The Health Status Note dated 9/17/24 at 9:15 AM labeled Late Entry documented the staff started 1 on 1 care with Resident #21 after the incident. They received permission to search his room. The nurse and Maintenance Manager completed the room search. They removed all sharp objects, plastic bags, cords, and a belt from the room. The staff notified Resident #21's wife they relocated all of his cords in the medication room for his personal items such as his electric razor. The Health Status Note dated 9/17/24 at 9:30 AM indicated an ambulance arrived to the facility to transport Resident #21 to the emergency room (ER) at 10:20 AM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The emergency room department report dated 9/17/24 documented Resident #21 arrived by ambulance for a psychiatric evaluation. Per the nursing home report, Resident #21 entered the facility on 8/27/24 for skilled placement didn't transition well. Resident #21 made multiple threats to kill himself since entering the facility. In addition, he refused to take his medications. During the initial evaluation in the ER, Resident #21 reported that they are a pain in the butt over there, when speaking about the nursing home. The report listed the clinical impression as situational anxiety. The Provider notes described Resident #21 as calm and cooperative in the emergency department. Resident #21 denied suicidal thoughts or having a plan. Resident #21 stated he really didn't want to be at the rehab facility so he intentionally made it difficult on the staff. The note documented Resident #21 as not suicidal and with no emergent medical condition. The Order Note dated 9/17/24 at 2:15 PM documented Resident #21 returned from the ER with no new orders received. The staff assisted Resident #21 to his recliner and he continued to show escalated anxiety. The facility contacted the ARNP, who provided the following new orders: a. Discontinue hydroxyzine (antihistamine) b. Start clonazepam 0.5 mg (milligrams) twice a day c. Give lorazepam 1 mg one-time now and continue previous as needed order. The facility form titled 15-minute check sheet for Resident #21 dated 9/17/24 lacked signatures for 15-minute checks from 6:45 PM to 9:45 PM, indicating no one completed the checks. On 9/24/24 at 10:21 AM, Staff F, Certified Medication Aide (CMA) reported she worked the morning of 9/17/24. She stated she went into Resident #21's room sometime between 8 8:30 AM and he had blankets over his head. She stated she tapped him on the shoulder and he made a noise. When she asked him why he had the blankets over his head and pulled back the blanket she saw the bed cord wrapped around his neck twice. She immediately took the cord off his neck and put the cord at the end of bed on the floor so he couldn't reach it. She looked for marks around his neck and didn't see any. She stated the cord wasn't tight. She described Resident #21 as angry and stated he tried to kill himself. She reported Resident #21 as mad at her from earlier in the shift. She stated at 6:15 AM he had his call light on and he wanted to go to the bathroom. She stated she got him up to the bathroom. Since he was up, she offered to give him a shower. He agreed so she got his clothes out, laid them over the wheelchair, and got the shower chair. She stated Resident #21 asked her what she was going to do with the shower chair and when she told him, she planned to give him a shower, he changed his mind, and wanted to go back to bed. She stated he got mad at her for asking him to take a shower at 6:15 AM. He made her put his clothes back into the closet. She assisted him back to bed and left the room. Staff F stated she told Staff D, Licensed Practical Nurse (LPN), about the incident as soon as she ensured his safety. She stated Staff D came right away, when she asked Resident #21 what was wrong, he reported he wanted to die. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165522	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Manor Care Center	1009 Third Street Reinbeck, IA 50669

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/24/24 at 11:31 AM, Staff G, RN (Registered Nurse), acknowledged the entry she made on 9/14/24 regarding the call light necklace/cord. While outside of his room by the medication carts, she heard can someone help me. She went into Resident #21's room and he asked if she could get that off of him because it got tight. Staff G didn't recall what type of material used for Resident #21's call light necklace. She didn't remember if the call light necklace used breakaway material or not. She cut it off and put the call light on a band on his wrist for his safety. He agreed to have it on his wrist. She stated she didn't recall how or how many times the call light necklace/cord got wrapped around his neck. On 9/24/24 at 11:58 AM, Resident #21 acknowledged he wrapped a bed cord around his neck the previous week. Resident #21 reported he did it because he got tired of everything and wanted to end his life. When asked what he was tired of, he responded the way things went around there. He stated staff didn't come in to answer his call light. When asked if he was mad at something or someone the morning he attempted to end his lift, he stated not that he could remember. He reported he yelled a lot because he needed to go to the bathroom. He reported sometimes the staff came in when he yelled and other times they didn't. When asked if he still wanted to end his life he stated no. On 9/24/24 at 12:05 PM, observed an unsecured power cord underneath the bed (not zipped tied) plugged into the wall outlet at the foot of the bed. Across from the bed, next to the recliner, observed a television on a stand with a satellite box. Noted the television power cord, cable cord, and two direct tv cords in place and not secured (not zipped tied). In addition, observed one black cord not plugged in, unsecured, and hanging over the side of the TV stand. On 9/24/24 at 12:05 PM, Staff D reported Staff F came out of Resident #21 room and told her when she removed the blanket off of him, she found the bed cord wrapped around his neck twice. She described Resident #21 as very anxious, so Staff F assisted him to the toilet. Staff D reported she sat the nursing station when Staff F told her. Staff F went right back in the room. Staff D stated Resident #21 sat on the toilet in the room when she entered. She stated she asked Resident #21 if he was okay and if he had any trouble breathing. She did an assessment and didn't find marks or redness around the neck. She asked Resident #21 why he wrapped the bed cord around his neck, he replied he wanted to kill himself. When she asked if he would do it again, he responded yes. She reported they got him ready and assisted him to breakfast. She stated the DON sat with him while he ate and then he stayed in the common area by the fish tank for 1 to 1 visual supervision. She reported she started 15-minute checks and he still had the checks in place. Staff D stated it had been communicated to her before the incident on 9/17/24 that Resident #21 made a comment that he could choke himself with the pendant, but she didn't hear him say that. She reported they changed the pendant necklace to a bracelet. Staff D reported while at the facility on 9/17/24, the ARNP gave orders to send Resident #21 to the ER. Staff D stated Resident #21 told the ambulance driver he wanted to kill himself. He went to the ER and got assessed. The hospital called her back to report Resident #21 wasn't suicidal anymore and they would send him back. She stated he returned with no new orders. The staff removed cords, belts, TV/cable cords, the lamp from his room, and anything else that could be unsafe. She stated he got the cable and TV cords back because he couldn't reach them. She stated the maintenance man put the cords back in the room so he could watch TV. Staff D reported she wasn't sure which day he got the cords back. She stated not having the TV made his anxiety worse. Staff D reported Resident #21 was usually in his bed or recliner when he in his room. She reported Resident #21 could wheel himself with his feet short distances. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The clinical record lacked an assessment or documentation regarding Resident #21's mental status or physical status prior to replacing the unsecured television and cable cords in his room. On 9/24/24 at 1:44 PM, The DON reported Resident #21 didn't have a formal intervention of 15-minute visual checks. She stated they put the 15 minutes checks in place to keep track of Resident #21's location. She stated they did the checks as a part of their quality assurance (QA) process. She stated the paper documentation didn't say for QA but she would add that. She reported the interventions after the suicide attempt as sending Resident #21 to the ER and the medication changes. The DON reported his wife requested he get the TV and cable cords back in his room on Friday, 9/20/24 before the weekend so Resident #21 could watch football. The wife wouldn't be at the facility that weekend as much due to family visiting and the wife felt football would help keep him calm. When asked if they completed an assessment prior to putting the cords back in his room, the DON acknowledged they didn't complete an assessment or documentation. She reported the thought process of putting the cords back into the room related to the fact Resident #21 didn't attempt to move except for rolling out of bed. When asked about the black power cord underneath his bed, she stated Resident #21 didn't attempt to reach the cord. On 9/26/24 at 7:58 AM, the Maintenance Manager reported he removed the curtains and cords from Resident #21's room when the incident occurred on 9/17/24. He reported the DON asked him to put the TV cords back in the room on Thursday (9/19/24) or Friday (9/20/24). He stated he didn't think Resident #21 should have the cords back, but the wife became livid Resident #21 couldn't watch TV and he liked to watch football. The maintenance manager reported he put the TV cords in a slip knot and had the TV against the wall. He reported the slip knot would have come out if the TV was moved or pulled out from the wall. He reported the aides sometimes moved the TV in front of his recliner. The Resident at Risk for Suicide/Homicide policy effective October 2010 directed when a resident is at risk of a suicide attempt, verbalized a plan of suicide, verbalized a plan of hurting themselves in some way, or had homicidal ideation the following measures would be implemented: 1. Notify the charge nurse. 2. Notify Social Services/Household Coordinator, Nurse Mentor, DON, Administrator, or designee. 3. Nursing staff will contact family/representative and physician or involved mental health professionals to alert them of the situation. 4. After obtaining verbal consent from the resident's representative, the staff will conduct a room search and would remove items such as: plastic bags, sharp objects, nail clippers, electric cords, call light cords, and other items as deemed necessary by the charge nurse. Any cords that cannot be removed will be zip tied or secured to the bed frame or other areas to shorten the length of the cord to a length needed for function of item. The call light may be replaced with a bell or other alert system. 5. Following an assessment by Social Services Household Coordinator, Nurse Mentor, DON, Administrator or designee will begin a safety precaution and visual monitoring as documented in the clinical record. For example: staff will make visual contact every 15 minutes on all three shifts until determination is made otherwise. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. Care Plan will be updated as needed. 7. Nursing and Social Services/Household Ongoing Coordinator would complete communication between them to determine when they could discontinue visual monitoring. 8. Social Services/Household Coordinator would provide or arrange counseling or other such mental health services as deemed appropriate.