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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review, and staff interviews, the facility failed to ensure resident's current code status was available for 1 out of 13 residents reviewed (Resident #130). The facility reported a census of 26 residents. Findings include: Resident #130's clinical record lacked a completed Minimum Data Set (MDS) assessment. The Clinical Census listed Resident #130 admitted to the facility on [DATE] to room [ROOM NUMBER] 1. The Clinical record lacked documentation regarding advance directives for Resident #130. On [DATE] at 3:26 PM unable to locate an Iowa Physician Orders for Scope of Treatment (IPOST) for Resident #130 in the IPOST binder on top of the crash cart inside the nurses' station. Staff D, Licensed Practical Nurse (LPN), reported the binder on the crash cart as only place the facility kept the residents' IPOST. Staff D reported the facility could only keep the IPOST in one place. When asked what she would do if she needed to know a resident's code status, she replied if the binder didn't have the IPOST, she would call the Director of Nursing (DON). Staff D agreed calling the DON would slow down the process if the resident required CPR. On [DATE] at 1:30 PM, Staff C, LPN, verified the facility kept the residents' IPOST in a binder on the crash cart. Staff C stated all residents should have an IPOST in the binder and if they didn't have one she would look in the computer to see if they uploaded it into the electronic health record. She stated if she couldn't find one, she would ask the DON. She explained in an emergent situation and she couldn't locate the IPOST, she would start CPR. She stated if the resident lived, then they could be mad; but it is better to be safe than sorry. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:10 PM, the DON described the procedure for advance directives as the nurse completing the admission process to take the IPOST with them, complete it with the resident if they are capable and/or if they can't complete it, involve the family. After they complete the IPOST, they need to place a copy in the binder and send the original to the Physician for signature. She stated the nurses must get a verbal order until the Physician signed the IPOST. She stated she writes the verbal order on the bottom of the IPOST. The DON reported the facility only kept the IPOST in the binder on the crash cart. She reported she knew Resident #130 didn't have an IPOST in the binder until [DATE]. She stated Resident #130's family had their IPOST at home and the daughter kept saying she would bring it in. The DON reported she called Hospice on [DATE] for the IPOST. Hospice faxed a copy of the IPOST to the facility from their computer system. She stated she received the IPOST the morning of [DATE] and put it in the binder. She reported if a resident didn't have an IPOST in the binder and the staff couldn't locate their code status, they needed to start CPR. She acknowledged if the binder didn't have the IPOST, it could delay the CPR process. A facility policy titled IPOST Form revised [DATE] instructed the facility acknowledged that in the last stages of illness, health decisions can be complicated and difficult for the resident, their families, and even the treating health providers. The IPOST form helps health providers guide and support the resident and their family during this sensitive time. A completed IPOST form creates a clear declaration of the resident's healthcare treatment choices and assures that the resident's wishes are fulfilled at the prescribed time. The policy documented the following procedure: a. All current IPOSTs will be kept in a binder at the nurse's station/office. b. In the event there is no IPOST, the resident is considered a full code. c. The document will be reviewed with the resident or resident's representative, signed by the resident or resident's representative, and a copy placed in the IPOST binder at the nurse's station/office until the original is returned. d. Staff members will obtain either a primary care provider (PCP) signature or verbal order to follow the IPOST as written (for example: Follow IPOST as written). If a verbal order is obtained, a copy of the verbal order will be attached to the IPOST. The provider's signature on the IPOST will be requested as soon as practicable.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review, staff interview, and policy review the facility failed to notify the Physician and family regarding the development of a new pressure ulcer for 1 of 2 residents reviewed (Residents #15). The facility reported a census of 26 residents. Findings include: Resident #15's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMs) score of 3, indicating severely impaired cognition. The MDS identified Resident #15 required substantial/maximal assistance with bed mobility, transfers, and toileting. The MDS identified Resident #15 had an indwelling catheter. The MDS included diagnoses of anemia, hypertension (high blood pressure), heart failure (inability of the heart to pump blood well), atrial fibrillation, renal (kidney) disease, and benign prostatic hyperplasia. (BPH). The MDS identified Resident #15 was at risk for developing pressure ulcers/injuries. A Progress Note titled Skin/Wound note dated 8/7/24 documented an abrasion from the elastic brief near right groin/right gluteal fold was closed and intact with fragile epithelium. The note documented to continue the current treatment of Calmoseptine cream (cream used to treat and prevent minor skin irritations) for protection. The wound nurse to follow Resident #21 as needed. A Progress Note titled Skin/Wound note dated 8/21/24 documented Resident #15 had an unstageable pressure ulcer that measured 3.8 cm (centimeters) x 8.5 cm due to a medical device (catheter) to the right groin/gluteal fold. The note documented the pressure injury as a large, linear, irregularly shaped open area covered mostly with yellow slough (nonviable tissue), and some area of brown slough. The note documented Calmoseptine cream to continue as a treatment to the area. The note recommended trying to prevent the catheter tubing from rubbing and/or applying direct pressure over the right groin/gluteal fold areas. The Clinical record lacked documentation that the facility notified the Physician or family of the new pressure ulcer from the medical device (catheter). On 9/30/24 at 9:08 AM, the Director of Nursing (DON) verified she couldn't locate any Physician or family notification regarding the pressure ulcer. She reported she expected the facility to notify the Physician and family of a new pressure ulcer right away. A facility policy titled Resident Representative and PCP notification revised October 2023 documented the facility would notify the Resident Representative and Primary Care Provider in person or by phone as soon as possible with a significant change in condition.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review, staff interviews, and review of Medicare guidelines, the facility failed to provide a notice of Medicare Non coverage 48 hours in advance of services ending. In addition, the facility failed to provide the correct Skilled Nursing Facility Advance Beneficiary Notice of Non Coverage (SNF ABN) form for 1 of 3 residents reviewed (Resident #133) whose skilled stay ended and they continued to reside in the facility. The facility reported a census of 26 residents. Findings include: Resident #133's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMs) score of 13, indicating intact cognition. The Clinical Census listed Resident #133 admitted to the facility on [DATE] for a Medicare Part A Skilled stay. Resident #133 skilled stay ended on 5/8/24 and they remained in the facility. On 5/28/24 the facility discharged Resident #133 from the facility. They readmitted on [DATE] for a Medicare Part A stay. Resident #133 skilled stay ended on 6/28/24 and they remained in the facility. Review of the Medicare Notices provided to Resident #133 revealed the facility didn't give the Advance Beneficiary Notice of Non-Coverage (CMS 10055) their skilled stay ended on 5/8/24. In addition, the facility didn't give the Notice of Medicare Non Coverage (CMS 10123 NOMNC) when the skilled say ended on 6/28/28. Resident #133 signed the CMS (CMS R 131) (Expiration 6/30/23) titled Advance Beneficiary Notice of Non coverage (ABN) on 6/26/24. The form provided to Resident #133 was the incorrect form. On 9/25/24 at 9:28 AM, the Administrator verified she didn't provide both forms (NOMNC form CMS 10123 and SNF ABN form CMS 10055) when they discharged Resident #133 from skilled care and their remained in the facility. A facility policy titled Skilled Nursing Facility-ABN and NOMNC revised January 2024 instructed to provide an advanced notice regarding Medicare non coverage upon admission, when Medicare Services end, and periodically during the resident's stay. The policy directed to provide a Medicare Part A resident with remaining Part A days available who is being discontinued from Part A services and staying in the building the ABN form CMS 10055 and NOMNC form CMS 10123 two days prior to services ending.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review, staff interview and policy review the facility failed to develop a Care Plan to address risk factors and interventions for 1 out of 13 residents (Residents #21) reviewed for comprehensive Care Plans. The facility reported a census of 26 residents. Findings include: Resident #21's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. The MDS listed Resident #21 as independent with bed mobility and required partial/moderate assistance with transfers. The MDS identified Resident #21 used a manual wheelchair and required partial/moderate assistance with locomotion. Resident #21's MDS included diagnoses of atrial fibrillation (abnormal heart beat), 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. A Physician order dated 9/6/24 directed staff to administer Sertraline HCL (antidepressant) 12.5 mg (milligrams) in the morning for 7 days and then increased to 25 mg in the morning related to anxiety disorder. A Physician order dated 9/17/24 directed staff to administer Clonazepam (anti anxiety) 0.5 mg one tablet two times a day for anxiety disorder. On 9/23/24 the physician order was changed to decrease the clonazepam to 0.25mg one tablet two times a day. A Physician order dated 9/17/24 directed staff to administer Ativan (anti anxiety) 0.5 mg one tablet every 4 hours as needed for anxiety disorder. Resident #21's Care Plan with a target date of 12/21/24 lacked information about the usage of antidepressants and/or antianxiety medications, potential side effects, and what to monitor for while taking the high-risk medication. On 9/25/24 at 7:58 AM, Staff K, Corporate Nurse, reported she expected the Care Plan to include the high-risk medications and side effects. A facility policy titled Comprehensive Person-Centered Care Planning revised October 2023 instructed to include in the Comprehensive Care Plan services furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review, staff interviews, and policy review the facility failed to revise a Care Plan for 3 of 13 residents reviewed (Residents #15, #21, #6). The facility reported a census of 26 residents. Findings include: 1. Resident #15's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMs) score of 3, indicating severely impaired cognition. The MDS indicated Resident #15 required substantial/maximal assistance with bed mobility, transfers, and toileting. The MDS identified Resident #15 had an indwelling catheter. The MDS included diagnoses of anemia (low iron in the blood), hypertension (high blood pressure), heart failure (inability of the heart to pump blood well), atrial fibrillation (abnormal heart rate), renal (kidney) disease, and benign prostatic hyperplasia (BPH enlarged prostate). The MDS identified Resident #15 had a risk for developing pressure ulcers/injuries. A Progress Note dated 3/11/24 at 1:46 PM documented Resident #15 refused to lie down for application of treatment of powder to his scrotum, bilateral groin, perianal area, and buttocks. A Progress Note dated 3/18/24 at 1:17 PM documented Resident #15 refused to lie down for treatment to scrotum, bilateral groin, perianal area and buttocks. A Progress Note titled Skin/Wound Noted dated 4/24/24 at 9:50 AM documented nursing staff reported Resident #15 sat up more and refused to lie down. A Progress Note dated 6/25/24 at 9:52 PM documented Resident #15 wasn't willing to lie down at HS (hour of sleep) right away. A Progress Note titled Skin/Wound note dated 8/21/24 at 12:05 PM documented Resident #15 had an unstageable pressure ulcer that measured 3.8 cm (centimeters) x 8.5 cm due to a medical device (catheter) to the right groin/gluteal fold. The note described the pressure injury as a large, linear, irregularly shaped open area covered mostly with yellow slough (nonviable tissue) and some area of brown slough. The note documented Calmoseptine cream (cream used to treat and prevent minor skin irritations) to continue as a treatment to the area. The note recommended trying to prevent the catheter tubing from rubbing and/or applying direct pressure over the right groin/gluteal fold areas. A Progress Note dated 9/16/24 at 3:16 PM documented Resident #15 refused to lay down for treatment to scrotum, bilateral groin, perianal area and buttocks. On 9/25/24 at 8:50 AM, Staff N, CNA (Certified Nursing Assistant), reported Resident #15 refused to reposition often and liked to be up in his wheelchair throughout the day. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan with a target date of 12/22/24 reflected Resident #15 had a risk for pressure ulcer development related to decreased mobility and use of an indwelling catheter related to BPH. The Care Plan lacked documentation regarding the new pressure ulcer from 8/21/24 or intervention regarding how to prevent pressure or rubbing from the catheter tubing. The Care Plan didn't address using a leg strap to keep the catheter positioned. In addition, the Care Plan didn't address or direct staff what to do if Resident #15 refused to lie down or reposition during the day. On 9/26/24 at 12:10 PM, the DON (Director of Nursing) reported Resident #15 liked to stay up in the morning and would lay down after lunch or sit in the recliner. On 9/30/24 at 9:08 AM, the DON reported she reviewed Resident #15's Care Plan and acknowledged the Care Plan lacked information regarding the new pressure ulcer, how to prevent pressure or rubbing from the catheter, and what to do if Resident #15 refused to be repositioned. She stated the CNAs are to tell the nurse if Resident #15 refused to be repositioned and the nurse was to document it. 2. Resident #21's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. The MDS listed Resident #21 as independent with bed mobility and required partial/moderate assistance with transfers. The MDS identified 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. Review of Progress Notes from 8/27/24 (admission) to 9/23/24 revealed Resident #21 had six falls on the following dates: 8/28/24, 8/29/24, 9/2/24, 9/19/24, 9/22/24, and 9/23/24. The Care Plan Focus revised 9/22/24 reflected Resident #21 had a risk for falls related to a history of falls at home. The Interventions directed the following: 8/27/24: Be sure my call light is within reach and encourage me to use it for assistance as needed. 9/23/24: Fall mat next to bed on floor. The Care Plan lacked interventions for the falls on 8/28/24, 8/29/24, 9/2/24, 9/19/24 and 9/22/24, until 9/24/24. An incident report dated 9/2/24 indicated Resident #15 fell from his bed. The Incident Report included a new intervention to keep the bed in the lowest position while in use. On 9/24/24 at 11:58 AM, observed Resident #21 lying in bed, without the bed in the lowest position, and a fall mat on the floor next to the bed. On 9/25/24 at 7:58 AM, Staff K, Corporate Nurse, acknowledged the facility updated Resident #21's fall Care Plan interventions on 9/24/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/24 at 10:00 AM observed with the Director of Nursing (DON) Resident #21 in bed with the bed not in a low position. The DON acknowledged the bed wasn't in a low position. She reported she would get the bed remote and lower the bed. The DON acknowledged the facility didn't update the Care Plan with fall interventions until 9/24/24. She reported she expected some to update the Care Plan after each fall occurred. 49056 3. Resident #6's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating cognition intact. The MDS included diagnoses of hypertension (high blood pressure), diabetes mellitus, anxiety, and depression. Review of Resident #6's Progress Notes included documentation of a fall with injury on 8/15/24. The Care Plan Focus revised 2/17/24 lacked an intervention for the fall on 8/15/24, until 9/25/24. The Comprehensive Person Centered Care Planning policy dated April 2019 instructed to develop and implement the Comprehensive Care Plan consistent with the resident's rights. Include measurable objectives and timeframes to meet the resident's medical, nursing, and mental/psychosocial needs that are identified in the comprehensive assessment. The Comprehensive Care Plan will state any services not provided due to the resident's exercise of his/her right to refuse treatment. Interview on 9/30/24 at 12:27 PM with the Director of Nursing (DON), explained the nurses sometimes put the interventions on the Care Plan, other times they left it for her to do.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056 Based on record review and staff interviews the facility failed to follow physician orders regarding checking placement of a jejunostomy tube (J tube: a soft plastic tube that is surgically inserted into the small intestine to provide nutrition and medicine until a person can eat normally) for 1 of 1 resident reviewed (Resident #10). The facility reported a census of 26 residents. Findings include: Resident #10's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS included diagnoses of cancer, hypertension (high blood pressure), renal insufficiency (impaired kidney function), anxiety, and depression. The MDS reflected Resident #10 used a feeding tube while a resident. The Clinical Physician Orders reviewed on 9/24/24 included an order dated 5/17/24 to verify position of J tube each shift and evening shift by auscultating for a swooshing sound of an air bolus or measurement from the abdominal wall to the top edge of the external tube is 12.75 to 13.75 inches, (above + = intact) and (below - = abnormal see progress note). On 9/24/24 at 11:40 AM observed Staff D, Licensed Practical Nurse (LPN), provide medications to Resident #10. Prior to giving medications Staff D failed to check placement as ordered by the physician. On 9/25/24 at 8:25 AM witnessed Staff D administer Resident #10's medications via the J-tube. Staff D failed to check placement per physician orders. Interview on 9/24/24 at 11:50 AM Staff D reported they checked placement by checking residual. Interview on 9/24/24 at 3:47 PM the Director of Nursing (DON) reported she expected the staff to check placement by utilizing a stethoscope and auscultate (listen) as they push air in and pull back to check residual. Review of facility policy named Enteral Feedings dated April 2019 directed to check patency of a Jejunostomy Feeding tube by gently auscultating the epigastric (stomach) region and instilling (put in) 5-10 cubic centimeters (cc) air bolus.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056 Based on record review, staff and family interviews and facility policy the facility failed to complete and document treatment to a stage 2 pressure ulcer consistent with professional standards of practice for 1 of 2 residents reviewed (Resident #8). The facility reported a census of 26 residents. The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only, it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but didn't obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone muscle interface. Findings include: Resident #8's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired cognition. The MDS listed Resident #8 as dependent on staff to do more than half of the effort regarding their activities of daily living. The MDS included diagnoses of hypertension (high blood pressure), diabetes mellitus, Alzheimer's Disease, and muscle weakness. The MDS identified the resident as at risk for pressure ulcers, had a pressure ulcer/injury, a scar over a bony prominence, or a non removable dressing/device. The MDS indicated Resident #8 had a pressure reducing device in their chair and their bed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Care Plan Focus revised 12/19/23 indicated Resident #8 had an actual problem with open areas and pressure injuries related to a history of type 1 diabetes and a history of open areas specifically on his buttocks and heels, making the areas extremely fragile even when they close. The Interventions directed the following: a. 11/3/21: Braden scale every quarter and as needed b. 11/3/21: Assess his skin with care, look for reddened areas and new bruises. Report areas of concern to the nurses for further evaluation and treatment c. 11/3/21: Nurses to conduct a systemic skin inspection weekly, paying attention to the boney prominence and reporting areas of concern to my doctor as noted. d. 11/3/21: Provide incontinent cares after each incontinent episode: apply moisture barrier to his perineal (peri) area after each incontinent episode e. 3/4/23: Foot cradle to be utilized when in bed. I need assistance to turn/reposition at least routinely, more often as needed or requested. f. 3/12/23: Administer treatments as ordered and monitor for effectiveness. g. 3/12/23: Assess, record, and monitor wound healing. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the physician. h. 3/12/23: Alternating low air loss mattress to my bed and pressure reducing device on my chair. i. 3/12/23: Monitor nutritional status. Serve diet as ordered. j. 3/6/24: Heel boots to be worn when in bed Resident #8's Care Plan lacked new interventions following 3/6/24. Resident #8's Braden Scale (skin health) assessment dated [DATE] reflected a score of 11, indicating a high risk for pressure ulcers. The facility failed to complete a Braden Scale each quarter. Resident #8's February 2024 to September 2024 Treatment Administration Record (TAR) indicated an order dated 2/14/24 to apply Calmoseptine (thick paste) external ointment to the open areas on his buttocks topically as needed (PRN) to open areas only with incontinent cares. The TARs only documentation reflected Resident #8 only received the treatment on 2/19/24. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	The Skin/Wound Note dated 2/21/24 at 10:12 AM indicated Resident #8's right ischium (ischium forms the lower and back region of the hip bone) opened, measuring about 0.9 centimeters (cm) X 1.4 cm (length x width). The wound had some purple discoloration (questioning deep tissue injury DTI) (a type of pressure ulcer that occurs when soft tissue is damaged by prolonged pressure or shear forces at the bone muscle interface) and scattered fine slough (dead tissue within a wound that can impede or promote healing depending on its quantity and characteristics) with red edges. Plan to continue current treatment. The Skin/Wound Note dated 2/28/24 at 10:06 AM reflected Resident #8's left buttock area measured 0.5 cm X 0.5 cm, right buttock measured 1.2 cm X 0.5 cm, right ischium remained open measuring about 1.0 cm X 1. 0 cm, wound bed consisted mostly of fine slough (unstageable), and some red, moist tissue. Plan to continue current treatment. The Skin/Wound Note dated 3/6/24 at 10:14 AM Resident #8's right buttock area measured 2.3 cm X 1.3 cm. The scarring to right ischium remained open, measuring 0.5 cm X 0.5 cm. The wound bed appeared red, clean, and shallow (stage 2 pressure ulcer). The Skin/Wound Note dated 4/3/24 at 9:03 AM indicated Resident #8 had an extensive light purple discoloration to his bilateral (both sides) buttocks (chronic tissue injury from sitting most of the time). The note reflected the area had no erythema (redness), odor, or drainage. The bilateral buttocks had faded, purple scar tissue form previous wounds and some crusting. The note lacked measurements for Resident #8's buttocks wounds. The Skin/Wound Note dated 4/10/24 at 11:15 AM reflected Resident #8's scarring to right ischium opened with a stage 2 pressure ulcer that measured about 0.8 cm x 0.6 cm. Continue current treatment to buttocks, ischium, and sacrococcygeal (base of the tailbone) skin. The Skin/Wound Note dated 4/17/24 at 9:50 AM indicated Resident #8's Stage 2 pressure ulcer had scarring of the right ischium measured 0.8 cm x 0.5 cm. Base is clean and shallow, continue with treatment. The Skin/Wound Note dated 4/24/24 at 11:06 AM identified Resident #8's bilateral buttock areas opened with a stage 2 pressure ulcer on each side. The right buttock measured 2.7 cm X 0.6 cm, and left buttock measured 3.7 cm X 0.9 cm. Both openings appeared clean and shallow. The Skin/Wound Note dated 5/1/24 at 11:08 AM documented Resident #8's Stage 2 pressure ulcer to right buttock consisted of 2 clean, shallow openings; with 1 larger 1 measuring about 0.9 cm X 0.5 cm. The Skin/Wound Note dated 5/8/24 at 11:16 AM reflected Resident #8's had an extensive light purple discoloration to his bilateral (both sides) buttocks (chronic tissue injury from sitting most of the time). The note reflected the area within the ridged, fragile epithelium closed up with no drainage, erythema, and odor. The bilateral buttocks had faded, purple scar tissue form previous wounds and some crusting. The left lower buttock had a pustule measuring 0.3 cm X 0.3 cm. Resident #8 had a history of abscesses and staph infections. (continued on next page)

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	165522	A. Building B. Wing	09/30/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Skin/Wound Note dated 5/15/24 at 10:55 AM indicated Resident #8's left medial buttock stage 2 pressure ulcer area opened slightly measuring 0.5 cm X 0.3 cm. No drainage or erythema noted. Right medial (middle) buttock showed an intact, maroon colored area measuring 1.2 cm X 0.6 cm, questioning DTI. The Skin/Wound Note dated 5/22/24 at 11:16 AM identified Resident #8's left medial buttock stage 2 pressure ulcer area remained about the same, measuring 0.5 cm X 0.3 cm. The note lacked documentation of the right buttock. The Skin/Wound Note dated 5/29/24 at 10:57 AM reflected Resident #8 had a stage 2 pressure ulcer on each buttock. The right medial buttock stage 2 pressure ulcer area measured about 3.6 cm X 1.9 cm. The left medial buttock stage 2 pressure ulcer measured about the same size. The Skin/Wound Note dated 6/5/24 at 10:50 AM indicated Resident #8's stage 2 pressure ulcer to each buttock improved. The left buttock measured 1.0 cm x 0.7 cm and the right buttock measured 0.2 cm x 0.5 cm. The Skin/Wound Note dated 6/12/24 at 10:19 AM identified Resident #8's stage 2 pressure ulcer to his left buttock increased in size, measuring 5.2 cm X 1.5 cm The Skin/Wound Note dated 6/19/24 at 10:18 AM reflected Resident #8's stage 2 pressure ulcer to his left buttock decreased in size with 2 openings (one measured about 1.0 cm X 1.0 cm, the other is pinpoint sized). The right buttock stage 2 pressure ulcer area opened again, measuring about 3.7 cm X 1.7 cm. The Skin/Wound Note dated 6/26/24 at 10:39 AM indicated Resident #8's stage 2 pressure ulcer to his left buttock decreased to 1 opening measuring 1.0 cm X 1.3 cm. The right buttock stage 2 pressure ulcer decreased in size considerably, measuring 0.3 cm X 0.4 cm. The pressure ulcer area within the scarring of his right ischium opened again (stage 2), measuring about 1.0 cm X 1.0 cm with fine yellow slough centrally (in the middle) and clean, shallow tissue peripherally (towards the edge). The Skin/Wound Note dated 7/3/24 at 9:32 AM reflected Resident #8's stage 2 pressure ulcers to both buttocks appeared mostly intact with just a few, scattered, pinpoint sized openings. The pressure ulcer area within the scarring of right ischium closed again. The Skin/Wound Note dated 7/10/24 at 10:17 AM identified Resident #8's stage 2 pressure ulcers to both buttocks appeared mostly intact with just a few, scattered, pinpoint sized openings. Throughout his buttocks and bilateral ischial regions, had some scattered areas of faded, purple scar tissue. The pressure ulcer area within scarring of right ischium remained closed, showing intact, fragile, pink epithelium. The Skin/Wound Note dated 7/17/24 at 11:19 AM indicated Resident #8's Stage 2 pressure ulcers to both buttocks opened again. The left buttock wound area measured 1.9 cm X 0.8 cm. The right buttock stage 2 pressure ulcer measured 1.5 cm X 0.5 cm with a clean, shallow base. (continued on next page)

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	165522	A. Building B. Wing	09/30/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Skin/Wound Note dated 7/24/24 at 10:34 AM, documented the nurse questioned DTI to his bilateral buttocks. His left buttock wound area had black discoloration to the shallow opening, wound measured 3.4 cm X 1.6 cm. The distal to right buttock had black discoloration measuring about 1.0 cm x 0.7 cm. The Skin/Wound Note dated 7/31/24 at 11:17 AM reflected Resident #8's left buttock wound area no longer showed black discoloration to the shallow opening (stage 2 pressure ulcer). The wound measured 2.9 cm X 0.9 cm. The right buttock appeared intact, with the black discoloration noted the previous week appeared as an area of erythema measuring 2.0 cm X 2.0 cm. The Skin/Wound Note dated 8/7/24 at 11:21 AM indicated Resident #8's left buttock stage 2 pressure ulcer closed and appeared intact with slight crusting. The wound didn't have drainage, odor, or erythema. Medial to this is a new, open, abraded area measuring about 1.0 cm X 0.6 cm. The wound didn't have drainage, odor, or erythema. His right buttock appeared intact, without erythema. His bilateral buttocks had a ridged, fragile epithelium, and extensive light purple discoloration (chronic tissue injury from pt. sitting most of the time). No erythema or other discoloration noted to buttocks. Throughout his buttocks and bilateral ischial regions, have some scattered areas of faded, purple scar tissue. The pressure ulcer area within scarring of right ischium remained closed, showing intact, fragile, pink epithelium. The Skin/Wound Note dated 8/14/24 at 11:17 AM identified Resident #8's left buttock with the stage 2 pressure ulcer opened again, measuring about 0.9 cm X 0.3 cm, medial, open, abraded area is about 0.5 cm X 0.2 cm. The pressure ulcer area within the scarring of the right ischium opened again (stage 2). The wound appeared clean, shallow, and measured 2.2 cm X 0.9 cm. The nurse applied Calmoseptine ointment to the openings and protective ointment to the surrounding, intact skin to buttocks, ischium, and sacrococcygeal skin. The Skin/Wound Note dated 8/21/24 at 11:34 AM reflected Resident #8's left buttock stage 2 pressure ulcer area measured about 0.9 cm X 0.5 cm. The pressure ulcer area within the scarring of right ischium opened again (stage2) appeared clean, shallow, and measured 3.3 cm X 2.8 cm. The nurse planned to continue the current treatment of Calmoseptine ointment to opening areas and protective ointment applied to the surrounding, intact skin of the buttocks, ischium, and sacrococcygeal skin. The Skin/Wound Note dated 8/28/24 at 10:58 AM indicated Resident #8's left buttock stage 2 pressure ulcer area recently noted had closed, and had intact with fragile epithelium. The wound had no erythema, but had a few, very small, denuded areas proximally (towards the center of the body) and medially within the fragile scarring. The medial area measured about 0.7 cm X 0.2 cm. The right buttock remained intact and without erythema. The bilateral buttocks had ridged, very fragile epithelium, and extensive light purple discoloration (chronic tissue injury from sitting most of the time). No erythema or other discoloration noted to buttocks. Throughout buttocks and bilateral ischial regions, there are some scattered areas of faded, purple scar tissue. The pressure ulcer area within the scarring of right ischium closed and had intact skin with fragile, pink epithelium, without erythema, odor, or drainage. The left ischium appeared intact with no erythema. Resident #8 had history of abscesses and staph infections. The rest of the buttocks and sacrococcygeal skin appeared intact without erythema. Plan to continue current treatment (Calmoseptine ointment to openings and protective ointment to surrounding, intact skin) to the buttocks, ischium, and sacrococcygeal skin. The right lateral-posterior thigh wound closed and appeared intact with fragile epithelium. (continued on next page)

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	165522	A. Building B. Wing	09/30/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Skin/Wound Note dated 9/5/24 at 10:16 AM identified Resident #8's left buttock pressure ulcer area remained closed and intact with fragile epithelium. The wound had no erythema but had few, very small, denuded areas noted proximally and medially the previous week closed and appeared intact within the fragile scarring. The right buttock remained intact and without erythema. The Skin/Wound Note dated 9/11/24 at 11:11 AM reflected Resident #8's left buttock measured 3.1 cm X 0.7 cm with slight abrasions. The right buttock measured 1.0 cm X 1.5 cm. The Skin/Wound Note dated 9/18/24 at 11:08 AM indicated Resident #8's left and right buttocks appeared intact with very Fragile and intact epithelium. The slightly abraded areas noted the previous week resolved with no erythema to either buttock. The Skin/Wound Note dated 9/25/24 at 10:48 AM indicated Resident #8's left and right buttocks opened in a few areas with slight abrasions. The largest of these to left lateral buttock measured 3.9 cm X 1.6 cm, and the 2 smaller abrasions to the left medial buttock and right buttock. The pressure ulcer area within the scarring of right ischium is intact, yet with a linear, intact abrasion about 1.0 cm X 3.0 cm. Plan to continue current treatment (Calmoseptine ointment PRN to openings and protective ointment to surrounding, intact skin) to buttocks, ischium, and sacrococcygeal skin. The Skin & Wound Assessments reviewed on 9/25/24 reflected the facility assessed Resident #8's right ischial tuberosity (the bones in the pelvis used to support the body when sitting and attaches multiple muscles) on the following days: a. 8/14/24: Deteriorating - 1 month old. Measured 1.42 centimeters squared (cm2) in area, 0.9 cm length, and 2.16 width. A picture reflected a large pink, reddened area, the picture included a white circle around a smaller area of the large pink, red area. b. 8/21/24: Deteriorating - 1 month old. Measured 8.73 cm2 in area, 3.29 cm length, and 2.84 width. A picture reflected a large pink, reddened area, the picture included a white circle to measure around most of the large pink, red area with some yellow discoloring in the upper middle of the wound. The picture measured more of the area than the previous assessment. c. 8/28/24: Resolved - 1 month old. Measured 0 cm2 in area, 0 cm length, and 0 width. A picture showed the wound without a white circle to measure the area. d. 9/5/24: Resolved - 20 days old. Measured 0 cm2 in area, 0 cm length, and 0 width. A picture showed the wound without a white circle to measure the area. The majority of the wound appeared pink with small areas of yellow discoloring and two areas of darker red coloring. One area is significantly larger than the other area. e. 9/25/24: Deteriorating - Age Unknown. Measure 3.45 cm2 in area, 1 cm length, and 3.01 width. A picture showed the wound with a white circle to measure the area. The wound looked mostly pink but with approximately four areas with darker areas of red coloring. (continued on next page)

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	165522	A. Building B. Wing	09/30/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The February 2024 to September 2024 TARs lacked documentation that the staff completed the current treatment to the buttock area. The Pressure Injury Skin Assessments effective April 2019 defined the purpose as to promote healing of pressure sores, to document care provided, and to provide follow up for each pressure ulcer in a sequential (in order) document. The staff need to assess any new pressure area as soon as discovered; then cleanse and measure. The Nurse Manager or designee conducts the initial staging. Staff to document all pertinent information on pressure injury document and sign the assessment. Staff to notify the Nurse Mentor or designee for treatment options and update the Care Plan, notify the physician, the family member, responsible party, Registered Dietitian, and therapy. In addition, they must communicate with direct care staff of interventions and care. Interview on 9/25/24 at 11:04 AM the Wound Nurse reported Resident #8's had a continuous issue with his skin areas. The Wound Nurse voiced she would continue with the current treatment. She voiced changing the treatment to a dressing wouldn't work due to Resident #8 incontinence, nursing staff would have to continually change the dressing. Interview on 9/25/24 at 3:34 PM the Wound Nurse clarified the order for the Calmoseptine. They said to apply to the area when open and the protective ointment to the area when he had intact skin. Wound nurse stated the zinc kept the skin dry to prevent further maceration and when the skin is intact, that's when it needed protection. Interview on 9/25/24 at 3:50 PM the DON stated she expected the nurses to complete the documentation when they completed the treatment. The DON voiced she would fax the physician to change the treatment order to coincide with the wound nurse documentation of the wounds to Resident #8's buttocks. Interview on 9/25/24 at 4:57 PM Resident #8's family member reported she didn't see the staff do the treatment to his bottom in a while.

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	165522	A. Building B. Wing	09/30/2024

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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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	165522	A. Building B. Wing	09/30/2024

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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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	165522	A. Building B. Wing	09/30/2024

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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

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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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	165522	A. Building B. Wing	09/30/2024

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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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	165522	A. Building B. Wing	09/30/2024

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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.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on record review, staff interview, and policy review, the facility failed to have a Physician or a Non Physician Practitioner (NPP) provide a face to face visit, including a comprehensive assessment, once every 60 days for 1 of 5 residents (Residents #15) reviewed for Physician Services. The facility reported a census of 26 residents. Findings include: Resident #15's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMs) score of 3, indicating severely impaired cognition. The MDS identified Resident #15 required substantial/maximal assistance with bed mobility, transfers, and toileting. The MDS indicated Resident #15 had an indwelling catheter. The MDS included diagnoses of anemia (low blood iron), hypertension (high blood pressure), heart failure (inability of the heart to pump blood well), atrial fibrillation (abnormal heart rate), renal (kidney) disease, and benign prostatic hyperplasia (BPH - enlarged prostate). The Clinical record reflected a Physician saw Resident #15 on the following dates: a. 2/15/24 b. 6/20/24 - 127 days since the last comprehensive Physician or NPP assessment c. 9/24/24 - 96 days since the last comprehensive Physician or NPP assessment On 9/30/24 at 11:00 AM, Staff K, Corporate Nurse verified Resident #15 missed two physician visits for April 2024 and August 2024. She reported she expected Resident #15 saw a Physician every 60 days. A facility policy titled Physician Visits/ Frequency of Visits reviewed November 2023 documented according to OBRA federal guidelines, physician and/or physician assistants/nurse practitioners are required to see resident every 30 days for the first 90 days after admission and once 60 days thereafter depending on whether the resident was admitted for skilled nursing care (SNF) or nursing care (NF). The visit must be within 10 days of the physician's due date. After the initial visit, the visits may alternate between the physician and a physician's assistant or nurse practitioner.

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	165522	A. Building B. Wing	09/30/2024

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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** 46875 Based on clinical record review, resident interview, staff interview, family interview, facility records and facility policy review the facility failed to provide sufficient staff to meet the needs of residents who resided in the facility for 4 residents reviewed (Residents #23, #21, and #10). The facility reported a census of 26 residents. Findings include: 1. Resident #23's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The Clinical Census revealed Resident #23 resided in room [ROOM NUMBER] A 1. On 9/23/24 at 4:18 PM, Resident #23 reported call light times can be a problem at times especially on the weekends. She stated she had her call light on up to 30 minutes before. She reported the long call lights happen a couple times a month. She stated she knew the staff must answer the call lights within 15 minutes. She explained she times the call light response time with the clock on her wall. She reported she had bowel and bladder accidents before due to waiting for someone to answer her call light. She stated the staff help clean her up but it didn't make her feel good. A facility call light report for 9/23/24 to 9/26/24 reflected Resident #23 had two call lights on greater than 15 minutes: a. 9/23/24 12:57 PM to 1:22 PM = 24 minutes b. 9/23/24 6:28 PM to 6:54 PM = 26 minutes On 9/26/24 at 10:10 AM, the Administrator reported they expected the staff to answer the call lights within 15 minutes or less. On 9/26/24 at 11:00 AM, the Administrator reported they had plenty of staff on day shift to answer the call lights. She reported she agreed that evenings and weekends are more challenging with staff. The DON (Director of Nursing) reported she tried to over staff on the weekends. The DON stated they had call ins or agency staff who didn't show or came in late. 2. Resident #21's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. (continued on next page)

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	165522	A. Building B. Wing	09/30/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/23/24 at 1:20 PM, Resident #21's wife reported Resident #21 can get upset, have outbursts and show his temper when someone didn't answer his call light right away. She stated normally someone answered his call light in around 5 minutes but they had one time when she visited during supper, the staff took other residents out of the dining room and it took someone 20 25 minutes for them to answer Resident #21's. She added Resident #21 needed to go to the bathroom and he had to wait quite a while. She reported Resident #21 had his room next to the nurses' station and he got upset when the nurses didn't answer his call light when they are sitting there. She stated it was primarily the aide's job to answer the call light and Resident #21 didn't understand that. On 9/24/24 at 11:58 AM, Resident #21 acknowledged he had wrapped a bed cord around his neck the week before. Resident #21 reported he did it because he was tired of everything and wanted to end his life. When asked what he was tired of, he stated the way things went around there. He stated staff didn't come to answer his call light. When asked if he was mad at something or someone that morning, he stated not that he could recall. He reported he yelled a lot because he needed to go to the bathroom. He reported sometimes the staff come in when he yells and other times they didn't. On 9/24/24 at 12:05 PM, Staff D, LPN (Licensed Practical Nurse), described Resident #21 as very impatient. If someone didn't answer his call light immediately he gets upset. She stated he didn't use his call light much now, as he yelled out instead, and/or will put himself on the floor. A facility call light report for 9/23/24 to 9/26/24 revealed Resident #21 had four call lights on greater than 15 minutes: a. 9/22/24 5:18 PM to 5:40 PM = 22 minutes b. 9/22/24 6:16 PM to 7:03 PM = 46 minutes c. 9/23/24 6:15 PM to 6:36 PM = 21 minutes d. 9/24/24 8:18 AM to 8:35 PM = 17 minutes 3. Resident #7's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. Resident #7 required a mechanical lift with two staff assistance for transfers and toilet use. The MDS included diagnoses of hypertension (high blood pressure), cancer, weakness and unsteadiness on feet. On 9/23/24 at 1:18 PM with Resident #7 reported that on the weekends the call light can get past 15 minutes. They don't have much help and it is hard to get people to work on Saturday or Sunday. I watch my clock when I turn the call light on, that is how I know it is past the 15 minutes. Review of facility call light reports for the last 72 hours dated 9/21/24 to 9/24/24 for Resident #7 revealed a call light duration of 22 minutes on 9/24/24. 49056 (continued on next page)

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	165522	A. Building B. Wing	09/30/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #10's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS included diagnoses of cancer, hypertension (high blood pressure), renal insufficiency (impaired kidney function), anxiety, and depression. The MDS reflected Resident #10 used a feeding tube while a resident. On 9/23/24 at 1:15 PM Resident #10 reported times when the staff took longer than 15 minutes to come answer the call light. They checked the time when they pushed the call light. Review of facility call light reports for the last 72 hours dated 9/21/24 to 9/24/24 for Resident #10 revealed: a. a duration of 49 minutes on 9/21/24 b. a duration of 32 minutes on 9/22/24 at 6:57 AM c. a duration of 21 minutes on 9/22/24 at 5:38 PM d. a duration of 30 minutes on 9/24/24 at 1:12 AM On 9/25/24 at 2:54 PM Staff H, certified nursing assistant (CNA), reported they didn't have sufficient staff to answer the call lights in a timely manner. On 9/25/24 at 2:54 PM Staff I, CNA, reported they didn't have sufficient staff to answer call lights in a timely manner. On 9/25/24 at 2:54 PM Staff J, CNA, reported they didn't have sufficient staff to answer call lights in a timely manner. Resident Council Minutes dated 8/26/24 at 10:30 AM reflected a discussion of old business indicating the still had an issue with call lights, but had some better shifts. The New Business discussion indicated the facility had call lights on too long in the afternoons and weekends. Resident Council Minutes dated 9/23/24 at 10:30 AM identified a New Business discussion that they still had issue with call lights. Review of facility policy named Call light Response dated April 2019 identified the staff members receive notification of call lights or resident needs in one of the following ways: a. Lights above the door or the call light box at nurse's station, or, b. Via handheld electronic devices. Call lights should be responded to within 15 minutes. In the rare circumstances when call lights are in operable (don't work), begin watch procedures of an employee(s) circulating through the building every 15 minutes to check on resident needs.

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	165522	A. Building B. Wing	09/30/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056 Based on clinical record review, staff interview and facility policy review, the facility failed to have an adequate clinical rationale for a gradual dose reduction (GDR) declination (decline) for 4 out of 5 residents reviewed for unnecessary medications (Residents #3, #8, #9, #11). The facility reported a census of 26 residents. Findings include: 1. Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 3, indicating severely impaired cognition. The MDS included diagnoses of non Alzheimer's dementia, anxiety and depression. The MDS documented Resident #3 received an antipsychotic, antianxiety, and antidepressant medication during the lookback period. A Physician order dated 5/18/23 directed staff to administer Aripiprazole (antipsychotic) 2 mg (milligrams) by mouth daily. A Physician order dated 10/20/21 directed staff to administer Bupropion (antidepressant) 150 mg by mouth twice daily. The Note to Attending Physician/Prescriber dated 8/22/24, signed by the physician on 9/17/24, reflected the physician denied a GDR request for Resident #3's aripiprazole, lorazepam, escitalopram, trazodone and bupropion. The form lacked a clinical rationale as to why they didn't make any changes in the orders. 2. Resident #8's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired cognition. The MDS listed Resident #8 as dependent on staff to do more than half of the effort regarding their activities of daily living. The MDS included diagnoses of hypertension (high blood pressure), diabetes mellitus, Alzheimer's Disease, and muscle weakness. The MDS listed Resident #8 received an antipsychotic and antidepressant medication during the lookback period. A Physician order dated 6/20/23 directed staff to administer Seroquel (antipsychotic) 50 mg by mouth nightly. A Physician order dated 1/5/24 directed staff to administer Sertraline (antidepressant) 50 mg by mouth twice daily. The Note to Attending Physician/Prescriber dated 4/20/24, signed by the physician on 5/13/24, reflected the physician denied the GDR request for Resident #8's Seroquel. The form lacked a clinical rationale as to why they didn't make any changes in the orders. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Note to Attending Physician/Prescriber dated 7/23/24, signed by the physician on 8/12/24, reflected the physician denied a GDR request for Resident #8's Seroquel and Sertraline. The form lacked a clinical rationale as to why they didn't make any changes in the orders. 3. Resident #9's MDS assessment dated [DATE] identified a BIMS score of 9, indicating moderately impaired cognition. The MDS included diagnoses of Alzheimer's disease, hypertension (high blood pressure), and depression. The MDS documented Resident #9 received an antipsychotic and antidepressant medication during the lookback period. A Physician order dated 9/7/24 directed staff to administer brexpiprazole (antipsychotic) 3 mg by mouth nightly. A Physician order dated 8/6/24 directed staff to administer Seroquel (antipsychotic) 50 mg by mouth three times a day. A Physician order dated 5/3/24 directed staff to administer duloxetine (antidepressant) 20 mg, give 2 capsules by mouth daily. The Note to Attending Physician/Prescriber dated 2/21/24, signed without a date by the physician, reflected the physician denied the GDR request for Resident #9's Seroquel. The form lacked a clinical rationale as to the physician didn't make any changes in the orders. The Note to Attending Physician/Prescriber dated 4/20/24 signed without a date by the physician, reflected the physician denied the GDR request for Resident #9's Cymbalta. The form lacked a clinical rationale as to why they didn't make any changes in the orders. 4. Resident #11's MDS assessment dated [DATE] identified an incomplete BIMS score due to them being rarely or never understood. The MDS included diagnoses of Alzheimer's Disease and anxiety. The MDS documented Resident #11 received an antipsychotic and antianxiety medication during the lookback period. A Physician order dated 9/24/20 directed staff to administer haloperidol (antipsychotic) 4 mg by mouth nightly. A Physician order dated 7/24/23 directed staff to administer alprazolam (antianxiety) 1 mg three times a day as needed. The Note to Attending Physician/Prescriber dated 5/24/24, signed by the physician on 6/6/24, reflected the physician responded no changes to Resident #11's Haloperidol. The form lacked a clinical rationale as to why they didn't make any changes in the orders. Interview on 9/26/24 at 11:00 AM the Director of Nursing (DON)reported she provided the recommendations to the physician. The DON stated she would speak with the physician regarding giving a clinical rationale when the GDR's are denied or returned with no medication changes. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy named Antipsychotic/GDR dated April 2019 defined the purpose as to observe resident response to antipsychotic drug therapy, to attempt gradual dose reduction of medications and to use behavioral programming, if possible, to reduce medication use. Notify physicians of findings and recommendations. Obtain order for attempts at dose reduction. GDR's must be attempted in 2 separate quarters with at least one month between attempts, unless contraindicated. All attempts at reducing doses of medications need to be clearly documented in nurses' notes. Any changes resulting from reduced doses should be noted by staff members. Adverse effects of GDR which are noted will be reported to PCP.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on staff interviews, clinic record review, and policy review, the facility failed to administer medication appropriately for 1 out of 13 residents (Resident #1) which resulted in a significant medication error. Resident #1 received Xanax and morphine that wasn't prescribed to her, but to Resident #6; who had the same first name as Resident #1. The facility reported a census of 26 residents. Findings include: Resident #1's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMs) score of 9, indicating moderately impaired cognition. The MDS identified Resident #1 required partial/moderate assistance with bed mobility, transfers, walking, and toileting. The MDS included diagnoses of anemia (low blood iron), hypertension (high blood pressure), heart failure (inability of the heart to pump blood well), bradycardia (slow heart rate under 60 beats/minute), and renal (kidney) disease. The MDS indicated Resident #1 didn't receive opioid or antianxiety medications. A facility Medication Discrepancy Report dated 9/7/24 at 11:30 PM documented Resident #1 received two unauthorized drugs (a drug administered without a physician order) that included morphine (opioid medication) 15 mg (milligrams) extended release tablet and alprazolam (anti anxiety medication) 0.25 mg tablet. The medication discrepancy report documented a failure to follow manufacturer's specifications, accepted professional standards, and gave medications to the wrong person. A Progress Note dated 9/8/24 at 5:41 AM documented on 9/7/24 at 11:31 PM the Advanced Registered Nurse Practitioner, Resident #1 and Resident #1's responsible party was notified Resident #1 received Alprazolam 0.25mg and Morphine Sulfate 15 mg by the second shift staff member at HS (hour of sleep). New orders were received to monitor Resident #1 throughout the night and call as needed. If respiratory rate falls below 8 breaths per minute, give a one-time dose of Narcan (naloxone) (medication to reverse an opioid overdose) 0.4 mg/1ml (milligrams/milliliters) injection IM (intramuscular) and notify the provider. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/24 at 12:31 PM, Staff L, LPN (Licensed Practical Nurse), reported she worked at the facility as an agency nurse for the first time on 9/7/24. Staff L reported she hadn't worked with the facility's electronic clinical record for a while. Staff L reported she missed giving Resident #6 her Morphine. She explained she popped out a Xanax instead of the morphine. She reported the on-coming nurse, Staff M, Registered Nurse (RN), identified she gave Xanax instead of the morphine. She stated she gave morphine to Resident #1 thinking she gave the Xanax to the right person before. She stated Staff M saw her leaving from the wrong place and identified she gave Resident #6's medications (morphine and Xanax) to Resident #1. Staff L reported she didn't have any training from the facility. She added she only received a nurse report, asked for assist levels, and how the residents took their medications. She stated she had training on the electronic clinical record before a long time ago at another facility. She stated the facility had pictures in electronic clinical record of the residents. She stated she already gave the residents other medications so she didn't take the computer with her, so she didn't have the pictures to compare to the person. She stated after the medication error occurred, Staff M took vitals, called the family, and the provider. She stated she filled out the medication discrepancy report. She reported she hadn't worked at the facility since the medication error and didn't receive any education or training from the facility or her agency after the medication error occurred. On 9/25/24 at 1:20 PM, the DON (Director of Nursing) reported Staff M called her the night of the medication error with Staff L present and they went over the corrective measures together. She stated Staff M wrote the corrective measures down on the medication discrepancy report. She reported Staff L hadn't come back to work at the facility since the medication error occurred. On 9/25/24 at 1:30 PM, Staff M reported on 9/7/24 he came into work, got a nurse report and was doing the medication (narcotic) count. He stated during count he realized Resident #6 didn't get a morphine dose, so he stopped doing the count. He told Staff L, she should give Resident #6 her morphine if she was still awake. He stated Resident #6 already had a Xanax. He stated Staff L went to administer the morphine medication. He stated while at the nurses' station, he saw Staff L coming from Resident #1's area of the building. He reported Resident #6 lived on the North end of the building and not in that area. He added he didn't question any medication errors until that time. He reported Staff L verbally confirmed she Resident #1 a Xanax (earlier) and morphine at that time. He stated he pulled up the Medication Administration Record (MAR), pictures of the residents, and Staff L verified she gave Resident #1 the morphine and Xanax. He stated he called the family, DON, and provider. He reported he monitored Resident #1 throughout the night. Staff M stated he documented measures to prevent reoccurrence on the medication discrepancy report. He stated he talked to Staff L about being an agency nurse in the building for the first time and that she needed to use safeguard measures for herself and the residents. He added he didn't go over the measures with her step by step but he told her she needed to use the MAR and verify the resident names. On 9/25/24 at 3:55 PM, the Administrator reported she couldn't locate an orientation checklist for Staff L for 9/7/24. On 9/26/24 at 8:45 AM, the DON reported she expected the charge nurse leaving at the beginning of the Agency Nurse's shift complete the orientation checklist with the agency nurse if it was the first time working in the facility. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/26/24 at 11:05 AM, the DON reported she expected all staff passing medications to take the computer, use the pictures to identify the resident, and ask what them their name. She expected all staff passing medications to follow the 6 rights of medication administration. On 9/26/24 at 1:00 PM, Staff C, LPN, verified she didn't do an agency orientation checklist with Staff L on 9/7/24. She stated she probably didn't know it was her first time at the facility. She stated she provided a report sheet with information about the residents. She stated usually the agency staff member came in an hour early to get orientation. A facility policy titled Medication Administration revised November 2023 directed to administer medications in as prescribed in a safe and timely manner. The policy directed the individual administering the medications must verify the resident's identity before giving them their medications. Methods of identifying the resident included checking photographs attached to the medical record or calling the resident by name.

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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** 49056 Based on observation, record review, document review and staff interview the facility failed to provide appropriate infection prevention practices by not following guidelines for enhanced barrier precautions and medication administration for 3 out of 3 residents reviewed (Residents #3, #10, and Resident #1). The facility reported a census of 26 residents. Finding include: 1. Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 3, indicating severely impaired cognition. The MDS reflected Resident #3 used an indwelling catheter while a resident. The MDS included diagnoses of non Alzheimer's dementia, anxiety and depression. The MDS documented Resident #3 received an antipsychotic, antianxiety, and antidepressant medication during the lookback period. The Care Plan revised 11/23/21 indicated Resident #3 had an indwelling catheter. On 9/26/24 at 1:24 PM observed Staff O, certified nursing assistant, (CNA) assisted Resident #3 with catheter care. As she they provided the catheter care, they wore no enhanced barrier precautions (EBP), Staff O failed to put on a gown during the catheter care. Interview on 9/26/24 at 1:30 PM Staff O, CNA, revealed she thought wearing EBP was optional. 2. Resident #10's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS included diagnoses of cancer, hypertension (high blood pressure), renal insufficiency (impaired kidney function), anxiety, and depression. The MDS reflected Resident #10 used a feeding tube while a resident. The Care Plan revised 10/11/23 reflected Resident #10 has a feeding tube for nutritional support. On 9/24/24 at 11:40 AM witnessed Staff D, Licensed Practical Nurse (LPN), complete Resident #10's medication administration. As she provided medications via the feeding tube, she didn't wear enhanced barrier precautions (EBP), gown. On 9/24/24 at 12:00 PM Staff D explained she didn't think she had to wear EBP with Resident #10. Interview on 9/25/24 at 9:17 AM the DON reported she expected the staff to apply EBP when providing care to a resident with a feeding tube and catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Centers for Disease Control and Prevention website titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug resistant Organisms (MDROs), visited 10/1/24 and updated 7/12/22 revealed recent changes included, additional rationale for the use of Enhanced Barrier Precautions (EBP) in nursing homes, including the high prevalence of multidrug resistant organisms (MDRO) colonization among residents in this setting. Expanded residents for whom EBP applies to include any resident with an indwelling medical device or wound (regardless of MDRO colonization or infection status). Expanded MDROs for which EBP applies. Clarified that, in the majority of situations, EBP are to be continued for the duration of a resident's admission. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status and Infection or colonization with an MDRO. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care. The Infection Control Precautions/Guidelines policy dated May 2020 directed staff to apply enhanced barrier precautions for wounds and/or indwelling medical devices. 3. On 9/25/24 starting at 7:51 AM observed Staff P, certified medication assistant (CMA), complete a medication pass. During the medication pass, as Staff P prepared some medications, he dropped 1 pill into the medication cart drawer. Staff P picked up the pill and placed it into the medication cup with his bare hands, then finished administering the medication to Resident #1. When questioned if Staff P dropped the pill into the draw and put it into the cup, he replied yes, the pill did. He said he thought more about if it went to the floor, if that happened he would get a new pill and order a replacement dose from the pharmacy. Interview on 9/24/24 at 8:55 AM the DON explained she expected the staff to throw away the pill and get a new pill to administer it to the resident. The Medication Administration policy dated April 2019 instructed to administer medications as prescribed, in a safe and timely manner. If a dose is wasted (dropped etc.) and another dose is needed, the needed dose is to be punched from the last day of the month on the medication card, then notify the pharmacy in order to replace the dose. The reason for wasted dose must be recorded in the electronic health record.