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	08/21/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and policy review, the facility failed to maintain a sanitary kitchen and dining room. In addition, the facility failed to handle dishes in a sanitary manner to reduce the risk of cross contamination and food borne illness. The facility reported a census of 26.Findings include:On 8/18/25 at 9:45 AM observed during the initial walk through of the kitchen, limescale and rust on the dishwasher. In addition, the ice machine in kitchen had limescale build-up inside and outside. In the dining room saw the ice/water machine had limescale rust with rust on the waterspout. Observed dirty hand-washing stations in the dishwashing room and kitchen. The floor in the dishwashing room looked very dirty and had leaves under the shelves. On 8/19/25 at 11:40 AM during a follow-up observation of the kitchen witnessed the limescale remained on the dishwasher and ice machines. The hand washing stations remained dirty. During the observation Staff A, Dietary Aide, walked through the kitchen with a stack of clean [NAME] (special non-spill cups) cups he carried holding them against his shirt. He filled the glasses and took them out to a table in the dining room for a resident. The dishwashing room floor remained very dirty with leaves still under the shelves. On 8/19/25 at 11:55 AM, Staff A verbalized he cleaned the dishes and the dish sinks, but he didn't clean the hand washing sinks. Staff A reported he cleaned the dishes, the shelves, and the carts. Staff A reported he didn't have a cleaning schedule, but the cook looked at his area before he leaves.On 8/19/25 at 12:35 PM Staff B, Dietary [NAME] reported she cleans her area as she goes and checks refrigerator food for dates. Staff B further reported she sweeps and mops floors. She also checks the clean list on board for chores.On 8/19/25 at 12:40 PM Dietary Manager verbalized the staff followed a monthly cleaning list and daily tasks that usually took about 15-20 minutes not big jobs. She reported they didn't do cleaning tasks on Tuesday and Friday due to truck delivery. She verbalized in the dining room; they wiped down the juice machine and ice machine daily. They de-limed the ice machine in the dining room and kitchen weekly. The Dietary Manager acknowledged they had an ongoing problem de-liming the dishwasher and ice machines. She reported she expected the staff to wipe them down daily.On 8/19/25 at 1:50 PM the Administrator verbalized they expected the staff to clean the ice machine and dishwasher monthly.On 8/19/25 at 2:15 PM the Dietary Manager gave the kitchen monthly numbered cleaning task list dated 7/30/24. The numbered task listed matched a sign-off sheet to indicate completion of the scheduled tasks. The signing sheet reflected to initial the date and have someone verify a second signature for the cleaning job. The August 2025 signing sheet lacked the completion for multiple tasks of the second set of initials. In addition, the evening shift (PM) had only 1 initial for all tasks, on 8/14/25.The following on the check list address cleaning areas of concern:AM PREPa. Empty, clean and sanitize the ice machine. Polish the outside and dust the vents on the sides.b. Delime the dishwasher using 2 quarts of de-[NAME]. Delime the doors, front, and top. Clean the hose and sprayer in the dish room along with the cupboard and polish sink.c. Inside of the upper cupboards in the dining room and de-lime the dishwater using 2 quarts of de-[NAME]. Clean the doors, front, and top.PM Cooka. Clean and polish the vegetable and hand sink in the kitchen. Clean and straighten mop room and door.PM aide/[NAME]. Scrub out garbage disposal and polish the entire dish (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	machine.The facility policy titled Sanitation revised December 2024 directed the dining service supervisor as the person responsible to develop a cleaning schedule and ensure they followed through satisfactorily. In addition, the policy instructed to clean the floors routinely. The policy lacked instruction on cleaning the hand washing stations, de-liming the dishwasher and ice machine.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, family, and staff interview, the facility failed to provide a homelike environment by keeping register covers on the floor in 4 out of 4 resident rooms (Rooms #1, #6, #10 and #18). The facility reported a census of 26 residents.Findings include:During a walkthrough of the building on 8/18/25 at 12:28 PM, observed base board boiler system register covers detached and/or on the floor of the identified rooms #1, #6, #10 and #18.During a walkthrough of the building on 8/19/25 at 6:45 AM, observed base board boiler system register covers detached and/or on the floor of the identified rooms #1, #6, #10 and #18.During a walkthrough of the building on 8/20/25 at 1:20 PM, observed base board boiler system register covers detached and/or on the floor of the identified rooms #1, #6, #10 and #18.In an interview on 8/20/25 at 1:20 PM, an anonymous family member reported it is typical to see the base board boiler system register covers detached and/or on the floor. The family remember verbalized at times the floor had dust, candy wrappers and a toothbrush under the bed or dressers. In an interview on 8/20/25 at 1:46 PM, Staff D, Certified Nursing Assistant (CNA), verbalized the staff complete maintenance slips for repairs needed in resident rooms. Staff D reported he observed base board boiler system register covers detached and/or on the floor of the identified rooms #1, #6, #10 and #18.In an interview on 8/20/25 at 1:49 PM, Staff E, Housekeeper, verbalized she reported anything broken in a resident's room to the maintenance staff. Staff E said she spoke directly to the maintenance staff and filled out maintenance slips. Staff E verbalized rooms are cleaned every day, including sweeping under dressers and beds. Staff E, acknowledge they saw the identified room base board boiler system register covers detached and/or on the floor.In an interview on 8/20/25 at 1:56 PM, Staff F, Maintenance Supervisor, explained the work order slips consist of a 2-part form. One part of the part of the form is provided to maintenance, and one part is provided to the Administrator. Staff F reported he didn't have any work order slips for the base board boiler system register covers detached and/or on the floor. Staff F stated the rooms have their base board boiler system register covers off daily, as they easily come off when bumped by lifts, beds, or wheelchairs. In an interview on 8/20/25 at 2:12 PM, the Administrator reported they routinely saw the base board boiler system register covers off. The Administrator reported he didn't have any maintenance work order slips for base board boiler system register covers. The Administrator added he tossed the maintenance work order slips once he received notice they repaired the item. The Administrator expected the staff to fill out maintenance work order slips for the base board boiler system register covers detached and/or on the floor. He expected housekeeping staff to sweep under beds and dressers when cleaning the resident's rooms.The Environmental Services policy effective April 2009, directed the staff to ensure:a. The junction of floors and walls, or doorways or doorjambs had no buildup or accumulation of dirt in the corners.b. The difficult-to-clean areas such as under furniture or overhead areas are kept clean.c. Report any hazardous conditions or needed repairs to your supervisor and make out a work request for maintenance.d. Baseboard areas are cleaned as needed.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy, and staff interview, the facility failed to notify the long-term care (LTC) Ombudsman for 2 of 2 residents who transferred to the hospital (Residents #6 and #24). The facility reported a census of 26 residents. Findings include:1. Resident #6's Minimum Data Set (MDS) assessment dated [DATE] listed the most recent entry as 5/22/25, from a short-term general hospital. The MDS identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of heart failure, coronary artery disease, and depression.Resident #6's Clinical Census reviewed 8/19/25 listed the following changes in level of care:a. 5/19/25: Unpaid hospital leaveb. 5/22/25: Resident #6 returned to the facility.The Health Status Note dated 5/19/25 at 2:00 PM reflected Resident #6 transferred to the local hospital. The Health Status Note dated 5/20/25 at 3:06 AM indicated the facility received a call reporting Resident #6 transferred to another hospital.The Admission/readmission UDA dated 5/22/25 at 3:31 PM documented Resident #6 returned to the facility from the hospital.The May 2025 facility record titled Notice of Transfer Form to Long Term Care Ombudsman lacked documentation of Resident #24's transfer to the hospital. On 8/19/25 at 2:20 PM, the Social Worker reported she didn't always know when someone went to the hospital to update the Ombudsman's report but if residents transferred to the hospital, it should be on the report. The facility policy titled Ombudsman Notification revised October 2024 directed the staff to submit a summary of all transfers and discharges from the facility to the State LTC Ombudsman.2. Resident #24's MDS assessment dated [DATE] listed their most recent entry as 1/27/25 from a short-term general hospital. The MDS identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The MDS included a diagnosis of heart failure, anemia and depression. Resident #24's Clinical Census reviewed identified the following changes in level of care:a. 1/22/25 admitted to hospitalb. 1/27/25 readmitted to facilityThe Health Status Note dated 1/22/25 at 11:12 PM indicated the hospital called and reported they admitted Resident #24. The Admission/readmission UDA dated 1/27/25 at 5:12 PM reflected Resident #24 readmitted to the nursing facility from the hospital. The January 2025 facility record titled Notice of Transfer Form to Long Term Care Ombudsman lacked documentation of Resident #24's transfer to the hospital.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy and staff interview, the facility failed to submit a Preadmission Screening and Resident Review (PASRR) evaluation for 1 of 2 residents reviewed with a new mental health diagnosis (Resident #24). The facility reported a census of 26 residents.Findings include:Resident #24's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The MDS included a diagnosis of depression. In addition, Resident #63 received antidepressant medication during the lookback period.The Care Plan Focus initiated 11/8/22 reflected Resident #24 used an antidepressant due to his diagnosis of major depressive disorder, recurrent, moderate.Resident #24's Level 1 PASRR dated 10/22/22 lacked a diagnosis of major depression. Resident #24's clinical record lacked a PASRR after 10/22/22. On 8/19/25 at 2:02 PM the Administrator reported if a resident had a diagnosis change or medication change, the facility should submit a new PASRR. The facility policy titled PASRR Screens/Level I & Level II Evals revised November 2024 directed the staff that if a resident received a new mental health diagnosis, they should complete a follow up PASRR.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, facility document review, and staff interviews, the facility failed to post the staff daily posting with the required staffing data. The facility reported a census of 26 residents. Findings include:On 8/18/25 at 11:17 AM observed the facility staff posting didn't include the total hours worked for each category nor identify if the type of nurse, Licensed Practical Nurse (LPN) or Registered Nurse (RN), for each shift.On 8/19/25 at 9:55 AM witnessed the facility staff posting didn't have the total hours worked for each category nor identify the type of nurse, LPN or RN, for each shift.An observation on 8/20/25 at 2:57 PM noted the facility staff posting didn't have total hours worked for each category nor identify the type of nurse, LPN or RN, each shift.In an interview on 8/20/25 at 2:58 PM, Staff C, LPN verbalized the overnight shift puts the daily posting out. Staff C had been unsure why the hours per shift weren't on the daily staff posting. In an interview on 8/20/25 at 3:10 PM, the Director of Nursing (DON) reported she puts the next day's posting behind the current day posting at the end of the day. The DON verbalized they had new scheduling software, and the program didn't allow edits to the document to add the hours per shift. In an interview on 8/20/25 at 3:31 PM, the Administrator reported they rolled out the new scheduling software at the end of June 2025. The Administrator noted they had a few problems with the program to get it to work for the facility's needs. The facility lacked a policy for the required daily staff posting.