

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  285243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/06/2024
NAME OF PROVIDER OR SUPPLIER  Parkview Home, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE  930 2nd Street Dodge, NE 68633	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45613</p> <p>Licensure Reference Number 175 NAC 12-006.09D7</p> <p>Based on observation, interview, and record review the facility failed to assess residents for use of the whirlpool bath chair per manufacturer guidelines. This affected 1 out of 1 residents. The facility census was 30.</p> <p>Findings are:</p> <p>A. Record review of [NAME] Spas Cascade Premier and Elite Premier Bathing Systems manufacture's guidelines the facility provided, revealed that for residents unable to support themselves in an upright position, [NAME] supplies the second belt (chest belt) which allows you to secure the resident in an upright position for safety. The chest belt should be placed across the chest of the resident and around the frame through the belt holes and secured to the D ring connector.</p> <p>Record review of the facility's document dated 10/9/2019 titled Fall Protocol revealed they will identify interventions related to the resident's specific risks to try to prevent falls and to try to minimize complications from falls.</p> <p>B. Record review of Resident 1's undated Admission Record revealed an initial admitted [DATE] to the facility.</p> <p>Record review of Resident 1's undated Medical Diagnosis sheet revealed an Admitting diagnosis of: Pain, Colostomy aftercare, and Abdominal Aortic Aneurysm dated 12/5/2023.</p> <p>Record review Resident 1's Admission Minimum Data Set (MDS-a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) dated 12/10/2023 revealed a Brief Interview for Mental Status (BIMS- a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) score of 9, which indicated the resident was moderately impaired.</p> <p>Record review of a discharge MDS dated [DATE] revealed Resident 1 was dependent for transfers and needed substantial/maximal assistance with bathing.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 285243	If continuation sheet Page 1 of 4

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident 1's facility assessment titled; Admission assessment dated [DATE] revealed poor balance with an abdominal surgical incision.</p> <p>Record review of Resident 1's Comprehensive Care Plan initiated on 12/7/2023 revealed a Focus that Resident 1 had limited physical mobility related to a recent surgery and had an open wound to their abdomen. The Care Plan identified interventions initiated on 12/7/2023:</p> <ul style="list-style-type: none"> <li>-resident may shower</li> <li>-utilize two staff members for assistance with transfers</li> </ul> <p>Record review of Resident 1's Fall assessment dated [DATE] was 15, which revealed Resident 1 was a moderate risk for falls.</p> <p>Record review of Resident 1's Incident Report dated 2/16/2024, revealed that the resident was in the whirlpool tub and was assisted by (Nursing Assistant) NA-B. The resident kept leaning forward and NA-B asked the resident to lean back. While the resident was being taken out of the tub NA-B was behind the bath chair and heard a metal [NAME] and the resident fell forward and their face hit the bottom of the whirlpool.</p> <p>Record review of Resident 1's Emergency Department and Intensive Care initial assessment list dated 2/16/2024 revealed: Acute blood loss anemia, Fall trauma, Closed head injury, Hematoma of scalp, Sepsis, and Scalp laceration.</p> <p>Record review of Resident 1's radiology report dated 2/19/2024 revealed a Nondisplaced distal fibula fracture.</p> <p>Interview on 2/21/2024 at 9:20 AM with the Director of Nursing (DON) revealed that Resident 1 leaned forward often since being readmitted to the facility in December 2023 after the abdominal surgery.</p> <p>Interview 2/21/2024 at 9:36 AM with the facility Maintenance (Mnt) - A revealed there had not been any work order put in for the bath chair, tub, or belt.</p> <p>Observation on 2/21/2024 at 9:38 AM of the bathhouse, whirlpool tub, and the bath chair revealed there was one belt in place, however, there were two hooks for the placement of a second belt.</p> <p>Interview on 2/21/2024 at 10:13 AM with the facility Administrator (Adm) confirmed the facility had only 1 belt for the whirlpool bath chair for use around a resident's waist and there was metal hooks for another belt for a resident's chest area. The Adm confirmed [gender] was only aware of the whirlpool bath chair only having one belt.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview at on 2/22/2024 at 9:10 AM with NA-B confirmed the waist strap was on Resident 1 at the time of the fall on 2/16/24. It was looped on each side of the resident at the waist and then connected in the middle above the colostomy bag. NA-B also stated that the strap must have gotten wet and just slipped off during the rinse as the resident was leaning forward and the bathaide was behind the resident holding onto the handle bars of the bath chair getting the resident out of the tub. The resident's feet were off the ground about 2 inches.</p> <p>Interview on 2/22/2024 at 9:46 AM with Licensed Practical Nurse (LPN)-G confirmed that Resident 1 was on the floor in the bath house on 2/16/2024 in the morning and the belt was connected to the chair. LPN-G was not able to get a blood pressure because the resident's arms were underneath the resident. LPN-G revealed there was a large amount of blood on the floor and therefore didn't touch Resident 1 and called 911.</p> <p>Interview on 2/22/2024 at 12:03 PM with the DON confirmed that Resident 1 was admitted with poor balance, an abdominal incision and was having pain at times. It was further confirmed the resident fell out of the bath chair and was only wearing one belt and it was not safe. The DON confirmed the facility did not perform assessments for the use of safety belts to be utilized within the whirlpool tub.</p> <p>Interview on 2/22/24 at 4:24 PM with the DON confirmed the 2nd bath safety belt had arrived at the facility and all nursing staff will begin utilizing both belt with all whirlpool baths.</p> <p>Record Review of Abatement Statement to remove the immediacies of the situation on 2/21/2024 at 6:06 PM revealed the following:</p> <ul style="list-style-type: none"> <li>- the whirlpool room key will be locked in DON's office until the primary bath aide will be educated on both bath belts before using whirlpool tub and the tub would not be used until education is completed,</li> <li>- all nursing staff will be educated to use both safety belts before giving residents whirlpool baths,</li> <li>- education will include proper tightening of both safety belts before resident entering the whirlpool.</li> </ul>		