STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285261	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Haven Nursing Home	1203 4th Street Deshler, NE 68340

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50348 Licensure Reference Number 175NAC 12-006.09D 3(5) Based on record review and interviews; the facility failed to ensure routine bowel movement for 3 (Resident 10, 13, and 21) of 3 sampled residents. The facility census was 27. Findings are: A. A review of a facility document labeled Bowel Management Protocol dated 4/1/2020 revealed the following procedures for no bowel movement: -Day 2-A dose of Prune juice or fruit and fiber will be given. -Day 3- A dose of Milk of Magnesia (MOM) will be given. -Day 4-A Bisacodyl (Dulcolax) suppository (a medication placed in the rectum) will be given. -Day 5- The provider will be contacted for further orders. A review of Resident 10's Admission Record dated 5/21/24 revealed Resident #10 admitted to the facility on [DATE]. A review of Resident 10's Medical Diagnosis list dated 5/21/24 revealed the following diagnoses: -Alzheimer's disease -Constipation A review of Resident 10's Minimum Data Set (MDS- a comprehensive assessment that is completed by long term care facilities that measures a residents health status and functional abilities) dated 5/2/24 revealed the following: - A BIMS (Brief Interview for Mental Status) score off 99 which indicated the resident was cognitivley severely impaired. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident 10 did have the ability to usually make themself-understood to others, and sometimes understood others. - Resident 10 required substantial assistance with oral care, personal or toileting hygiene, and lower body dressing. - Resident 10 required maximum assistance for toilet transfers or repositioning, - Resident 10 is frequently incontinent of bladder and bowel. The bowel incontinence indicator was a 9 which meant not rated due to Resident 10 did not have a bowel movement the entire 7 day look back period of the MDS. A review of Resident 10's Care Plan dated 5/21/24 (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) revealed there was not a focus, goal, or intervention related to Resident 10's diagnosis of constipation. A review of Care Plan Notes dated 5/15/24 did not address that constipation was a concern for Resident 10. A review of the residents Bowel Elimination Task report from 4/22/24 to 5/20/24 revealed that resident did not have a bowel movement documented from: - 4/25/24-4/29/24 (5 days) -5/16/24 - 5/19/24 (4 days) A review of Resident 10's Order Report dated 5/21/24 revealed the following orders: - MiraLAX Oral Packet 17 Grams (GM) (Polyethylene Glycol) Give 8.5 gram by mouth one time a day every other day scheduled related to constipation. -Day 2 with no bowel movement, 4-ounces of prune juice or fruit & fiber was to be given. -Day 3 with no bowel movement, Milk of Magnesia (MOM) 30 milliliters by mouth was to be given every 24 hours. -Day 4 without a bowel movement, a 10 milligram Bisacodyl suppository was to be given every 24 hours. A review of Resident 10's Medication Administration Record (MAR) for April 2024 revealed that no bowel care medications were provided between 4/25/24-4/28/24. On 4/29/24 a dose of MOM was given and documented ineffective. Resident 10's next documented bowel movement was day 6 per the Bowel Elimination Task report from 4/22/24-5/20/24. A review of Resident 10's MAR for May 2024 revealed that a dose of MOM was given on 5/18/24 and 5/19/24. There were no results documented and no further bowel care or assessment documented. Resident 10s next documented bowel movement was day 5 per the Bowel Elimination Task report from 4/22/24-5/20/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 5/22/24 at 8:00 AM with Nursing Assistant-B (NA-B) revealed [gender] is given a list of residenst who have not had bowel movements and if the identified residents have a bowel movement they are to notify the nurse. An interview on 5/23/24 at 10:48 AM with the Director of Nursing (DON) confirmed that Resident 10 did not have a bowel movement or intervention between 4/25/24-4/28/24. The DON revealed the resident did not have a documented bowel movement between 5/16/24-5/19/24. The DON revealed there was no documnetation regarding an assessment, bowel interventions, or notification for Resident 10 per [gender] expectations. B. A review of the Admission Record dated 5/21/24 revealed that Resident 13 was admitted to the facility on [DATE]. A review of the Medical Diagnosis list dated 5/21/24 revealed the following diagnoses: -Diverticulitis of large intestine -Constipation A review of Resident 13's MDS dated [DATE] revealed the following: - A BIMS (Brief Interview for Mental Status) score of 9 which indicated the resident's cognition was moderately impaired. - The resident did have the ability to make self-understood to others and understands others. - Resident 13 required maximum assistance with toileting and personal hygiene and was total depedent for lower body dressing. - Resident 13 was frequently incontinent of bladder and occasionally incontinent of bowel. A review of Resident 13's Care Plan dated 4/27/23 revealed: - A focus on constipation related to decreased mobility - Notify the physician that resident had hard stools. - Encourage resident to sit on toilet to evacuate bowels if possible. - Follow facility bowel protocol for bowel management. - Monitor/document/report as needed signs and symptoms of complications related to constipation. - Record bowel movement pattern each day. Describe amount, color and consistency. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 13's Bowel Elimination Task report from 4/22/24 to 5/20/24 revealed the resident did not have a bowel movement documented from 5/15/24-5/20/24 (6 days). A review of Resident 13s' Order Report dated 5/21/24 revealed the following orders: - Dulcolax Rectal Suppository 10 milligrams insert 1 suppository rectally every 24 hours as needed for constipation -Day 2 with no bowel movement, 4-ounces of prune juice or fruit &fiber as needed for constipation. - Milk of Magnesia (MOM) 30 milliliters by mouth every 24 hours as needed for constipation. A review of Resident 13's MAR for May 2024 revealed that a Dulcolax 10 mg suppository was given on 5/18/24 and was not effective. There were no results documented and no further bowel care documentation. Resident 13's next documented bowel movement was day 7 per the Bowel Elimination Task report from 4/22/24-5/20/24. An interview on 5/23/24 at 10:48 AM with the Director of Nursing (DON) revealed Resident 13 did not have a bowel movement between 5/15/24-5/20/24. The DON revealed one intervention was provided and was ineffective. The DON confirmed there was not a follow up assessment or provider notification per the DON expectation. C. A review of the Admission Record dated 5/21/24 revealed that Resident 21 was admitted to the facility on [DATE]. A review of the Medical Diagnosis list dated 5/21/24 revealed the following diagnosis: -Constipation A review of Resident 21's MDS dated [DATE] revealed the following: - A BIMS score of 10 which indicated the resident's cognition was moderately impaired. - Resident 21 had the ability to make themselves understood to others and could understand others. - Resident 21 required maximum assitance with upper and lower body dressing, personal and toileting hygiene. - Resident 21 was frequently incontinent of bladder and occasionally incontinent of bowel. A review of Resident 21's Care Plan dated 10/24/23 revealed: -A focus on constipation related to decreased mobility, pain, use/side effects of medication, Norco and Tramadol - Notify the physician of bowel regulation issues. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Update the physician of increase constipation. - Follow facility bowel protocol for bowel management - Encourage resident to sit on toilet to evacuate bowels daily after lunch if possible. - Follow facility bowel protocol for bowel management. - Monitor/document/report as needed signs and symptoms of complications related to constipation. - Record bowel movement pattern each day. Describe amount, color and consistency. A review of the residents Bowel Elimination Task report from 4/22/24 to 5/20/24 revealed that resident did not have a bowel movement documented from: - 4/23/24-4/25/23 (3 days), - 4/27/24-4/30/24 (4 days) - 5/12/24-5/15/24 (4 days) -5/17/24-5/19/24 (3 days). A review of Resident 21's Order Report dated 5/21/24 revealed the following orders: - Dulcolax Rectal Suppository 10 mg insert 1 suppository rectally every 24 hours as needed for constipation -Day 2 with no bowel movement, 4-ounces of prune juice or fruit &fiber as needed for constipation. -MiraLAX Oral Packet 17 gram by mouth every 24 hours as needed for constipation. -Senna oral capsule 8.6 MG give 1 capsule by mouth one time a day for constipation. A review of Resident 21s's MAR for April 2024 revealed that MiraLAX 17 GM was given on 4/30/24 and was not effective. There were no results documented and no further bowel care documentation was revealed from the dates 4/22/24-4/30/24. A review of Resident 21's MAR for May of 2024 revealed that a Bisacodyl rectal suppository was given both on 5/15/24 and 5/20/24 documented as ineffective. MiraLAX was documented as given on 5/14/24, 5/17/24, and 5/19/24 and those too were documented as ineffective. An interview on 5/23/24 at 10:48 AM with the Director of Nursing (DON) confirmed that Resident 21 did not have a bowel movement between the following dates: - 4/23/24-4/25/23 (3 days), - 4/27/24-4/30/24 (4 days) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 5/12/24-5/15/24 (4 days) -5/17/24-5/19/24 (3 days). The dates of intervention were as follows: - 4/30/24 -5/14/24 -5/15/24 -5/17/24 -5/19/24 The DON confirmed that the documentation revealed the interventions were ineffective. A confirmation was also received that there was not a follow up for these dates noted in the form of a nurses note, assessment, or physician notification per DON expectation.