

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Parkview Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>Licensure Reference Number 175 NAC 12-007.03(E)</p> <p>Based on observations and interviews, the facility failed to ensure 1 resident (Resident 19) out of 6 sampled residents was able to use the bathroom sink, medicine cabinet and was able to turn on the bathroom sink faucets without struggling. The facility census was 24.</p> <p>Findings are:</p> <p>An interview on 5/19/25 at 9:30 AM with Resident 19 revealed the sink being too high up, not being able to use the medicine cabinet, and (gender) struggles to turn the faucets on to brush (gender) teeth and wash face and hands.</p> <p>An observation on 5/20/25 at 8:15 AM of Resident 19 in the bathroom sitting in wheelchair trying to turn on the sink faucets and to reach the medicine cabinet. Resident 19 was able to open the medicine cabinet after struggling to reach it but unable to remove any items. Resident 19 had a stand in between the sink and toilet that had (genders) personal items such as hair brush/combs, and toothbrush and toothpaste that will fall between the bars. Resident 19 revealed that once it hits the floor (gender) is unable to pick items up.</p> <p>An interview on 05/21/25 at 10:14 AM with Maintenance confirmed that the sink is 34 inches in height and that is code for handicap assessable, so the sink is up to code. Maintenance confirmed that the turn faucets can be changed out to a swing faucet to assist Resident 19 with easier access for turning the faucets off and on. Maintenance was not sure if the sink could be lowered to accommodate Resident 19 easier access.</p> <p>A record review of The Americans with Disability Act (ADA): ADA Requirements for Bathrooms: Standards and Compliance revealed the sink should have a rim height of no more than 34 inches (86.36 cm) above the floor to accommodate wheelchair users. The knee clearance should be at least 27 inches (68.58 cm) high, 30 inches (76.2 cm) wide, and 19 inches (48.26 cm) deep to allow wheelchair users to approach the sink comfortably.</p> <p>An interview on 5/21/25 at 11:00 AM with the Administrator confirmed that the facility dropped the ball with Resident 19's bathroom. The management team had discussed Resident 19 concerns with the sink being too high and the faucets but then forgotten about it until now. The Administrator confirmed that the facility will get the bathroom taken care of.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Parkview Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Licensure Reference Number 175 NAC 12-006.02(H)</p> <p>Based on record reviews, observations, and interviews, the facility failed to send an investigation report within 5 days to the State Agency for 2 (Resident 16 and Resident 17) of 6 sampled residents. The facility census was 24.</p> <p>Findings are:</p> <p>A.</p> <p>Record review of Resident 16's Clinical Census Record dated 5/20/25 revealed admission to the facility was 8/15/22.</p> <p>Record review of facility documentation titled Internal Investigation Summary for the incident on 9/16/24 indicated Nurse Aide (NA)-B transferred Resident 16 onto bed with a Hoyer lift (a mechanical lift to transfer a person) without other staff members assistance. Resident 16 received a right arm injury that resulted in pain and swelling after this transfer.</p> <p>Record review of facility's investigation report regarding Resident 16's incident on 9/16/24 revealed:</p> <p>-On 9/17/24 the Restorative Aide (RA) reported to the Director of Nursing (DON) that there was something wrong with Resident 16's right arm and that resident was complaining of a lot of pain. The resident was assessed by</p> <p>the DON and Minimum Data Set Coordinator (MDSC) and found when resident's right arm was moved [gender] frowned and moved away from the nurse, indicating pain. The DON called the Advanced Practice Registered</p> <p>Nurse (APRN) to report the findings and the APRN was going to come up the next morning to examine resident.</p> <p>-On 9/17/24 NA-B went into the DON's office and said that during report the staff was informed that Resident 16 was having a lot of right arm pain. NA-B reported the following to the DON: that on 9/16/24 at</p> <p>approximately 3:30 PM, Resident 16 slipped out of the wheelchair onto the pedals. NA-B stated [gender] hooked the resident up to the Hoyer lift and lifted them off the pedals and placed the resident onto the bed.</p> <p>NA-B</p> <p>reported that (gender) told Licensed Practical Nurse (LPN)-C about the fall and that NA-B transferred Resident 16 by Hoyer lift and placed them on the bed.</p> <p>-On 9/17/24 The DON notified Resident 16's primary care provider and the power of attorney of the fall and potential injury to right arm (pain with movement).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Parkview Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 9/18/2024 the APRN assessed Resident 16 and ordered the following:</p> <ul style="list-style-type: none"> -Oxycodone 5 mg per peg tube every 6 hours as needed for severe pain -Envelope sling to right arm - have doctor recheck sling on rounds -May send for x-ray of right humerous shoulder if family agrees. <p>-On 9/19/24 at 1:19 PM the facility notified Adult Protective Services (APS) via on line report.</p> <p>-On 9/25/25 at 2:26 PM the Administrator (ADM) emailed the Internal Investigation Summary to the State Agency.</p> <p>Record review of the facility's Abuse Investigations policy dated/reviewed 4-25 revealed: All reports of abuse, neglect, exploitation, theft, misappropriation of resident property, accidents with serious injury, elopement and/or injuries of an unknown cause shall be promptly and thoroughly investigated. The investigation record and applicable forms will be faxed to the appropriate agency in five (5) working days of the reported incident.</p> <p>Interview on 5/21/25 at 2:13 PM with ADM confirmed the fall investigation for Resident 16 was not sent into the State Agency within 5 working days as required and should have been.</p> <p>B.</p> <p>Record review of Resident 17's fall investigation report dated 3/23/2025 at 8:28 AM revealed:</p> <ul style="list-style-type: none"> -Resident 17 was walking in the hall with walker and suddenly became very weak and fell down. -Most of the impact of the fall was on [gender] left side of head and the left shoulder. -Resident was complaining of severe pain. -Resident was transported to the emergency room and returned to the facility at 12:35 PM. -Family reports that Resident 17 was hurt but nothing was broken. <p>-On 3/23/25 the Administrator notified APS by email at 10:07 AM .</p> <p>Record review of an e-mail from Administrator, sent on 3/30/25 at 10:02 PM to the State Agency revealed that the facility was aware of being late sending in the 5-day investigation report.</p> <p>Record review of an email from the Administrator revealed the 5-day investigation report was emailed to the State Agency on 3/31/25 at 10:21 AM, which was considered day 6.</p> <p>Interview on 5/21/25 at 1:55 PM with the Administrator confirmed that a 5-day investigation report regarding a fall on 3/23/25 for Resident 17 was not sent into the State Agency until 3/31/25 and should have been sent within 5 working days as required.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Parkview Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(I)</p> <p>Based on interviews and record reviews, the facility failed to ensure safe transfers for 1 (Resident 16) of 2 sampled residents and failed to assess the resident prior to moving the resident after the fall for 1 (Resident 16) of 2 sampled residents. The facility census was 24.</p> <p>Findings are:</p> <p>Record review of Resident 16's Clinical Census Record dated 5/20/25 revealed Resident 16 admitted to the facility on [DATE].</p> <p>Record review of Resident 16's diagnosis dated 5/20/25 revealed: Hemiplegia (one-sided weakness or paralysis) and Hemiparesis (one-sided muscle weakness) following Cerebral Infarction (stroke) affecting right dominant side, Other Chronic Pain, Other Specified Disorders of Bone, Upper Arm.</p> <p>Record review of Resident 16's MDS (Minimum Data Set, a comprehensive assessment of each resident's functional capabilities) dated 5/9/25 revealed:</p> <p>-Section B: no speech, usually understood and usually understands</p> <p>-Section C: BIMS (Brief Interview for Mental Status, 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) was 99 indicating severe cognitive impairment and inattention present.</p> <p>-Section G: one side limitation in upper range of motion, one side limitation in lower range of motion, and uses wheelchair. Dependent for all activities of daily living, moderate assistance with repositioning, and dependent assistance for transfers.</p> <p>Record review of Resident 16's progress note revealed:</p> <p>9/9/2024 9:32 PM Note Text: 3-11 Shift Summary- Is total assist with all aspects of ADL's. Is incontinent of both bowel and bladder. Uses wheelchair for mobility, needs to be pushed. Does try to refuse feedings at times. zero medication issues identified, takes meds per tube. No alarms or secure care. Takes routine Tylenol. Seldom indicates pain. Entirely fed by tube. Sometimes is able to communicate needs. Skin is intact, sometimes is red around tube insertion site. Hoyer for transfers.</p> <p>Record review of Resident 16's Care plan dated 5/20/25 revealed:</p> <p>-Resident is at risk for falls related to deconditioning, paralysis, history of osteoporosis, seizures, 9/18/23-Right arm swelling/wears sling Date Initiated: 10/27/22, Revision on: 4/15/25</p> <p>-Interventions -3/14/24-Seen by Advanced Practical Registered Nurse (APRN) Orders activity level up as tolerated, dependent for wheelchair (w/c) mobility and use hoyer lift with transfers. Date Initiated: 3/14/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Parkview Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-9/18/24-Noted increased complaints of discomfort, limited range of motion, and swelling to the right shoulder/axillary area. Seen by APRN at the facility and orders: Oxycodone 5 mg per G-tube q 6 hrs PRN for severe pain, apply envelope sling to the right arm. May send for x-ray of the right humerus/shoulder if family agrees. Date Initiated: 9/18/24.</p> <p>-Received fax from Dr. to keep trying to do gentle range of motion to Resident's right shoulder. Date Initiated: 09/19/2024 Revision on: 10/14/24.</p> <p>Record review of facility's investigation report regarding Resident 16's incident on 9/16/24 revealed:</p> <p>-On 9/17/24 the Restorative Aide (RA) reported to the Director of Nursing (DON) that there was something wrong with Resident 16's right arm and that resident was complaining of a lot of pain. The resident was assessed by the DON and Minimum Data Set Coordinator (MDSC) and found when resident's right arm was moved [gender] frowned and moved away from the nurse, indicating pain. The DON called the Advanced Practice Registered Nurse (APRN) to report the findings and the APRN was going to come up the next morning to examine resident.</p> <p>-On 9/17/24 NA-B went into the DON's office and said that during report the staff was informed that Resident 16 was having a lot of right arm pain. NA-B reported the following to the DON: that on 9/16/24 at approximately 3:30 PM, Resident 16 slipped out of the wheelchair onto the pedals. NA-B stated [gender] hooked the resident up to the Hoyer lift and lifted them off the pedals and placed the resident onto the bed. NA-B reported that (gender) told Licensed Practical Nurse (LPN)-C about the fall and that NA-B transferred Resident 16 by Hoyer lift and placed them on the bed.</p> <p>-On 9/17/24 The DON notified Resident 16's primary care provider and the power of attorney of the fall and potential injury to right arm (pain with movement).</p> <p>-On 9/17/24 at 5:00 PM, LPN-C spoke with DON and reported that LPN-C assisted NA-B to adjust the lift pad for Resident 16 who was in bed. LPN-C reported to DON that (gender) was not aware of a fall.</p> <p>-On 9/17/24 at approximately 8:30 PM the Administrator (ADM) interviewed NA-B. NA-B reported that Resident 16 started to slip from wheelchair to foot pedals so NA-B hooked resident up to Hoyer lift and moved Resident 16 to bed, NA-B reported that they notified the charge nurse.</p> <p>-On 9/18/2024 the APRN assessed Resident 16 and ordered the following:</p> <p>-Oxycodone 5 mg per peg tube every 6 hours as needed for severe pain</p> <p>-Envelope sling to right arm - have doctor recheck sling on rounds</p> <p>-May send for x-ray of right humerus shoulder if family agrees.</p> <p>-On 9/19/24 at 1:19 PM the facility notified Adult Protective Services (APS) via on line report.</p> <p>-On 9/25/25 at 2:26 PM the Administrator (ADM) emailed the Internal Investigation Summary to the State Agency.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Parkview Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Pain Level Summary revealed facility assigns a value of pain using a PAINAD or Numerical Scale. PAINAD scale is a Pain Assessment in Advanced Dementia Scale that scores:</p> <ul style="list-style-type: none"> -Breathing Independent of Vocalization -Negative Vocalization -Facial Expression -Body Language -Consolability <p>Total scores range from 0 to 10, with a higher score indicating more severe pain (0=no pain; 10=severe pain)</p> <p>Record Review of Resident 16's Pain Level Summary printed on 5/22/25 revealed the following:</p> <ul style="list-style-type: none"> -9/10/24 at 7:41 AM Pain Value=0 -9/11/24 at 2:46 PM Pain Value=0 -9/12/24 at 8:17 AM Pain Value=0 -9/13/24 at 10:36 AM Pain Value=0 -9/14/24 at 5:40 PM Pain Value=0 -9/15/24 at 7:22 AM Pain Value=0 -9/16/24 at 2:49 PM Pain Value=0 -9/17/24 at 8:45 AM <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Parkview Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Pain Value=0</p> <p>-9/17/24 at 2:20 PM</p> <p>Pain Value=6</p> <p>-9/17/24 at 6:08 PM</p> <p>Pain Value=5</p> <p>-9/17/24 at 7:50 PM</p> <p>Pain Value=3</p> <p>-9/18/24 at 12:32 AM</p> <p>Pain Value=6</p> <p>-9/18/24 at 2:48 AM</p> <p>Pain Value=2</p> <p>-9/18/24 at 7:54 AM</p> <p>Pain Value=4</p> <p>-9/18/24 at 12:04 PM</p> <p>Pain Value=7</p> <p>-9/18/24 at 2:04 PM</p> <p>Pain Value=4</p> <p>-9/18/24 at 2:44 PM</p> <p>Pain Value=4</p> <p>-9/18/24 at 11:45 PM</p> <p>Pain Value=7</p> <p>-9/19/24 at 5:09 AM</p> <p>Pain Value=2</p> <p>-9/19/24 at 8:06 AM</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Parkview Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Actual harm Residents Affected - Few	Pain Value=5 -9/19/24 at 11:50 AM Pain Value=6 -9/19/24 at 2:53 PM Pain Value=0 -9/19/24 at 4:10 PM Pain Value=0 -9/19/24 at 8:18 PM Pain Value=4 -9/19/24 at 8:57 PM Pain Value=0 -9/20/24 at 6:03 AM Pain Value=3 -9/20/24 at 10:28 AM Pain Value=0 -9/20/24 at 1:27 PM Pain Value=5 -9/21/24 at 12:07 AM Pain Value=5 -9/22/24 at 10:20 AM Pain Value=4 -9/23/24 at 4:17 PM Pain Value=7 -9/24/24 at 12:11 PM (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Parkview Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Actual harm Residents Affected - Few	Pain Value=8 -9/25/24 at 12:10 PM Pain Value=6 -9/26/24 at 10:53 AM Pain Value=4 -9/27/24 at 05:08 AM Pain Value=4 -9/28/24 at 7:29 PM Pain Value=5 -9/29/24 at 3:18 PM Pain Value=5 -9/30/24 at 11:35 PM Pain Value=4 -10/1/24 at 11:58 AM Pain Value=5 -10/2/24 at 8:03 AM Pain Value=5 -10/3/24 at 5:32 AM Pain Value=5 -10/4/24 at 12:38 AM Pain Value=7 -10/5/24 at 10:52 AM Pain Value=3 Record review of Limited lift Policy dated October 2005 revealed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Parkview Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Policy: This limited lift/resident handling policy is to ensure a safe working environment for resident handlers. It is to be reviewed and signed by all staff that perform or may perform resident handling.</p> <p>Procedure:</p> <ul style="list-style-type: none"> -Mechanical lift transfer. (Hoyer type) with two caregivers. -Should a resident fall to the floor, the resident will be first be assessed by a nurse. If the resident is deemed medically appropriate to transfer from the floor, a full size mechanical Hoyer type lift will be used. If not deemed mechanically appropriate, the rescue unit will be notified. <p>Record review of Hoyer Lift policy undated revealed:</p> <p>Purpose: To provide safe and easy transfer for the resident and the staff.</p> <ul style="list-style-type: none"> -Ask a coworker for help. -To lift resident from the floor: <p>Note: The Hoyer lift should never be used by one staff person alone, period. Two or more staff should be utilized for these procedures. As indicated by the residence condition.</p> <p>Record review of facility's Limited Lift Policy dated October 2005 revealed NA-B was trained on Limited Lift Procedures on 3/27/24 and signed on 3/27/24 indicating being trained.</p> <p>Record review of facility's Employee Orientation Record, reviewed/revised 2/2023 revealed NA-B was trained on Limited Lift Procedures, Sit-to Stand, Hoyer, Gaitbelt, 1 & 2 person ambulating, Walker, Unusual Event Report, and Accident/Incident Report on 3/27/24 and signed 3/27/24 indicating being trained.</p> <p>Interview on 5/21/25 at 2:13 PM with the ADM confirmed that the staff should use 2 staff members when assisting residents that utilize the hoyer lift. ADM also confirmed there was no assessment done by the nurse prior to moving resident after the fall.</p> <p>Interview via phone call on 5/21/25 at 6:37 PM with NA-B regarding incident occurrence on 9/16/24. NA-B said that another staff was to come help NA-B transfer Resident 16 but they didn't come to the room. NA-B said, I got the resident ready, I don't know how things went wrong, it happened so fast. I don't remember everything, it happened back in August or September. The resident kept sliding out of the wheelchair. I thought [gender]was in the wheelchair good, so I went to get RN-C. When we got back to the room the resident was sitting on the pedals of the wheelchair. We got Resident 16 up with the hoyer lift and back into bed. The nurse looked resident over and we assisted [gender] to the wheelchair again using the hoyer lift.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Parkview Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 5/22/25 at 9:49 AM via phone with RN-C that worked on 9/16/24 with NA-B revealed NA-B came and got me that evening early sometime after 5:00 PM. When I got to Resident 16's room, resident was on the bed with the lift pad underneath [gender]. NA-B hooked the lift pad to the Hoyer lift and we transferred resident to the wheelchair. The resident did not have any complaints, although [gender] is aphasic, but there were no grimaces noted. The next day the DON called me and I told the DON what had happened. I worked the next day I think, and got report about Resident 16's right arm. I did notice [gender] was guarding it and it was a little swollen. Resident 16 saw the doctor and we started using a sling.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Parkview Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.19(A)</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure the positioning rail on the bed was secure and in a proper position to prevent potential harm to 1 (Resident 2) of 1 sampled residents. The facility census was 24.</p> <p>Findings are:</p> <p>Record review of Resident 2's Clinical census record dated 5/20/25 revealed Resident 2 admitted to the facility on [DATE].</p> <p>Record review of Resident 2's Diagnoses dated 5/20/25 revealed: Alzheimer's Disease (progressive mental deterioration, due to generalized degeneration of the brain), hemiplegia (a medical condition characterized by paralysis or severe weakness on one side of body) and hemiparesis (weakness or the inability to move on one side of the body) following cerebral infarction (occurs when blood flow to the brain is blocked, causing brain tissue to die) affecting right dominant side, aphagia (a neurological disorder that impairs a person's ability to process and understand language, affecting communication.) following cerebral infarction, and cognitive communication deficit (a type of communication disorder where difficulties stem from cognitive impairments, rather than from a primary language or speech deficit).</p> <p>Record review of Resident 2's Bed Rail Assessment was completed by the facility on 4/1/25 revealed that the side rail/assist bar was indicated and served as an enabler to promote independence.</p> <p>Record review of Parkview Haven nursing home Policy of bed rails dated 4/18/25 revealed:</p> <p>-Any decision regarding bed rail use or removal should be made based on the individual resident or residence assessment. If a bed rail has been determined to be necessary, steps should be taken to reduce the known risks associated with its use.</p> <p>Before you install bed rails:</p> <p>-Make sure the individual is an appropriate candidate for bed rails. Bed Side rails should not be used as a substitute for proper monitoring, especially for people at high risk for entrapment.</p> <p>-Avoid the routine use of adult bed rails without first conducting an individual, resident or resident assessment.</p> <p>Bed rails should be inspected by maintenance at a minimum. Of once a month and by nursing and all other staff entering the room daily. Inspection should include the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Parkview Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Inspect and regularly check the mattress and bed rails to make sure they are still installed correctly and for areas of possible entrapment and falls. Regardless of mattress width, length and/or depth, the bed frame, bedside rail, and mattress should leave no gap wide enough to entrap a resident's head or body.</p> <p>-Inspect, evaluate, maintain, and upgrade equipment., beds. Mattresses, bed rails to identify and remove potential fall and entrapment hazards.</p> <p>-Be aware that gaps can be created by movement. For compression of the mattress, which may be caused by patients' weight, patients' movement, movement or bed position.</p> <p>Record review of Resident 2's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 4/3/25 revealed the following:</p> <p>-Section C: Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score: 13-15: cognitively intact, 8-12: moderately impaired, 0-7: severe impairment. Resident 2's BIMS was 99 indicating severe cognitive impairment and has inattention present.</p> <p>-Section E: daily wandering</p> <p>-Section G: one limitation in upper range of motion, one limitation in lower range of motion, and uses wheelchair. Needs supervision for eating, moderate assistance for oral hygiene, maximum assistance with toileting hygiene, maximum assistance with bathing, maximum assistance with upper body dressing, dependent assistance with lower body dressing and footwear, maximum assistance for personal hygiene, moderate assistance with repositioning and transfers, moderate assistance to roll left to right in bed, maximum assistance from sitting to standing from bed, maximum assistance from lying to sitting on the side of the bed, moderate assistance from sit to stand from sitting in bed, toilet or chair.</p> <p>Record review of Resident 2's Care plan dated 5/20/25 revealed:</p> <p>-[Gender] has an ADL self-care performance deficit relate to Activity Intolerance, Alzheimer's, dementia (progressive cognitive decline), fatigue, hemiplegia, impaired balance, aphasia, cognitive communication deficit, history of TIA's (Transient ischemic attack -a brief or mini stroke)-Date Initiated: 06/17/2024, Revision on: 04/16/2025</p> <p>Intervention: Applied fall mat beside [gender] bed due to frequent falls when trying to transfer self-unassisted into wheelchair. Date Initiated: 04/07/2025</p> <p>The resident requires partial to extensive assistance by 1 staff to turn and reposition in bed 2-3 hours and as necessary.</p> <p>Orders to apply positioning bar to the left side of bed to assist with transfers and positioning while in bed. Date Initiated: 06/17/2024, Revision on: 08/14/2024</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Parkview Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-[Gender] is a high risk for falls related to Confusion, Gait/balance problems, Paralysis, Poor communication/comprehension, unaware of safety needs, Vision/hearing problems. Date Initiated: 06/17/2024 Revision on: 04/16/2025</p> <p>Interview on 5/21/25 at 9:33 AM with MA-E revealed Resident 2 tries to get out of bed alone sometimes and staff places a mat in front of the bed and keeps the bed in low position to prevent injuries.</p> <p>Observation on 5/21/25 at 9:59 AM of Resident 2 revealed resident lying in the middle of the bed asleep. The positioning bar on the left side of the bed, near the head of bed, was raised and was loose and leaning out-away from bed at an approximate 120 degree angle. The width between the mattress and rail was at least 10 inches. The bed was in low position and there was a mat on the floor beside the bed.</p> <p>Interview on 5/21/25 at 10:01 AM with Maintenance Supervisor revealed side rail checks are done every month but stated I might have missed it last time. Sometimes the resident is in bed, or the nurse is in there, so I go back later. Maintenance Supervisor said [gender] didn't put this positioning bar on, that is not [gender] work, but confirmed the positioning bar was not in the correct position and needed to be fixed -I will do it now.</p> <p>Surveyor brought Administrator into Resident 2's room on 5/21/25 at 10:05 AM. Administrator stated That's not good, the positioning bar should be upright and tight. If [gender] rolled and got their head in between the mattress and positioning bar [gender] could choke or worse. At this time the Administrator confirmed that the positioning bar was not in the correct position.</p> <p>Record review of side rail maintenance log for 2025 completed by maintenance staff revealed that every month was checked indicating the positioning bar for Resident 2 was OK.</p> <p>Observation on 5/21/25 at 10:30 AM revealed all side rails and positioning rails in the nursing home that were on any residents' beds had no gaps between the mattress and side rails.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Parkview Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18(D) and 12-006.18(B)</p> <p>Based on observations, interviews, and record review, the facility failed to ensure staff performed hand hygiene prior to donning (putting on) gloves, between glove changes, change gloves often during cares, wash hands for 20 seconds for 2 of (Residents 16 and 20) of 2 sampled residents, and failed to wear a gown during cares for 2 of (Resident 16, and 20) of 2 sampled residents. The facility census was 24.</p> <p>Findings are:</p> <p>A.</p> <p>Record review of Resident 20's Clinical Census record dated 5/20/25 revealed Resident 20 admitted to the facility on [DATE].</p> <p>Record review of Resident 20's Diagnosis dated 5/20/25 revealed: Retention of urine.</p> <p>Record review of Resident 20's MDS (Minimum Data Set, a comprehensive assessment of each resident's functional capabilities) dated 5/7/25 revealed:</p> <p>-Section C: BIMS (Brief Interview for Mental Status, 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) was scored 10 indicating moderate cognitive impairment.</p> <p>-Section G: Needs setup for eating, supervision for oral hygiene, maximum assistance with toileting hygiene, maximum assistance with bathing, moderate assistance with upper body dressing, dependent assistance with lower body dressing and footwear, maximum assistance for personal hygiene, moderate assistance with repositioning, and maximum assist for transfers.</p> <p>Record review of Resident 20's Care plan dated 5/20/25 revealed: Functional bladder incontinence r/t Activity Intolerance, Dementia, Impaired Mobility, Physical limitations, acute kidney failure, benign prostatic hypoplasia, and neoplasm of prostate.</p> <p>Interventions -Administering UTI stat 30 ml po BID for prophylaxis for history of urinary track infection's.</p> <p>Date Initiated: 06/14/2024.</p> <p>-Use enhanced barrier precautions using gown and gloves with high contact areas per CDC with cares. Date Initiated: 04/15/2024.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Parkview Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 5/21/25 at 7:15 AM with Nurse Aide (NA)-D and Medication Aide (MA)-E completed Resident 20's peri-cares (The cleaning and maintenance of the genital and anal areas.) and Suprapubic catheter (a type of urinary catheter that is inserted directly into the urinary bladder through the abdomen, just above the pubic bone) cares (Regular cleaning, flushing, and monitoring of the catheter and surrounding skin to prevent complications like infection.). MA-E got the wash clothes ready. NA-D and MA-E donned gloves without hand hygiene and did not put gowns on. NA-D removed Resident 20's brief, and cleansed groin with washcloth with peri-wash on it while folding cloth for each swipe, then rinsed with another wet washcloth. NA-D then cleansed resident's external genitalia with same washcloth as used on groins, folding washcloth over each time, then wiped with the other washcloth as used before to rinse area and dried with dry towel. MA-E stated the surveyor made [gender] nervous and forgot they forgot to put on the gowns. MA-E & NA-D removed their gloves, donned a gown and new gloves without completeing hand hygiene. MA-E did get a clean washcloth wet with peri-wash and a wet cloth for rinse, and a towel ready. MA-E removed the split gauze dressing around the suprapubic catheter. MA-E did not perform hand hygiene or change gloves. MA-E cleansed the skin around suprapubic catheter opening area with a clean washcloth with peri-wash and rinsed with a wet washcloth and dried the area without completeing hand hygiene. MA-E then applied split gauze dressing and taped to skin. MA-E and NA-D washed hands with soap and water x 20 seconds.</p> <p>Interview on 5/21/25 at 7:32 AM with MA-E confirmed [gender] did not complete hand hygiene prior to putting on gloves, when changeing gloves, and did not wear a gown during cares for Resident 20 and should have.</p> <p>Interview on 5/21/25 at 7:45 AM with NA-D confirmed [gender] did not complete hand hygiene prior to putting on gloves, when changeing gloves, and did not wear a gown during cares for Resident 20 and should have.</p> <p>Interview on 5/21/25 at 9:00 AM with the Director of Nursing (DON) confirmed staff are to wash hands prior to donning gloves, when changing gloves, and wear gown when doing per-care and catheter cares.</p> <p>Record review of Hand Hygiene Policy dated 9/2020 revealed:</p> <p>Policy: Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors.</p> <ul style="list-style-type: none"> -Hand hygiene when using soap and water: -Wet hands with water. Avoid using hot water because repeated exposure to hot water may increase the risk of dermatitis. -Apply enough soap to cover all hand surfaces. -Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. -Dry thoroughly with a single-use towel. -Use towel to shut off the faucet. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Parkview Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The use of gloves does not replace hand washing. Wash hands after removing gloves.</p> <p>Record review of Perineal care dated 7/21/24 revealed:</p> <p>Purpose: The perineum needs special care for some residents in order to keep skin clean and skin healthy.</p> <p>Procedure for:</p> <p>-Wash hands.</p> <p>-Fill Basin half-full with warm water and place on over bed table on top of the towel.</p> <p>-Wet the washcloth in warm water, wring out and apply soap. Fold washcloth into fourths, making it easier to use a different section of the washcloth or disposable wipe for each stroke. Do not put the washcloth into the basin of water. Change washcloths as necessary, placing use cloths in separate plastic bag. Never place used tissue or washcloth on the bed or over bed table.</p> <p>-Hold penis upright.</p> <p>-Wash the urinary meatus (the external opening of the urethra, the tube that carries urine from the bladder to the outside of the body) in a circular motion starting at the tip. Use a clean part of the washcloth for each stroke. Be sure to wash all skin folds thoroughly. Always wash away from the urinary meatus. Be sure to wash all skin folds thoroughly. (Always wash away from the urinary meatus).</p> <p>-Using a clean washcloth, rinse using the same process (Note: if disposable peri wipes are used, rinsing may not be necessary).</p> <p>-Pat the area dry in same direction used for washing.</p> <p>-Wet and soap a new washcloth. With downward strokes (away from the urinary meatus), wash down the shaft of the penis, then scrotum, perineum, and thigh creases. Follow by rinsing and patting dry in the same order and direction as washing.</p> <p>-Wash and dry the lower abdomen and over the pubic hair.</p> <p>-Turn the resident on the side with back towards you and legs slightly bent. Expose the resident's buttocks. Apply bed protector if not already in place.</p> <p>-Remove gloves and perform hand hygiene and replace gloves.</p> <p>-Apply incontinent brief if used and remove the bed protector and place it in plastic bag.</p> <p>-Remove gloves and wash hands.</p> <p>Record review of enhanced barrier precautions policy reference by Center for Disease Control and Prevention dated July 12, 2022 revealed:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Parkview Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Policy: Is the policy of this facility that Enhanced Barrier Precautions, in addition to Standard and Contact Precautions will be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring a multidrug-resistant organism. (MDRO), such as a resident with wounds, indwelling medical devices or residents with infection or colonization with an MDRO.</p> <p>-Overview: Enhanced barrier precautions will not only focus on residents with infection or colonization with MDRO's but will also address residents at risk for developing or becoming colonized. Enhanced barrier precautions are precautions that are between standard precautions and contact precautions. Enhanced barrier precautions require gown and glove use for residents with a novel or targeted MDRO or any resident with a wound or indwelling medical device during specific high contact.</p> <p>Purpose. The purpose of Enhanced Barrier Precautions is to prevent opportunities for transfer of MDRO's to employee's hands and clothing during cares, beyond situations in which staff anticipate exposure to blood or body fluids.</p> <p>B.</p> <p>Record review of Resident 16's Clinical Census Record date 5/20/25 revealed Resident 16 admitted to the facility on [DATE].</p> <p>Record review of Resident 16's Diagnoses dated 5/20/25 revealed:</p> <p>Hemiplegia and Hemiparesis following affecting right dominant side, Aphagia following Cerebral Infarction, and Gastrostomy Status.</p> <p>Record review of Resident 16's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 5/9/25 revealed: Section K: feeding tube</p> <p>Observation on 5/20/25 at 1:00 PM with Liscened Practical Nurse (LPN)-A giving medication and doing Gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food.) cares for Resident 16. Resident 16 was lying in bed with head of bed at 90 degrees. LPN-A donned gown and gloves without performing hand hygiene. LPN-A checked the placement of gastrostomy tube by using a stethoscope and instilling air into the tube by a syringe and listening to the stomach for air. LPN-A flushed the gastrostomy tube with 60 milliliters of water, gave medication Gabapentin 100 milligrams (2 capsules) that was emptied into a small amount of water in a medicine cup and poured into the tube, then flushed again with water. LPN-A administered 8 ounces of Jevity into the syringe, then 75 milliliters of water. LPN-A closed the gastrostomy tube. LPN-A cleansed the skin surrounding the gastrostomy with soap and water and dried without cleansing hands or changing gloves prior. LPN-A applied a split 4x4 gauze around the gastrostomy area and taped it to skin. LPN-A lowered the bed, removed gloves and gown, then tied up trash and dirty laundry, and left the room without washing hands. LPN-A took the trash and dirty clothes to the hopper room, then went to nursing station and washed hands with soap and water x 16 seconds.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Parkview Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with LPN-A on 5/20/25 at 1:24 PM confirmed [gender] did not perform hand hygiene before applying the gloves and giving medicine, perform hand hygiene and change gloves when starting on gastrostomy cares and wash hands before leaving the resident's room, and perform hand hygiene with the soap and water for 20 seconds and should have.</p> <p>Interview on 5/20 at 2:30 PM with the DON revealed staff should have performed hand hygiene before applying the gloves and giving medicine, perform hand hygiene and change gloves when starting on gastrostomy cares, wash hands before leaving the resident's room, and perform hand hygiene with the soap and water for 20 seconds.</p> <p>Record review of Hand Hygiene Policy dated 9/2020 revealed:</p> <p>Policy: Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors.</p> <p>-Hand hygiene when using soap and water:</p> <p>-Wet hands with water. Avoid using hot water because repeated exposure to hot water may increase the risk of dermatitis.</p> <p>-Apply enough soap to cover all hand surfaces.</p> <p>-Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers.</p> <p>-Dry thoroughly with a single-use towel.</p> <p>-Use towel to shut off the faucet.</p> <p>-The use of gloves does not replace hand washing. Wash hands after removing gloves.</p> <p>Record review of enhanced barrier precautions policy reference by Center for Disease Control and Prevention dated July 12, 2022 revealed:</p> <p>-Policy: Is the policy of this facility that Enhanced Barrier Precautions, in addition to Standard and Contact Precautions will be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring a multidrug-resistant organism. (MDRO), such as a resident with wounds, indwelling medical devices or residents with infection or colonization with an MDRO.</p> <p>-Overview: Enhanced barrier precautions will not only focus on residents with infection or colonization with MDRO's but will also address residents at risk for developing or becoming colonized. Enhanced barrier precautions are precautions that are between standard precautions and contact precautions. Enhanced barrier precautions require gown and glove use for residents with a novel or targeted MDRO or any resident with a wound or indwelling medical device during specific high contact.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Parkview Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Purpose. The purpose of Enhanced Barrier Precautions is to prevent opportunities for transfer of MDRO's to employee's hands and clothing during cares, beyond situations in which staff anticipate exposure to blood or body fluids.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Parkview Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0923</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Have enough outside ventilation via a window or mechanical ventilation, or both.</p> <p>Licensure Reference Number 175 NAC 12-007.04(D)</p> <p>Based on observations, record review and interviews, the facility failed to ensure bathroom ventilation system was functioning preventing lingering odors from permeating for 10 occupied resident rooms, and the facility failed to ensure the ventilation system was free of dust in Rooms 103,104, 105, 106,107, 109, 110, 113,115, 117. This had the potential to affect all residents. The facility census was 24.</p> <p>Findings are:</p> <p>An observation on 5/19/25 at 8:59 AM revealed the bathrooms ventilation in rooms103,104,105,106,107,109, 110,113,115, and 117 did not have functional ventilation as tested with a 1 ply square of toilet paper held flat against the ventilation cover that did not hold the paper which indicated that there was no air draw and the ventilation system did not work. All vents had a white substance on the air grill, and the rooms revealed a stale ammonia odor.</p> <p>An observation on 5/20/25 at 8:03 AM revealed the bathrooms ventilation in rooms103,104,105,106,107,109, 110,113,115, and 117 did not have functional ventilation as tested with a 1 ply square of toilet paper held flat against the ventilation cover that did not hold the paper which indicated that there was no air draw and the ventilation system did not work. All vents had a white substance on the air grille, and the rooms revealed a stale ammonia odor.</p> <p>An interview on 05/20/25 at 9:03 AM with the Maintenance confirmed that the ventilations were not working for rooms 103-115 and 117 and that someone had shut off the switch. Maintenance confirmed that (gender) had not cleaned the vents yet this month.</p> <p>A record review of the monthly maintenance checklist for ventilation was marked yes for May 2025, that all fans are clean, free of debris and in working order.</p> <p>An interview on 5/20/25 at 9:14 AM with the Administrator confirmed that (gender) expectations are the ventilations are to be cleaned monthly and staff are to be checking it regularly and the ventilations are to be checked daily due to a resident shutting the switch off and with the ventilation system not working or being turned off the bathroom could have an odor build up.</p>