STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165547	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Home	102 North Jackson Street Wayland, IA 52654

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on observation, interview, and record review the facility failed to ensure accurate care planning of antipsychotic medication on the comprehensive Care Plan and failed to ensure the comprehensive Care Plan addressed wandering behavior for 1 of 13 residents reviewed for Care Plans (Resident #3). The facility reported a census of 32 residents. Findings include: Review of the Minimum Data Set (MDS) assessment for Resident #3 dated 6/25/24 revealed the resident scored 3 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment the resident took antipsychotic medication and wandered 1 to 3 days during the 7-day look-back period. Review of Resident #3's clinical record revealed an admitted to the facility on [DATE]. a. Review of Resident #3's Care Plan for psychotropic medication use dated 6/4/24 revealed the following: I use psychotropic medications (Haloperidol) r/t (related to) anxiety/Depression and Paranoid Schizophrenia. Review of the resident's Medication Administration Record (MAR) dated May, June, and July 2024 lacked administration of Haloperidol for this resident. Review of the resident's physician orders lacked an order for Haloperidol. b. Review of Resident #3's comprehensive Care Plan lacked a focus area to address wandering/elopement. The Baseline Care Plan Summary dated 5/22/24 revealed, Resident had an elevated risk for wandering and elopement. The Progress Note dated 6/5/24 at 3:18 AM revealed, Before supper last evening, resident was walking in the halls and alarm sounded when she went out of the end door on 200 hall. Resident just made it outside the door a little ways and staff was following her. Returned inside the building. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note dated 6/6/24 at 1:31 AM revealed, Pt (patient) after dinner went to the front door of the building and was trying to leave. Pt was easily redirected. Will report to oncoming of patient exit seeking The Progress Note dated 6/8/24 at 9:30 PM revealed, Resident attempted to leave facility by exiting doors alone on 400 hall. Resident cooperative as staff assisted her back into facility. Resident voices no c/o and is unable to state why she attempted to leave. The Orders-Administration Note dated 6/24/24 at 3:34 PM revealed, in part, res (resident) is wandering a lot today. will not sit down to allow this writer to change dressing. Review of the Wandering Risk Scale assessments dated 5/27/24 and 6/25/24 identified the resident at high risk to wander with a score of 11, then 12 on the assessment. Observation conducted 7/30/24 at 1:29 PM revealed Resident #3 walked with a walker down the hallway where the resident resided, then turned and walked back. Observation revealed a staff member asked Resident #3 where they were going, and Resident #3 responded, I don't know. On 8/1/24 at 3:52 PM, the MDS Coordinator queried about Haldol (Haloperidol), as was observed on the resident's Care Plan. The MDS Coordinator explained she did see the resident had Risperdal (a different antipsychotic medication). The MDS Coordinator explained she was going to take out the Haldol and put in psychotropic medication so did not happen again. When queried about wandering/elopement, the MDS Coordinator explained she saw the resident had a behavior Care Plan but did not have specifics. The MDS Coordinator explained she would update it. On 8/1/24 at 4:55 PM during an interview with Staff B, Registered Nurse (RN), Staff B explained the resident wandered a little bit, and was easily redirected. On 8/1/24 at 4:19 PM, a Facility Policy which addressed care plans, both comprehensive and revision, was requested from the facility. The policy was not provided prior to the exit of the survey.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48888 Based on interviews, clinical record review, and facility policy review, the facility failed to include person center care needs or identify interventions related to seizure disorders and medications taken to prevent seizures within the Care Plan for 2 of 5 residents (Resident #12 and #26) reviewed for medication regimen. The facility reported a census of 32 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #12, dated 6/11/24, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 indicating moderate cognitive impairment. Diagnoses included: Parkinson's Disease, non-Alzheimer's dementia, anxiety disorder, and depression. The Care Plan, revised 7/09/24, lacked identification of seizure disorder or anticonvulsant medications administered on a routine basis. The Medication Administration Record (MAR), dated August 2024, revealed medications ordered included: 1. Levetiracetam 500 milligrams (mg), given one and a half tablets by mouth every day and evening shift for Altered Mental Status (AMS), started on 3/27/24. 2. Carbamazepine 200 mg, given 1 tablet by mouth every day and evening shift for anticonvulsant, started on 3/27/24. A Hospital Inpatient Note, dated 12/22/23, revealed Resident #12's Past Medical History (PMH) had episode concerning for seizure 7/2023. Resident #12 taking Levetiracetam and Carbamazepine. A Hospital Inpatient Note, dated 12/30/23, revealed Resident #12's medical history included seizures. 2. The Minimum Data Set (MDS) for Resident #26, dated 5/28/24, revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating moderate cognitive impairment. Diagnoses lacked seizure disorder at time of assessment. The Care Plan, revised 7/25/24, lacked identification of seizure disorder or administration of anticonvulsant medications. The Medication Administration Record (MAR), dated July 2024, revealed an order for Levetiracetam 500 milligrams (mg) twice per day for seizure activity, started on 7/12/24 and discontinued on 7/26/24. The Order Summary dated August 2024, revealed an order for Ativan 2 milligrams (mg) per milliliter (mL), give 1 mg as needed intramuscularly for active seizure. The order start date on 6/19/24 with no discontinue date. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Hospital Note, dated 6/12/24, revealed a Principle Diagnosis of subdural hematoma (bleed in the brain membrane) status post fall. Resident #26 had been given Levetiracetam (Keppra) intravenously with recommendation from Neurosurgery to start Keppra 500 mg twice per day. A Nursing Progress Note, dated 6/12/24 at 1:22 PM, revealed nursing received communication from the Hospital that Resident #26 sustained a large subdural hematoma in which family had declined treatment and would discharge back to facility. Resident #26 returned to the facility with new medication order Keppra for seizure activity. On 6/19/24 at 2:00 PM, a Nursing Progress note revealed that the Provider ordered many oral medication to be discontinued per family request, including Keppra, and an as needed order for Ativan Intramuscular injection to be given for active seizure. At 3:24 PM, the facility additionally initiated seizure pads to be placed on Resident #26's bed as safety intervention. On 8/01/24 at 3:52 PM, Staff D, MDS Registered Nurse (RN), revealed that she had recently become responsible for updating the facility's Care Plans and worked offsite, communication regarding changes received from the facility in a weekly meeting and as needed. Staff D informed that if a resident has a diagnosis of seizure disorder whatever the facility's goal and interventions should be included in the resident's Care Plan. On 8/01/24 at 4:55 PM, Staff B, Registered Nurse (RN) revealed she had been responsible for updating fall related interventions in resident Care Plans but believed seizure disorders would be in resident Care Plans. Staff B informed that Resident #26 continued to have the seizure pads on bed intervention in place. On 8/1/24 at 4:19 PM, a Facility Policy which addressed Care Plans, both comprehensive and revision, was requested from the facility. The policy was not provided prior to the exit of the survey.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on observations, interviews, and clinical record review, the facility failed to ensure interventions had been effective to prevent recurring falls in 1 of 5 residents reviewed for accidents (Resident #19). The facility reported a census of 32 residents. Findings include: The Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 indicating moderate cognitive impairment. The MDS revealed Resident #19 required partial to moderate amount of staff assistance to transfer and ambulate. Diagnoses included Parkinson's Disease, non-Alzheimer's dementia, anxiety disorder, asthma, and muscle weakness. The MDS revealed Resident #19 had 2 or more falls since the last assessment date. The Care Plan, dated 5/08/24, revealed Resident #19 had been at high risk of falls with a history of multiple falls and listed the following dates in which a fall occurred: 2/18/24, 2/25/24, 3/21/24, 4/21/24, 4/22/24, 4/29/24, 5/01/24, 5/24/24, 5/25/24, 5/28/24, 5/30/24, 6/04/24, 6/18/24, 6/21/24, 7/30/24. The Care Plan revealed Resident #19 required the assistance of one staff for transfers, ambulation, and toileting needs using a walker and gait belt. Additionally the Care Plan revealed Resident #19 had impaired cognitive function and impaired thought processes related to delirium with impaired decision making and behavioral problems such as verbal aggression and refusal of cares. Review of Resident #19's Incident Reports, revealed 8 of 18 falls had intervention to remind resident to use call light or call for help. A review of incident reports indicated the following interventions implemented: 1. On 02/16/24 at 3:50 PM, unwitnessed fall in resident's room, reminder for staff to look and make sure belongings are off the floor. 2. On 02/25/24 at 8:30 PM, unwitnessed fall in resident's room, intervention for staff to assist resident to get ready for bed at 8 PM per her request. 3. On 3/23/24 at 3:45 AM, unwitnessed fall in resident's bathroom, intervention for staff to leave her door open or cracked at night. 4. On 4/11/24 at 7:00 PM, unwitnessed fall in resident's room, intervention for staff to frequently check on resident and encourage use of call light. 5. On 4/21/24 at 9:00 PM, unwitnessed fall in resident's room with door closed, intervention for staff to leave door open or cracked for closer supervision. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. On 4/22/24 at 8:00 AM, unwitnessed fall in resident's room, intervention for staff to open curtains once resident is ready for the day. 7. On 4/29/24 at 2:30 PM, unwitnessed fall in resident's room, intervention to place non slip strips next to the bed. 8. On 4/30/24 at 7:00 PM, unwitnessed fall in resident's room, intervention to encourage resident to use call light and staff continue with frequent checks. 9. On 5/24/24 at 6:06 PM, unwitnessed fall in resident's room, staff to continue to remind resident to not get up without assistance as resident does not remember. 10. On 5/25/24 at 12:50 PM, unwitnessed fall in resident's room, staff remind resident to use controls for recliner and call for help. 11. On 5/28/24 at 8:50 AM, unwitnessed fall in resident's room, staff continuously remind resident to call for help. 12. On 6/04/24 at 8:15 PM, witnessed fall in bathroom when handrail moved, intervention to replace or repair bathroom handrail. 13. On 6/12/24 at 2:00 PM, unwitnessed fall in resident's room, intervention to place bed in lowest position when the bed is made. 14. On 6/12/24 at 3:30 PM, unwitnessed fall in resident's room, intervention to place reminder sign on walker and in room. 15. On 6/18/24 at 1:50 PM, unwitnessed fall in resident's room, staff continue to work with resident to call for help. 16. On 6/21/24 at 9:15 PM, unwitnessed fall in resident's room, staff re-educated on getting resident ready for bed at 8 PM per her request. 17. On 6/26/24 at 5:45 AM, unwitnessed fall in resident's room, shorten oxygen tubing, resident continues to get up without assistance. 18. On 7/17/24 at 9:30 AM, unwitnessed fall in resident's room, Resident #19 found with eyes open, not responding, had a laceration to back of head and pain in right hip. Incident report indicated last time resident toileted is unknown, resident transferred to the hospital and returned without fracture sustained. Intervention for all departments to spend one on one time with resident when able and continue to encourage resident to call for assistance. The Transfer Assessment Form, dated 7/17/24, revealed Resident #19 had been sent to the Hospital due to fall and informed that resident had frequent falls due to resident ambulation in room without assistance. Injuries included left hip pain and head laceration. Head pain rated 7-8 out of 10. A Primary Care Provider Note, dated 7/19/24, revealed Resident #19 had fall on 7/17/24 that required a trip to the Emergency Department as a result of laceration to head, that required 2 staples. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/24 at 1:29 PM, Resident #19 ambulated in room without walker, noted non gripper socks on her feet, a Certified Nursing Assistant (CNA) passed by and asked Resident #19 to sit back down in her recliner. On 7/29/24 at 1:38 PM, Resident #19 walked around room without walker, attempted to move a wheelchair to get into drawers. Resident #19's gait unsteady as she moved about room. On 7/30/24 at 1:09 PM, Resident #19 walked around in room, CNA passed by and asked to sit down. On 7/30/24 at 1:25 PM, Resident #19 walked around room, Nurse passed by and tried to get Resident #19 to sit down. Resident #19 stated, she is tired of sitting and needed something to do, Nurse called activity director to get resident a puzzle. On 8/01/24 at 10:10 AM, Staff B, Registered Nurse (RN), revealed that Resident #19 is non-complaint with waiting for help and has had repeated falls. Staff B stated the staff try to keep an eye on Resident #19 and try to keep her door open. Staff B informed that interventions in place to prevent falls include one on one with resident, inviting her to activities, and frequent checks. Staff B revealed Resident #19 had confusion and sometimes understood use of call light. On 8/01/24 at 1:22 PM, Staff A, Certified Medication Assistant (CMA) informed that fall interventions for Resident #19 included frequent checks, sign placed on wall to remind her to call, and keep resident items close to her. Staff A revealed that Resident #19 will sometimes push call light but not always. On 8/01/24 at 4:28 PM, Staff C, Registered Nurse (RN), informed that Resident #19 often is non-compliant with calling for help and stated staff constantly help her back to chair. Staff C revealed interventions to prevent Resident #19 falls included give resident her call light, offer a snack, bring to nurses station, and frequent checks.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 48888 Based on observation, interview, hospital record review, and clinical record review, the facility failed to include self harm monitoring, triggers, and safety interventions in the plan of care following attempted suicide for 1 of 2 residents reviewed for behavioral health needs (Resident #12). The facility reported a census of 32 residents. Findings include: The Minimum Data Set (MDS) assessment, dated 6/11/24, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderate cognitive impairment. The MDS indicated Resident #12 had verbal behaviors directed at others and rejection of cares reported during the review period. Diagnoses included Parkinson's Disease without dyskinesia, non-Alzheimer's dementia, anxiety disorder, depression, and adjustment disorder with depressed mood. The MDS revealed Resident #12 required antidepressant and antipsychotic medications. The Care Plan, revised on 7/09/24, revealed Resident #12 had impaired cognitive function, verbal aggression, and inappropriate behaviors at times with staff. The Care Plan listed the goal that resident's behaviors will not interfere with other residents. Behavioral interventions included: 1. Administration of medications as ordered, monitor for side effects and effectiveness 2. Provide opportunity for positive interaction with resident, stop and talk with him as passing by. 3. Psychiatric services initiated. 4. If reasonable, discuss resident's behavior and explain why it is inappropriate or unacceptable to the resident. 5. Intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, remove from situation and take to alternate location as needed. 6. Monitor behavior episodes and attempt to determine underlying cause, document behavior and potential causes. 7. Praise any indication of resident's progress or improvement in behavior. 8. Provide a program of activities of interest and accommodate resident's status. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Hospital Adult Psychiatric Inpatient Note, dated 12/22/23, revealed a transfer and admission to the Hospital related to suicide attempt, increasing depressive symptoms, and agitation. The Hospital Note revealed that on 12/20/23, Resident #12 was found at the facility, in his closet, with a belt wrapped around his neck, attempting to tie the belt to the rod in the closet. Resident #12 had stated he was trying to hurt himself and that he does attempt to hurt self everyday. Note revealed accompanying documentation from facility included several communications from Resident #12 to his children that appeared to be suicide notes. Hospital Note additionally revealed past trauma related to abuse. Hospital completed suicide risk assessment, Resident #12 determined to be at moderate to high risk. Review of Nursing Progress Notes, revealed the following entries: a. On 11/27/23 at 4:09 PM, family discussed concern about Resident #12 increase in odd behaviors and requested dementia testing be done. b. On 12/01/23 at 7:10 PM, another call from family regarding concern about increase in Resident #12's odd behaviors, again requesting dementia testing be done. Nursing charted they would notify Director of Nursing and Primary Care Provider. c. On 12/06/23 at 10: 32 AM, nursing staff report increased verbal and sexual behaviors with staff that had not improved since initiation of Sertraline on 10/29/23. Update sent to Psychiatric Provider to report concerns and schedule appointment. d. On 12/18/23 at 1:09 PM, Resident #12 refused to eat, spoke only minimally and appeared upset, quietly declined cares. e. On 12/20/23 at 6:22 PM, Resident #12 sat on footrest of recliner, did not know where he was going or what he was doing. Resident #12 had eyes very wide open and appeared mixed up. Nursing had suggested to day shift to get a hold of Psychiatric Provider to discuss recent behaviors and possible medication change. f. On 12/20/23 at 6:41 PM, Resident #12 requested a sheet of paper and a pen to write a letter, staff gave him a sheet of blank computer paper and a pen. g. On 12/20/23 at 9:51 PM, staff went into Resident #12's room when he was not seen in bed or chair, found Resident #12 in the closet with belt around his neck attempting to hang himself. Nursing noted resident had been in a tormented state all shift, called people constantly and wrote letters. Nurse called Director of Nursing who text Resident #12's Psychiatric Provider, order to transfer Resident #12 to Emergency Department for psychiatric evaluation. h. On 3/27/24 at 2:30 PM, Resident #12 returned to facility from Hospital, mildly aggressive mood during admission assessment, refused to have weight checked. i. On 4/04/24 at 9:17 PM, Nursing noted after evening meal, Resident #12 started verbalizing that he would die tonight, stated he was not going to do anything to cause it, but he just had the feeling. Resident went around to tell other residents that this was his last night. 15 minute checks initiated on Resident #12 through the evening and night. Primary Care Provider at facility, talked to resident and made aware of the situation. DON also made aware. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	j. On 4/18/24 at 12:04 AM, Resident #12 asked staff if he could have his belt back, belt had been removed from room due to history of suicide attempt. Belt remained at nurses station. k. On 4/21/24 at 5:57 PM, Resident #12 asked if he could have the Certified Nursing Assistant's (CNA) gait belt, CNA told him no. l. On 4/21/24 at 8:38 PM, Resident #12 worked at over bed table all evening writing notes, nursing informed staff would continue to monitor him closely. m. On 7/07/24 at 10:40 AM, Resident #12 in his room taking razor apart and trying to put back together. Resident #12 threw the wheelchair foot pedals at staff's feet who entered room. n. On 7/08/24 at 5:23 PM, Resident #12 found on floor knelt in front of bed with head pressed down in a blanket, told staff he wanted to die and did not want to be here. On 7/29/24 at 1:46 PM, Resident #12 sat in recliner in room, only provided a nod in response, offered no verbal responses. On 8/01/24 at 4:04 PM, Staff D, MDS Registered Nurse (RN), revealed that any self harm or suicide attempts would be included in the Care Plan under the behaviors and safety sections. Staff D worked offsite and received information from the facility through communication with Interdisciplinary Team during weekly meetings. Staff D revealed other disciplines should update their areas such as sections specific to Social Work, Dietary, and Activity staff. On 8/01/24 at 4:28 PM, Staff C, RN, reported Resident #12 would put himself on the floor at times and had agitated behaviors. Staff C recalled Resident #12 recently stated he felt he would die one evening, but informed he wasn't going to do anything to harm self. In response, Staff C stated Resident #12 had been put on suicide watch, notified Director of Nursing, and had staff sit outside resident's door overnight to watch him. Staff C recalled Resident #12's belt had been at the Nurse's Station, unable to recall additional items Resident #12 was not allowed to keep in room for safety reasons. On 8/01/24 at 4:40 PM, Staff E, Social Services staff, revealed Resident #12 often had behaviors such as putting self on the floor, making calls to 911, and destroying phones. Staff E stated Resident #12 had not attempted to harm self since prior suicide attempt at facility. Staff E informed that when Resident #12 had admitted to facility he said he would rather die than stay at facility. Staff E revealed that everything cord like had been taken out of room such as strings and belts. On 8/01/24 at 4:55 PM, Staff B, Registered Nurse (RN) informed that Resident #12 had no additional suicidal ideation since he returned to the facility from hospital. Staff B stated if Resident #12 had indication to harm self, he would tell someone. Staff B reported interventions to prevent harm included removal of the closet bar from Resident #12's room and no gait belts in room. Staff B revealed Resident #12 did still have call light cord in room. Staff B stated Certified Nursing Assistants (CNAs) could check for safety interventions on Resident #12's Care Plan/Kardex. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/01/24 at 5:17 PM, Facility Administrator, indicated there had no longer been a concern with Resident #12's safety related to self harm or re-attempted suicide. Administrator reported Resident #12 had changed since hospitalization , and that Resident #12 stated he would not do that again. Administrator informed that staff had in-service training on trauma informed care, but denied use of screening assessment for Post Traumatic Stress Disorder (PTSD).