STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165306	A. BUILDING _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER	2237 HIGHWAY 34 FAIRFIELD, IA 52556

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
POC OK 11.17.22 SjS	Correction date 10-14-2022.			
	The following deficiencies resulted from the facility's annual recertification and investigation of complaints #97763-C, #97864-C, #102024-C, #102277-C, #10228-C, and 103628 were conducted on August 8, 2022 to August 11, 2022. The survey was conducted by Healthcare Management Solutions, LLC on behalf of the Iowa Department of Inspections and Appeals. Complaint #102024-C was substantiated. Complaints #097763-C, 097846-C, #102277-C, #102278-C, and #103628-C were not substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sarah Slattery | TITLE: Administrator | (X6) DATE: 10-14-2022

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.

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F 580	Continued From page 1 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and policy review, the facility failed to ensure that one resident's (Resident (R) 9) representative was notified of a change in condition from a total sample of 17.	F 580		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 580	Continued From page 2 Findings Include: Review of the facility's undated policy titled, "Change in Condition," provided by the facility, revealed "The facility will make every effort to inform the resident, consult with the resident's physician, and notify consistent with his or her authority, the resident representative where there is the following: an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the physical, mental, or psychological status, which is a determination in health, mental or psychological status in either life threatening conditions or clinical complications; a need to alter treatment significantly, that is a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment; a decision to transfer or discharge the resident from the facility." Review of Resident#9's review of facility provided Resident Face Sheet indicated that she was admitted to the facility on 10/31/16 with a diagnosis that includes generalized anxiety disorder (GAD) and major depressive disorder (MDD). Review of Resident Progress Notes for the Resident dated 10/13/21 to 10/20/21 lacked documentation that a resident representative had been notified of the incident that had occurred on 10/13/22. Review of R9's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 09/10/21 revealed that R9 has a Brief Interview for Mental Status (BIMS) score of a 12, indicating	F 580		

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F 580	Continued From page 3	F 580		

she is moderately impaired. Continued review indicated that R9 does have verbal behavior toward others, occurring one to three days.

A Progress Note dated 10/13/21 at 10:52 a.m., indicated that Resident#35 denied touching Resident#9 but confirmed that he (R35) flipped Resident#9's (R9) chair up and R9 landed on the floor, striking the left side of her face. R9 had a large hematoma surrounding her left eye. The Progress Note documented that R35 had reported that R9 had harassed him by saying "there goes R35 out to smoke".

Review of Fall Investigation (provided by the facility), dated 10/13/21, revealed that "R35 had upset R9's chair in the dining room. R9 had a large swollen left eye that is almost shut. Was sitting on the floor with chair tipped over." Continued review revealed no evidence that R9's guardian was not made aware of the incident.

A State of Iowa Court Order dated 9/30/22 revealed that the court found good cause to appoint a Guardian ad Litem for the resident. The court appointed a attorney to ensure that the residents rights are protected, and that if the resident had been found to not to be competent, then the court should be notified so that a conservator shall be appointed.

Review of court papers for order appointing guardian ad litem for surviving spouse dated 9/30/2020 (provided by the facility) revealed that the court found good cause to appoint a Guardian ad Litem and appointed an attorney to ensure that the surviving spouse's rights are protected. Further review revealed that if R9 is found to not be competent, then the court should be notified

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F 580	Continued From page 4 so that a conservator shall be appointed. Interview with Activity Director (AD) on 08/10/22 at 1:50 PM, she reported that R9 is her own person, but had a Guardian ad Litem appointed by the courts, who she has had contact with on several occasions. This Guardian ad Litem was appointed after R9's husband passed in 2020. During a follow- up interview at 2:33 PM, the AD confirmed that if the Guardian ad Litem was still involved at the time of the incident, then they should have been notified; however, confirmed that the Guardian ad Litem was not notified of the incident on 10/13/21. Interview with the Director of Operations (DOO) on 8/10/22 at 2:50 pm, confirmed that if a Guardian ad Litem was still appointed to R9 then they should have been notified of the incident that happened on 10/13/21.	F 580		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		

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F 600	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, review of facility policy, and Facility Reported Incident (FRI), the facility failed to ensure that one resident (Resident# 9) of two residents reviewed for abuse was free from physical abuse. Findings include: Review of the facility's policy titled, "Abuse," provided by the facility, revised 06/08/22, revealed "Facility will not permit its residents to be subjected to abuse by any person, including staff members, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, friends or other individuals. Any resident-to-resident altercation shall be reported to state agencies where there is injury, or where there is evidence of psychological distress to either resident involved." 1. Review of Resident#9's (R9) FaceSheet indicated that she had been admitted to the facility on 10/31/16 with a diagnosis which included generalized anxiety disorder (GAD) and major depressive disorder (MDD). During review of electronic medical record progress notes R9 had a history of making negative statements toward other residents. Review of R9's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date 09/10/21 revealed that R9 had a Brief Interview for Mental Status (BIMS) of a 12, indicated she had been moderately impaired. Continued review indicated that R9 does have verbal behavior	F 600		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 600	Continued From page 6 toward others, occurring one to three days per week. The Progress Note for R35, dated 10/13/21, revealed that ". . . (R9) had harassed him by stating there goes R35 out to smoke." Further review indicated that R35 denied touching R9 but confirmed that R35 flipped R9's chair up and R9 landed on the floor, and struck the left side of her face. R9 had a large hematoma that surrounded her left eye. R35 had been advised that if it happened again, then the police would be contacted. R35 reported that he would do it again if R9 did not stop harassing him. Observation of R9 on 08/08/22 at 10:00 AM, revealed that R9 had sat in the activity room with her head kept down. During another observation, and interview, on 08/08/22 at 1:00 PM, R9 had sat in her bedroom doorway, looking at her coloring pages and crayons. R9 was calm and cooperative. R9 reported that she had been a cop, and that she gets along with all other residents. R9 denied the incident between her and R35 . Observation of R9's face revealed no swelling and/or marks noted to the left side. R9 confirmed no concerns with vision. Further observation at 4:10 PM, revealed R9 had sat at a table in the dining room, calm and cooperative. 2. R35's Face Sheet indicated that he had been admitted to the facility on 07/10/18 with a diagnosis that includes drug and alcohol abuse, and dementia. Review of electronic medical record progress notes revealed no history of physical abuse toward others. R35's Quarterly MDS with the date of 10/08/21 revealed that R35 has a BIMS of a 14, which	F 600		

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F 600	Continued From page 7	F 600		

indicated that he had been cognitively intact. Continued review indicated that R35 has no behaviors.

Observation on 08/08/22 at 09:40 AM, R35 sat quietly in his bedroom watching baseball on the television. R35 had been calm, cooperative, and alert and orientated. During resident interview, R35 reported he had no confrontations with any other residents at the facility.

Review of the "Self-Report", dated 10/31/21 at 8:04 AM had been submitted to the State Survey Agency.

Interview with Registered Nurse (RN) 2 on 08/08/22 at 2:49 PM, she confirmed that she had been in the building when R32 reported to her about the incident on 10/13/21 between R9 and R35. R32 reported that R35 pushed R9's chair over. RN2 went to see R9, who had been in the dining room, and with the help of two aides, R9 had been assisted up off the floor. She went to talk with R35 about this incident, who stated that R9 had made comments about him smoking and he was tired of those comments, so R35 confirmed that he pushed R9's chair over but denied hitting R9. Upon assessment, R9's left eye had completely shut with black/blue on the left side of her face, with a hematoma covering her left eye. Confirmed no blood. RN2 reported that the Nurse Practitioner (NP) came into see both residents, and that neurological checks had been started. RN2 reported that R9 did not complain of any pain, and denied having a headache. RN2 reported that R9 had been sent to the hospital, and confirmed that there have been no further incidents. RN2 reported that R9 could get "lippy" with several residents; however, R9 had not

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F 600	Continued From page 8 made any further comments since this incident. Interview with NP on 08/09/22 at 10:00 AM, she stated that she spoke with R35 about the incident, saying that this type of behavior would not be tolerated in the facility, and the next time, the police would be contacted. She said that she did assess R9's injury, and she was alert without any loss of conscious (LOC). Said that R9 was placed on frequent checks per facility policy. Confirmed that R9 did not go out to the hospital, but ice packs were applied to R9's face. She confirmed that R9 could be "very stubborn" and could get angry at times. Said that R9 does refuse care at times and could be critical of both staff and other residents, but mainly of residents. To her knowledge, there had been no incidents of this kind before and/or after this incident. Confirmed that both residents (R9 and R35) have some degree of underlying cognitive issues. The Director of Operations (DOO) on 08/10/22 at 2:50 PM, reported that the residents should be immediately separated and an investigation conducted. The DOO confirmed that there had been no further incidents between R9 and R35. The DOO stated that R9 had been moved for a period to another dining room without any further issues. Confirmed that R35 just wants to be left alone, and not bothered.	F 600		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged	F 610		

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PARKVIEW CARE CENTER	2237 HIGHWAY 34 FAIRFIELD, IA 52556

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F 610	Continued From page 9 violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and policy review, the facility failed to ensure that an investigation was completed for resident-to-resident abuse between two of two residents (Resident#9 and 32) reviewed for abuse. Findings include: The Abuse Policy, with the revised date of 06/08/22, directed staff as follows; the facility will thoroughly investigate all allegations of resident abuse, including neglect or misappropriation of resident property, and will report all findings to the state abuse registry, licensure boards, and state department of inspections and appeals. The Administrator or his/her designee must complete an incident report and obtain written, signed, and dated statements from the person (s) reporting the incident. A completed copy of the incident report and written statements from witnesses, if any, must be provided to the Administrator within twenty-four (24) hours of the occurrence of such incident. An immediate investigation will be made	F 610		

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F 610	Continued From page 10	F 610		

and will include interviewing all staff who worked in the area where the incident occurred and who worked during the 24 hours prior to the incident, and a copy of the finding of such investigation will be provided to the Administrator within three (3) working days of the occurrence of such incident. Suspected abuse must be reported immediately and no later than two hours after the alleged incident. The Administrator, Director of Nursing, or Charge Nurse will obtain a written, signed, and dated statement from the person reporting the incident. Written statement will include at least the following information: the name of the resident involved, the date and time that the incident occurred, where the incident took place, the name (s) of the person (s) committing the alleged incident, in known the name (s) of any witnesses to the incident, the type of abuse that was committed (i.e. verbal, physical, sexual, etc.), and other information that may be requested by the Administrator or Charge Nurse. The charge nurse or director of nursing shall immediately examine the resident. Findings of the examination will be recorded in the resident's medical record. The director of nursing will request that a representative of the social services department monitor the resident's feelings concerning the incident as well as the resident's reactions to his/her involvement in the investigation. Unless otherwise requested by the resident, the social service representative will provide the Administrator and the director of nursing with a written report of his/her findings. The charge nurse will report any change in the resident's condition or status to the resident's attending physician and the resident's representative. The Administrator or director of nursing will obtain completed copies of written statements from witnesses, if any, within

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F 610	Continued From page 11 twenty-four (24) hours of the occurrences of such alleged incident." The document titled, "Self-Report" dated 10/31/21 at 08:04 AM, revealed that Resident#9 (R9) was sitting in the main dining room and stated to Resident#35 (R35), "there goes R35 going out to smoke" repeating as R9 always does. R35 pushed her chair down, stating "I've told her not to talk to me and stay out of my business." R32 witnessed the incident. The two residents were separated, R35 was counseled on the incident and behavior, and seen by the Nurse Practitioner (NP). R9 was encouraged to remain in her room between meals and not to sit in the dining room all day. R9 was also seen by the NP. The Progress Note for R35, dated 10/13/21, revealed that ". . .resident (R9) was harassing him by saying there goes R35 out to smoke." Further review indicated that R35 denied touching R9 but confirmed that he flipped R9's chair up and R9 landed on the floor, striking the left side of her face. R9 has a large hematoma surrounding her left eye. R35 was advised that if this happens again, then the police would be contacted. R35 said that he would do it again if R9 did not stop harassing him. Review of untitled and undated summary of the incident revealed that R9 was sitting in the main dining room when she stated "here goes R35 going out to smoke" repeating as she always does. R35 pushed R9's chair down, stating "I've told her not to talk to me and stay out of my business." R32 witnessed the incident and informed RN2. The incident occurred at 5:45 AM on 10/13/21. R9 had a history of making comments to others and always sat in the main	F 610		

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F 610	Continued From page 12 dining. R9 had a hematoma to her left eye, neurological checks initiated every 15 minutes times four for the first hour. Neurological checks will continue per protocol. R9 did not require hospitalization. The facility failed to complete interviews with staff and/or residents. The Director of Nursing (DON) on 08/9/22 at 11:00 AM, reported that she did not find any paperwork where this incident had been investigated; however, had been able to print off information that was sent to the State Survey Agency (SSA) after the resident to resident abuse occurred. During a follow up interview on 8/9/22 at 11:41 AM, the DON confirmed that the Administrator had been contacted and is unaware of where the investigation paperwork is located. The Director of Operations (DOO) on 08/10/22 at 2:50 PM, reported that anytime that abuse is alleged then there is a report to the SSA within two hours and an investigation is to be completed. Continued interview revealed that the investigation should include interviews, assessments, if any behaviors have occurred then documentation of the interventions and follow up with revised interventions. Also, the residents should be immediately separated and a follow up to the SSA should occur after investigation.	F 610		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		

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	165306	A. BUILDING _____ B. WING _____	08/11/2022

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F 761	Continued From page 13 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and manufacturer's recommendations review, it was determined the facility failed to ensure the proper storage and labeling of two out of three Tuberculin Purified Protein, Derivative (Mantoux) vials in one out of two medication storage rooms, creating the potential for inaccurate reading of tuberculosis skin tests of the residents. Findings include: The facility's policy titled, "Policy for Medication Storage and Disposition, " Parkview Care Center Pharmaceutical Services," revised 12/01/98, indicated, "Policy, Nursing services will properly store all drugs and biological's. Under Containers: Nursing staff will store all drugs and	F 761		

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F 761	Continued From page 14 biological in the containers in which they are received, and under Labels: Nursing services will assure that all drugs and biological are properly labeled, including appropriate accessory and cautionary instructions and the expiration date. Nursing personnel will return containers with missing, damaged, incomplete, or illegible label to the pharmacy for proper labeling before storing. Under Inspection: the consultant pharmacist and the Director of Nursing will inspect medication storage quarterly. They will sign and file an inspection report with the Administrator. The report will certify the absence of the following: Expired Medications Deteriorated medications Improper labels Medications for which there is no current physician's order Improperly stored medications" Observation on 08/10/22 at 5:30 AM, of the A hallway medication refrigerator in the medication storage room, revealed two opened and un-dated or initialed multi-dose vials of Tuberculin Purified Protein, Derivative (Mantoux) Tubersol, which expired 06/17/23.. Vial # 1 was observed to contain approximately 0.1milliliter (ml) of solution, and vial # 2 was observed to contain less than 0.5 ml of solution. The front label of the vial states to discard opened product after thirty days. The manufactures' recommendations state a vial of Tubersol which has been entered and in use for 30 days should be discarded, do not use after expiration date. Licensed Practical Nurse (LPN) 5 on 08/10/22 at 5:40 AM Staff LPN5 verified the two Tuberculin Purified Protein, Derivative (Mantoux) Tubersol vials had been opened and not dated. "You	F 761		

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F 761	Continued From page 15 should always date a vial when it is opened." The Director of Nursing on 08/10/22 at 6:17 PM reported it was her expectation that all multi-use medication vials should be dated when opened, to ensure the potency of the medication, and to discard the vial after 30 days according to manufacturer's recommendations. She stated she was new to her position and did not currently have a routine of inspecting the medication storage room and medication carts but would work on developing one with the pharmacist and licensed nursing staff.	F 761		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, the Quality Assurance (QA) committee failed to ensure required members of	F 868		

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F 868	Continued From page 16 the committee attended the quarterly meetings. This failure had the potential to affect all residents who currently live in the facility. The facility had a census of 42 Findings include: Review of the facility sign-in log for the "Quality Assurance and Assessment Committee" meeting dated 09/29/21 revealed both the Administrator and the Director of Nursing (DON) failed to attend the meeting. Review of the facility document titled, "Quality Assurance and Performance Improvement (QAPI), an undated document, revealed, "It is the policy of the facility to develop a QAPI plan in accordance with Federal Guidelines to describe how the facility will address clinical care, resident quality of life and residents' choice ...Procedure: 3. The facility maintains documentation and can demonstrate evidence that the program meets CMS (Center for Medicare and Medicaid) requirements. 5. The Quality Assessment and Assurance Committee consists at a minimum of: a. The director of nursing services; b. The Medical Director or his/her designee; c. At least three other members of the facility's staff, at least one of who must be the administrator (sic) ..." On 08/11/22 at 12:35 PM an interview with the Director of Operations (DOO) was conducted. During the QAPI interview the DOO stated that "the QAPI committee meets quarterly and is attended by the Medical Director, DON, Administrator and department heads." When the sign-in logs were reviewed the DOO stated, "the administrator and the DON failed to attend the 09/29/22 quarterly meeting."	F 868		

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F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 18 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure staff maintained appropriate infection control measures for the safe handling of medication during the administration of medication for five of 13 residents (Resident (R) 26, R45, R41, R20, and R25) during the observation of medication pass. Findings Include:	F 880		

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F 880	Continued From page 19 During a medication pass on 08/09/22 from 3:00 PM through 3:25 PM, Registered Nurse (RN) 9 was observed preparing and administering R26's oral medication without performing hand hygiene (washing her hands with soap and water or using Alcohol Based Hand Rub.) Following the administration of R26's medication, RN9 was not observed to perform hand hygiene, however she was observed to touch the resident, medication cart and keys prior to the preparation of the next resident's medication. RN9 was then observed to prepare and administer R45's and R41's oral medication without performing hand hygiene. Following the administration of R41's medication, RN9 was not observed to sanitize her hands after the administration of medication, however RN9 was observed to touch the back of R41 with her right hand, then touched keys with her right hand, then touch the top of the medication cart with both hands, then touch the computer keyboard with both hands and the mouse of computer with her right hand prior to the preparation of the next resident's medication, R20. With continued observation RN9 then prepared and administered R20's oral medication without performing hand hygiene. Following the administration of R20's medication RN9 failed to sanitize her hands and was observed to touch another resident, R25, with her left hand, prior to the preparation of R25's medication. With continued observation RN9 then prepared and attempted to administer R 25's medications without hand hygiene, however R 25 refused to take the medication, and RN 9 was observed to return the Cranberry Concentrate capsule and the	F 880		

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F 880	Continued From page 20 Colace with Senna 50/8 two tablets into the original strips of medication with her hands, touching the medications with her fingers while replacing the medication into the storage package. With continued observation RN9 did not perform hand hygiene between the preparation and administration of oral medications between all five residents: R 26, R 45, R 41, R 20, and R 25. An interview was attempted with RN9 on 08/10/22 and 08/11/22 but was not able to be completed. On 08/11/22 at 9:14 AM, an interview with Certified Nursing Assistant (CNA) 7, who is also a Certified Medication Technician (CMT), reported she always washed her hands when she goes into a resident's room, after giving the resident medication, and between the medication administration of residents. "I would never touch medication with my fingers or put medication back into the medication packets, if the resident refused to take the medication, I would destroy the medication in front of a nurse." The Director of Nursing (DON) on 08/10/22 at 6:11 PM regarding infection control practices and the administration of medication, the DON "stated it was her expectation that all the licensed nurses and medication technicians sanitize their hands before the administration and preparation of all medications for every resident. It is my expectation that all the licensed nurses and medication technicians never touch a resident's medication with their fingers, and/or re-insert medication into the original packaging strip of the resident's medication."	F 880		

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F 921	Continued From page 21	F 921		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility policy review, the facility failed to ensure an environment free from potential accident hazards when the emergency exit door at the rear of the "Special Care Unit" (secure unit located off "B" hall) was bent and is held secure by the magnetic lock. The "panic bar" is unable to properly latch and the door is gapped. Findings include: Observation performed on 08/08/22 at approximately 10:35 AM revealed, the emergency exit door at the rear of the "Special Care Unit" (secure unit located off "B" hall) was bent and is held secure by the magnetic lock. The "panic bar" is unable to properly latch and the door is gapped. There is approximately a 1.5-2.0-inch gap between the door and the door frame. This surveyor was able to place fingers between the door and door frame. On 08/09/22 at 10:40 AM the Maintenance Director (MD) reported, "the door is bent and the "panic bar" is unable to latch due to the door being bent. The bottom of the door is gapped." On 08/10/22 at approximately 4:30 PM an interview and observation of the door was conducted with the Director of Operations (DOO).	F 921		

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F 921	Continued From page 22 The DOO confirmed that the exit door at the rear of the Special Care Unit is bent. "The door is secured by the magnetic lock, but the door is bent and not closing properly." "The door is gapped at the bottom and has approximately 1.5-2.0-inch opening. "You can fit your fingers in the gap above the panic bar. The panic bar is not latched." Review of the facility policy, "Preventive Maintenance" dated 11/15/98, revealed, "Policy: Maintenance services will properly complete the routine maintenance checks and task required for preventive maintenance. Procedure: Preventive maintenance, In order to ensue preventive maintenance, maintenance services will complete routine maintenance checks and tasks as scheduled. See the schedules in the appendix. Maintenance services will keep these checklists on file to show that equipment has been checked regularly. Appendix 5, Monthly checklist - doors directed staff to check magnetic releases for the doors."	F 921		

Plan of Correction

Parkview Care Center

Survey: August 8, 2022, to August 11, 2022

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies were executed solely because the provisions of State and Federal law require it.

F580 Notify of Changes

An audit was completed on all other similarly situated residents and family notification were reviewed on 9/22/2002.

The family notification policy was reviewed and revised on 8/18/2022.

Nurses were educated on 8/18/2022 regarding notification of family/POA's for all incidents, change of conditions, new physician orders, and etc.

Audits will be completed by the DON/or Designee periodically to ensure compliance. **Ongoing**

Audit findings will be brought to the monthly QAPI meetings. **Ongoing**

F600 Free from Abuse, Neglect and Exploitation

Without waiving the foregoing statement, the facility states that with respect to the Abuse Reporting.

Facility does investigate and report allegations of abuse.

Re-education to management staff regarding the abuse policy on keeping a resident free from abuse, neglect, and exploitation completed on 8/18/2022.

Abuse will be reported/investigated per policy.

An audit was completed to ensure all employees have completed their Dependent Adult Abuse required training on 8/25/2022.

An audit was completed to ensure no other potential abuse has occurred in the building.

An audit was completed by the Administrator or Designee periodically to ensure compliance. **Ongoing**

Audit findings will be brought to the monthly QAPI meetings. **Ongoing**

F610 Investigation of Abuse

Without waiving the foregoing statement, the facility states that with respect to the Abuse Reporting.

Facility does investigate and report allegations of abuse.

Re-education to management staff regarding the abuse policy investigating abuse completed on 8/18/2022.

Abuse will be reported/investigated per policy.

An audit was completed to ensure all employees have completed their Dependent Adult Abuse required training on 8/25/2022.

An audit was completed to ensure no other potential abuse has occurred in the building on 9-29-2022.

Audits will be completed by the Administrator or Designee periodically to ensure compliance. **Ongoing**

Audit findings will be brought to the monthly QAPI meetings. **Ongoing**

F761 Label/Store Drugs and Biologicals

The TB vials were discarded by Staff (Director of Nursing) on 8/10/2022.

The medication storage policy was reviewed on 8/10/2022.

The Staff (LPN) 5 was re-educated regarding the medication storage policy on 8/10/2022.

All other nurses and CMA's were re-educated regarding the medication storage policy on 8-10-2022.

Audits will be completed by the DON/or Designee periodically to ensure compliance. **Ongoing**

Audit findings will be brought to the quarterly QAPI meetings. **Ongoing**

F868 QAA Committee

The DON and Administrator were re-educated on QAPI meeting attendance on 8/15/2022.

All other management staff were re-educated on QAPI meeting attendance on 8/15/2022.

The QAPI plan was reviewed with the management team on 9/29/2022.

Audits will be performed periodically to ensure QAPI meeting attendance is occurring. **Ongoing**

Audit findings will be brought to the quarterly QAPI meetings. **Ongoing**

F880 Infection Prevention and Control

Staff RN 9 was re-educated on proper hand hygiene on 9-23-2022.

The Infection Control/Infection Prevention Policy was reviewed on 9/29/2022.

Re-educated and in-serviced the required video "Clean Hands" to staff during a staff in-service on 10-15-2022.

On 10-15-2022, the Administrator, DON/Infection Preventionist completed the Root Cause Analysis for proper hand washing.

Audits will be completed by the DON/or Designee periodically to ensure compliance. **Ongoing**

Audit findings will be brought to the monthly QAPI meetings. **Ongoing**

F921 Safe/Functional/Sanitary/Comfortable Environment

Without waiving the foregoing statement, the facility states that with respect to the resident safety.

The door on the SCU does need to be replaced. A quote was obtained from the Lock Doctor, LLC by the Maintenance Director on 8-15-2022.

Education was provided on 8-15-2022 to the maintenance director regarding preventive maintenance and will complete routine maintenance checks monthly.

Audits will be completed by the Administrator or designee periodically to ensure compliance. **Ongoing**

Audit findings will be brought to the monthly QAPI meetings. **Ongoing**

Submitted by,

Sarah Flattery, Administrator

Parkview Care Center