STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285261	A. Building B. Wing	05/22/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Licensure Reference Number 175 NAC 12-006.02(H) 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. Findings are: A. Record review of Resident 16's Clinical Census Record dated 5/20/25 revealed admission to the facility was 8/15/22. 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. Record review of facility's investigation report regarding Resident 16's incident on 9/16/24 revealed: -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. -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 (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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. -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). -On 9/18/2024 the APRN assessed Resident 16 and ordered the following: -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. -On 9/19/24 at 1:19 PM the facility notified Adult Protective Services (APS) via on line report. -On 9/25/25 at 2:26 PM the Administrator (ADM) emailed the Internal Investigation Summary to the State Agency. 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. 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. B. Record review of Resident 17's fall investigation report dated 3/23/2025 at 8:28 AM revealed: -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. -On 3/23/25 the Administrator notified APS by email at 10:07 AM . 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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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.