STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165340	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Healthcare Center	800 Fifth Street SE Oelwein, IA 50662

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on observation, clinical record review, and staff interview the facility failed to apply hand splints and complete a passive range of motion Restorative Nursing Program (RNP) per the therapy discharge recommendations for 1 of 1 residents reviewed (Resident #7). The facility identified a census of 55 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #7 in a persistent vegetative state/no discernible consciousness with functional impairments of the bilateral upper and lower extremities. The MDS identified Resident #7 as dependent in all self-care (eating, dressing, toileting, personal hygiene) and mobility. The MDS listed diagnoses of chronic respiratory failure, stroke, aphasia (a neurological disorder that affects the ability to communicate and understand language), and quadriplegia (a condition characterized by the partial or total loss of function in all four limbs and the torso). The MDS further documented Resident #7 received passive range of motion 1 out of 7 days of the assessment look-back period and received a brace/splint program 7 out of 7 days of the assessment period. The undated Care Plan Focus noted Resident #7 at risk for alteration in skin integrity related to the need of assistance for bed mobility. The Care Plan directed the staff to use palm protectors to both hands outside of the splints. The Care Plan lacked direction of a RNP and how/when to use the hand splints. A 12/06/24 Occupational Therapy (OT) Treatment Encounter Note signed by Staff A, Certified Occupational Therapy Assistant (COTA; a healthcare professional who works under the supervision of a Registered OT) documented Resident #7 as contracted in a fetal position. Staff B, Qualified Medication Aide (QMA) educated on passive range of motion (PROM) of all joints. Staff C, Licensed Practical Nurse (LPN), Staff D, Certified Nursing Assistant (CNA), and Staff E, CNA present for education on hand splints on 2 hours and off 2 hours. The CNA's reported this acceptable as they reposition the resident every two hours. The 1/28/25 OT Discharge Summary signed by Staff A included discharge recommendations, recommending PROM to the bilateral upper extremities (BUE) (shoulders, elbow, wrist, hands, fingers) and bilateral lower extremities (BLE) (hips, knees, ankle, foot, toes) daily. (continued on next page)

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #7 April 2025 Task Record directed the restorative staff to provide PROM to the BLE and BUE with stretch daily; hand splints two hours on/two hours off; program frequency three times a week and as needed. Observation on 4/06/25 at 10:05 AM, 11:43 AM and 1:09 PM revealed Resident #7 lying in bed with no white palm splints or rolled wash cloths in hands. Fingers were contracted into the palms of both hands. The blue hand splints lay on the window ledge. During an interview on 4/06/25 at 2:03 PM a family member expressed concerns as they had visited and never seen the hand splints in use. Observation on 4/07/25 at 7:35 AM revealed Resident #7 lying in bed with no rolled wash cloths, palm protectors, or blue hand splints in hands. During an interview on 4/07/25 at 1:04 PM Staff B reported Resident #7 wears the hand splints two hours on and two hours off. Resident #7 is to wear white hand rolls when the splints are not in use. The April 2025 Documentation Survey Report V2 Report documented 4/06/25 at 10 AM, 12 PM, 2 PM, and 4 PM a N to indicate resident #7 had not refused the restorative program and had the hand splints placed for 120 minutes for each of the recorded times were in use. Observation on 4/07/25 at 1:05 PM Staff G, CNA and Staff B performed Resident #7 BUE/BLE PROM RNP starting at 1:05 PM and ending the RNP at 2:40 PM. During an interview on 4/08/25 at 7:50 AM Staff A reported she recommended Resident #7 to have the PROM program every day due to his quadriplegia and contractures. Generally, she leaves the RNP frequency up to the MDS nurse to address, but in his case she gave more specific recommendations. On 4/08/25 at 9:19 AM Staff H, CNA reported Resident #7 used to use palm protectors when the hand splints were not on, but she didn't' know if he was using them currently. As far as she knows the splints are still in use and she has been putting them on. They document the use of the hand splints in the electronic medical record system. During an interview on 4/08/25 at 9:23 AM Staff I, QMA reported Resident #7 wears hand splints on two hours and off 2 hours. They document the use of the splints in the electronic health care record. She voiced in the restorative documentation screen a question pops up asking if the resident refused the RNP. They can choose yes or no. A no answer means the resident did not refuse the hand splints and then they document the number of minutes the resident used the splints, so two hours would be the 120 minutes. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/06/25 at 11:32 AM Staff B reported she is the main person responsible for completing Resident #7 RNP. She thought his RNP was to be completed five days a week. Other restorative programs are usually 3-5 days per week, but his is five days a week. She reported she had checked with OT before doing the RNP on 4/07/25 and OT told her to hold the stretch for 10 seconds versus the 5 seconds that she usually provides so it took her longer to do the program. Staff B explained she does Resident #7 RNP on the days she is scheduled to work and she works three days a week. She is not sure who is responsible to do the RNP when she is not scheduled to work. She places the blue hand splints on when she is finished with his RNP. She didn't know why she had not placed the blue hand splints on Resident #7 when she completed the RNP on 4/07/25. She further voiced it is pretty common that Resident #7 does not have his blue hand splints in use. She goes in first thing in the morning between 6-6:30 AM and the hand splints are usually not on. Observation on 4/08/25 at 12:53 PM revealed Resident #7 laying in bed with no splints on. The blue hand splints lay on the window ledge. The small white palm protectors lay on the residents bedside table. Observation on 4/08/25 at 2:45 PM revealed Resident #7 laying in bed with no hand splints on. The blue hand splints lay on the window ledge. Interview on 4/08/25 at 3:59 PM Staff F, Registered Nurse (RN) reported it is the responsibility of the restorative staff or the CNA's to put on Resident #7 hand splints for his hand contractures. The nurses also chart on the Treatment Administrative Record (TAR) that the hand splints are on. The aides report if the resident refuses the hand splints so that the nurse can document on the TAR. She reported she did not know how long Resident #7 was to wear his hand splints, but he also has small white palm guards that he wears when the blue hand splints are not in use. Resident #7 April 2025 TAR lacked documentation the nurses were signing off any use of the hand splits or palm protectors. Further review on 4/08/25 of the April 2025 Documentation Survey Report V2 revealed on April 2nd and 4th the record was blank indicating the resident did not receive the RNP hand splint program. The Documentation Survey Report V2 for April 1, 3, 5, 6 from 10 PM through 4 AM, the RNP was documented with a Y to indicate the resident refused the Restorative Nursing Program. During an interview on 4/08/25 at 5:11 PM Staff J, CNA reported she primarily works the night shift and does work with Resident #7. She reported Resident #7 does not refuse his hand splints. She has never been trained in how to put the hand splints on so she does not use them or the palm splints. Staff J voiced the problem with restorative charting is they can only answer yes/no if the resident did the restorative program or refused the program. Since she doesn't put the hand splints or palm protectors on, she marks the restorative documentation with a yes to indicate the resident refused the RNP. He really isn't refusing the hand splints, she just doesn't use them. She has reported this to the nurses in the past but couldn't remember which nurses she had reported to. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/09/25 at 6:54 AM Staff K, RN reported that she is responsible for the RNP's. She completes a review with the quarterly MDS assessment schedule and documents the RNP in the electronic medical record under the Restorative Program Evaluation Assessment. Staff K explained she doesn't look at the therapy discharge, she just gets a communication email from therapy. She stated the RNP is put in the CNA task record of the electronic medical record to communicate to the CNA's the frequency of the program. She reviewed Resident #7 and reported he is set up for three times a week and as needed on the task record. If OT wanted daily, then she must have misunderstood what therapy wanted. She usually just reviews hand splints quarterly to make sure the resident is still able to wear them and the splints are not leaving marks on the resident hands. On 4/09/25 at 7:02 AM Staff K reported she expects the staff to follow the therapy recommended RNP. If the RNP was supposed to be daily, then the splints should be used per the program. She thought splints were to be used during the night, but the RNP doesn't state that. She voiced the RNP should be (PROM) in the morning and then staff should alternate the hand splints 2 hours on/2 hours off with the white palm splints used in the hands when the blue hand splints are not in use. On 4/09/25 at 7:50 AM Staff K reported she had checked the assessment tab of the electronic medical record and Resident #7 had not had any RNP review by a nurse completed. On 4/09/25 Staff K provided an email dated 12/16/24 from Staff A to Staff K communicating Resident #7 was discharging from therapy. He required PROM to the BLE/BUE with stretch and (hand) splints on 2 hours, off 2 hours. Staff A indicated in the email to Staff K to let her know if she had any questions. A 4/09/25 review of the 2025 Documentation Survey Report V2 reports revealed: a. February 2025 for the RNP showed the 10 PM to 6 AM shift with eight days documenting a N to indicate Resident #7 did not refuse the RNP and the hand splits were in use. The RNP contained blank for no restorative documentation on February 1, 2, 4, 5, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 20, 22, 23, 24, & 27. The Report documented the Resident received the PROM exercise program on February 5,7,10, 17, 19, 20, 25, & 27 with all sessions between 15-20 minutes. b. March 2025 Report for the RNP showed the 10 PM to 6 AM shift with only six days documenting a N to indicate the resident did not refuse the RNP and the hand splints were in use. The RNP record had blanks for March 1, 2, 5, 12, 14, 15, 16, 17, and March 30th. The Report documented Resident #7 received the PROM program on March 3 for 15 minutes; March 7th for 20 minutes, March 26 for 20 minutes, and March 28 for 20 minutes. During an interview on 4/09/25 at 8:00 AM the Director of Nursing (DON) reported she had been confused as well as to how Resident #7 RNP went from daily to only three days a week. She stated therapy gives RNP recommendations upon discharge and the RNP's are put in the task record of the electronic medical record to communicate the RNP to restorative staff and the aides. She expects the RNP's to be completed per the therapy discharge recommendations and the RNP's followed or staff should be reporting in why the RNP cannot be completed. The DON stated the facility does not have a restorative nursing policy/procedure.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 42133 Based on observation, clinical record review, and staff interview the facility failed to follow the manufacturer's directions for use in priming an insulin pen and proper administration of the insulin pen for 1 of 1 residents sampled (Resident #109). The facility reported a census of 55 residents. Findings include: The Order Review History Report electronically signed by the Provider on 3/28/25 listed a physician order for Insulin Glargine Subcutaneous Solution 100 units (U) per milliliter (ML) inject 45 units subcutaneously two times a day for diabetes mellitus. During an observation on 4/08/25 at Staff L, License Practical Nurse (LPN) removed Resident #109's Lantus Glargine pen from the medication cart. Staff L checked the physician order on the April 2025 Blood Glucose/Insulin Administration Record and set the pen to 45 units without priming the pen with two units of insulin. Staff L injected the insulin pen into Resident #109's lower right abdominal quadrant, pushed the button to inject the insulin, then withdrew the insulin pen without holding for 10 seconds per the manufacturer recommendations. During an interview on 4/08/25 at 2:49 PM Staff F, Registered Nurse (RN) relayed she sets the dial on the insulin pen a few units and primes the pen until she sees insulin clear the needle. She then presses the insulin pen to the site and hits the button to injection the insulin. Interview on 4/08/25 at 2:55 PM Staff K, RN explained she applies the needle to the pen, sets the dial to one or two units to prime the pen, then dials the pen to the physician ordered amount of insulin. She holds the pen for a few seconds at the injection site to ensure the resident receives the insulin. During an interview on 4/08/25 at 3:15 PM the Director of Nursing (DON) reported she expects the nurses to follow the manufacturer directions to administer the insulin pens. The Medication Administration Injection Policy, revised 4/2024, under Insulin Pen directed to prime the insulin pen per the manufacturer's guidelines and to hold the pen (to the skin) during administration at the site for 6-10 seconds before pulling the needle out. The Lantus Insulin Glargine Injection Manufacturer's Directions Step-by Step guide to using the Lantus Solo Star Pen directed the following: a. After attaching the needle, take the outer needle cap off and save it. b. Remove the inner needle cap and dial a test dose to 2 units. c. Hold the pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the top of the needle. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. d. If no insulin comes out, repeat the test 2 more times. e. If there is still no insulin coming out, use a new needle and do the safety test again. f. Always perform the safety test before each injection. g. Never use the pen if no insulin comes out after using a second needle. h. Keep the pen straight, insert the needle into the skin. Use the thumb to press the injection button all the way down, slowly count to 10 before removing. The dose window should return to zero.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50874 Based on observation, resident and staff interviews, the facility failed to place a barrier between the foot and the bed linen for a wound treatment to prevent cross contamination for 1 of 1 residents reviewed. The facility reported a census of 55 residents. Findings include: Resident #17's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14/15, indicating intact cognition. The MDS documented diagnoses of coronary artery disease, peripheral vascular disease, diabetes mellitus, and multi-drug-resistant organism (MDRO). The MDS documented Resident #17 had two unstageable pressure ulcers due to coverage of wound bed by slough (a layer of dead tissue separated from the surrounding or underlying tissue) and/or eschar (hardened, dry, black or brown dead tissue that forms a scab-like covering over deep wounds). The MDS documented Resident #17 had an infection of the foot. A review of the electronic health record (EHR) Orders tab, revealed two treatments for the left foot. The treatment for the left lateral foot (the outside of the left) with a start date of 4/4/2025 directed staff to: * Cleanse with wound cleanser or soap and water * Apply betadine to both wound bed * Cover with abdominal gauze pad (ABD), roll gauze and tape * Monitor for signs of infection, red area outlined with a black marker The treatment for the left medial foot (the inner side of the foot) with a start date of 4/4/2025 directed staff to: * Cleanse with wound cleanser or soap and water * Apply betadine to both wound beds * Cover with ABD pad, roll gauze and tape * Monitor for worsening signs of infection, any redness outlined with a black marker A review of the EHR Progress Note revealed a physician visit note dated 4/4/2025 at 1:00 PM that documented Resident #17 had been seen by the wound clinic on 4/3/2025. Resident #17 was started on Doxycycline for empirical treatment of infection to wounds. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/8/2025 at 2:08 PM, observed Staff F Licensed Practical Nurse (LPN) knock on Resident #17 door and donned a gown. Staff F, LPN washed her hands and donned gloves. The treatment cart had been pushed through the doorway and closed. Resident #17 had been positioned in bed with the head of bed raised to approximately 45 degrees. Resident #17 had a blanket across her legs. Staff F, placed a barrier on the surface of the treatment cart and placed the treatment supplies on the barrier. Staff F, removed the blanket and the blue cushioned boot from Resident #17's left foot. Staff F, placed a pillow under the left knee and calf. The left foot had been rotated outwards. Staff F, removed the roll gauze from the left foot. Staff F, held the left foot under the heal with her gloved left hand with the outer side of the foot parallel to the bed linen. Staff F, used her right gloved hand to remove the ABD pad from the outer and inner wound areas. A small amount of drainage had been observed on the ABD pad. Staff F, released the left foot allowing the left outer foot to touch the bed linen. Staff F, removed her gloves and donned new gloves. Staff F, used gauze sprayed with wound cleanser to wipe off the inner and outer wounds. Staff F, released Resident #17's left foot with the outer side of the foot on the bed linen. Staff F, placed her left hand under the heal of the left foot raising it off the bed linen and applied betadine to the inner and outer wound areas. Staff F, released the left foot allowing the outer side of the left foot to rest on the bed linen. There had been no odor noted. The wound area on the outer left foot appeared to be black in color approximately 2.5 inches by 2 inches. Staff F, placed the ABD on the wound areas and wrapped the left foot with rolled gauze. Staff F, placed the blue cushioned boot on the left foot and pulled the blankets across Resident #17's legs. Resident #17 did not show any distress, facial grimacing, or voice any concerns with pain during the treatment. Staff F, removed her gown and gloves and disposed of them in the biohazard bin. Staff F, washed her hands. During an interview on 4/8/2025 at 2:21 PM Staff F, LPN acknowledged a barrier should have been placed between Resident #17's left foot and the bed linen to prevent cross contamination to the wound area. During an interview on 4/8/2025 at 2:22 PM, the Director of Nursing (DON) acknowledged she observed no barrier had been placed between the bed linen and Resident #17's left foot during the treatment and observed the left outer foot directly on the bed linen. On 4/8/2025 at 4:43 PM, Resident #17, revealed her bed linens had not been changed after the wound treatment had been completed. During an interview on 4/9/2025 at 8:08 PM, Staff M, Certified Nursing Assistant (CNA)/Paid Nutritional Assistant (PNA) revealed bed linens are changed once per week. Staff M, CNA/PNA acknowledged Resident #17's bed linens had been changed during the morning on 4/8/2025. A review of the Skin Evaluation Pressure Wound assessment for Resident #17 completed on 4/9/2025 at 9:33 AM, documented the onset of the pressure wound to be 3/15/2025. The left outer foot had been identified as pressure and measured 2.7 in length, 2.3 in width and 0.1 in depth. The area is documented as a diabetic ulcer. A moderate amount of serosanguinous (fluid that contains clear, watery liquid and blood) drainage had been present. The Skin Evaluation Pressure Wound assessment noted Resident #17 is treated by the wound clinic. The Skin Evaluation Pressure Wound assessment had been completed by the DON and electronically signed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Infection Prevention and Control Program (IPCP) Guidelines with a revision date of 09/2022 directed staff to utilize standard precautions on all residents, regardless of the suspected or confirmed presence of an infectious agents. Potentially contaminated articles are stored and disposed of in appropriate containers. Enhanced barrier precautions (EBP) as an approach of targeted gown and glove use during high contact resident care activities. EBP may be applied to residents with any of the following: * Wounds - this generally includes residents with chronic wounds, not those with only shorter-lasting wounds, such as skin breaks or skin tears covered with a Band-aid or similar dressing. Examples of chronic wounds include, but are not limited to pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous status ulcers. The policy further states contaminated linen should be bagged at the time of use.