STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165499	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blackhawk Life Care Center	73 West 5th Street Lake View, IA 51450

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on observation, record review, and staff and resident interview, the facility failed to ensure a resident was treated with dignity and respect when trying to assist with his own care for 1 of 5 residents reviewed (Resident #1). The facility reported a census of 25 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident had diagnoses including acute respiratory failure with hypoxia (low oxygen in the tissues) and chronic lung disease. The April 2025 Treatment Administration Record (TAR) documented the resident had the order to apply leg compression devices 2 times a day for 20 minutes. They were kept in the therapy room but the resident knew how to apply them. Apply 2 times a day to help decrease edema in lower extremities related to epidermal thickening and type 2 diabetes without complications. Leg pumps for 20 minutes, then remove with a start date 3/27/25. The Progress Notes dated 4/3/25 at 2:45 p.m. documented Resident #1 wanted to file a grievance on Staff E Registered Nurse (RN) and the way she acted putting his boots on the previous night. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A concurrent observation and interview on 5/6/25 at 8:50 a.m. revealed the resident ambulated from his room across the hall independently with a walker. Resident #1 stated he had an appointment to one clinic with the physician and he told the Provisional Administrator to order him a pair of these compression deals that went on his legs and feet. They were Velcro, rolled on, and then you plugged them in and pushed the button. It ran for 20 minutes and it compressed and then released, compressed and released. When they first got there and doctor prescribed, a nurse had to put them on him. They were kept in the therapy room because they started him in there with them, and Staff D Certified Nursing Assistant (CNA) Restorative Aide (RA) was doing it. Her dad passed away so there was almost a week she wasn't there to put them on him so the other nurses brought them into his room for him to do it in there, but a nurse had to watch him put them on or help him put them on. Most of the time he was doing it, and the nurses did their watch cause they didn't know what he was doing. When you pushed the button it would run for 20 minutes and it shut itself off. Staff E Registered Nurse (RN) came in one night like 11:45, just before midnight to put them on him. She gave his night medications, and while he took them she started putting the one on. The resident said there's a Velcro deal goes across the foot, a smaller one here and a bigger one up here (pointed to the lower and upper leg). Staff E put the one on and there was a gap the resident could stick 2 or three fingers down. He thought that would not do any good if it wasn't tight, so he reached out and loosened it and then she scowled at him like he stole something. Then he tried to help with the 2nd boot and she didn't allow it. Resident #1 said the boots were his in the first place. He hadn't seen her since. He said he tried to help her and Staff E said he was not supposed to do this, she was. Staff E said let me do my job. He thought fine he would sit back let her do it. Like he said he could stick the fingers down and with compression on there it's got to be snug to your leg before you turn them on. And that's what he did. He tightened that up just a little bit and she didn't like that. On 5/6/25 at 3:28 p.m. Staff E stated she stopped several times while trying to put the resident's boots on because he kept putting his hands down in there. She stopped and waited a minute or two, and then she'd say could you please move your hands back. That's all she did. Staff E said Resident #1 knew they were supposed to be putting his boots on. She'd never had him do that with her before. Staff E just waited for him to get his hands out of the way and had to keep asking him to to let her do it. On 5/7/25 at 2:30 p.m. the Provisional Administrator stated Resident #1 did know how to apply his compression boots and should have been allowed to participate in their application. The facility, Resident's [NAME] of Rights reviewed 9/9/24 identified the purpose included the resident had the right to a dignified existence, self determination, and communication with access to persons and services inside and outside the facility. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. The resident has the right to be informed of, and participate in his or her treatment.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review and staff interview, the facility failed to maintain an accurate record of medication administration for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 25 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident had diagnoses including acute respiratory failure with hypoxia (low oxygen in the tissues) and chronic lung disease. The April 2025 Medication Administration Record (MAR) showed the resident had an order for Albuterol inhaler 2 puffs orally every 3 hours as needed for wheezing, with a start date of 3/14/25. The MAR lacked documentation of receiving the medication 4/1-13/25. On 5/6/25 at 4:20 p.m. Staff C Certified Nursing Assistant (CNA) stated one night the resident requested his inhaler. She told the nurse, Staff I Licensed Practical Nurse. Staff I could not find his inhaler. On 5/7/25 at 9:34 a.m. the Provisional Administrator stated he was on vacation for three days the 11th 12th and 13th (of April) and when she came back she found out that there had been something going on with the resident's inhaler. On 5/7/25 at 2:59 p.m. Staff I stated she was getting Resident #1's medication ready, and he had asked for his Albuterol inhaler a night or 2 before that, so she would take it with her, but it was not in the med cart. She checked to see if it got left in the resident's room and it wasn't. Since she had given it a day or 2 before she checked in her car, but didn't find it there. She said she had checked the med room once and decided to check again and she found an inhaler with the residents name on the box, hidden. She then spilled her drink, which ruined the label on the box, so she put the inhaler in a baggie with his name and instructions on it. She put on the pharmacy sheet to order a new inhaler. She knew this inhaler did not look like the one he had been using but it was the same dose. She showed it to the resident and explained it was the same medication, same dose. The resident was aware it was different. She said the resident did not need the inhaler that night. A Workflow and Delivery Details sheet showed a new inhaler delivered for the resident April 13, 2025 at 8:04 p.m. On 5/8/25 on 9:01 a.m. Resident #1 stated one night he asked for his Albuterol inhaler and they couldn't find it. They came to his room to see if got left in there. They ended up finding another inhaler that was a different color than the one he had, but it was the same medication, same dose. He used the inhaler. Staff I failed to document the resident received the inhaler the night she had to search for the inhaler, or a night or 2 before. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Medication Administration revised 10/22/24, included the individual who administered the medication dose recorded the administration on the resident's MAR directly after the dose was given.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review and staff interview, the facility failed to provide adequate assessment and timely intervention for a change in condition for 1 of 5 residents reviewed. The facility reported a census of 25 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #4 scored 99 on the Brief Interview for Mental Status (BIMS) indicating the resident's inability to complete the interview. Staff Assessment determined the resident had both long and short term memory problems, and severely impaired cognitive skills for daily decision making. The resident had diagnoses including Ahlzheimer's disease. The resident did not hold food in his mouth/cheeks after meals, or cough or choke during meals. The resident was on a mechanically altered diet. The Care Plan initiated [DATE] identified the resident at risk for weight change related to altered nutrition intake and changes in hydration status secondary to diagnoses of Alzheimer's, vascular dementia, little communication; need for mechanically altered diet due to difficulty swallowing and pocketing food. Interventions included serving a pureed diet with thin liquids as ordered. The resident needed close supervision for meals. Staff would provide him with cues/prompting and encouragement as needed for eating meals. He may fluctuate on amount of assistance needed. A Speech Therapy Evaluation and Plan of Treatment with a certification period of [DATE] to [DATE] documented the resident had Ahlzeimer's disease and dysphagia (difficulty swallowing). A Speech Therapy Discharge Summary with dates of service [DATE] to [DATE] documented interventions provided included swallow treatment instruction in alternating liquis/[NAME] to increase pharyngeal clearance, modification to bolus sizes and order/method of food/liquid presentation and facilitation of rate control during oral intake. Instructed nursing caregivers in safe swallow techniques in order to enable patient to safely consume the highest level of intake with the least amount of supervision with 100% carryover demonstrated by primary caregivers. The intake protocol to facilitate safety and efficiency, it was recommended the patient use the following straegies and/or maneuvers: a. Lingual sweep (sweeping the tongue along the inside of the mouth to remove lingering food or debris), reswallow, b. Alternation of liquids/solids, c. Rate modification and bolus size modification, d. Upright posture during meals and upright posture for >30 minutes after meals. (continued on next page)

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	165499	A. Building B. Wing	05/08/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Notes dated [DATE] at 5:07 p.m. documented the nurse received a summons to the resident's dining room table, because he had pocketed food in his mouth. The nurse removed whole kernels of corn from the resident's mouth and gave him water to wash it down. The resident had a pureed diet. They questioned if the resident took corn off his spouse's plate at lunch. The resident's spouse educated to put plate on left side of the table when done eating. The Progress Notes dated [DATE] at 1:20 p.m. documented the resident had a poor appetite. He was given cranberry juice and sipped some. The Progress Notes dated [DATE] at 8:05 a.m. documented the nurse called to the resident's room. The resident had labored breathing. The vitals obtained showed the resident's oxygen 82% on room air, increased heart rate, and fever. Oxygen applied. At 8:10 a.m. family called to update. At 8:12 a.m. the ambulance called At 8:14 a.m. ER called and report given. At 8:20 a.m. O2 88% on 2L increase to 3. At 8:25 a.m. O2 at 91% on 3L. The Admission History and Physical dated [DATE] documented the resident brought from the facility by ambulance with the complaint of lethargy, fever, and hypoxia. Apparently he had not felt well the past few days. He ate some of his spouses food and they had the impression that he aspirated because of a different consistency. Initially his oximetry was 82% before he started oxygen. He was febrile on arrival, quite lethargic, and not responding well. A Discharge Summary dated [DATE] documented the principle discharge diagnosis of aspiration pneumonia of the left lower lobe. Patient started on intravenous (IV) hydration, antibiotics, and required oxygen at 4 liters to maintain his saturation over 90%. His condition was discussed with family and they did not want aggressive treatment due to his age and dementia. They agreed on hospice care and transferring him back to the nursing home. The IV medications were discontined and the resident discharged to the facility on oxygen and comfort medications. Tho Progress Notes on [DATE] at 9:35 a.m. documented on readmission the resident had O2 via nasal cannula, and the head of the bed (HOB) elevated. The resident had a moist/loose non-productive cough noted. On [DATE] at 11:17 a.m. Staff F Certified Nursing Assistant (CNA) stated he worked for agency. The resident always had a cough and stuffiness until one day it got worse. When the resident came back from the hospital he was already hospice. On [DATE] at 12:19 p.m, Staff B CNA said she had not heard anything about the resident pocketing food. She didn't know the exact time frame he was struggling with the whole business of eating. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:12 p.m. Staff G CNA stated Resident #4 had been going downhill ,d+[DATE] weeks before his hospitalization . Staff G remembered one night the resident was sitting in his recliner it was after supper and his one cheek looked huge so she went and told the nurse and said something's in his mouth, and we need to go down and try to get it out. The nurse said they tried, so I went back down there and I wrote on his whiteboard if he could swallow what was in his mouth. He shook his head yes. He opened his mouth and he kind of pushed it up into the front of his mouth and then he just put it right back and he didn't swallow it. Staff G went and told the nurse again and she don't know if he ever swallowed it. He sat up in his recliner. She said it was pureed food, because it was all mushy inside his cheek and he just was holding it. You couldn't go to a meal without him coughing, whether they fed him or he fed himself. When he fed himself it was almost like he rushed it too much and then he would cough. On [DATE] at 3:12 p.m. Staff H CNA agency stated her frustration with Resident #4 was that not only herself but several other staff that had worked with him that knew, and had been telling nurses that something was not right with him. She said the resident died from aspiration pneumonia. While their dining room was right there by the nurse's station, it's not like the nurses couldn't see what was going on with him. It got progressively worse to where it would happen with every bite and every drink. Then they finally decided they were gonna do a swallow study. They had made an appointment for that, and then a couple days later he was shipped out to the hospital and even then, it took one of the CNA's to say hey Resident #4's not right, you need to come see him. The nurse was like go get him ready and bring him out and she would examine him out there. The CNA said she needed to go to his room now. Staff H had gone in there the night before he was shipped out because she was on night shift that night and there untill 10:00 a.m. the morning he shipped out. She noticed he sat up pretty high for him, he always slept flat. The nurse on duty that night was on her first or 2nd night. Staff H told the nurse, Resident #4 was not right. His lips were purple. The day nurse said the night nurse told her nothing was wrong with Resident #4. Staff H looked at the day nurse and said absolutely not, she said she told the night nurse things were not right with him, and she didn't even acknowledge it. On [DATE] at 2:30 p.m. the Provisional Administrator stated she had been reviewing Resident #4's chart and saw that the nurse did not assess, or notify the physician when the resident was found with regular food pocketed in the cheeks. She said he should have gone on hot charting and assessed routinely for 72 hours.

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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** 26527 Based on observation, record review, and staff interview, the facility failed to ensure appropriate interventions were in place to prevent falls for 1 resident reviewed (Resident #2). The facility reported a census of 25 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #2 scored 5 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required partial/moderate assist with sit to stand, chair to bed transfer, toilet transfer, and supervision or touching assist walking 10 feet, 50 feet and 150 feet. The resident had diagnoses including hypertensive chronic kidney disease, atrial fibrillation, and repeated falls. The Care Plan revised 9/27/24 identified the resident at risk for decline in functional status and falls/injury due to a need for assist at times. The interventions included a sign placed on her walker to remind her to use her walker for assistance 10/3/24, and resident to wear a gait belt with all transfers 3/2/25. On 1/19/25 a chair and bed alarm were added (to notify staff if the resident tried to get up unattended). The Care Plan identified the resident at risk for altered skin integrity related to needing assist with some self care & mobility tasks. The diagnoses included chronic kidney disease, diabetes, and depression. The interventions included walker in reach for safety 4/18/25. The Progress Notes dated 3/2/25 at 11:45 a.m. documented the resident had a witnessed fall that ocurred in the resident's room. The resident walked to the bathroom with a walker and her knees gave out. The nurse paged to the resident's room over the walkie. When entering the room, Staff A Registered Nurse (RN) stood next to the resident who knelt on the floor, holding onto her walker. The floor dry and free of debris. The resident did have her shoes on, but did not have a gait belt on. On 5/5/25 at 2:30 p.m. the resident sat in the recliner in her room, her walker by the bathroom, not in the resident's reach. On 5/6/25 at 12:19 p.m. Staff B Certified Nursing Assistant (CNA) stated they did not leave the resident's walker within reach because she would try to get up by herself. On 5/6/25 at 1:28 p.m. the resident laid on her bed. Her walker was not in reach. On 5/6/25 at 4:20 p.m. Staff C CNA stated they were told by management they could not leave the walker within her reach. She said that was not what her care plan directed. On 5/7/25 at 10:15 a.m. the resident sat in the recliner, her walker not in reach. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/25 at 3:15 p.m. the Provisional Administrator stated residents needing assistance should have a gait belt in use for transfer and ambulation. She put a note on the resident's walker to keep it in her reach.