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	10/14/2025

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 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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 0658 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, clinical record and hospital report review, the facility failed to follow the physicians' directive to notify if/when a resident had blood glucose (BG) levels reach outside the established parameters for 1 of 3 residents reviewed (Resident #5). Resident #5 had an order to contact the doctor if her BG registered higher than 400. When the staff failed to follow the directives, Resident #5 required hospitalized for severe hyperglycemia (high blood glucose). The facility reported a census of 35 residents.Findings include:Resident #5's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive deficit. She required partial assistance with dressing, hygiene, transfers and walking. The MDS included diagnoses of diabetes mellitus, hyperlipidemia (high blood glucose), non-Alzheimer's dementia, and iron deficiency.The Care Plan Focus revised 6/27/25 indicated on 5/28/25 Resident #5 had a significant decline in ability with an increased need for assistance.The Care Plan Focus revised 6/26/25 reflected Resident #5 had diabetes mellitus and received oral medications. She had cognitive limitations that prevented her from understanding her diabetes diagnosis. On 6/26/25 Resident #5 started insulin on readmission. The Interventions directed the following dated 6/27/25:a. Administer glucagon (medication used to raise blood sugar) per ordersb. Administer insulin as ordered and check the blood sugar as needed for signs and symptoms of hyperglycemia or hypoglycemia (high blood glucose and low blood glucose).c. Perform blood sugars as order, notify the doctor is the blood sugar is less than 60 and/or greater than 400.d. Send to the emergency room for hypoglycemic episodes.The Document titled All About Blood Glucose dated 2009 retrieved 10/14/25 from the American Diabetes Association website directed the following recommended targets for Blood Glucose (BG) levels:a. Before meals 80 to 130 mg/dlb. 2 hours after the start of a meal below 180 mg/dl.Resident #5's Order Details dated 6/12/25 instructed to check her blood sugar 2 times daily and notify the doctor with blood sugar less than 60 or greater than 400.The Medication Administration Note dated 6/20/25 at 7:22 AM indicated the nurse faxed the provider due to Resident #5's blood sugar greater than 400 limit.The Blood Sugar Summary printed 10/6/25 at 10:58 AM listed a blood sugar on 6/20/25 at 7:22 AM of 429.The N Adv Skilled Evaluation Note dated 6/20/25 at 9:18 AM listed a BG of 429.The Blood Sugar Summary printed 10/6/25 at 10:58 AM listed a blood sugar on 6/20/25 at 9:08 PM of 457.The Nurses Note dated 6/20/25 at 10:13 PM indicated Resident #5's had a BG of 457.The Nurses Note dated 6/20/25 at 10:17 PM reflected the nurse faxed the provider regarding the blood glucose.Resident #5's clinical record lacked documentation of follow-up from 9:18 AM until 9:08 PM.The Blood Sugar Summary printed 10/6/25 at 10:58 AM listed a blood sugar on 6/21/25 at 8:05 AM and 7:38 PM as 397.The Blood Sugar Summary printed 10/6/25 at 10:58 AM listed a blood sugar on 6/22/25 at 9:31 AM of 525.The N Adv Skilled Evaluation dated 6/22/25 at 11:41 AM identified Resident #5's BG as 525.The Nurses Note dated 6/22/25 at 12:54 PM reflected Resident #5's BG as 525. The indicated the nurse notified the provider.The Blood Sugar Summary printed 10/6/25 at 10:58 AM listed a blood sugar on 6/22/25 at 8:34 PM of 526.Resident #5's clinical record lacked documentation of a follow-up between 11:41 AM and 8:34 PM on 6/22/25.The Blood Sugar Summary printed 10/6/25 at 10:58 AM listed a blood sugar on 6/23/25 at 6:48 AM of 458.The clinical record lacked documentation from 8:34 PM on 6/22/25 until 6:48 AM on 6/23/25.The Nurses Note dated 6/23/25 at 7:46 AM, identified a BG of 458. The nurse faxed a blood sugar log and medication summary to the Primary Care Physician (PCP.)The Nurses Note dated 6/23/25 at 9:05 PM, reflected the nurse called the emergency room (ER) to update the provider of Resident #5's BG of 536. The nurse described her as disoriented and lethargic. The ER doctor gave a verbal order for Rocephin (antibiotic.)Resident #5's clinical record lacked a follow-up from 7:46 AM until 9:05 PM on 6/23/25.The Nurses Note dated 6/24/25 at 7:05 AM, listed a BG of 536 from 6/23/25 at 8:51 PM. The nurse called the doctor and received a new order for Rocephin related to urinary tract infection.The Blood Sugar Summary printed 10/6/25 at 10:58 AM listed a blood sugar on 6/24/25 at 7:06 AM of 490.The Medication Administration Note dated 6/24/25 at 7:06 AM, listed Resident #5's BG as 590 and described her as without symptoms at that time.Resident #5's clinical record lacked documentation from 9:05 PM on 6/23/25 until 7:06 AM on 6/24/25. The Nurses Note dated 6/24/25 at 7:48 AM reflected the nurse called the family and she left a message indicating she felt Resident #5 needed seen in the ER.The Medication Administration Note dated 6/20/25 at 7:23 AM faxed to the provider included a handwritten note to the provider asking if they wanted to increase the times of day for blood sugar checks or add insulin, as metformin recently increased. The facility received

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the staff used safe transfer techniques for 1 of 3 residents (Resident #3). Resident #3 required assistance of 2-staff with transfers on and off the toilet. Resident #3 lost her balance getting off the toilet with just one staff assisting her and sustained an ankle sprain. After the incident, Resident #3 required the use of a mechanical lift for transfers. The facility reported a census of 35 residents.Findings include:Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderated cognitive deficits. The MDS listed her as totally dependent on staff for toileting hygiene, sit to stand, and toilet transfers. The MDS included diagnoses of non-Alzheimer's dementia, Parkinson's Disease, anxiety disorder, and chronic pain.A Care Conference Summary, dated 5/8/25, reflected 2 staff would assist Resident #3 with ambulation. The staff could use the standing mechanical lift at times to transfer her from surface to surface. The Care Plan Focus revised 9/2/25, indicated Resident #3 had an impaired functional ability and had a risk for falls. The Interventions directed the following:a. Resident #3 needed assistance with self-care and mobility tasks due to weakness related to Parkinson's Disease.b. 9/12/25: Resident #3 could ambulate with the assist of 2 staff, gait belt and a walker. 9/4/25: Per physician orders Resident #3 could bear weight as tolerated.In an observation on 10/7/25 at 1:00 AM, Staff D Certified Nurse Aide (CNA) and Staff E CNA transferred Resident #3 from the commode to the recliner with the use of the standing mechanical lift. With much coaching and encouragement, Resident #3 could put her feet on the platform of the stand and held onto the handles. Staff D said she used the mechanical lift for about a month. Resident #3 fell and had a swollen ankle. Since then, they used the standing mechanical lift. Before the fall, she walked. An incident report dated 8/31/25 at 6:40 PM, identified as Resident #3 got off the toilet, she lost her footing, and almost fell. Upon assessment Resident #3 reported pain in her left ankle and had bruising on her right hand. The staff stated Resident #3's foot slipped out from underneath her and they lowered her to the floor. She had her left leg bent underneath her, twisting her left ankle. The report indicated the Agency staff member didn't follow the Care Plan Kardex direction of 2 assist. On 9/2/25 the ankle swelled and bruised. Resident #3 complained of pain. She had bruising around her outer ankle alongside the outer edge of her foot. Updated on 9/4/25 the reported instructed to continue using the standing mechanical lift until further notice from therapy. The Director of Nursing (DON) added a note on the report that Agency staff didn't follow the Kardex of 2 assist. Intervention - immediate verbal education proved to agency aide.The Nurses Note dated 9/2/25 at 9:07 AM, described Resident #3's left outer ankle had light green/purple bruising area that measured 9.5 centimeters (cm) x 10 cm and had 2+ pitting edema (moderate swelling where an indentation remains after applying pressure). Resident #3 reported pain when standing or walking.The Nurses Note dated 9/2/25 at 12:30 PM reflected Resident #3 had a negative X-ray for a fracture of her left ankle.The Nurses Note dated 9/4/25 at 10:29 AM indicated therapy recommended to use the standing mechanical lift transfers only at that time due to her ankle sprain.On 10/7/25 at 3:40 PM Staff I, CNA, said she assisted Resident #3 in the restroom on 8/31/25. She explained Resident #3 lost her balance but didn't fall to the floor. Staff I said she didn't know they used a standing mechanical lift to transfer her. When she previously worked with Resident #3, she transferred with one assist and a gait belt. Staff I said on 8/31/25, when she helped Resident #3 off the toilet, her legs got weak and she went down to the floor. Staff I said she caught her and eased her down. As she went down, her ankle bent sideways underneath her. Staff I said she could get Resident #3 up and into bed. Then she explained to the Director of Nursing (DON) what happened. Staff I maintained she didn't receive orientation when she started working at the facility, nor did she get report from the previous shift before she started working with the residents that evening.On 10/7/25 at 2:54 PM, the DON acknowledged she worked the evening of 8/31/25 when Resident #3 lost her balance in the bathroom. She said Resident #3 had the standing mechanical lift in front of her as she sat on the toilet. The staff member explained to her that she tried to get her up off the toilet, and she chicken winged with the standing mechanical lift sling, and leaned off to the left. She said she twisted her ankle when that happened. The DON said she expected the staff member to check the Kardex and ensure they had 2 staff members present when transferring Resident #3.On 10/7/25 at 1:00 PM, the Assistant Director of Nursing (ADON) said that agency had access to Kardex, and staff that worked with them were expected to let them know to follow the sheets and find out how the residents were transferred. The ADON said that all residents who required the standing mechanical lift

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents remained free from significant medication errors for 1 of 3 residents reviewed (Resident #5). While hospitalized from [DATE] - [DATE] due to hyperglycemia (high blood sugar), the facility staff failed to put Resident #5's medications on hold. Upon readmission to the facility, the staff failed to accurately reconcile the medication list from the hospital. As a result, the facility failed to administer the updated metformin (antidiabetic agent) orders and failed to call the doctor for clarification on duplicate long-acting insulin orders (Tresiba and Lantus). The cascade of breakdowns (a chain reaction of issues that started from one problem) resulted in the administration of 2, long-acting insulins, and the incorrect dose of metformin. Resident #5 returned to the hospital on [DATE] with hypoglycemia (low blood sugar) resulting in an Immediate Jeopardy to the health, safety, and security.The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of [DATE], on [DATE]. The facility removed the IJ on [DATE]th through the following actions:a. If the facility received an order between 8:00 AM - 5:00 PM with the Director of Nursing (DON) or Administrator (Admin) in the building, the DON or Admin would review the order.b. Any order received when the DON or Admin were not present in the building to review, the nurse on duty would be required to call the on-call nurse to review the order via phone or in person.c. If the on-call nurse felt the order needed clarification, the nurse on duty would call the physician, if during clinic hours. If after clinic hours they would call the emergency room (ER) doctor. The nurse would hold the medication until they received clarification.d. After receiving clarification, the nurse on duty would call the on-call nurse to review the clarification. If on-call nurse felt they received the needed clarification, she would have the nurse put the order in.e. After the nurse entered the order in electronic clinical record, she would take a picture of the order leaving out the resident's name from the picture so the on-call nurse could look at it and make sure the nurse entered the order correctly. If the nurse didn't enter the order in correctly, the on-call nurse would call the nurse on duty and walk her through what needed corrected. f. The facility wouldn't administer the medication to the patient until they completed all the above steps.g. The facility posted the typed procedure at the nurse's station. In addition, each nurse working received verbal education on the proper procedure by the on-call nurse at beginning of their shift. The removal plan listed the on-call nurses as the DON, RN, ADON, RN, and Administrator, Licensed Practical Nurse (LPN).h. The facility would enter in the electronic health record under each insulin in the additional information section the type of insulin, such as long- or short-acting, as well as onset, peak, and duration (when the medication starts to work, how long until it is most effective, and how long it stays in the body). They placed the information on their diabetic box which contained their supplies. The facility worked with the clinical Pharmacist on education. The facility assigned the DON/ADON as responsible to ensure each directive went in place.i. The facility verbally reviewed the procedure for receiving medication and posted at the nurses' station. After the charge nurse checked to ensure the medications are correct, the nurse would put the medication into the medication (med) room in a designated locked cupboard. If the facility received the medication after hours or on the weekend and a resident needed it right away, the charge nurse would call the on-call nurse to review the medication to ensure accuracy. After the on-call nurse gave the okay to place the medication on the appropriate med cart and which drawer to place in. In addition, they would remind them to pull the old med card if applicable. The facility assigned the DON/ADON as responsible for double checking all medications received, ensuring the facility had the right medication, dose, route, time, frequency, and it went to the right resident. They had the responsibility of placing them in the correct location on the medication cart.The scope lowered from a J to a G prior to the survey exit after ensuring the facility implemented the removal plan.The facility fixed the noncompliance prior to the survey on [DATE] by completing the following items:a. [DATE]: Started daily monitoring of medication administration, documentation, random observations, and one-to-one (1:1) follow-up with staff.b. [DATE]: The facility-initiated education to the nurses regarding condition changes, blood sugars out of range, notification of the on-call emergency room (ER) provider for the weekends and after hours.c. [DATE]: The facility provided education on proper medication administration processes to the nurse who administered the incorrect dose of Metformin, and the Director of Nursing or designee observed medication pass with the nurses.d. [DATE]: The facility-initiated provided written education to all of the facility's current nurses and consistent staffed agency nurses on double noting orders and high-risk medications that should prompt a call