STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165531	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Care Center	1200 West Nishna Road Shenandoah, IA 51601

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 37074 Based on facility investigative file review, staff interviews and policy review the facility failed to report a reportable event in a timely manner for 1 of 3 residents (Resident #6) reviewed for reportable events. The facility reported a census of 41 residents. Findings include: The facility's 5-day investigation summary involving Resident #6 documented the alleged incident occurred on 3/23/24 and was reported on the company compliance hotline on 3/27/24. The summary documented the following description of the incident: the caller reported on the compliance hotline that Staff A Licensed Practical Nurse (LPN) had said to a paralyzed resident that you f***ing stink. There's no reason your lazy a** can't shower. Get in the shower now. The staff reported it happened on 3/23/24. On 4/4/24 at 10:49 AM Staff B LPN stated she called the corporate hotline to report on 3/23/24 that Staff B told Resident #6 that he stinks, is lazy and needs to get up to shower because he stinks. Staff B indicated she was at the nurse's station when she heard this. When Staff B came to the nurse's station Staff A asked her if she just told someone they stink in which Staff A stated it was true, they stink and can smell them in the hallway. Staff B indicated she sat on this information for a couple days and it bothered her more as she thought about it. She indicated her grandma was in a nursing home and if this happened to her, she would move her. Staff B stated she could not tell the Administrator because she has favorite staff and Staff A is one of them. When asked why a delay in reporting her concerns, she stated she thought about the consequences with her reporting it, was it abuse or was it not, if it was abuse what would happen to Staff A's job. On 4/4/24 at 2:28 PM the Regional Director of Clinical Services stated staff should report allegations of abuse immediately and would expect them to notify staff in the facility first. The call came in on the compliance hotline on 3/27/24 and the facility reported it to the State Agency at the same time. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 3:33 PM the Administrator stated staff should report any allegation of abuse immediately and staff just educated on this. Not all staff have been educated because some have not worked since then or are as needed (PRN) staff members. During the education she talked about abuse and neglect, gave examples of verbal abuse too. She instructed them to call her immediately, not to text her phone after 9:00 PM because she would not hear it. They need to call her and speak with her. She also let them know she has two hours to report abuse allegations to the state agency. The Administrator acknowledged she is the Abuse Coordinator. She indicated the message on the compliance hotline stated the alleged incident happened on 3/23/24 and staff called the hotline the morning of 3/27/24. The facility's Abuse Prevention Program and Reporting Policy with a revision date of 4/2023 documented each employee is responsible to immediately report any suspected abuse. Each incident will be investigated and required reporting completed. Staff are to notify the shift supervisor immediately if suspected abuse, neglect, mistreatment or misappropriation of property occurs. Report the incident immediately to the Administrator and Director of Nursing (DON). Any staff member with knowledge of the event is responsible for notifying Administrator and/or DON.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074 Based on clinical record review, staff interview, hospital staff interview and policy review the facility failed to allow a resident to return to the facility after a facility initiated transfer to an acute setting for 1 of 3 residents (Resident #2) reviewed for appropriate discharge. The facility reported a census of 41 residents. Findings include: According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 3/7/24 Resident #2 had a Brief Interview Mental Status (MDS) score of 14. A BIMS score of 14 suggested no cognitive impairment. The MDS documented he had no physical, verbal, or other behavioral symptoms directed to others during the review period. Resident #2 also did not reject care during the review period. The MDS documented the following diagnoses: malignant neoplasm of rectum, unspecified mood disorder, constipation, and moderate intellectual disabilities. The MDS documented active discharge planning occurring for the resident to return to the community and no referrals made to the Local Contact Agency due to the referral was not wanted. The Care Plan focus area with an initiated date of 11/10/23 documented Resident #2 wished to discharge to the community. The care plan indicated the facility was to evaluate and discuss with Resident #2 the prognosis for independent or assisted living. Staff were to identify, discuss and address his limitations, risks, benefits and needs for maximum independence. Review of Resident #2's Behavior Monitoring and Interventions Plan of Care Response History with a review date of 3/6/24-4/4/24 revealed staff last documented he had behaviors on 3/21/24 at 11:55 AM that consisted of: cursing at others, expressed frustration/anger at others, screaming at others and disruptive sounds. The following Progress Notes were documented for Resident #2: a) On 3/1/24 at 1:47 PM Resident #2 became upset when female resident accused him of starting a conflict in the TV lounge. Resident #2 did not say anything to the female resident but did leave the area and went back to his room. b) On 3/9/24 at 12:52 PM this nurse did not witness incident, heard yelling and crashing coming from dining room. Once in the dining room, saw another resident sitting in his wheelchair by the kitchen door. Staff reported that Resident #2 was yelling at a resident and slammed two ice chest carts into another resident's right foot. The two residents were immediately relocated to different areas in the facility. c) On 3/21/24 at 1:46 PM staff reported to this nurse that Resident #2 became upset and agitated once he was informed that he did not qualify for placement in another facility. The resident starting throwing things and yelling. The Administrator went outside with the resident to walk around and calm him down some. After approximately 15 to 20 minutes he returned to the dining room and ate his lunch. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d) On 3/26/24 at 9:10 PM Resident #2 was asked politely by this staff to go away from the nurse's station due to HIPPA and nurse needing to call Administrator about another resident. He was told by another staff nearby that he would be notified when it's time to go outside and smoke. He yelled, walked away from the station, kicked the mechanical lift and the cart holding trash/linens on the way to his room cursing multiple times, very loudly as he walked to his room. He slammed his door, cursing loudly, kicked his furniture and the wall. He then opened and slammed his door multiple times. Shortly after that, he came walking down the hallway toward the nurse's station with his coat on. This staff caught up with him sitting in the area where employees smoke. He was breathing heavily. He said no negative words to this staff. This resident smoked two cigarettes, disposed of hem correctly, and went inside. He went straight to his room, quietly. No new behaviors after he came back inside. Notified Administrator of incident. e) On 3/27/24 at 12:20 PM the Administrator presented Resident #2 with an emergency discharge letter at the hospital emergency room (ER). The facility's Social Service Director was with the Administrator for the presentation. The Progress Notes lacked documentation of any behaviors or the transfer to theER on [DATE]. Review of Resident #2's March 2024 Medication Administration Record (MAR) documented he had the following as needed (PRN) order: Lorazepam (antianxiety) 0.5 milligrams (mg) 1 tablet every 1 hour as needed for anxiousness. The MAR documented staff last administered this medication on 3/21/24 at 12:18 PM. The MAR lacked documentation of Lorazepam administration on 3/1/24, 3/26/24 or 3/27/24. The local hospital provided an Emergency Involuntary Discharge letter dated 3/27/24 addressed to Resident #2 at the local ER. The letter stated he had been discharged from the facility because his discharge is mandated to protect the health, safety and welfare of other residents and/or staff. Specifically, he exhibited aggressive and violent behaviors yelling, threatening, and throwing items in the presence of staff and other residents. The letter documented he was discharged to the local medical center on 3/27/23. On 4/2/24 at 10:38 AM a hospital staff member stated when Resident #2 came to their ER it was said he had disruptive behaviors then the facility came to serve him with an eviction notice, on 3/27/24. They served the notice the same day he came to the ER, the facility was not going to take him back. The hospital had no choice but to keep him and admit him for inpatient observations. Since he has been in the hospital they have had no issues with any behaviors and remains in the hospital until they can find placement for him. She indicated a hospital is not a proper place for him he needs to be in a group home. She indicated when the hospital received his MAR, he hadn't received a PRN since 3/21/24. They were told Resident #2 had received the news he was not approved for waiver placement and that was upsetting to him. The facility sent him to theER on the 27th because he had increased behaviors for the last week but they noted no PRN's were given to help with his behaviors. The staff member also reported no one call the ER and gave them report on what was going on before he came to the ER. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 3:33 PM the Administrator stated Resident #2 was sent to the hospital because he had increased behaviors and they could not calm him down. On the day they completed the tornado drill he was upset about not being able to go out to smoke because another resident he does not get along with was outside smoking. Staff informed him he needed to wait until she was done and he became upset; started to yell and scream. Since the tornado drill was taking place all the residents were in the hall way, he stormed off as a resident stepped out of her room he went off on her because she asked him not to go in her room. As he went down the hall to his room he was beating on the wall, slamming his door, and he slammed his door so hard the resident's stuff on the other side of his wall, fell off. Resident #2 then went outside and the Activities Director followed him outside. The resident pushed the door in the Activities Director's face, walked around the building and came back in through the laundry door, down the hall and in to the Dietary Manager's office. She tried to calm him down but he was screaming at her, throwing things in the dining room, beating his head with his hands. At that time the Administrator called 911 because they needed someone to help calm him down. They had the police and Emergency Medical Service (EMS) come in the backdoor and he continued to hit his head, scream and looked for things to throw. He went out the door and wanted a cigarette as the police tried to calm him down. Resident #2 then went off on the police, got up and they must have thought he was going to go after them because they put his upper body face down on a car and administered a medication nasally. EMS then took him to the hospital. The Administrator stated prior to this he was wanting to go to a group home in Des Moines but the week before he was told he was not accepted. He became agitated at that time by throwing things at the Social Service Director. The Activities Director took him outside, to see if it would calm him down but he was so agitated he would not calm down. The Administrator was informed there was no documentation in the resident's Electronic Health Record (EHR) to reflect these behaviors she stated every one probably said well that's just Resident #2 and did not document it. She was also informed of Resident #2 not receiving a PRN to help with his anxiousness since 3/21/24, she stated it was probably offered but he refused. There was not documentation to support this, she indicated she knew this because she did a review of his chart after he went to the ER. The Administrator stated she has had staff members wanting to quit because they are scared of him and residents are scared of him as well. At that point, she knew they could not have him return to the facility. She called the facility's main office and started the emergency discharge paperwork. She indicated over the weekend prior to him going to the hospital, Resident #2 had behaviors. When she was informed there was no documentation to support this in his progress notes or behavior charting. She again indicated she reviewed his chart and saw there was no documentation but there was enough to be documented. She reiterated that staff just thought it was just Resident #2 so they did not document. When asked why the emergency discharge was given to him while in the ER she stated for the safety of her staff and residents. There was no way to control him or protect them, it's their right to be free of abuse. She did not feel everyone in the facility was safe. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Discharge Management policy with a revision date of 12/2019 documented the federal regulation articulates rights that the resident has related to admission, transfer, or discharge, some of the procedures facilities must follow, and records they must keep. The definition of transfer and discharge here applies to movement to a bed outside the certified facility (including differently licensed beds in the same physical plant), but does not apply to movement to a different bed in the certified facility. The rules regarding transfer or discharge (a) establish the conditions under which a resident may be transferred involuntarily, including that the facility is closing, the resident has improved so that he/she no longer needs the care, the facility is unable to provide the resident with the necessary care, the resident is a danger to self or others, and the resident has failed to pay for care or (if supported by third parties, including Medicaid) has failed to have the care paid for. The federal rule establishes expectations for documentation regarding transfers (including the reason), and written notice to the residents of at least 30 days, unless the reason for transfer is related to urgent medical needs of the resident or health and safety of others. The written notice must include the reasons for the transfer/discharge, the effective date, the location of discharge or transfer, the right of appeal, and notification of how to reach the long-term care ombudsman and/or the appropriate Protection and Advocacy agency in the case of individuals with developmental disabilities or persons who are mentally ill. Further, the facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 37074 Based on clinical record review, staff interviews and policy review the facility failed to complete a recapitulation of stay for 2 of 3 residents (Resident #4 & #5) reviewed. The facility reported a census of 41 residents. Findings include: 1. According to the discharge return not anticipated Minimum Data Set (MDS) assessment tool with a reference date of 3/1/24 Resident #4 discharged from the facility. The MDS documented active discharge planning occurred for the resident to return to the community. The Care Plan focus area with an initiation date of 2/13/2024 documented Resident #4 wished to be discharged to the community. On 3/1/24 at 4:39 PM a progress note documented discharged . Review of the documents tab in Resident #4's clinical record contained a document titled discharge paperwork with an uploaded date of 3/6/24. The discharge paperwork lacked a recapitulation of the resident's stay that included course of illness/treatment or therapy, pertinent lab, radiology, and consultation results, reconciliation of all pre-discharged medications with the resident's post-discharge medications (both prescribed and over-the-counter). The discharge paperwork also lacked a post-discharge plan of care that is developed with the resident and representative which will assist the resident to adjust to her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post discharge medical and non-medical services. 2. According to the discharge return not anticipated MDS assessment tool with a reference date of 2/18/24 Resident #5 discharged from the facility. The MDS documented an unplanned discharge but discharge planning occurring for the resident to return to the community. The Care Plan focus care area with an initiation date of 2/14/24 documented Resident #5 wished to discharge to the community. On 2/18/24 at 11:57 AM a progress note documented Resident #5 left with his family to transfer to another facility. Medications and belongings sent with him. Record review revealed it lacked a recapitulation of the resident's stay. On 4/4/24 at 4:29 PM the Director of Clinical Services stated their policy does not have a timeframe on staff completion of a recapitulation of stay but it should be completed ASAP, at a maximum of 2 weeks. He would make sure it's done within a couple days of discharge. He looked at what the Social Service Director had done for other residents for their discharge summary and he would have expected the nurse and resident to go over their current orders and sign off that that was completed. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Discharge Documentation with an original date of 6/2015 documented nursing staff work with the interdisciplinary team to prepare a resident/patient for discharge from the facility, as indicated. Nursing documentation includes education and training on the disease process and ongoing clinical care needs of the resident/patient. Education and training may also be provided to the family/responsible party of the resident/patient as indicated. Staff are to complete the nursing section of the Interdisciplinary Discharge Summary/Recapitulation Form.

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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. 37074 Based on clinical record review, staff interviews and facility policy review the facility failed to complete discharge assessments when 3 of 3 residents (Resident #2, #4, and #4) discharged from the facility. The facility reported a census of 41 residents. Finding include: 1. According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 3/7/24 documented Resident #2 had a Brief Interview Mental Status (MDS) score of 14. A BIMS score of 14 suggested no cognitive impairment. The MDS documented he had no physical, verbal, or other behavioral symptoms directed to others during the review period. Resident #2 also did not reject care during the review period. The MDS documented the following diagnoses: malignant neoplasm of rectum, unspecified mood disorder, constipation, and moderate intellectual disabilities. The Care Plan focus area with an initiated date of 11/10/23 documented Resident #2 wished to discharge to the community. The care plan indicated the facility was to evaluate and discuss with Resident #2 the prognosis for independent or assisted living. Staff to identify, discuss and address his limitations, risks, benefits and needs for maximum independence. On 3/27/24 at 12:20 PM a progress note documented the Administrator presented Resident #2 with an emergency discharge letter at the hospital emergency room . The facility's Social Service Director was with the Administrator for the presentation. The resident's clinical record lacked a discharge assessment prior to him going to the emergency room . 2. According to the discharge return not anticipated Minimum Data Set (MDS) assessment tool with a reference date of 3/1/24 Resident #4 discharged from the facility. The MDS documented active discharge planning occurred for the resident to return to the community. The Care Plan focus area with an initiation date of 2/13/2024 documented Resident #4 wished to be discharged to the community. On 3/1/24 at 4:39 PM a progress note documented discharged . The resident's clinical record lacked a discharge assessment prior to her going home with family. 3. According to the discharge return not anticipated MDS assessment tool with a reference date of 2/18/24 Resident #5 discharged from the facility. The MDS documented an unplanned discharge but discharge planning occurring for the resident to return to the community. The Care Plan focus care area with an initiation date of 2/14/24 documented Resident #5 wished to discharge to the community. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/18/24 at 11:57 AM a progress note documented Resident #5 left with his family to transfer to another facility. Medications and belongings were sent with him. The resident's clinical record lacked a discharge assessment prior to his transfer to another facility. On 4/4/24 at 3:33 PM the Administrator stated when a resident is discharged from the facility an assessment should be part of the recapitulation of stay. When asked about Resident #5's discharge she indicated he went home with his wife for a day then to another nurse facility. When asked about a discharge assessment she stated it should be part of the recapitulation of stay. On 4/4/24 at 4:29 the Director of Clinical Services stated when a resident is discharged from the facility he would have expected staff to get a set of vitals, current weight, review the orders on their Medication Administrator Record (MAR) and Treatment Administration Record (TAR) with the resident, who they are leaving the facility with or with the receiving facility, mode of transportation, and where their personal belongings went. A review of their progress notes, skin sweep and discussion about any follow up appointments should be completed too. The facility's Discharge Documentation with an original date of 6/2015 documented nursing staff work with the interdisciplinary team to prepare a resident/patient for discharge from the facility, as indicated. Nursing documentation includes education and training on the disease process and ongoing clinical care needs of the resident/patient. Education and training may also be provided to the family/responsible party of the resident/patient as indicated. Procedure: 1. Document resident/patient progress towards goals and plan for discharge with the interdisciplinary team, resident/patient and family/responsible party. a. Verify Care Plan is updated and reflects resident/patient clinical status b. Review and verify the following documentation is accurate and reflects resident/patient clinical status: Vital signs Weight Record MAR / TAR Progress notes Skin Sweep 2. Document the treatments and services that have been arranged for the resident/patient discharge. Treatments and/or Services may include, but are not limited to: Chemotherapy (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dialysis Home health services Home medical equipment (e.g., oxygen therapy, tube feedings, adaptive equipment) Lab tests Out-patient therapy Physician follow up visits Transportation 3. Record resident/patient and/or family education on the Resident / Family Education Record. 4. Complete the nursing section of the Interdisciplinary Discharge Summary/Recapitulation Form. 5. Assist Social Services in completing the Discharge Information. Provide a copy of the completed document to the resident/patient prior to discharge. 6. Complete the Inventory List in the Documentation program prior to discharge. 7. Complete any additional transfer documentation as required by state regulation.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074 Based on clinical record review, staff interview, hospital staff interview, and policy review the facility failed to have complete and accurate medical records for 1 of 3 residents (Resident #2) reviewed. The facility reported a census of 41 residents. Findings include: According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 3/7/24 Resident #2 had a Brief Interview Mental Status (MDS) score of 14. A BIMS score of 14 suggested no cognitive impairment. The MDS documented he had no physical, verbal, or other behavioral symptoms directed to others during the review period. Resident #2 also did not reject care during the review period. The MDS documented the following diagnoses: malignant neoplasm of rectum, unspecified mood disorder, constipation, and moderate intellectual disabilities. The Care Plan focus area with an initiated date of 11/10/23 documented Resident #2 wished to discharge to the community. The care plan indicated the facility was to evaluate and discuss with Resident #2 the prognosis for independent or assisted living. Staff to identify, discuss and address his limitations, risks, benefits and needs for maximum independence. Review of Resident #2's Behavior Monitoring and Interventions Plan of Care Response History with a review date of 3/6/24-4/4/24 revealed staff last documented he had behaviors on 3/21/24 at 11:55 AM that consisted of: cursing at others, expressed frustration/anger at others, screaming at others and disruptive sounds. The following Progress Notes were documented for Resident #2: a) On 3/1/24 at 1:47 PM Resident #2 became upset when female resident accused him of starting a conflict in the TV lounge. Resident #2 did not say anything to the female resident but did leave the area and went back to his room. b) On 3/9/24 at 12:52 PM this nurse did not witness incident, heard yelling and crashing coming from dining room. Once in the dining room, saw another resident sitting in his wheelchair by the kitchen door. Staff reported that Resident #2 was yelling at a resident and slammed two ice chest carts into another resident's right foot. The two residents were immediately relocated to different areas in the facility. c) On 3/21/24 at 1:46 PM staff reported to this nurse that Resident #2 became upset and agitated once he was informed that he did not qualify for placement in another facility. The resident starting throwing things and yelling. The Administrator went outside with the resident to walk around and calm him down some. After approximately 15 to 20 minutes he returned to the dining room and ate his lunch. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165531	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Care Center	1200 West Nishna Road Shenandoah, IA 51601

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d) On 3/26/24 at 9:10 PM Resident #2 was asked politely by this staff to go away from the nurse's station due to HIPPA and nurse needing to call Administrator about another resident. He was told by another staff nearby that he would be notified when it's time to go outside and smoke. He yelled, walked away from the station, kicked the mechanical lift and the cart holding trash/linens on the way to his room cursing multiple times, very loudly as he walked to his room. He slammed his door, cursing loudly, kicked his furniture and the wall. He then opened and slammed his door multiple times. Shortly after that, he came walking down the hallway toward the nurse's station with his coat on. This staff caught up with him sitting in the area where employees smoke. He was breathing heavily. He said no negative words to this staff. This resident smoked two cigarettes, disposed of hem correctly, and went inside. He went straight to his room, quietly. No new behaviors after he came back inside. Notified Administrator of incident. e) On 3/27/24 at 12:20 PM the Administrator presented Resident #2 with an emergency discharge letter at the hospital emergency room (ER). The facility's Social Service Director was with the Administrator for the presentation. The Progress Notes lacked documentation of any behaviors, assessments or the transfer to theER on [DATE]. Review of Resident #2's March 2024 Medication Administration Record (MAR) documented he had the following as needed (PRN) order: Lorazepam (antianxiety) 0.5 milligrams (mg) 1 tablet every 1 hour as needed for anxiousness. The MAR documented staff last administered this medication on 3/21/24 at 12:18 PM. The MAR lacked documentation of Lorazepam administration on 3/1/24, 3/26/24 or 3/27/24. The local hospital provided an Emergency Involuntary Discharge letter dated 3/27/24 addressed to Resident #2 at the local ER. The letter stated he had been discharged from the facility because his discharge is mandated to protect the health, safety and welfare of other residents and/or staff. Specifically, he exhibited aggressive and violent behaviors yelling, threatening, and throwing items in the presence of staff and other residents. The letter documented he was discharged to the local medical center on 3/27/23. The local hospital provided an Emergency Involuntary Discharge letter dated 3/27/24 addressed to Resident #2 at the local emergency room (ER). The letter stated he had been discharged from the facility because his discharge is mandated to protect the health, safety and welfare of other residents and/or staff. Specifically, he exhibited aggressive and violent behaviors yelling, threatening, and throwing items in the presence of staff and other residents. The letter documented he was discharged to the local medical center on 3/27/23. On 4/2/24 at 10:38 AM a hospital staff member stated when Resident #2 came to their ER it was said he had disruptive behaviors then the facility came to serve him with an eviction notice, on 3/27/24. Since he has been in the hospital they have had no issues with any behaviors and remains in the hospital until they can find placement for him. She indicated a hospital is not a proper place for him he needs to be in a group home. She stated when the hospital received his MAR, he hadn't received a PRN since 3/21/24. They were told Resident #2 had received the news he was not approved for waiver placement and that was upsetting to him. The facility sent him to theER on the 27th because he had increased behaviors for the last week but they noted no PRN's were given to help with his behaviors. The staff member also reported no one call the ER and gave them report on what was going on before he came to the ER. (continued on next page)

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	165531	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Care Center	1200 West Nishna Road Shenandoah, IA 51601

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 3:33 PM the Administrator stated staff sent Resident #2 to the hospital because he had increased behaviors and they could not calm him down. On the day they completed the tornado drill he was upset about not being able to go out to smoke because another resident he does not get along with was outside smoking. Staff informed him he needed to wait until she was done and he became upset; started to yell and scream. Since the tornado drill was taking place all the residents were in the hall way, he stormed off as a resident stepped out of her room he went off on her because she asked him not to go in her room. As he went down the hall to his room he was beating on the wall, slamming his door, he slammed his door so hard the resident's stuff on the other side of his wall, fell off. Resident #2 then went outside and the Activities Director followed him outside. The resident pushed the door in the Activities Director's face, walked around the building and came back in through the laundry door, down the hall and in to the Dietary Manager's office. She tried to calm him down but he was screaming at her, throwing things in the dining room, beating his head with his hands. At that time the Administrator called 911 because they needed someone to help calm him down. They had the police and Emergency Medical Service (EMS) came in the backdoor and he continued to hit his head, scream and looked for things to throw. He went out the door and wanted a cigarette as the police tried to calm him down. Resident #2 then went off on the police, got up and they must have thought he was going to go after them because they put his upper body face down on a car and administered a medication nasally. EMS then took him to the hospital. The Administrator stated prior to this he was wanting to go to a group home in Des Moines but the week before he was told he was not accepted. He became agitated at that time by throwing things at the Social Service Director. The Activities Director took him outside, to see if it would calm him down but he was so agitated he would not calm down. The Administrator was informed there was no documentation in the resident's Electronic Health Record (EHR) to reflect these behaviors she stated every one probably said well that's just Resident #2 and did not document it. She was also informed of Resident #2 not receiving a PRN to help with his anxiousness since 4/21/24, she stated it was probably offered but he refused. There was not documentation to support this, she stated she knew this because she did a review of his chart after he went to the ER. She stated over the weekend prior to him going to the hospital, Resident #2 had behaviors. When she was informed there was no documentation to support this in his progress notes or behavior charting. She again stated she reviewed his chart and saw there was no documentation but there was enough to be documented. She reiterated that staff just thought it was just Resident #2 so they did not document. The facility policy titled Documentation with an original date of 8/2015 documented facility nursing staff documents the provision of nursing care according to nursing standards and regulatory requirements. Documentation tools are designed, when completed, to demonstrate the clinical care provided to the resident/patient and to ensure the appropriate information is available to all interdisciplinary team members regarding treatment interventions and responses. Frequency of nursing documentation is based on resident/patient clinical status, clinical need and regulatory requirements. Components of the nursing documentation process include, but are not limited to the following: o Identification and implementation of daily and weekly data collection tools based on resident/patient clinical condition and regulatory requirements o Documentation in progress notes that reflect the ongoing clinical condition of the resident/patient o Development and documentation of resident/patient individualized interventions and goals through the care plan process (continued on next page)

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	165531	A. Building B. Wing	04/05/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Ongoing, periodic evaluations according to the resident/patient clinical status and regulatory requirements Facility nursing staff maintains daily, weekly, monthly and quarterly documentation to demonstrate nursing care provided to the resident/patient and assists the interdisciplinary team in evaluating the resident/patient clinical condition. Daily and weekly documentation is also done to assist in accurate completion of the MDS and to meet regulatory requirements. Monthly documentation summarizes the resident/patient clinical status and Quarterly documentation re-evaluates the resident/patient status for any changes required in the comprehensive care plan.