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	09/11/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49628 Based on observations, resident interviews, staff interviews and policy review the facility failed to maintain a safe and comfortable environment free of possible hazards by having insufficient linens, and residents' beds not being made on a consistent basis. The facility reported a census of 37 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #6 dated 6/26/24 identified a Brief Interview for Mental Status (BIMS) score of 15 which indicated normal cognition. Resident #6 on 9/7/24 at 1:20 PM stated the facility runs out of bed soakers frequently. The resident stated that with the size of the facility they should have a large enough supply to not run out of linens, but they do. 2. The MDS for Resident #10 dated 6/5/24 identified a BIMS score of 15 which indicated normal cognition. Resident #10 on 9/9/24 at 8:06 AM stated that she had returned from dialysis on multiple days where her bed had not been made. The resident stated she goes to dialysis later in the day on Mondays, Wednesdays, and Fridays. 3. The MDS for Resident #11 dated 8/19/24 identified a BIMS score of 15 which indicated normal cognition. Resident #11 on 9/10/24 at 2:07 PM stated the staff did not always make her bed. Observed the resident's bed to have dirty, stained sheets, and was unmade. 4. The MDS for Resident #7 dated 8/22/24 identified a BIMS score of 12 which indicated a moderate cognitive impairment. Observation on 9/7/24 at 1:50 PM revealed Resident #7's bed to be unmade and not having a fitted sheet. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff C, Certified Nursing Assistant (CNA), on 9/6/24 at 3:52 PM stated had previously worked the overnight shift and had recently begun working the evening shift. The staff stated the facility ran out of bed pads/soakers during both the evening and night shifts. Staff C stated they used additional sheets on the bed to compensate for the lack of soakers. Staff D, Licensed Practical Nurse (LPN), on 9/6/24 at 4:18 PM stated the CNA's have come to her stating they did not have sheets or bed pads. The staff stated she has gone to the laundry to ask for clean linens or look for them when there had not been a supply in the closets. Staff E, LPN, on 9/7/24 at 10:41 AM stated the facility ran out of fitted sheets and soaker pads. Staff stated when the supplies were not available she would look in the laundry and would substitute flat sheets and bariatric sheets for fitted sheets. The staff stated she had notified the administration of the need for increased bed pads and sheets. Staff I, CNA, on 9/7/24 at 1:49 PM stated the facility ran out of soakers, sheets, and residents' personal clothing. Staff I stated when they ran out of linens they could not make the residents' beds or would improvise with use of other linens or repositioning. On 9/8/24 at 1:50 PM Staff G, CNA, and Staff S, CNA, stated residents' beds were typically changed on bath days, unless soiled. Staff stated they had not noticed Resident #7's bed had not been made. The staff did not explain why the resident's bed did not have a fitted sheet. Staff Q, Housekeeping Assistant, on 9/9/24 at 8:47 AM stated the facility had been low on bed pads and sheets. The staff stated if supplies were low or out in the morning, the restock would be in the supply closets by mid/late morning. The staff stated residents' beds should be remade by noon. Staff Q stated as a general rule the laundry should be put away at the end of the day. Staff R, Laundry Aide, on 9/9/24 at 9:09 AM stated she had suggested to her department head and the facility administrator to purchase more bed pads and sheets. The staff stated the response she had received from administration was ordering would be completed at the beginning of the month. The staff stated the facility also ran out of blankets as some residents required multiple blankets on their beds. The facility provided policy, Homelike Environment, revised 2/21, revealed characteristics of a homelike facility should include: clean bed and bath linens in good condition.

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on observation, record review, policy, and staff interviews, the facility failed to prevent physical and verbal abuse of Resident #2 and Resident #5. On 8/26/24 between 5:00 pm and 5:30 pm, a CNA witnessed another CNA physically and verbally abuse Resident #2 and Resident #5. The investigation revealed the same CNA had a history of verbally and physically abusing Resident #2 and Resident #5 without being separated. This failure resulted in residents living at the facility exposed to the actual abuse and the potential of abuse therefore causing an Immediate Jeopardy to the health, safety, and security of the resident. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of August 26, 2024 on September 8, 2024 at 11:30 a.m The facility staff removed the IJ on September 8, 2024 through the following actions: -Resident and staff interviews to determine any unreported incidence of abuse conducted on 8/28-29/24. -All Staff are educated on Abuse types, Reporting Requirements, and Requirement of immediate separation on 8/28-29/24 and continuing 9/8/24 with all employees being educated on the abuse policy prior to working with residents. -The Administrator has been identified as the Abuse Coordinator and signage for phone number/contact for 24/7 reporting has been placed conspicuously in the facility. The scope lowered from a J to a D at the time of the survey after ensuring the facility implemented education and their policy and procedures. The facility identified a census of 37 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. The MDS assessment also indicated Resident #2 required substantial / maximal assistance with dressing and undressing the upper and lower body. Review of Resident #2's electronic health record (EHR) titled, Weekly Skin Assessment-V5 dated 8/27/24 at 3:55 PM documented by Staff D, Licensed Practical Nurse (LPN) 3 bruises to the chest. Bruising measured 2 cm x 2 cm, 4 cm x 3 cm, and 1 cm x 1.5 cm. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility provided incident report dated 8/25/24, completed by the Administrator revealed as the Administrator was interviewing staff regarding another incident with Resident #2, it was reported that Staff U had stated to Resident #2 don't f-ing hit me. I'll never take care of you again. when Resident #2 had hit Staff U on the side kinda in her back. The Administrator was not able to interview Resident #2 due to her mental status. Resident #2's BIMS is 3/15. The Administrator focused on interviewing Certified Nurses Assistants (CNA) that would have worked with Resident #2 and employees, as well as other staff. Random resident interviews reflected no issues regarding being verbally threatened by a staff member or another resident. Random staff interviews reflected some had no concerns with employees being verbally abusive to residents. Others mentioned Staff U and how she talks to residents, threatening to hit the residents when they hit her during care. The Administrator could substantiate that verbal abuse had occurred, but not the specific dates due to interview comments. Review of the facility provided incident report with incident date of 8/27/24, completed by the Administrator revealed it was noted that Resident #2 had 3 fingertip bruises to her chest when staff were getting her up on 8/27/24. The Administrator focused on interviewing staff that worked from Sunday, (8/25) to Tuesday, (8/27) to address if they worked with Resident #2 and, if so, what date, in what capacity, did they provide care to Resident #2 or assist with cares, if assisting who did they assist, did they notice any bruises, and if they noticed any bruises who and when did they report it. Staff D, Licensed Practical Nurse (LPN) was given a report of bruising and thought she would address the bruising with Resident #2's skin assessment that was due on 8/27/24. When Staff D went to do a skin assessment, she stopped the minute she saw the fingerprint type bruising and asked the DON to come with her to complete the skin assessment. Employees interviewed had not seen the bruising until the morning of 8/27/24 when getting resident up for the day. Staff M left a statement under the Administrators door on 8/27/24 because she worked after the Administrator left, stating that Staff U had pushed Resident #2 down in her chair after changing her. Staff M stated that Staff U had aggressively pulled Resident #2 down into her chair from the shoulder area. Based on staff members' interviews the facility could substantiate that physical abuse occurred as Resident #2 had fingerprint bruises and Staff M witnessed Staff U pull Resident #2 down into her chair. This is most likely caused due to resident diagnosis/disposition and the alleged perpetrator's poor disposition, lack of empathy, and understanding of the resident population. On 9/6/24 at 9:45 AM the Administrator stated facility staff acknowledged that they were probably wrong for not reporting the abuse. The Administrator stated she did not look at Resident #2 or Resident #5 because the nurse addressed the concern right then about Resident #2. The Administrator stated the facility's expectation was that all possible abuse would be reported to the management but the nurse did not see this as abuse. The Administrator stated she thought that the possible verbal and physical aggression to Resident #2 and #5 probably should have been reported to the state agency as an allegation. The Administrator stated the allegations to both Resident #2 and #5 were unreported. The Administrator stated she wrapped everything in on the 2 facility reported incidents because it was related to Staff U. On 9/6/24 at 4:20 PM Staff D stated staff had told her that Staff U had pushed Resident #2 back in the wheelchair. Staff D stated Resident #2 was a weekly skin assessment that day. Staff D stated she asked Staff J and Staff J told her the bruising was on Resident #2's chest. Staff D stated there were 3 bruises that resembled fingers on Resident #2's left upper chest. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/7/24 at 10:26 AM Staff V stated Staff J brought the bruise on Resident #2 to her attention at 6:10 AM. Staff V stated Staff D came in at 6:20 AM. Staff V stated she was fired related to not assessing the bruise. 2. The MDS assessment dated [DATE] documented Resident #5 had a BIMS score of 6 indicating severe cognitive impairment. The MDS assessment also indicated Resident #5 was dependent on staff for dressing and undressing the upper body, lower body and for toileting. On 9/6/24 at 1:43 pm Staff B, Certified Nursing Assistant (CNA) stated she used to work on evenings shift. Staff B stated she worked with Staff U and had seen her be aggressive to residents. Staff B stated Resident #5 was one of the residents. Staff B stated Resident #5 did not want to get up for supper. Staff B stated Staff F, Certified Medication Assistant (CMA) was present and Staff U grabbed Resident #5 by his feet and swung them over the bed and pulled him up by his arms unnecessarily rough. Staff B stated Resident #5 was cussing and asked what she was doing. Staff B stated Staff F was asking Resident #5 why he was being so mean. Staff B stated she wrote a statement about it and it was in the statement. Staff B stated this incident happened recently. Staff B stated Staff U was suspended the next day. Staff B stated the day after Staff U was suspended she found a bruise on Resident #5's arm Staff B stated talk to Staff L she had been around a lot of things Staff U did that was not acceptable. On 9/7/24 at 11:30 AM Staff G, CNA stated she had heard a staff member speak very verbally abusive. Staff G stated the CNA was Staff U. Staff G stated Resident #5 told Staff U to leave him alone and called her a f***ing bitch. Staff G stated Staff U said to Resident #5 you are not going to talk to me like that you f***ing a**hole. Staff G stated one time Staff U was getting Resident #5 up and Staff U took Resident #5's legs and flung his legs in an aggressive manner out of bed. Staff G stated it was done in a manner that if it was done to her it would have hurt her back. Staff G stated Resident #5 would say he would punch Staff U and Staff U would say she would punch him before he could get to her. Staff G stated she had seen the 3 finger bruises and it looked like finger print marks on Resident #2. Staff G stated she found it right when she was got Resident #2 up the morning of 8/27/24. Staff G stated that Staff L came in the evening of 8/27/24 and she said she knew where those bruises came from. Staff G stated Staff L stated Staff U had pushed Resident #2 back and down in her wheelchair. On 9/7/24 at 1:51 PM Staff K CNA stated she had seen Staff U be unnecessarily rough with Resident #2. Staff K stated when Staff U completed personal cares for Resident #2 she would talk down to Resident #2 and tell her that she shouldn't piss her pants. Staff K stated she should have reported the incident. Staff K stated these verbal and physical incidents towards residents had been happening since May. Staff K stated Resident #5 cussed at staff and residents. Staff K stated Staff U was very mean to Resident #5. Staff K stated Staff U would say to Resident #5 you f***ing bitch i will hit you before you hit me. Staff K stated Resident #5 does not like taking his shirt off and Staff U would force his shirt off over his head. Staff L stated Staff U was very forceful. Staff U stated Staff U would pull Resident #2 up by the arms and swing the legs very forcefully out of bed. Staff K stated she had seen Staff U push Resident #2 back in the chair and pulling her back by the shoulders but did not remember if she did the evening of 8/26/24. Staff stated she worked with Staff U the night before the bruise was found on Resident #2. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/7/24 at 2:27 PM Staff L, CNA stated Staff U, her and Staff E went into Resident #5's room to put him to bed and Staff L was very new at that time. Staff L stated they had sat Resident #5 in bed and Staff U told Resident #5 don't f***ing kick me or I will hit you. Staff L stated Staff U was not very gentle when assisting Resident #2 with care. Staff L stated had heard Staff U tell Resident #2 to stop f***ing hitting her or she will never take care of her again. Staff L stated she saw the bruises on Resident #5 on the 27th 2-10 PM shift and they looked like finger bruises. On 9/7/24 at 3:07 PM Staff M, CNA stated had seen physical and verbal abuse by Staff U. Staff M stated Staff U was physical with Resident #2 before getting her ready for dinner on 8/26/24. Staff M stated she worked 8/26/24 2:00 AM - 6:00 AM and then returned at 4:30 PM. Staff M stated they were getting Resident #2 changed before supper and Staff U went to stand Resident #2 up next to the sink, changed her, and Resident #2 would not sit down. Staff M stated Staff U put her hand over Resident #2's shoulder and pushed her down in the wheelchair. Staff M stated when Resident #2 wouldn't sit Staff U put her whole hand over Resident #2's shoulder and forcefully sat Resident #2 down. Staff M stated she told Staff U not to do that and then she went and told Staff V. Staff M stated the bruise on Resident #2 looked like 3 perfect fingerprints and appeared in the same spot that Staff U had put her hands on Resident #2. Staff M stated she was in the room when Staff U said don't f***ing hit me because I will hit you back to Resident #5. On 9/7/24 at 4:00 PM the Administrator stated most of the complaints from the staff were about Staff U's negative attitude. The Administrator stated Staff U was given a final written warning regarding harassment to other staff. The Administrator stated Staff U was suspended because of verbal abuse. The Administrator stated when the bruises showed up on Resident #2, she tried to figure out where the bruise came from and that is when the verbal abuse came out. The Administrator stated as the facility was going through the investigation it was discovered how rough Staff U was with Resident #2 and #5. The Administrator acknowledged Staff U should have been separated immediately from resident care and that did not occur. On 9/7/24 at 4:28 PM Staff U stated when she was terminated she worked the PM shift and worked AM shift for almost [AGE] years at the facility prior. Staff U stated the staff that worked at the facility treated the residents with dignity and respect. Staff U stated she never witnessed any staff being physically and verbally aggressive. Staff U stated she never heard any staff cuss at the residents. Staff U stated she never cussed at any residents. Staff U stated she never forced a resident to move if they did not want to. Staff U stated she had worked with Resident #2 and #5. Staff U stated she had never seen Resident #2 have any bruising of unknown origins. Staff U stated she was accused of verbally abusing residents. Staff U stated she did not abuse any residents at the facility. Review of documents titled, Employee Questionnaire for Abuse Allegations dated 8/29/24, Staff G documented she had witnessed Staff U telling Resident #2 and #5 if you hit me I will hit you back and had witnessed her being rough with both of them like harshly pulling their legs out of bed. Staff G also documented Staff U had called them a**holes. Staff L documented Staff U yelled at Resident #5 don't f***ing kick me or I will hit you. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of policy titled, Abuse Prevention Program and Reporting Policy revised 4/23 documented abuse was defined as willful infliction of injury, unreasonable confinement, intimidation with resulting physical harm or pain or mental anguish, and punishment with resulting physical harm or pain or mental anguish. Verbal abuse was defined as oral, written, or gestured language that willfully includes disparaging and derogatory terms to the resident or within their hearing distance, regardless of their age, ability to comprehend, or disability. Physical abuse was defined including hitting, slapping, pinching, scratching, spitting, holding roughly. It also includes controlling behavior through corporal punishment.

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on observation, record review, policy, and staff interviews, the facility failed to report an allegation of abuse to the Iowa Department of Inspections & Appeals and Licensing (DIAL) within 2 hours of an allegation of physical and verbal abuse of Resident #2 and Resident #5. On 8/26/24 between 5:00 pm and 5:30 pm, a CNA witnessed another CNA physically and verbally abuse Resident #2 and Resident #5. The CNA stated she reported the physical abuse of Resident #2 to a nurse on 8/26/24 between 5:00 pm - 5:30 pm. Neither the CNA nor the nurse reported the physical abuse to the state agency or the administration. The investigation revealed the same CNA had history of verbally and physically abusing Resident #2 and Resident #5 and those allegations were also not reported. This failure resulted in residents living at the facility to be exposed to actual abuse and the potential of abuse therefore causing an Immediate Jeopardy to the health, safety, and security of the resident. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of August 26, 2024 on September 8, 2024 at 11:30 AM. The facility staff removed the IJ on September 8, 2024 through the following actions: -Resident and staff interviews to determine any unreported incidence of abuse conducted on 8/28-29/24. -All Staff are educated on Abuse types, Reporting Requirements, and Requirement of immediate separation on 8/28-29/24 and continuing 9/8/24 with all employees being educated on the abuse policy prior to working with residents. -The Administrator has been identified as the Abuse Coordinator and signage for phone #/contact for 24/7 reporting has been placed conspicuously in the facility. The scope lowered from a J to a D at the time of the survey after ensuring the facility implemented education and their policy and procedures. The facility identified a census of 37 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. The MDS also indicated Resident #2 required substantial / maximal assistance with dressing and undressing the upper and lower body. Review of Resident #2's electronic health record (EHR) titled, Weekly Skin Assessment-V5 dated 8/27/24 at 3:55 PM documented by Staff D, Licensed Practical Nurse (LPN) 3 bruises to the chest of Resident #2. Bruising measured 2 cm x 2 cm, 4 cm x 3 cm, and 1 cm x 1.5 cm. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. The MDS assessment dated [DATE] documented Resident #5 had a BIMS score of 6 indicating severe cognitive impairment. The MDS also indicated Resident #5 was dependent on staff for dressing and undressing the upper body, lower body and for toileting. Review of the facility provided incident report dated 8/25/24, completed by the Administrator revealed as the Administrator was interviewing staff regarding another incident with Resident #2, it was reported that Staff U had stated to Resident #2 don't f-ing hit me. I'll never take care of you again when Resident #2 had hit Staff U on the side kinda in her back. The Administrator was not able to interview Resident #2 due to her mental status. Resident #2's BIMS is 3/15. The Administrator focused on interviewing Certified Nurses Assistants (CNA) that would have worked with Resident #2 and employees, as well as other staff. Random resident interviews reflected no issues regarding being verbally threatened by a staff member or another resident. Random staff interviews reflected some had no concerns with employees being verbally abusive to residents. Others mentioned Staff U and how she talks to residents, threatening to hit the residents when they hit her during care. The Administrator could substantiate that verbal abuse had occurred, but not the specific dates due to interview comments. Review of the facility provided incident report with incident date of 8/27/24, completed by the Administrator revealed it was noted that Resident #2 had 3 fingertip bruises to her chest when staff were getting her up on 8/27/24. The Administrator focused on interviewing staff that worked from Sunday, (8/25) to Tuesday, (8/27) to address if they worked with Resident #2 and, if so, what date, in what capacity, did they provide care to Resident #2 or assist with cares, if assisting who did they assist, did they notice any bruises, and if they noticed any bruises who and when did they report it. Staff D, Licensed Practical Nurse (LPN) was given a report of bruising and thought she would address the bruising with Resident #2's skin assessment that was due on 8/27/24. When Staff D went to do a skin assessment, she stopped the minute she saw the fingerprint type bruising and asked the DON to come with her to complete the skin assessment. Employees interviewed had not seen the bruising until the morning of 8/27/24 when getting the resident up for the day. Staff M left a statement under the Administrators door on 8/27/24 because she worked after the Administrator left, stating that Staff U had pushed Resident #2 down in her chair after changing her. Staff M stated that Staff U had aggressively pulled Resident #2 down into her chair from the shoulder area. Based on staff members' interviews the facility could substantiate that physical abuse occurred as Resident #2 had fingerprint bruises and Staff M witnessed Staff U pull Resident #2 down into her chair. This is most likely caused due to resident diagnosis/disposition and the alleged perpetrator's poor disposition, lack of empathy, and understanding of the resident population. On 9/6/24 at 9:45 AM the Administrator stated facility staff acknowledged that they were probably wrong for not reporting the abuse. The Administrator stated she did not look at Resident #2 or Resident #5 because the nurse addressed the concern right then about Resident #2. The Administrator stated the facility's expectation was that all possible abuse would be reported to the management but the nurse did not see this as abuse. The Administrator stated she thought that the possible verbal and physical aggression to Resident #2 and #5 probably should have been reported to the state agency as an allegation. The Administrator stated the allegations to both Resident #2 and #5 were unreported. The Administrator stated she wrapped everything in on the 2 facility reported incidents because it was related to Staff U. (continued on next page)

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F 0609

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

On 9/6/24 at 1:43 PM Staff B, Certified Nursing Assistant (CNA) stated she used to work on evenings shift. Staff B stated she worked with Staff U and had seen her be aggressive, physically and verbally abusive to residents. Staff B stated on that day she did not speak to the nurse or the management because she felt when you tell certain people here that nothing really happened. Staff B stated the day after Staff U was suspended she found a bruise on Resident #5's arm and she reported this to the Administrator because Staff U had pulled him up out of bed by his arms. Staff B stated talk to Staff L she had been around a lot of things Staff U did that was not acceptable.

On 9/6/24 at 4:20 PM Staff D stated staff had told her that Staff U had pushed Resident #2 back in the wheelchair. Staff D stated Staff V was the overnight nurse and told her to look at the bruising on Resident #2 as the overnight nurse had not looked at it. Staff D stated Resident #2 was a weekly skin assessment that day. Staff D stated she asked Staff J and Staff J told her the bruising was on Resident #2's chest. Staff D stated there were 3 bruises that resembled fingers on Resident #2's left upper chest. Staff D stated she immediately reported this to the DON of the suspicious marks.

On 9/7/24 at 10:26 AM Staff V stated Staff J brought the bruise on Resident #2 to her attention at 6:10 AM. Staff V stated Staff D came in at 6:20 AM. Staff V stated she was fired related to not assessing the bruise. Staff V stated she did not look at the bruise but Staff D was at the facility about 5 minutes after notified.

On 9/7/24 at 11:30 AM Staff G, CNA stated she had heard a staff member speak very verbally abusive to residents. Staff G stated the CNA was Staff U. Staff G stated she felt like Staff U would have retaliated if she told the nurses or administration. Staff G stated she had seen the 3 finger bruises and it looked like finger print marks on Resident #2. Staff G stated she reported this to Staff V. Staff G stated Staff V did not come down and look at the bruises. Staff G stated she found it right when she was got Resident #2 up the morning of 8/27/24. Staff G stated Staff L stated Staff U had pushed Resident #2 back and down in her wheelchair. Staff G stated she felt that she should have reported Staff U's behavior towards the residents and she did not.

On 9/7/24 at 1:51 PM Staff K CNA stated she had seen Staff U be unnecessarily rough with Resident #2. Staff K stated these verbal and physical incidents towards residents had been happening since May. Staff K stated she did not know if what Staff U was doing was counted as abuse but was told yesterday that all of it was counted as abuse. Staff K stated she had worked in the last 2 weeks. Staff K stated she works 5 hours at least 2 days a week. Staff K stated has worked at least 20 hours since the incident. Staff K stated she noticed the bruises on Resident #2. Staff K stated she had seen Staff U push Resident #2 back in the chair and pulling her back by the shoulders but did not remember if she did the evening of 8/26/24.

On 9/7/24 at 2:27 PM Staff L, CNA stated she reported multiple times to the Administrator about the way Staff U spoke to the residents. Staff L first spoke to the Administrator about Staff U's behavior back in May the first time. Staff L stated she had worried about retaliation at work.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165531	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Garden View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 West Nishna Road Shenandoah, IA 51601	

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/7/24 at 3:07 PM Staff M, CNA stated she had seen physical and verbal abuse by Staff U. Staff M stated Staff U was physical with Resident #2 before getting her ready for dinner on 8/26/24. Staff M stated she told Staff U not to do that and then she then told Staff V. Staff M stated she told Staff V and Staff V said she would talk to Staff U and report it to the Administrator. Staff M stated she probably should have told the Administrator herself but she thought Staff V would tell the Administrator. Staff M stated the bruise on Resident #2 looked like 3 perfect fingerprints and appeared in the same spot that Staff U had put her hands on Resident #2. Staff M stated Staff V never looked at the bruise. On 9/7/24 at 4:00 PM the Administrator stated most of the complaints from the staff were about Staff U's negative attitude. The Administrator stated Staff U was given a final written warning regarding harassment to other staff. The Administrator stated Staff U was suspended because of verbal abuse. The Administrator stated when the bruises showed up on Resident #2 they tried to figure out where the bruise came from and that is when the verbal abuse came out. The Administrator stated as the facility was going through the investigation it was discovered how rough Staff U was with Resident #2 and #5. The Administrator acknowledged Staff U should have been separated immediately from resident care and that did not occur. On 9/7/24 at 4:28 PM Staff U stated when she was terminated she worked the PM shift and worked the AM shift for almost [AGE] years at the facility prior. Staff U stated the staff that worked at the facility treated the residents with dignity and respect at the facility. Staff U stated she never witnessed any staff being physically and verbally aggressive. Staff U stated she never heard any staff cuss at the residents. Staff U stated she never cussed at any residents. Staff U stated she never forced a resident to move if they did not want to. Staff U stated she had worked with Resident #2 and #5. Staff U stated she had never seen Resident #2 have any bruising of unknown origins. Staff U stated she was accused of verbally abusing residents. Staff U stated she did not abuse any residents at the facility. Review of documents titled, Employee Questionnaire for Abuse Allegations dated 8/29/24 documented Staff G had witnessed Staff U telling Resident #2 and #5 if you hit me I will hit you back and have been rough with both of them like harshly pulling their legs out of bed. Staff G also documented Staff U had called them a**holes. Staff L documented Staff U yelled at Resident #5 don't f***ing kick me or I will hit you. Review of policy titled, Abuse Prevention Program and Reporting Policy revised 4/23 documented when witnessed abuse or suspected abuse occurs staff should notify the shift supervisor immediately. Report the incident immediately to the Administrator, and Director of Nursing. Any staff member with knowledge of the event is responsible for notifying the Administrator and/or DON. Report the appropriate state agency immediately by fax or telephone or on-line reporting after identification of alleged/suspected incident. Initiate process according to State-specific regulations. Notify the legal guardian, spouse, or responsible family member/significant other of the alleged or suspected abuse, neglect, mistreatment, and/or misappropriation of property immediately. The Facility Administrator is responsible to initiate contact with local law enforcement, immediately, when warranted, as required by state law. Consult with management consulting companies as needed for additional support.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on clinical record review, facility document review, staff interviews and policy review, the facility failed to separate an alleged CNA abuser to prevent further verbal and physical abuse of Resident #2 and Resident #5 and failed to complete a comprehensive investigation immediately. On 8/26/24 between 5:00 pm and 5:30 pm, a CNA witnessed another CNA physically and verbally abuse Resident #2 and Resident #5. The CNA stated she reported the physical abuse of Resident #2 to a nurse on 8/26/24 between 5:00 pm - 5:30 pm. The CNA stated the nurse never assessed the area. The CNA continued to work with Resident #2 and Resident #5 after the CNA witnessed the abuse. On 8/27/24 the staff identified a bruise to the upper left side of Resident #2's chest in the shape of fingers. Upon investigation of the bruises on Resident #2, it was identified the same CNA had history of verbally and physically abusing Resident #2 and Resident #5. This failure resulted in residents living at the facility to be exposed to actual abuse and the potential of abuse therefore causing an Immediate Jeopardy to the health, safety, and security of the resident. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of August 26, 2024 on September 8, 2024 at 11:30 AM. The facility staff removed the IJ on September 8, 2024 through the following actions: - Resident and staff interviews to determine any unreported incidence of abuse conducted on 8/28-29/24. -All Staff are educated on Abuse types, Reporting Requirements, and Requirement of immediate separation on 8/28-29/24 and continuing 9/8/24 with all employees being educated on the abuse policy prior to working with residents. -The Administrator has been identified as the Abuse Coordinator and signage for phone #/contact for 24/7 reporting has been placed conspicuously in the facility. The scope lowered from a J to a D at the time of the survey after ensuring the facility implemented education and their policy and procedures. The facility identified a census of 37 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. The MDS assessment also indicated Resident #2 required substantial/maximal assistance with dressing and undressing the upper and lower body. Review of Resident #2's electronic health record (EHR) titled, Weekly Skin Assessment-V5 dated 8/27/24 at 3:55 PM documented by Staff D, Licensed Practical Nurse (LPN) 3 bruises to the chest of Resident #2. Bruising measured 2 cm x 2 cm, 4 cm x 3 cm, and 1 cm x 1.5 cm. (continued on next page)

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility provided incident report dated 8/25/24, completed by the Administrator revealed as the Administrator was interviewing staff regarding another incident with Resident #2, it was reported that Staff U had stated to Resident #2 don't f-ing hit me. I'll never take care of you again. when Resident #2 had hit Staff U on the side kinda in her back. The Administrator was not able to interview Resident #2 due to her mental status. Resident #2's BIMS is 3/15. The Administrator focused on interviewing Certified Nurses Assistants (CNA) that would have worked with Resident #2 and employees, as well as other staff. Random resident interviews reflected no issues regarding being verbally threatened by a staff member or another resident. Random staff interviews reflected some had no concerns with employees being verbally abusive to residents. Others mentioned Staff U and how she talks to residents, threatening to hit the residents when they hit her during care. The Administrator could substantiate that verbal abuse had occurred, but not the specific dates due to interview comments. Review of the facility provided incident report with incident date of 8/27/24, completed by the Administrator revealed it was noted that Resident #2 had 3 fingertip bruises to her chest when staff were getting her up on 8/27/24. The Administrator focused on interviewing staff that worked from Sunday, (8/25) to Tuesday, (8/27) to address if they worked with Resident #2 and, if so, what date, in what capacity, did they provide care to Resident #2 or assist with cares, if assisting who did they assist, did they notice any bruises, and if they noticed any bruises who and when did they report it. Staff D, Licensed Practical Nurse (LPN) was given a report of bruising and thought she would address the bruising with Resident #2 ' s skin assessment that was due on 8/27/24. When Staff D went to do a skin assessment, she stopped the minute she saw the fingerprint type bruising and asked the DON to come with her to complete the skin assessment. Employees interviewed had not seen the bruising until the morning of 8/27/24 when getting resident up for the day. Staff M left a statement under the Administrators door on 8/27/24 because she worked after the Administrator left, stating that Staff U had pushed Resident #2 down in her chair after changing her. Staff M stated that Staff U had aggressively pulled Resident #2 down into her chair from the shoulder area. Based on staff members' interviews the facility could substantiate that physical abuse occurred as Resident #2 had fingerprint bruises and Staff M witnessed Staff U pull Resident #2 down into her chair. This is most likely caused due to resident diagnosis/disposition and the alleged perpetrator ' s poor disposition, lack of empathy, and understanding of the resident population. 2. The MDS assessment dated [DATE] documented Resident #5 had a BIMS score of 6 indicating severe cognitive impairment. The MDS assessment also indicated Resident #5 was dependent on staff for dressing and undressing the upper body, lower body and for toileting. On 9/6/24 at 9:45 AM The Administrator stated facility staff acknowledged that they were probably wrong for not reporting the abuse. The Administrator stated she did not look at Resident #2 or Resident #5 because the nurse addressed the concern right then about Resident #2. The Administrator stated the facility's expectation was that all possible abuse would be reported to the management but the nurse did not see this as abuse. The Administrator stated she thought that the possible verbal and physical aggression to Resident #3 and #5 probably should have been reported to the state agency as an allegation. The Administrator stated the allegations to both Resident #3 and #5 were unreported. The Administrator stated she wrapped everything in on the 2 facility reported incidents because it was related to Staff U. (continued on next page)

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/6/24 at 1:43 pm Staff B, Certified Nursing Assistant (CNA) stated she used to work on evenings shift. Staff B stated she worked with Staff U and had seen her be aggressive to residents. Staff B stated Resident #5 was one of the residents. Staff B stated Resident #5 did not want to get up for supper. Staff B stated Staff F, Certified Medication Assistant (CMA) was present and Staff U grabbed Resident #5 by his feet and swung them over the bed and pulled him up by his arms unnecessarily rough. Staff B stated Resident #5 was cussing and asked what she was doing. Staff B stated Staff F was asking Resident #5 why he was being so mean. Staff B stated she wrote a statement about it and it was in the statement. Staff B stated this incident happened recently. Staff B stated Staff B was suspended the next day. Staff B stated on that day she did not speak to the nurse or the management because she felt when you tell certain people here that nothing really happened. Staff B stated the day after Staff U was suspended she found a bruise on Resident #5's arm and she reported this to the Administrator because Staff U had pulled him up out of bed by his arms. Staff B stated talk to Staff L she had been around a lot of things Staff U did that was not acceptable. On 9/6/24 at 4:20 PM Staff D stated staff had told her that Staff U had pushed Resident #2 back in the wheelchair. Staff D stated Staff V was the overnight nurse and told her to look at the bruising on Resident #2 as the overnight nurse had not looked at it. Staff D stated Resident #2 was a weekly skin assessment that day. Staff D stated she asked Staff J and Staff J told her the bruising was on Resident #2's chest. Staff D stated there were 3 bruises that resembled fingers on Resident #2's left upper chest. Staff D stated she immediately reported this to the DON of the suspicious marks. On 9/7/24 at 10:26 AM Staff V stated Staff J brought the bruise on Resident #2 to her attention at 6:10 AM. Staff V stated Staff D came in at 6:20 AM. Staff V stated she was fired related to not assessing the bruise. Staff V stated she did not look at the bruise but Staff D was at the facility about 5 minutes after notified. On 9/7/24 at 11:30 AM Staff G, CNA stated she had heard a staff member speak very verbally abusive. Staff G stated the CNA was Staff U. Staff G stated Resident #5 told Staff U to leave him alone and called her a f***ing bitch. Staff G stated Staff U said to Resident #5 you are not going to talk to me like that you f***ing a**hole. Staff G stated one time Staff U was getting Resident #5 up and Staff U took Resident #5's legs and flung his legs in an aggressive manner out of bed. Staff G stated it was done in a manner that if it was done to her it would have hurt her back. Staff G stated with Resident #5 would say he would punch Staff U and Staff U would say she would punch him before he could get to her. Staff G stated she felt like Staff U would have retaliated if she told the nurses or administration. Staff G stated she had seen the 3 finger bruises and it looked like finger print marks on Resident #2. Staff G stated she reported this to Staff V. Staff G stated Staff V did not come down and look at the bruises. Staff G stated she found it right when she got Resident #2 up the morning of 8/27/24. Staff G stated Staff D might have arrived 5 minutes after she told Staff V. Staff G stated that Staff L came in the evening of 8/27/24 and she said she knew where those bruises came from. Staff G stated Staff L stated Staff U had pushed Resident #2 back and down in her wheelchair. Staff G stated she felt that she should have reported Staff U's behavior towards the residents and she did not. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/7/24 at 1:51 PM Staff K CNA stated she had seen Staff U be unnecessarily rough with Resident #2. Staff K stated when Staff U completed personal cares for Resident #2 she would talk down to Resident #2 and tell her that she shouldn't piss her pants. Staff K stated she should have reported the incident. Staff K stated these verbal and physical incidents towards residents had been happening since May. Staff K stated Resident cussed at staff and residents Staff K stated Staff U was very mean to Resident #5. Staff K stated Staff U would say to Resident #5 you f***ing bitch i will hit you before you hit me. Staff K stated Resident #5 does not like taking his shirt off and Staff U would force his shirt off over his head. Staff L stated Staff U was very forceful. Staff K stated she did not know if what Staff U was doing was counted as abuse but was told yesterday that all of it was counted as abuse. Staff U stated Staff U would pull Resident #2 up by the arms and swing the legs very forcefully out of bed. Staff K stated she had worked in the last 2 weeks. Staff K stated she works 5 hours at least 2 days a week. Staff K stated she has worked at least 20 hours since the incident. Staff K stated she noticed the bruises on Resident #2. Staff K stated she had seen Staff U push Resident #2 back in the chair and pulling her back by the shoulders but did not remember if she did the evening of 8/26/24. Staff stated she worked with Staff U the night before the bruise was found on Resident #2. On 9/7/24 at 2:27 PM Staff L, CNA stated she reported multiple times to the Administrator about the way Staff U spoke to the residents. Staff L first spoke to the Administrator about Staff U's behavior back in May the first time. Staff L stated Staff U, her and Staff E went into Resident #5's room to put him to bed and Staff L was very new at that time. Staff L stated they had sat Resident #5 in bed and Staff U told Resident #5 don't f***ing kick me or I will hit you. Staff L stated Staff U was not very gentle when assisting Resident #2 with care. Staff L stated had heard Staff U tell Resident #2 to stop f***ing hitting her or she will never take care of her again. Staff L stated she saw the bruises on Resident #5 on the 27th 2-10 shift and they looked like finger bruises. Staff L stated she had worried about retaliation at work. On 9/7/24 at 3:07 PM Staff M, CNA stated she had seen physical and verbal abuse by Staff U. Staff M stated Staff U was physical with Resident #2 before getting her ready for dinner on 8/26/24. Staff M stated she worked 8/26/24 2:00 AM - 6:00 AM and then returned at 4:30 PM. Staff M stated they were getting Resident #2 changed before supper and Staff U stood Resident #2 up next to the sink, changed her, and Resident #2 would not sit down. Staff M stated Staff U put her hand over Resident #2's shoulder and pushed her down in the wheelchair. Staff M stated when Resident #2 wouldn't sit Staff U put her whole hand over Resident #2's shoulder and forcefully sat Resident #2 down. Staff M stated she told Staff U not to do that and then she went and told Staff V. Staff M stated she told Staff V and Staff V said she would talk to Staff U and report it to the Administrator. Staff M stated she probably should have told the Administrator herself but she thought Staff V would tell the Administrator. Staff M stated the bruise on Resident #2 looked like 3 perfect fingerprints and appeared in the same spot that Staff U had put her hands on Resident #2. Staff M stated Staff V never looked at the bruise. Staff M stated she was in the room when Staff U said don't f***ing hit me because I will hit you back to Resident #5. (continued on next page)

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/7/24 at 4:00 PM the Administrator stated most of the complaints from the staff were about Staff U's negative attitude. The Administrator stated Staff U was given a final written warning regarding harassment to other staff. The Administrator stated Staff U was suspended because of verbal abuse. The Administrator stated when the bruises showed up on Resident #2 they tried to figure out where the bruise came from and that is when the verbal abuse came out. The Administrator stated as the facility was going through the investigation it was discovered how rough Staff U was with Resident #2 and #5. The Administrator acknowledged Staff U should have been separated immediately from resident care and that did not occur. On 9/7/24 at 4:28 PM Staff U stated when she was terminated she worked the PM shift and worked the AM shift for almost [AGE] years at the facility prior. Staff U stated the staff that worked at the facility treated the residents with dignity and respect at the facility. Staff U stated she never witnessed any staff being physically and verbally aggressive. Staff U stated she never heard any staff cuss at the residents. Staff U stated she never cussed at any residents. Staff U stated she never forced a resident to move if they did not want to. Staff U stated she had worked with Resident #2 and #5. Staff U stated she had never seen Resident #2 have any bruising of unknown origins. Staff U stated she was accused of verbally abusing residents. Staff U stated she did not abuse any residents at the facility. Review of documents titled, Employee Questionnaire for Abuse Allegations dated 8/29/24 revealed Staff G documented she had witnessed Staff U telling Resident #2 and #5 if you hit me I will hit you back and have been rough with both of them like harshly pulling their legs out of bed. Staff G also documented Staff U had called them a**holes. Staff L documented Staff U yelled at Resident #5 don't f***ing kick me or I will hit you. Review of policy titled, Abuse Prevention Program and Reporting Policy revised 4/23 documented identified events, such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse, neglect, and/or mistreatment and investigate. Injuries of unknown source classified as injuries of unknown source when both the following conditions are met. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time. Instruct staff, resident, family and visitor, to report immediately, without fear of reprisal, any knowledge or suspicion of suspected abuse, neglect, mistreatment, and/or misappropriation of property. Initiate an internal Incident/Accident Report immediately upon identification of actual or suspected abuse, neglect, mistreatment, and/or misappropriation of property. Provide for the immediate safety of the resident/patient upon identification of suspected abuse, neglect, mistreatment, and/or misappropriation of property. Means of providing protection include, but are not limited to: Immediately separating resident from alleged perpetrator. Moving residents to another room or unit. Provide 1:1 monitoring as appropriate. Implement discharge process immediately if the resident is a danger to self or to others. In the case of a direct caregiver being suspected of allegedly abusing, neglecting, or mistreating a resident, the Administrator must immediately relieve the individual of their duties without pay until the investigation is completed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49628 Based on clinical record review, staff interviews, and policy review the facility failed to develop, implement and follow Comprehensive Care Plans for 3 of 14 residents (#1, #2, #11) reviewed. The facility reported a census of 37 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #1 dated 7/24/24 identified a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented diagnoses that included: hypertension, renal insufficiency, non-Alzheimer's dementia, depression, chronic obstructive pulmonary disease (COPD), difficulty in walking, and unsteadiness on feet. The document revealed that since the previous quarterly assessment was completed on 5/1/24 the resident had 1 fall without injury and two or more falls with injury, except major. Resident #1 was independent with toileting, dressing, transfers, and ambulation. The resident utilized a walker and a wander/elopement alarm that was used daily. The Elopement Risk form dated 5/1/24 documented Resident #1 was a high risk for wandering. The Care Plan printed on 9/6/24 revealed the document did not contain a focus area or interventions for staff to follow until 8/26/24 regarding the resident's wandering behavior. The document did reveal Resident #1 had a Wanderguard System (WGS) in place initiated on 2/12/24. On 8/26/24 a focus area related to the resident's increased risk for wandering/elopement was initiated with interventions provided regarding the WGS, and specific directions regarding the resident. 2. The MDS for Resident #2 dated 6/18/24 identified a BIMS score of 3 which indicated severe cognitive impairment. The MDS documented diagnoses that included: cerebrovascular accident, non-Alzheimer's dementia, anxiety disorder, depression, and bipolar disorder. The resident required substantial/maximal assistance for transfers, and transitional movements of sit to/from stands. The document revealed Resident #2 utilized a wheelchair and was able to self propel distances of 150'. The Care Plan printed 9/9/24 revealed a focus area of assistance with activities of daily living (ADL's) with an intervention of transferring to a stationary chair during meal times to assist with increased eating during meal time with a revision date of 8/12/24. On 9/7/24 at 7:27 AM, 9/8/24 at 8:00 AM, 9/9/24 at 8:30 AM and 9/9/24 at 1:25 PM observed Resident #2 seated in her wheelchair at the dining room table consuming meals. On 9/9/24 at 1:55 PM Staff J stated she did not consistently transfer Resident #2 to a dining room chair. The staff stated if the resident was not wandering around the facility, the resident would remain in the wheelchair. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The MDS for Resident #11 dated 8/11/24 identified a BIMS score of 15 which indicated intact cognition. The MDS documented diagnoses that included: end stage renal disease, chronic venous hypertension with ulcer of left lower extremity, venous insufficiency (chronic) peripheral and multidrug resistant organism. The Care Plan printed on 9/9/24 revealed the document did not contain a focus area or interventions related to enhanced barrier precautions (EBP). The document did contain a treatment regime for lower extremity wounds. The Administrator on 9/7/24 at 6:50 AM stated that care plans needed to reflect resident needs and with multiple directors of nursing (DON's) some care plans may be lacking. The facility provided document, Elopement, dated 6/18/19 revealed a resident with significant wandering behavior had a care plan developed appropriately. The care plan would address the wandering as a specific problem with approaches that were formulated, patterns identified, and causes be addressed. The facility provided policy, Care Plans, Comprehensive Person-Centered, revised 3/22, revealed the care plan would provide information to meet the individual resident's physical, psychosocial, and functional needs. The document further revealed the care plan reflects currently recognized standards of practice for problem areas and conditions. The document stated interventions should address underlying sources of the problem area, and assessments were ongoing and care plans revised as the residents' conditions changed.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 49628 Based on observation, clinical record review, staff interviews, and policy review the facility failed to protect residents from possible accidents and injuries for 2 of 3 residents (Resident #1, Resident #9) reviewed for wandering and elopement. The facility failed to change the door code after knowledge of a resident who presented as an elopement risk knew the code and failed to ensure that door alarms worked properly. On 8/25/24 at 9:00 PM. facility staff realized Resident #1 was not in the building. The resident was last seen at 8:30 PM, and the police found the resident in Walmart around 10:00 PM. Resident #1 had a history of exit seeking behaviors, could enter the code to the front door to exit without setting off the alarm, and had presented with exit seeking behaviors the day of the elopement. When Resident #1 returned to the facility through the front door the Wanderguard System (WGS) alarm did not go off. The facility reported 3 residents wore WGS bracelets and the WGS for the main entry was last checked for functioning on 8/23/24. Resident #1 wore a WBS bracelet but it had not been checked to ensure it functioned properly. The State Agency informed the facility on 9/8/24 at 11:30 AM of the Immediate Jeopardy (IJ) that began on 8/25/24. The immediacy was removed on 9/8/24 when the facility implemented the following: -The code to the door was changed on 8/26/24. -All Residents had Elopement Risk Assessments reviewed and/or completed by 8/26/24. Elopement Binders were updated with current at risk residents and care plans were added to the binders regarding the resident's individual supervision needs. -Residents with WGS had Sensor Checks added to the Electronic Medication Administration Record (EMAR) for placement and function daily (QD). -The WGS door alarm checks were to be completed QD and audited by the Administrator starting 8/26/24. -The facility provided education to the staff on Elopement Procedures/Protocols which was completed 8/26/24. -Additional education was provided starting on 9/8/24 regarding supervision levels of residents per care plan and the removal plan. Employees will be educated over next week prior to the start of their next shift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 9/10/24 at 10:50 AM revealed a group of residents gathered in the large living room at the front of the building including Resident #9, identified by the facility as high risk for elopement and Resident #2, identified as moderate risk for elopement. Resident #14, identified by the facility as moderate risk for elopement, entered the code for opening the main door and proceeded to exit the building. The door alarm began going off as Resident #14, Resident #13, and Resident #12 exited the building. As Resident #9 came near the door, the WGS alarm began sounding. No staff responded to either alarm. The door closed due to the difficulty of a resident exiting the building. The alarms sounded for approximately 1.5 minutes before staff responded. Resident #9 indicated he did have an intention of exiting the building. The State Agency informed the facility on 9/10/24 at 11:40 AM the removal of the immediacy for the IJ was retracted and continued to be a concern. The immediacy was removed on 9/10/24 when the facility implemented the following: -Code to the front door was changed on 9/10/24 and staff educated that only staff members were to have the code. -No family members, residents, or visitors were to know the code for exiting the building. -The resident smoking area moved to the back of the facility. -Staff were re-educated on the elopement policy and not sharing the front door code on 9/10/24. The scope was lowered from a J to a D at the time of the survey after ensuring the facility implemented education and their policy and procedures. The facility reported a census of 37 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #1 dated 7/24/24 identified a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented diagnoses that included: hypertension, renal insufficiency, non-Alzheimer's dementia, depression, chronic obstructive pulmonary disease (COPD), difficulty in walking, and unsteadiness on feet. The document revealed that since the previous quarterly assessment was completed on 5/1/24 the resident had 1 fall without injury and two or more falls with injury, except major. Resident #1 was independent with toileting, dressing, transfers, and ambulation. The resident utilized a walker and had a wander/elopement alarm that was used daily. A Neuropsychological Evaluation completed on 1/18/24 revealed a diagnostic impression of Alzheimer's dementia with behavioral disturbance. The document provided a recommendation that due to the resident's diagnosis and evidence of cognitive impairment, she should be considered a vulnerable adult and supervision was recommended. An Elopement Risk assessment dated [DATE] revealed the resident had a score of 15 which indicated a high risk for wandering. The document revealed the resident was a known wanderer/history of wandering, but did not indicate the resident was known to have exit seeking/history of exit seeking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Fall Risk assessment dated [DATE] revealed a score of 8 which indicated a moderate risk for falls. The Care Plan printed on 9/6/24 revealed the document did not contain a focus area or interventions for wandering until 8/26/24. A Facility Investigation revealed Resident #1 was observed by Staff N seated in the lobby at 8:30 PM on 8/25/24. At 9:00 PM Staff N noted the resident was neither in the lobby nor in her bedroom. A search for the resident was initiated and the administrator was notified at 9:18 PM of the resident's unknown location. Staff were dispersed to look within the building, outside of the building, and local stores. The Administrator notified the police at 9:29 PM. The resident was located by the police in Walmart at 9:45 PM with the Administrator notified at 9:54 PM. The resident presented without injury upon return to the facility. The Administrator identified the WGS was not working on the front door. The resident had been demonstrating exit seeking behaviors previously that day, as had been asking staff to take her shopping. Further investigation revealed on 5/18/24 Resident #1 had demonstrated exit seeking behavior. On 9/7/24 at 10:41 AM Staff E stated on 5/18/24 the resident had been asking staff to take her to the bar and had stated she was going to leave the building. Despite redirection the resident entered the code to the front door and exited the building. The staff maintained visual eyesight on the resident until the Administrator had eyesight on the resident. The resident returned to the facility escorted by the Administrator. The facility did not complete an Elopement Risk Assessment after this event. Additionally, the Progress Notes within the electronic health record revealed an entry on 6/1/24 of Resident #1 attempting to leave the facility and signing herself out. Observation on 9/7/24 revealed the facility was located on a main east/west 2 lane road with a speed limit of 25 MPH without a shoulder or sidewalk. The Walmart was located .6 miles away on a 5 lane highway with posted speed limit of 35 MPH without a shoulder or sidewalk. The highway crossed over an active railroad. Review of the weather on 8/25/24 revealed the temperature was 86 degrees with 79% humidity and a low of 72 degrees. The sunset occurred at 8:30 PM. On 9/6/24 at 2:30 PM Staff T, Maintenance Director, stated he had to rewire the WGS because it was broken and not working appropriately after Resident #1's elopement on 8/25/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/7/24 at 1:00 PM Staff H stated when working on 8/25/24 she had provided Resident #1 her medications around 6:30 PM but did not see her after that time. The staff stated the door alarm did not go off when the resident returned to the building after 10:00 PM. Resident H stated she did not announce overhead the resident was missing due to concerns of a Health Insurance Portability and Accountability Act (HIPAA) concerns. The staff stated she could barely hear the WGS alarm at the nurse's station in the back of the building, but if there was additional noise or she was not near the nurse's station she could not hear it at all. The staff further revealed that the front doorbell could also not be heard at the rear of the building. Staff H stated she was aware that Resident #1 knew the door code to exit the building, as did other residents. The staff stated independent smokers were allowed to go out of the building alone. Staff H further revealed Resident #1 would assist other residents out of the building (independent smokers who did not know the door code), and visitors. The staff stated checking a resident's WGS bracelet involved visually seeing the bracelet, not checking the functioning of the device. On 9/7/24 at 3:20 PM Staff M stated on the night of 8/25/24 she did not have a lot of interaction with Resident #1. The staff stated she drove around the area to different stores looking for the resident when she was discovered to be missing. Staff M stated she did not recall the door alarm going off when the resident returned that night. The staff stated she could not hear the alarm in the back of the building when working. On 9/7/24 at 5:40 PM Staff N stated she had been told Resident #1 had been exhibiting exit seeking behaviors earlier in the day on 8/25/24. The staff did not recall the front door alarm going off on 8/25/24 at 9:00 PM when she went to prepare to take residents outside for a smoke break and discovered Resident #1 was not in the vicinity. The staff stated the alarm did not go off upon the resident's return that night. Staff N stated she was unable to hear the WGS alarm when working in the back of the building. The staff further revealed that prior to Resident #1's elopement, checking a resident's WGS bracelet consisted of visually seeing the bracelet, not checking for functioning. The Administrator stated on 9/7/24 at 4:01 PM Resident #1 had a history of wandering and exit seeking behaviors. The Administrator acknowledged Resident #1 as well as some other residents knew the door code to exit the building. The Administrator further acknowledged the facility should have completed an updated Elopement Risk Assessment for Resident #1 following her exit from the building. The administrator stated the WGS had repairs completed on 8/28/24 to ensure functioning appropriately. The facility provided document, Elopement Policy, dated 6/18/19, revealed specific plans would be developed for each resident identified at risk for elopement/wandering including causes and patterns. The document further revealed the facility would maintain a notebook with demographics and pictures of residents at risk for elopement, and keep its location in a known place for all staff to reference. The facility provided document, Missing Resident Protocol, dated 6/18/19, revealed staff would make an announcement overhead to alert all staff of the missing resident, and the missing resident would be considered a facility-wide emergency.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 49628 Based on clinical record review, facility document review, resident interviews, staff interviews, and policy review the facility failed to provide adequate nursing staff to assure residents safety and well-being. The facility reported a census of 37 residents. Findings include: 1. Review of the August 2024 schedule revealed on the day shift less than 4 CNA's worked on 8/25 and 8/31/24. Review of the August 2024 schedule revealed on the evening shift less than 3 CNA's worked on 8/25, 8/26, 8/27, 8/28, 8/29, 8/30, and 8/31/24. Review of the August 2024 schedule revealed on the overnight shift less than 2 CNA's worked on 8/26, 8/27, 8/30, and 8/31/24. Review of the September 2024 schedule revealed the day shift less than 4 CNA's worked on 9/1, 9/7, and 9/8/24. Review of the September 2024 schedule revealed the evening shift less than 3 CNA's worked on 9/1, and 9/4/24. Review of the September 2024 schedule revealed the overnight shift less than 2 CNA's worked on 9/1, 9/2, 9/3, 9/7, and 9/8/24. Review of the facility document, Facility Assessment, updated 8/14/24 revealed the ratio of registered and licensed practical nurses to aides shall be sufficient to assure professional guidance and supervision in the nursing care of residents. CMA and CNAs were based on Patients Per Day (PPD) of 1.95. CMA's staffed 1.5-2 for day and evening shifts. CNAs staffed: Day Shift (6 AM to 2 PM) 4 Evening Shift (2 PM to 10 PM) 3-3.5 Night Shift (10 PM to 6 AM) 2 The document further revealed the adequacy of nursing staffing would be evidenced by positive resident outcomes, appropriate nurse to resident ratios, balanced staffing mix, manageable nurse workloads, compliance with standards, availability of resources, and positive feedback from nurses. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/6/24 at 3:52 PM Staff C, Certified Nursing Assistant (CNA) stated she had previously worked on the overnight shift. The staff stated she had worked overnight shifts where she was the only CNA with the nurse, and other shifts where there was 1 other CNA and a nurse. The staff stated when there was not enough staff on the shift, the staff did not get their 30 minute breaks and residents had to wait longer for their care. On 9/6/24 at 4:18 PM Staff D, Licensed Practical Nurse (LPN) stated she has worked various shifts with low staffing. The staff stated many residents in the facility required higher care needs in ADLs and required mechanical lift transfers (required 2 staff for completion). Staff D also stated when low on staffing resident treatments may not get completed as ordered, as she will be assisting staff as CNA versus completing nurse duties. The staff stated the administration was aware of the staffing shortage. On 9/7/24 at 1:00 PM Staff H, Certified Medication Aide (CMA) stated that staffing was not good. The staff stated she had worked on shifts where there was only 1 medication aide and 1 nurse for the whole building. Staff H stated she has had to manage both medication carts for the whole building. The staff stated she had been waiting for something to happen like the elopement on 8/25/24 when there is 1 nurse caring for a resident, 2 CNAs in a room, and she is left on the floor, she was unable to hear the door alarms. Staff H further stated the residents did not get the care they deserved or required when there is not sufficient staff. 2. The Minimum Data Set (MDS) for Resident #6 dated 6/26/24 identified a Brief Interview for Mental Status (BIMS) score of 15 which indicated normal cognition. The MDS documented diagnoses that included: unspecified injury at C5 level of cervical spinal cord, polyneuropathy, and multi-system degeneration of the autonomic nervous system. Resident #6 was dependent on staff for all activities of daily living (ADLs) and transfers. The resident utilized a power wheelchair. On 9/7/24 at 1:20 PM Resident #6 stated the facility did not have enough staff on the overnight shift. The resident stated it can take up to an hour to answer call lights on overnights. 3. The MDS for Resident #10 dated 6/5/24 identified a BIMS score of 15 which indicated normal cognition. The MDS documented diagnoses that included: heart failures, renal insufficiency, depression, and type 2 diabetes. The resident required substantial/maximal assistance for transfers. The resident had bowel incontinence. On 9/9/24 at 8:06 AM Resident #10 stated she has had to wait for a long time for staff to answer call lights. The resident stated there were times when she had soiled herself as staff had not answered her call light in time. Resident #10 stated wait times for call lights were worse during meals and on holidays. On 9/9/24 at 11:34 AM the Administrator stated she had been doing call light audits and was aware of longer lights right after supper due to the requirement of 2 staff for personal cares and transfers of residents, as well as overnights. The Administrator stated the nurse was expected to help with care when necessary, especially on overnight shifts when there was only 1 CNA scheduled. The Administrator stated the goal was to have 2 staff on overnight shifts. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy, Staffing, revised 10/17, revealed the facility would provide sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and facility assessment. The staffing numbers and skill requirements of direct care staff were determined by the residents' needs based on their individualized care plans.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47673 Based on observation, record review and staff interviews the facility failed to maintain medical records that were systematically organized and failed to safeguard the medical records from loss or destruction. The facility reported a census of 37 residents. Findings include: On 9/9/24 at 9:40 AM a continuous observation of the building revealed the following: -Outside the facility to the left of the cellar door revealed a window well unable to determine depth with washed away soil next to the window well approximately 1 foot x 1.5 foot. -Observation of the basement revealed a room where the window well with washed away soil had a red painted wall with black fuzzy substance growing on the wall. The paint was chipping, loose, and bubbled up. Approximately the whole wall consistently had these concerns. Observation of 2 rooms filled with stacks of resident records. The boxes had fallen over and signs of water damage to the boxes and resident records in the boxes. On 9/9/24 at 9:55 AM Staff T Maintenance Director stated there had been concerns with the soil that washed away near that window well and it had been brought to the Administrator's attention. Staff T stated there was a room behind this area in the basement. Staff T stated the room with the window well has a big problem with water intrusion. Staff T stated during heavy rainfall water comes in through the wall and the window well and causes mud on the floor. Staff T acknowledged he had a concern with the black fuzzy substance on the wall as well as the mud on the floor and the conditions present in the basement of the facility. Staff T stated the Administrator was aware of the concerns Staff T acknowledged the damage to the boxes and files in the boxes. Staff T stated he was not in charge of the files or what happened to them. On 9/9/24 at 11:28 AM the Administrator stated she had been notified of the conditions of the basement and storage of resident medical records. The Administrator stated she was going to shred all the files but had not got to that yet. The Administrator stated the facility's expectation was the file would have been stored appropriately. The Administrator acknowledged the resident records were not appropriately being stored. Review of document titled, Location and Storage of Medical Records documented the facility shall protect and safeguard all medical records. Medical records are stored in a locked room and protected from fire, water damage, insects, and theft. Archived medical records (those being retained for a specified period beyond the resident ' s discharge or death) will be clearly identified as archive records and stored appropriately.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on facility record review, staff interviews, and facility policy review the facility failed to demonstrate evidence of systematic identification of reporting, investigation, analysis, and prevention of adverse events. The facility failed to demonstrate the development, implementation, and evaluation of corrective actions or performance improvement activities. The facility reported a census of 37 residents. Findings include: Review of the facility's past survey violations document revealed the following repeated deficiencies since the Administrator's hire date of 12/30/2019: -F609, reporting alleged violations, during surveys ending on 4/27/23, 8/8/23, 4/5/24 and current survey. Survey ending on 8/8/23 and current survey resulting in a harm level deficiency. -F689, free of accidents/hazards and supervision, during surveys ending on 3/19/2020, 4/20/2021, 10/5/22, 7/25/24 and current survey. Surveys ending on 4/20/21, 7/25/24, and current survey resulting in a harm level deficiency. -F725, sufficient nursing staff, during surveys ending on 4/20/2021, 2/2/24, 7/25/24 and current survey. -F880, infection prevention and control, during surveys ending on 3/19/2020, 4/20/23, 4/27/23, 7/25/24 and current survey (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/11/24 at 9:16 AM the Administrator stated the facility had not developed a performance improvement plan (PIP) currently per say on 609 because the regulation violation had been in several different areas of the 609 regulation. The Administrator stated there had been repeated education on reporting abuse. The Administrator stated the facility monitored the area of concern for 90 days but after that 90 days it seemed there was a complaint about the similar incident. The Administrator stated completing development of a plan can be hard when there is no consistent nursing leadership. The Administrator stated there has been an interim DON since July of 22 - July of 23 and another interim DON recently since mid December 23 till currently. The Administrator stated she was not a nurse. The Administrator stated if there was consistent dedicated nursing leadership there could have been appropriate risk management development. The DON stated there was no oversight by that department and things were missed. The Administrator stated the concerns with federal regulation for 689 were also separate issues inside of a very large regulation that were not related. The Administrator stated development of a plan that covers all the concerns under 689 was not accomplished. The Administrator stated staffing issues occur because agency employees cancel and then you are down to 1 on overnight shift. The Administrator stated there was no onboarding for employees done at the facility and the current owners set up the agency and onboarding process. The Administrator stated if she could onboard at the facility she could have onboarded and hired employees quicker. The Administrator stated the August nursing schedule was accurate with any changes in staffing reelected on that schedule. The Administrator stated the September schedule from [DATE]st through the 10 is also accurate. The Administrator stated all staff were identified that worked on the August and the September schedule. The Administrator stated there was no current PIP related to staffing but she was working on the issue. The Administrator stated she reached out to agency and sister facilities. The Administrator stated the facility's corporate office placed the online ads and interview quickly and then the facility's corporate office sent the score card and as soon as the corporate office gave a start date she reached out and asked when they could start. The Administrator stated with the new owner all onboarding will be in house so it should be more fluid. The Administrator acknowledged that hand hygiene was the previous concern with the multiple federal citation of 880. The Administrator stated the new assistant director of nursing (ADON) was working to get through the IP course and there had not been consistent nursing leadership prior to that. The Administrator stated the concerns with water intrusion and the state of the basement were not considered an infection and were not treated with antibiotics. The Administrator stated because there was no positive Covid, flu, or URI the concerns were not on the infection control log and there was no root cause analysis completed related to the concerns in the basement. The Administrator stated the facility really needed to use the root cause analysis from consistent staffing in the leadership portion of the nursing department. Stated the individual staff have access to the individual PIP's and she could not gather them at this time for the survey team. Review of policy titled, Quality Assurance Performance Improvement (QAPI) Quality Assessment Assurance (QAA) updated 12/28/23 documented the topics to be considered for performance improvement plans will be identified through the Feedback, Data Systems and Monitoring process. Prioritization of Performance Improvement Plans will be based on the scope and severity of the identified issue and the potential impact the issue has on Resident safety, clinical outcomes, and satisfaction. Performance Improvement Plan [NAME] will be developed by the QAPI committee when a topic is identified as requiring Performance Improvement Plan through the above process.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on observation, clinical record review, policy review, and staff interviews the facility failed to provide appropriate infection prevention practices for residents at the facility. The facility failed to prevent, investigate and identify possible infection control issues from the water intrusion and black substance in the basement. The facility reported a census of 37 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #7 had a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS also indicated Resident #7 had a dependence on supplemental oxygen, shortness of breath, chronic respiratory failure, and obstructive sleep apnea. Review of the document titled, Discharge Summary dated 8/16/24 for Resident #7 revealed after admission to the hospital on 8/9/24 Resident #7 developed acute hypoxic respiratory failure requiring BIPAP, that had been weaned off 8/14/24 to room air yesterday but on 8/15/24 required 3L of oxygen via nasal cannula. Review of the document titled, Doctor's Orders and Progress Notes documented on 8/22/24 at 10:00 AM Resident #7 was seen in the clinic for follow up from a recent hospitalization for shortness of breath and complaints of decreased hearing. New order to start loratadine 10 mg daily related to allergic rhinitis. Review of EHR revealed Resident #7 resided in room [ROOM NUMBER]-1 on hall A wing. On 9/6/24 at 9:45 AM the Administrator stated several residents had flu like symptoms in August. The Administrator stated those residents were tested [DATE], 19, 22, 25, and 29. The Administrator stated those residents were tested [DATE] and 5. The Administrator stated there were 3 or 4 residents that had flu like symptoms and they were not positive for Covid and Resident #5 was one of the residents. The Administrator stated there was a Covid assessment that was completed if the resident had symptoms. The Administrator stated a resident was sent to the hospital for evaluations as well but never tested positive for any virus. On 9/9/24 at 9:55 AM Staff T Maintenance Director stated there had been concerns with the soil that washed away near that window well and it had been brought to the administrator's attention. Staff T stated there was a room behind this area in the basement. Staff T stated the room with the window well has a big problem with water intrusion. Staff T stated during heavy rainfall water comes in through the wall and the window well and causes mud on the floor. Staff T acknowledged he had a concern with the black fuzzy substance on the wall as well as the mud on the floor and the conditions present in the basement of the facility. Staff T stated the Administrator was aware of the concerns. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165531	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/9/24 at 11:28 AM the Administrator stated she had been notified of the conditions of the basement and storage of resident medical records. The Administrator stated the crack in the hallway on A wing had been there since she started. The Administrator stated she was aware of the concerns in the basement and the wall was not a foundation issue more of how the wall was sealed to prevent the water intrusion. The Administrator stated the facility had not had anyone look at the wall related to structural integrity. The Administrator stated Resident #7 had respiratory issues prior to entry and was on 4 L of oxygen at times. The Administrator stated there was no root cause analysis completed related to the exacerbation because he had preexisting respiratory. The Administrator stated the infection prevention staff looked at pre-existing conditions and left it at that as opposed to looking at the root cause possible being the basement moisture and water intrusion aiding in the exacerbation of some of the respiratory symptoms. The Administrator stated there was a possibility that the water intrusion and the moisture and condition of the wall could possibly cause an exacerbation of respiratory symptoms and conditions. The Administrator acknowledged that a root cause analysis should have been completed to rule out the possibility of exacerbation related to the conditions of the basement. Review of policy titled, Infection Prevention and Control updated 10/1/22 documented an infection prevention and control program is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The elements of the infection prevention and control program consist of coordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The infection prevention and control committee is responsible for reviewing and providing feedback on the overall program. Surveillance data and reporting information is used to inform the committee of potential issues and trends. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infection, monitoring adherence to infection prevention and control practices, and detecting unusual pathogens with infection control implications. Data gathered during surveillance is used to oversee infections and spot trends. For prevention of infection identifying possible infections or potential complications of existing infections. instituting measures to avoid complications or dissemination.