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	02/27/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 37074 Based on observations, record review, staff and resident interviews, and policy review the facility failed to update 2 of 7 (Resident #4 and #5) resident's care plans. The facility reported a census of 37 residents. Findings include: 1. According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 1/14/2025, documented Resident #4 had a Brief Interview of Mental Status (BIMS) score of 14. A BIMS score of 14 suggested no cognitive impairment. The MDS documented Resident #4 had an indwelling catheter, ostomy and received tracheostomy care. The following diagnoses were listed for Resident #4: sepsis, renal failure, neurogenic bladder, multidrug-resistant organism, pneumonia, quadriplegia, multiple sclerosis, anxiety, respiratory failure, stage 4 pressure ulcer. The Care Plan focus area with a revision date of 11/4/2024 documented Resident #4 had bowel and bladder incontinence related to disease process, history of urinary tract infection (UTI), and impaired mobility. The Care Plan documented he used an adult brief and staff are to change the brief on rounds and as needed (PRN). The Care Plan documented Resident #4 was incontinent and staff were encouraged to check the resident on rounds and as required for incontinence. Review of Resident #4's February 2025 Treatment Administration Record (TAR) revealed the following orders: a) change foley catheter every 30 days, with a start date of 1/22/2025; b) change colostomy once a week and PRN, with a start date of 2/8/2023. On 2/25/2025 at 10:30 AM Staff E Certified Medication Aide (CMA) acknowledged Resident #4 had a catheter and colostomy. The Care Plan dated 11/4/2024 lacked revisions to show the resident had a catheter and colostomy and lacked directives for staff on the care of the devices. (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: 165531	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. According to the significant change MDS assessment tool with a reference date of 1/24/2025 documented Resident #5 had a BIMS score of 3. A BIMS score of 3 suggested severe cognitive impairment. Resident #5 had one sided impairment to her upper and lower extremities and utilized a wheelchair. The MDS documented Resident #5 did not have any falls since her admission/entry or reentry or prior assessment. The following diagnoses were listed for the resident: stroke, diabetes mellitus, dementia, anxiety disorder, depression, bipolar disorder, lack of coordination, abnormalities of gait and mobility, and muscle weakness. The Care Plan focus area with a revision date of 10/22/2024 documented Resident #5 required assistance with Activities of Daily Living (ADLs) related to a history of a stroke with weakness and abnormal gait, dementia and bipolar disorder. The Care Plan focus area with a revision date of 10/22/2024 documented Resident #5 was at risk for falls related to medication side effects, incontinence, noncompliance with safety interventions and a history of falls prior to her admission. On 12/2/2024 resident was found lying on mat by her bed. The Care Plan documented she required extensive assistance of two staff for a stand and pivot transfer. The Care Plan failed to instruct staff to utilize a fall mat when she is in bed. On 2/14/2025 at 10:40 AM Resident #5 was not in her room; observed a grey fall mat folded up under the resident's bed. On 2/13/2025 at 1:46 PM Staff B Certified Medication Aide (CMA) stated Resident #5 fell out of her bed on 2/12/2025; her bed was in the lowest position but her fall mat was not in place. On 2/19/2025 at 1:26 PM Staff C Licensed Practical Nurse (LPN) stated Resident #5's fall mat is to be in place whenever she is in bed and should be on her care plan as such. On 2/21/2025 at 10:13 AM Staff D Certified Nursing Assistant (CNA) stated Resident #5 is to have a fall mat on her floor when in bed. On 2/25/2025 at 9:29 AM Staff T CNA stated Resident #5's fall mat is to be on the floor next to her bed whenever she is in bed. It has been that way for at least 2 years. On 2/25/2025 at 10:30 AM Staff E CMA started Resident #5's fall mat is to be on the floor next to her bed whenever she is in bed. On 2/26/2025 at 11:45 AM the Director of Nursing (DON) stated Resident #5's fall mat should be in place anytime she is in bed. Staff told her on 2/12/2025, it was not in place prior to her fall. She acknowledged Resident #4 had a supra pubic catheter and a colostomy. She indicated someone in Corporate will initiate the Care Plans then the facility staff are able to go in and update them as needed. When asked if these things needed to be on their Care Plan, she indicated they should be. The facility provided a policy titled Care Plans, Comprehensive Person-Centered, with a revision date of March 2022. The policy statement indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9) Care Plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 11) Assessment of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. 12) The interdisciplinary team reviews and updates the care plan: a) when there has been a significant change in the resident's condition; b) when the desired outcome is not met; d) at least quarterly, in conjunction with the required quarterly MDS assessment.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074 Based on clinical record review, staff and resident interviews, and policy review the facility failed to follow physician order's for 2 of 4 residents (Resident #2 and #3) reviewed. The facility also failed to obtain an order to discontinue a medication prior to destroying it for 1 of 4 residents (Resident #6) reviewed. The facility reported a census of 37 residents. Findings include: 1. According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of [DATE] documented Resident #2 had a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested no cognitive impairment. The resident did not refuse cares during the review period and received insulin. The following diagnoses were listed for Resident #2: type 2 diabetes mellitus, renal failure. The Care Plan focus area with a revision date of [DATE] documented Resident #2 had diabetes mellitus type 2. Staff were directed to administer diabetes medications as ordered by her doctor and to monitor/document for side effects and effectiveness. The Care Plan focus area with a revision date of [DATE] documented Resident #2 had hypertension. Staff were to give her antihypertensive medications as ordered and monitor for any side effects. Review of Resident #2's [DATE] Medication Administration Record (MAR) revealed the following: a) Mounjaro (treatment of diabetes) Subcutaneous Solution Auto-Injector 15 milligrams (mg)/0.5 milliliters (mL). Inject 0.5 mL subcutaneous one time a day every Thursday related to type 2 diabetes mellitus; with an order date of [DATE] and discontinued date of [DATE]. The order was not signed out as being given on [DATE]. b) Hydralazine (treat hypertension) HCL 50 mg, give one tablet by mouth three times a day (TID) related to essential hypertension, hold if systolic blood pressure is less than 100; with an order date of [DATE]. The order was signed out as being given on [DATE] for a blood pressure of ,d+[DATE] and on [DATE] for a blood pressure of ,d+[DATE]. c) Weekly weights every day shift on Tuesdays for weight monitoring; with an order date of [DATE]. The order was not signed out as being completed on [DATE] and [DATE]. Review of Resident #2's [DATE] Progress Notes revealed there were no notes documenting the reason for her Mounjaro not being signed out as given. There were also no notes related to her Hydralazine given outside the ordered parameters nor were there notes about her weight not being obtained. Clinical record review revealed the following facsimile (fax) sent to Resident #2's physician on [DATE]: medication error from [DATE]. Resident #2 did not receive her morning medications. Any new orders? The physician replied, no new orders. Review of Resident #2's February 2025 MAR revealed the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a) Fenofibrate (treatment of high cholesterol) Micronized 67 mg capsule, give 1 capsule by mouth one time a day for high cholesterol; with an order date of [DATE]. The order was not signed out as being given on [DATE]. b) Humalog (treatment of diabetes) KwikPen Subcutaneous Solution Pen, inject per sliding scale; with an order date of [DATE]. The order was not signed out as being given at 11:00 AM on [DATE]. c) Humalog KwikPen Subcutaneous Solution Pen, inject per sliding scale; with an order date of [DATE] and discontinued date of [DATE]. On [DATE] at 9:00 PM her blood sugar was 201 and staff documented no insulin required. d) Blood sugars four times a day (QID); with an order date of [DATE]. The order was not signed out as being completed on [DATE]. Review of Resident #2's February Progress Notes revealed there were no notes documenting the reason her Fenofibrate was not signed out as being given. There were also no notes related to her Hydralazine given outside the ordered parameters, why her Humalog was not given and why it was given outside the ordered parameters. On [DATE] at 10:35 AM Resident #2 stated there was one day when the Assistant Director of Nursing (ADON) was on the floor passing medications but she did not give the residents on this hall their medications and insulin's. She added there were about 12 residents on the hall. She brought it up to the Activities Director, he agreed that was not right and to bring it up in the next council meeting to see if other residents had the same issue. When they had their January council meeting a lot of people said they did not get their medications and insulin's, the residents that could remember said that. Resident #2 has confronted the ADON on why she hadn't received her Tresiba one day, the ADO told she administered it when she was sleeping. Resident #2 disagreed because the morning medication aide came in that morning to wake her up for her blood sugar to be taken. This was at about 7:00 AM that morning. The ADON said it was at the same time but Resident #2 disagreed with her. The ADON told Resident #2 that she was correct, that was that. The ADON charted she gave her the Tresiba but she never got it. This was the same day the other resident did not get her medications. When she asked Staff C Licensed Practical Nurse (LPN) about what was going on because she still had not received her Tresiba. Staff C told her there were 12 other people that did not get their medications. She later learned that The ADON went in to her office and documented she had given all the residents their medications and insulin's. Resident #2 stated Staff A LPN is something else. When her blood sugars are under 200 Staff A will try to give her insulin and Resident #2 will remind her that order is written as over 200. Staff A would tell her to not tell her how to do her job. On [DATE] at 1:26 PM Staff C Licensed Practical Nurse (LPN) stated orders should be signed out at the time of them being administered. Some will walk away from the medication cart, administer the medication then sign the medication as being administered. Ideally, it should be signed out at the time the medication was given. If the order has parameters, they should be followed. If the medication has to be held for being outside of the parameters, there's an option that states see nurse's note then the nurse would chart why it was held. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. According to a Quarterly MDS assessment tool with a reference date of [DATE], Resident #3 had a BIMS score of 14. A BIMS score of 14 suggested no cognitive impairment. The MDS documented he did not reject care during the review period. The following diagnoses were listed for Resident #3: type 2 diabetes mellitus, renal failure, obstructive uropathy, seizures, depression and obesity. The Care Plan focus areas with a revision date of [DATE] documented he had a seizure disorder; diagnoses of essential hypertension, type 2 diabetes mellitus, hypothyroidism; and had the potential for pain. Staff were directed to give medications as ordered by the doctor. Review of Resident #3's [DATE] MAR revealed the following order: Humalog 100 U/mL, inject as per sliding scale: if ,d+[DATE] give 2 units; if ,d+[DATE] give 4 units. The MAR documented on [DATE] his blood sugar was 156, staff documented 7 indicating no insulin required. On [DATE] his blood sugar was 206, staff documented 7 indicated no insulin required. Review of Resident #3's Progress Notes revealed there were no notes to explain why the order was not followed as ordered. Review of Resident #3's [DATE] MAR revealed the following medications were documented as refused by the ADON, on [DATE] during the AM medication pass: a) Aspirin 81 mg, give one tablet in the AM, b) Finasteride (treatment of enlarged prostate) 5 mg, give one tablet in the AM, c) Folic Acid 1 mg, give one tablet in the AM, d) Lactobacillus (probiotic), give one tablet in the AM, e) Lasix (diuretic)20 mg, give two tablets in the AM, f) Lexapro (anti-depressant) 10 mg, give one tablet in the AM, g) Magnesium Oxide 400 mg, give one tablet in the AM, h) Pantoprazole (treatment of gastroesophageal reflux disease) 40 mg, give one tablet in the AM, i) Tamsulosin (treatment of enlarged prostate) 0.4 mg, give two capsules in the AM, j) Docusate Sodium 100 mg, give one capsule in the AM, k) Famotidine (treatment of GERD) 20 mg, give one tablet in the AM l) Levetiracetam (treatment of seizures) 750 mg, give two tablets in the AM, m) Metformin (treat diabetes) 1000mg, give one tablet in the AM, n) Vimpat (treat seizures) 100mg, give one tablet in the AM, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o) Ferrous Sulfate 325mg, give one tablet in the AM, p) Humalog 14 units before meals at 8:00 AM, q) Humalog sliding scale in the AM and at lunch. Review of Resident #3's Progress Notes revealed there were no notes in relation to his refusal of his morning medications. On [DATE] at 2:05 PM Resident #3 stated there was one day last month, the ADON was working on the floor for the first time. She was on the East Hall medication cart and he did not get his medications. He did not get his medications that he usually would get around breakfast time, until about 11:05 AM. His doctor advised him not to take them so he refused them. Everyone had called in that day, which left her to work on the floor that day. On [DATE] at 9:39 AM Staff C Licensed Practical Nurse (LPN) reviewed Resident #3's medications. She presented it was documented he refused his medications on [DATE]. She indicated he has never refused his medications before. 3. According to the quarterly MDS assessment tool with a reference date of [DATE], documented Resident #4 had a BIMS score of 14. A BIMS score of 14 suggested no cognitive impairment. The MDS documented Resident #4 had an indwelling catheter, ostomy and received tracheostomy care. The following diagnoses were listed for Resident #4: sepsis, renal failure, neurogenic bladder, multidrug-resistant organism, pneumonia, quadriplegia, multiple sclerosis, anxiety, respiratory failure, stage 4 pressure ulcer. Review of Resident #4's [DATE] MAR revealed the following orders were not signed out as being given: a) Apixaban (blood thinner) 2.5mg, give one tablet BID; not signed out as being given on the evening shifts of ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE] b) Dorzolamide HCL-Timolol Mal (treatment of increased eye pressure) Ophthalmic Solution 22XXX, d+[DATE].8mg/ML, instill one drop to left eye BID; not signed out as given on the evening shifts of , d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE] c) Protein Enteral Liqui, give one-ounce BID; not signed out as being given on the evening shifts of , d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE] d) Midodrine HCL (treatment of low blood pressure) 5mg, give 10mg TID; not signed out as being given on the evening shift of ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE] e) Tizanidine HCL (treatment muscle spasms) 2mg, give one tablet TID; not signed out as being given on , d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE] f) Simethicone drops oral suspension (assist with bloating) 20mg/0.3mL, give 1.2mL four times a day (QID); not signed out as being given ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE] (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #4's [DATE] Treatment Administration Record (TAR) revealed the following order was not signed out as being completed: a) change tracheostomy once per month on the 11th of every month, with an order date of [DATE] and discontinued date of [DATE]; not signed out as being completed on ,d+[DATE] b) change tracheostomy once per month on the 12th of every month, with an order date of [DATE]; not signed out as being completed on ,d+[DATE] c) change posey every week and as needed (PRN), every Friday; not signed out as being completed on , d+[DATE] d) okay to give oral cares with sponge only, every shift; not signed out as being completed at 2:00 PM on , d+[DATE] Review of Resident #4's Progress Notes in December revealed there were no notes to reflect why his orders were not signed as being given or completed. Review of Resident #4's [DATE] MAR revealed the following orders were not signed as being completed: a) Ambien (treatment of insomnia) 5mg, give one at bedtime; not signed out as being given on ,d+[DATE] b) Apixaban 2.5mg, give one tablet BID; not signed out as being given on ,d+[DATE], ,d+[DATE], ,d+[DATE] on the evening medication pass c) Dorzolamide HCL-Timolol Mal Ophthalmic Solution 22XXX,d+[DATE].8mg/mL; not signed out as being administered on ,d+[DATE], ,d+[DATE], ,d+[DATE] on the evening medication pass d) Protein Enteral Liquid, give one ounce BID; not signed out as being administered on ,d+[DATE], , d+[DATE], ,d+[DATE] on the evening medication pass e) Midodrine HCL 5mg, give 10mg TID; not signed out as being administered on ,d+[DATE], ,d+[DATE], , d+[DATE] on the evening medication pass f) Xanax (anti-anxiety) 0.25mg, give one tablet BID; order not signed out as being given on ,d+[DATE] AM medication pass g) Tizanidine HCL 2mg; give 1 tablet TID; not signed out as being administered on ,d+[DATE], ,d+[DATE], , d+[DATE] on the evening medication pass Review of Resident #4's [DATE] MAR revealed the following order: Midodrine HCL 5mg, give 10mg TID related to orthostatic hypotension. Hold if his systolic blood pressure is greater than 110. This order was signed out as given outside the ordered parameter on: a) ,d+[DATE] at lunch with a blood pressure of ,d+[DATE] (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b) ,d+[DATE] at AM medication pass with a blood pressure of ,d+[DATE] and at lunch with a blood pressure of ,d+[DATE] c) ,d+[DATE] at AM mediation pass with a blood pressure of ,d+[DATE], at lunch with a blood pressure of , d+[DATE], and the evening medication pass with a blood pressure of ,d+[DATE] d) ,d+[DATE] at AM medication pass with a blood pressure of ,d+[DATE] e) ,d+[DATE] at evening medication pass with a blood pressure of ,d+[DATE] f) ,d+[DATE] at evening medication pass with a blood pressure of ,d+[DATE] Review of Resident #4's [DATE] TAR revealed the following orders were not signed out as being completed: a) Change and date oxygen tubing and nebulizer mask and tubing every week; not signed out as being completed ,d+[DATE] b) Change colostomy 1 time a week and as needed (PRN); not signed out as being completed on ,d+[DATE] c) Change posey every week and PRN one time a day every Friday; not signed out as being completed on , d+[DATE] d) Change trach once per month on the 12th; not signed out as being completed on ,d+[DATE] e) Cover reddened area to left out ankle with mepilex dressing for pressure relief every 72 hours untiled; not signed out as being completed on ,d+[DATE], ,d+[DATE], ,d+[DATE] f) Cover wound on right buttock with mepilex dressing every day for pressure relief until healed; not signed out as being completed on ,d+[DATE] g) Change foley catheter every 30 days and PRN, with an order date of [DATE]; not signed out as being completed on ,d+[DATE] h) Change foley catheter monthly and PRN, every 30 days, with order date of [DATE] and a discontinued date of [DATE]; not signed out as being completed on ,d+[DATE] i) Ketoconazole to hair on baths every Tuesday and Friday; not signed out as being completed on , d+[DATE], ,d+[DATE] j) Left buttocks: cleanse area with house wound cleanser, apply collagen powder, cover with super absorbent dressing, change every day; not signed out as being completed ,d+[DATE] k) Left heel: cleanse with soap/water and rinse, apply skin prep, apply puracel+ or equivalent collagen dressing, cover with super absorbent dressing change every other day; order was not signed out as being completed on ,d+[DATE] (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	l) Lay in bed to offload for 2 hours every afternoon; not signed out as being completed on ,d+[DATE], , d+[DATE] m) Mepilex dressing to left buttocks, cleanse area, apply dressing every day until healed; not signed out as being completed on ,d+[DATE] n) Right heel; cleanse with soap and water and rinse, apply skin prep, cover with super absorbent dressing 3 times per week every Tuesday, Thursday, and Saturday; not signed out as being completed on ,d+[DATE] (Thursday) o) Right inner groin/thigh cleanse with wound cleanser, pat dry, collagen powder to open area. Place ABD pad between groin and thigh, no tape. Compete every day until healed; order not signed out as being completed on ,d+[DATE] p) Wash suction canister with hot soapy water, rinse well. Use mouthwash to help with odor; not signed out as being completed on ,d+[DATE] q) Weekly skin assessment to be completed on Fridays; not signed out as being completed on ,d+[DATE] r) Weekly weight on Fridays; not signed out as being completed ,d+[DATE], ,d+[DATE] s) Colostomy cares every shift; not signed out as being completed on ,d+[DATE] day shift Review of Resident #4's notes in January revealed there were no notes to reflect why his orders were not signed as being given or completed. Review of Resident #4's February 2025 MAR revealed the following orders were not signed out as being given: a) Ambien 5mg; not signed out as given on ,d+[DATE] and ,d+[DATE] b) Enteral feed order, clean tube site daily with soap and water-may apply drainage sponger if desired; not signed out as being completed on ,d+[DATE] c) Multivitamin and Mineral Liquid 5 milliliters (mL); not signed out as being given on ,d+[DATE] d) Trazadone (treatment of insomnia) 25 mg at bedtime; not signed out as being given on ,d+[DATE], , d+[DATE] e) Apixaban 2.5mg give 1 tablet BID; not signed out as being given on ,d+[DATE] evening medication pass f) Dorzolamide HCL-Timolol Mal Ophthalmic Solution 22XXX,d+[DATE].8mg/mL; not signed out as being administered during the evening medication pass on ,d+[DATE], ,d+[DATE], ,d+[DATE] g) Protein Enteral Liquid, give 1 ounce BID; not signed out as given during the AM medication pass on , d+[DATE] and evening medication pass on ,d+[DATE] (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 02/27/2025

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h) Xanax 0.25mg BID; not signed out as being given at bedtime on ,d+[DATE] i) Gabapentin 4mL TID: not signed out as being given at lunch on ,d+[DATE], ,d+[DATE] j) Midodrine HCL 10mg TID; not signed out as being given at lunch on ,d+[DATE] and ,d+[DATE], AM medication pass on ,d+[DATE], evening medication pass on ,d+[DATE], ,d+[DATE], ,d+[DATE] k) Tizanidine 2mg give one tablet TID; not signed out as being given during the evening medication pass on , d+[DATE], ,d+[DATE] l) Iprtropium-Albuterol Inhalation Solution 0XXX,d+[DATE].5mg/3mL every 6 hours; not signed out as being given at 12:00 AM on ,d+[DATE] and 6:00 PM on ,d+[DATE] Review of Resident #4's February 2025 MAR revealed the following order: Midodrine HCL 5mg, give 10mg TID related to orthostatic hypotension. Hold if his systolic blood pressure is greater than 110. This order was signed out as given outside the ordered parameter on: a) ,d+[DATE] at the lunch medication pass with a blood pressure of ,d+[DATE] b) ,d+[DATE] at the evening medication pass with a blood pressure of ,d+[DATE] c) ,d+[DATE] at the evening medication pass with a blood pressure of ,d+[DATE] d) ,d+[DATE] at the evening medication pass with a blood pressure of ,d+[DATE] Review of Resident #4's February TAR revealed the following orders were not signed out as being completed: a) Change colostomy 1 time a week and PRN every Wednesday; not signed as being completed on , d+[DATE] b) Change tracheostomy once per month; not signed out as being completed on ,d+[DATE] c) Cover reddened area to left outer ankle with mepilex dressing for pressure relief every 72 hours until healed; order not signed out as being completed on ,d+[DATE] d) Cover wound on right buttock wound, apply mepilex dressing every day for pressure relief until healed; order not signed out as being completed on ,d+[DATE], ,d+[DATE] e) Flush foley every day and [NAME] with 120mL of normal saline at night; order not signed out as being completed on ,d+[DATE], ,d+[DATE] f) Ketoconazole to hair on baths every Tuesday and Friday; not signed out as being completed on ,d+[DATE] g) Left buttocks: cleanse area with house wound cleanser, apply collagen powder, cover with super absorbent dressing, change every day; not signed out as being completed ,d+[DATE], ,d+[DATE] (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h) Left heel: cleanse with soap/water and rinse, apply skin prep, apply puracel+ or equivalent collagen dressing, cover with super absorbent dressing change every other day; order was not signed out as being completed on ,d+[DATE] i) Lay in bed to offload for 2 hours every afternoon; not signed out as being completed on ,d+[DATE], , d+[DATE] j) Mepilex dressing to left buttocks, cleanse area, apply dressing every day until healed; not signed out as being completed on ,d+[DATE], ,d+[DATE] k) Right heel; cleanse with soap and water and rinse, apply skin prep, cover with super absorbent dressing 3 times per week every Tuesday, Thursday, and Saturday; not signed out as being completed on ,d+[DATE], , d+[DATE] l) Right inner groin/thigh cleanse with wound cleanser, pat dry, collagen powder to open area. Place ABD pad between groin and thigh, no tape. Compete every day until healed; order not signed out as being completed on ,d+[DATE], ,d+[DATE] m) Wash suction canister with hot soapy water, rinse well. Use mouthwash to help with odor; not signed out as being completed on ,d+[DATE] n) Weekly weight, one time a day every Friday; not signed out as being completed on ,d+[DATE] o) Colostomy cares every shift; not signed out as being completed the night of ,d+[DATE], day shift on , d+[DATE] p) Contact/droplet isolation in place due to a highly contagious pathogen COVID-19. All meals, treatments to be completed in his room. Isolation x 10 days, vitals every shift, every day and night shift for 11 days; order not signed out as being completed on ,d+[DATE] night shift q) Cough assist: has four pressure settings, do up to 20 breathers with a minimum of 5 breathes. He can tell how many breaths he wants to do. This can be done up to 4 times a day; not signed out as being completed on ,d+[DATE], ,d+[DATE] AM medication pass and ,d+[DATE], ,d+[DATE], ,d+[DATE] at bedtime r) Foley catheter care every shift; not signed out as being completed on ,d+[DATE], ,d+[DATE] at night and , d+[DATE] during the day s) Maintain a blue line ultra portex size 8 tracheostomy; not signed out as being completed on ,d+[DATE], , d+[DATE] at 10:00 PM and ,d+[DATE] at 6:00 AM t) Trach cares very shift with peroxide and no dressing; not signed out as being completed on ,d+[DATE] on the AM shift, ,d+[DATE] and ,d+[DATE] at bedtime u) Utilize speaking valve with tracheostomy while in bed; not signed out as being completed on ,d+[DATE] on the AM shift, ,d+[DATE] and ,d+[DATE] at bedtime (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	v) Ok to give oral cares with sponge only; not signed out as being completed on ,d+[DATE], ,d+[DATE], , d+[DATE], ,d+[DATE], ,d+[DATE] at 2:00 PM, ,d+[DATE], ,d+[DATE] at 10:00 PM, ,d+[DATE] at 6:00 AM w) Oxygen to maintain oxygen above 90%; not signed out as being completed on ,d+[DATE], ,d+[DATE] evening and night shifts, ,d+[DATE] day shift Review of Resident #4's notes in February revealed there were no notes to reflect why his orders were not signed as being given or completed. On [DATE] at 11:48 AM Resident #4 stated he has been in and out of the hospital a lot lately because he was septic. He indicated he has wounds on hit buttocks and heels. He indicated the wound on his right heel is almost healed and his other wounds are getting smaller. Staff are doing his treatments to these areas every day, even when in the hospital. He added he has had issues with an overnight nurse not suctioning him when he needs it. He let them know he needed suctioned but the overnight nurse would not come and do it. When asked if that nurse every came in to suction him, he stated she did not and he had to wait until the morning shift nurse came in for him be suctioned. He denied anything negatively happening because he was not suctioned. He gets his medications as ordered and through his gastrostomy tube. On [DATE] at 11:43 AM Staff C Licensed Practical Nurse (LPN) stated about three weeks ago, staff called in and the ADON had to cover the floor which included doing the medication pass. Residents #1, #2, and #3 indicated they did not get their medications the day the ADON worked the floor. At lunch Resident #2 argued with the ADON about not receiving her insulin that morning, telling her she got it about 7am, which Resident #2 told that was a lie and she had received it. The ADON ended up giving the resident her insulin. Staff C asked if she supposedly gave the resident her insulin that morning, why would she give it again if she was insistent that she gave it to the resident that morning? That Friday the ADON grilled Staff C about filling out a medication error on Resident #2's behalf. Staff C noticed that day the medications were not signed out as being given. When she came in the next morning they were all signed off. During a follow up interview on [DATE] at 1:26 PM Staff C stated orders should be signed out at the time of medication administration or when completing a treatment. Some staff will administer the medications first then sign them out as being given. She acknowledged if an order read to hold a medication if the resident's blood pressure was less than 100, than it should be held if it's below 100. She added there is an option when documenting to see nurse's note, then make a note that the medication was held because the blood pressure was less than 110. On [DATE] at 1:16 PM Staff B Certified Medication Aide (CMA) stated Resident #2 swore to her she did not get her insulin when the ADON was working the floor. On [DATE] at 1:19 PM Staff E CMA stated Resident #2 has mentioned to her that she has not received her insulin before. On [DATE] at 11:03 AM Staff F Registered Nurse (RN) stated medications should be signed off as given as soon as they are administered. When asked if it was acceptable to sign off medications as administered, 5 hours after they were administered, she stated no. If an order reads to hold if the blood pressure was below 100 and the blood pressure was 97 what would you do, Staff F stated the medication would be held. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. According to the annual MDS assessment tool with a reference date of [DATE] documented Resident #6 had a BIMS score of 14. A BIMS score of 14 suggested no cognitive impairment. The MDS documented she received scheduled pain medications as well as, as needed (PRN) pain medications. Resident #6 received an opioid 7 days of the 7 day review period. The MDS documented the following diagnoses: stage 5 kidney disease, hypertension, renal failure, thyroid disease, Parkinson's disease, anxiety, depression, bilaterally below the knee amputations, and obesity. A Care Plan focus area with a revision date of [DATE] documented Resident #6 had chronic pain related to a compression fracture to her T11, arthritis, gout, and morbid obesity as evidenced by reports of waking up in pain or extremities asleep or pain if up too long. The care plan directed staff to administer her analgesics as ordered. Review of Resident #6's February 2025 MAR revealed she had the following orders: a) Oxycodone 5mg, give 1 tablet by mouth every 12 hours PRN for pain, with an order date of [DATE], b) Oxycodone 5mg, give 2 tablets by mouth every 12 hours PRN for pain, with an order date of [DATE]. Clinical record review revealed a Controlled Drug Administration Record Tablet for Resident #6's oxycodone order with a received date of [DATE] and a last administered date of [DATE]. The form documented a date of discontinuance of [DATE] with the 3 remaining tablets destroyed in the drug buster on [DATE]. Review of Resident #6's Progress Notes for September revealed no notes were documented with a reason the medication was destroyed. On [DATE] at 3:21 PM Staff K Certified Medication Aide (CMA) stated someone told her this morning the medication card was missing. She stated she honestly could not say the last time the medication card was there, Resident #6 has never asked for the medication. There should be a medication card because she has an order for it. She is pretty sure the resident has not had the medication for six months or more. On [DATE] at 1:26 PM Staff C Licensed Practical Nurse (LPN) stated orders should be signed out at the time of them being administered. Some will walk away from the medication cart, administer the medication then sign the medication as being administered. Ideally, it should be signed out at the time the medication was given. If the order has parameters, they should be followed. If the medication has to be hold for being outside of the parameters, there's an option that states see nurse's note then the nurse would chart why it was held. On [DATE] at 1:15 PM the Director of Clinical Nursing Services stated they found the count sheet for Resident #6 and the medication was destroyed on [DATE]. The pharmacy last sent the medication to the facility on [DATE]. They called the physician to get a discontinued order. When they reviewed the medication, Resident #6 had not used the medication since [DATE], thought the order had expired and that may have been why the medication was destroyed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:45 AM the Director of Nursing (DON) stated orders should be signed out immediately after they are completed. If an order has parameters on it, they should be followed and the medication should be given or held based on those parameters. She is unsure why Resident #6's PRN oxycodone cart was destroyed. Not sure if it was expired but there was no order to discontinue or destroy. The nurse that worked that day did not specify why it was destroyed, she was unsure what happened. The facility provided a policy titled Administering Medications with a revision date of [DATE]. The policy indicated: 3. Medications must be administered in accordance with the orders, including any required time frame. 4. Medications must be administered with in one hour of their prescribed time, unless otherwise specified (for example, before or after meal orders). 18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. 19. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones. 20. As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: a) the date and time the medication was administered g) the signature and title of the person administering the drug 21. Topical medications used in treatments must be recorded on the resident's TAR. The facility provided an untitled document that listed the following medication pass times: 1) AM: 6:30 AM-11:00 AM 2) Lunch: 11:00 AM-2:00 PM 3) Supper 4:00 PM-6:30 PM 4) HS (at bedtime): 7:00 PM-11:00 PM

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074 Based on clinical record review, staff interviews and facility policy review the facility failed to complete a full assessment, initiate neuros, and have a licensed nurse assess Resident #5 after she sustained an unwitnessed fall. The facility also failed to complete assessments for 6 residents (Resident #1, #8, #11, #12, #13, and #14) that tested positive for COVID-19 and 1 resident (Resident #9) that tested positive for influenza A. The facility reported a census of 37 residents. Findings include: 1. According to the significant change Minimum Data Set (MDS) assessment tool with a reference date of 1/24/2025 documented Resident #5 had a Brief Interview of Mental Status (BIMS) score of 3. A BIMS score of 3 suggested severe cognitive impairment. Resident #5 had one sided impairment to her upper and lower extremities and utilized a wheelchair. The MDS documented Resident #5 did not have any falls since her admission/entry or reentry or prior assessment. The following diagnoses were listed for the resident: stroke, diabetes mellitus, dementia, anxiety disorder, depression, bipolar disorder, lack of coordination, abnormalities of gait and mobility, and muscle weakness. The Care Plan focus area with a revision date of 10/22/2024 documented Resident #5 required assistance with Activities of Daily Living (ADLs) related to a history of a stroke with weakness and abnormal gait, dementia and bipolar disorder. The Care Plan focus area with a revision date of 10/22/2024 documented Resident #5 was at risk for falls related to medication side effects, incontinence, noncompliance with safety interventions and a history of falls prior to her admission. On 12/2/2024 resident was found lying on mat by her bed. The Care Plan documented she required extensive assistance of two staff for a stand and pivot transfer. Review of Resident #5's Progress Notes on 2/14/2025 at 10:17 AM revealed one progress note related to a fall that occurred on 2/11/2025 at approximately 9:00 PM. On 2/18/2025 at 11:03 AM the Administrator emailed a print out of incident reports from 1/22/2025 through 2/16/2025. The print out of incident reports listed Resident #5's last incident report related to a fall was dated 2/11/2025 at 9:00 PM. On 2/21/2025 at 11:52 AM the Administrator emailed an incident report documenting Resident #5's fall on 2/12/2025, that was completed by the Director of Nursing (DON). Review of a document titled Neurological Assessment Flow Sheet that was provided by the Administrator on 2/24/2025 at 4:13 PM via email, documented a set of vitals on 2/12/2025 at 2:30 PM, the next set of vitals was documented on 2/13/2025 at 10:30 AM. In addition to vitals, motor functions, pupil response and pain response were assessed. Review of Resident #5's assessment tab in her Electronic Health Record (EHR) revealed it lacked a post fall assessment from her fall on 2/12/2025. The only post fall full assessment was documented on 2/13/2025 by the DON. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/13/2025 at 1:36 PM Staff D Certified Nursing Assistant (CNA) stated on 2/12/2025 about 2:30 PM Resident #6 had fallen. She was found on the floor next to her bed, her fall mat was not in place, call light was not on and did not say what she was trying to do. Staff D went and got the Interim Administrator since there was no nurse in the building at the time. The Interim Administrator had told staff prior to this fall he was a nurse prior to being the Interim Administrator but was not licensed. The Interim Administrator assessed the resident: asked her if she had pain in specific areas, checked her legs and hips. The Interim Administrator and Staff B Certified Medication Aide (CMA) scooped the resident off of the floor, on to her feet as Staff D pushed the wheelchair behind Resident #6 so she could sit down. Staff D acknowledged a gait belt was not used to assist the resident off the floor to her wheelchair. On 2/13/2025 at 1:46 PM Staff B stated on 2/12/2025 at 2:30 PM Resident #6 fell out of her bed; her bed was in the lowest position but her fall mat was not in place. The Administrator came in, squeezed her calf, one of her knees, one of her thighs and they proceeded to stand her up with no gait belt. When asked how they assisted her up off the floor, Staff B stated her and the Administrator put one of their arms under her arm, held her pants and transferred her to the wheelchair. As she was trying to get report from the other CMA at 3:00 PM, the Administrator asked her to get vitals on Resident #5; 30 minutes after the fall occurred. When asked if neurological checks were started she stated they were not done but should have since it was an unwitnessed fall. When asked about the frequency of the neurological checks, she acknowledged she was not sure as that was a nurse's job. On 2/13/2025 at 3:46 PM the Administrator stated Resident #6 fell out of bed, he assessed her and got her in to her wheelchair. There were no injuries and follow-up vitals were done. When asked what kind of assessment he completed he stated he made sure she was not in pain, checked for bleeding. Her bed was in the lowest position so he felt confident that the fall was easy as she slid out of bed. When they got her up off the floor, she did not have discomfort or pain. The fall happened about 2:30 PM. After the fall she was out and about in the dining room without concerns of pain. He had Staff B get her vitals. When asked since this was an unwitnessed fall, who completed the neurological assessments; he stated the neurological checks did not happen. When asked how they assisted the resident off the floor he stated Staff D was behind the resident with him and Staff B on either side of the resident and they lifted her up. The Administrator denied using a gait belt for the transfer. On 2/19/2025 at 11:03 AM Staff F Registered Nurse (RN) stated when an unwitnessed fall occurs, the nurse needs to initiate neurological assessments, complete a full body assessment, pain assessment and if they resident is in pain, they should be checked out at the emergency room (ER). On 2/19/2025 at 1:26 PM Staff C Licensed Practical Nurse (LPN) stated when there is an unwitnessed fall before the resident is moved, vitals need to be obtained, range of motion (ROM) needs to be assessed, assess for pain and determine whether or not they hit their head, initiate neurological checks. Staff are not supposed to pick residents off the floor themselves, they are to us a mechanical lift. If the resident is experiencing pain they will call the emergency room (ER) to be evaluated. When asked when this type of assessment should be completed she stated the initial assessment is to be completed as soon as able. Waiting 30 minutes to get the first set of vitals is not appropriate. Neurological checks are also to be started right away. When asked who makes out the incident report after a resident has a fall she states whatever nurse is taking care of the situation and should be completed as soon as able to do so. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility provided a document titled Neurological Assessment with a revision date of October 2010. The purpose of this procedure is to provided guidelines for a neurological assessment: 2) when following an unwitnessed fall. General Guidelines: 1. Neurological assessments are indicated: a) following an unwitnessed fall 2. When assessing neurological status, always include frequent vitals. Particular attention should be paid to widening pulse pressure (different between systolic and diastolic pressures). This may be indicative of increasing intracranial pressure. 3. Any change in vital signs or neurological status in a previously stable resident should be reported to the physician immediately. Documentation: The following information should be recorded in the resident's medical record: 1. The date and time the procedure was performed. 2. The name and title of the individuals who performed the procedure. 3. All assessment data obtained during the procedure. 4. How the resident tolerated the procedure. 5. If the resident refused the procedure, the reason(s) why and the intervention taken. 6. The signature and title of the person recording the date. 2. Review of Resident #1's Progress Notes revealed the following note: 2/22/2025 at 12:57 AM: resident tested COVID-19 per CDC recommendations related to routine outbreak testing; positive results. Her physician and family were notified and resident placed in transmission-based precautions for 10 days. Review of Resident #1's assessment tab in her EHR revealed one COVID-19 Observation assessment completed on 2/22/2025. The tab lacked additional COVID-19 Observation assessments. Review of Resident #1's vitals tab in her EHR revealed vitals were obtained every shift. Resident #1's clinical record lacked respiratory assessments every shift once she had a positive COVID-19 test. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #8's Progress Notes revealed the following note: 2/22/2025 at 12:04 AM: resident tested COVID-19 per CDC recommendations related to routine outbreak testing; positive results. His physician and family were notified and resident placed in transmission-based precautions for 10 days. Review of Resident #8's assessment tab in his EHR revealed two COVID-19 Observation assessments completed on 2/22/2025 and 2/23/2025. The tab lacked additional COVID-19 Observation assessment. Review of Resident #8's vitals tab in his EHR revealed vitals were obtained every shift. Resident #8's clinical record lacked respiratory assessments every shift once he had a positive COVID-19 test. 4. The facility provided a hand-written note that indicated Resident #9 went in to isolation on 2/10/2025 due to a positive Influenza A test. The note documented he was symptomatic. Review of Resident #9's Progress Notes on 2/13/2025 at 3:30 PM revealed it lacked documentation of a positive Influenza A test. Review of Resident #9's assessment tab in his EHR revealed it lacked assessments. Review of Resident #9's vitals tab in his EHR revealed his temperature was not obtained on 2/10, 2/11, and only one time on 2/12 and 2/13. The facility failed to obtain and document his blood pressure, pulse, respirations and oxygen saturations from 2/10/2025-2/15/2025. Resident #9's clinical record lacked respiratory assessments every shift once he had a positive Influenza A test. 5. Review of Resident #11's Progress Notes revealed the following note: 2/22/2025 at 12:55 AM: resident tested COVID-19 per CDC recommendations related to routine outbreak testing; positive results. His physician and family were notified and resident placed in transmission-based precautions for 10 days. Review of Resident #11's assessment tab in his EHR reveal one COVID-19 Observation assessment was completed on 2/22/2025. The tab lacked additional COVID-19 Observation assessments. Review of Resident #11's vitals tab in his EHR revealed his blood pressure, pulse and temperature was only obtained once on 2/22 and 2/23. His oxygen saturation was obtained once on 2/22 and not at all on 2/23. His respiration rate was not obtained on 2/22 and 2/23. Resident #11's clinical record lacked respiratory assessments every shift once he had a positive COVID-19 test. 6. Review of Resident #12's Progress Notes revealed the following note: 2/22/2025 at 12:58 AM: resident tested COVID-19 per CDC recommendations related to routine outbreak testing; positive results. His physician and family were notified and resident placed in transmission-based precautions for 10 days. (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 02/27/2025
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #12's assessment tab in his EHR revealed one COVID-19 Observation assessment was completed on 2/22/2025 and 2/25/2025. The tab lacked additional COVID-19 Observations assessments. Review of Resident #12's vitals tab in his EHR revealed his blood pressure, pulse, oxygen saturation, and temperature were not obtained on 2/23/2025. Resident #12's clinical record lacked respiratory assessments every shift once he had a positive COVID-19 test. 7. Review of Resident #13's Progress Notes revealed the following notes: a) on 2/20/2025 at 6:17 AM the hospital called and said he was being admitted for pneumonia and COVID-19, b) on 2/21/2025 at 5:13 PM Resident #13 returned to the facility via squad. Review of Resident #13's assessment tab in his EHR revealed a COVID-19 Observation assessment was completed on 2/22/2025. The tab lacked additional COVID-19 Observation assessments. Review of Resident #13's vitals tab in his EHR revealed his blood pressure, pulse and temperature was only obtained once on 2/23. A second set of vitals were not obtained. Resident #13's clinical record lacked respiratory assessments every shift once he had a positive COVID-19 test. 8. Review of Resident #14's Progress Notes revealed the following note: 2/22/2025 at 12:48 AM: resident tested COVID-19 per CDC recommendations related to routine outbreak testing; positive results. Her physician and family were notified and resident placed in transmission-based precautions for 10 days. Review of Resident #14's assessment tab in her EHR revealed a COVID-19 Observation assessment was completed on 2/23/2025. The tab lacked additional COVID-19 Observation assessments. Review of Resident #14's vitals tab in her EHR revealed her blood pressure and pulse was only obtained once on 2/22/2025 and 2/23/2025, her oxygen saturation, temperature, respirations were not obtained on 2/22/2025 and 2/23/2025, and her respirations and temperature were obtained once on 2/24/2025. Resident #14's clinical record lacked respiratory assessments every shift once he had a positive COVID-19 test. (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 02/27/2025
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/26/2025 at 11:45 AM the Director of Nursing (DON) stated when a resident sustains an unwitnessed fall a head to toe assessment should be completed, then neurological checks should be initiated unless the resident is competent and able to tell staff if they hit their head or not. She would still assess the resident's head to see if there was anything that may suggest they hit their head. When asked if Resident #5 would be competent enough to say if she hit her head or not, she stated she would not be. When asked what the neurological assessment protocol is she stated every 15 minutes for 1 one, every 30 minutes for four hours, then every four hours four times, then every shift for 72 hours. When asked if neurological checks were initiated on 2/12/2025 when she fell , she stated no because she had an unwitnessed fall on the 11th so they continued with the neurological checks they had already been doing. The DON was asked if they should have been restarted when she fell on [DATE], she stated technically yes, if she fell they would have started over from the beginning. A head to toe assessment should be completed immediately after a resident fall, before the resident is even assisted off the floor. Vitals need to be obtained, check ROM, to see if there's any shortening of the legs that may indicate a broken hip. When asked what kind of assessment should be completed during their outbreak status she indicated any resident with COVID-19 should have a respiratory assessment completed every shift, document if they are symptomatic or not, a full set up vitals, and monitor other residents for symptoms; act accordingly. On 2/23/2025 at 10:00 AM located behind the nurse's station, a printout was posted on the bulletin board. The ADON stated the Corporate Infection Control Nurse sent this via email at the start of their outbreak. The print out contained the following information: COVID-19 1 positive, 2 staff: 1. Resident isolation x 10 days with today being day 0, to come off isolation on 2/21/2025. They may only exit room for medical necessary reasons with source control in place. Full set of vitals and respiratory assessment completed every shift for monitoring for 10 days. 2. Roommate of positive resident (if they have one) should be tested every 48 hours for 3 days and monitored for symptoms every shift with full set of vitals for 10 days. If the roommate is able to wear source control they may come out of their room, but only if they are willing to be tested per the above schedule and wear a mask when outside of their room. If they are unable and or unwilling to comply with that rule, they must be placed on contact/droplet isolation for 7 days until the final test confirms they are negative.

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	165531	A. Building B. Wing	02/27/2025

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Garden View Care Center	1200 West Nishna Road Shenandoah, IA 51601

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 37074 Based on observation, clinical record review, resident and staff interviews, and facility policy review the facility failed to complete treatments as ordered for 1 of 2 residents (Resident #1) with pressure ulcers. The facility reported a census of 37 residents. Findings include: According to the annual Minimum Data Set (MDS) assessment tool with a reference date of 11/19/2024, Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented she was at risk for developing pressure ulcers/injuries and had one stage two pressure ulcer. The MDS indicated she had 2 venous and arterial ulcers present. Resident #1 utilized a pressure reducing device for her chair, had nutrition or hydration interventions to manage skin problems, had pressure ulcer/injury care, and had orders for the application of nonsurgical dressing as well as ointments and/or medications. The following diagnoses were documented for Resident #1: end stage renal disease, anemia, diabetes mellitus, and stroke. The Care Plan focus area with a revision date of 11/21/2024 documented she had actual skin integrity impairment to bilateral lower extremities, posterior right lower extremity, left toes. Resident #1 goes to the wound clinic. She had stage two pressure ulcer, venous ulcers to her bilateral lower extremities. The Care Plan directed staff to follow doctor's orders for treatment of injuries. Staff are to monitor/document location, size and treatment of skin injury. The following Progress Notes were documented for Resident #1: a) On 12/13/2024 at 11:43 AM wound clinic faxed recent notes and wound measurements b) On 1/10/2025 at 12:29 AM Resident #1 was seen at the wound clinic on 1/9/2025. Bilateral lower extremities (BLE) order to continue with Xerofoam, ABD pad, then apply ace wraps to ulcers. Follow up with physician due to odor and green drainage from wounds and follow up with vascular due to persistent wounds. Resident #1 is to follow-up in 1 month on 2/6/2025 at 10:30 AM. c) On 2/6/2025 at 1:35 PM Resident #1 returned from the wound clinic today. No wound measurements, so the nurse called the clinic and requested they fax information on wounds. Record review revealed the following wound clinic notes: a) On 12/12/2024 at 10:30 AM new dressing and treatment orders, along with measurements of wounds. Resident return appointment in 1 month on 1/9/2025. b) On 1/9/2025 at 10:30 AM measurements of wounds documented, return appoint in 1 month, c) On 2/6/2025 at 10:30 AM measurements of wounds documented, recommend following up with vascular due to non-healing bilateral lower extremities (BLE) wounds and multiple ulcerations of foot. Review of Resident #1's assessment tab in her EHR revealed the following weekly skin assessments: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a) 12/10/24 weekly skin assessment BLE vascular no measurements no staging b) 12/17/24 weekly skin assessment BLE vascular no measurements no staging c) 12/31/24 weekly skin assessment BLE vascular no measurements no staging d) 1/8/25 weekly skin assessment BLE vascular no measurements, no staging e) 1/18/25 weekly skin assessment BLE vascular no measurements, no staging f) 1/31/25 weekly skin assessment BLE vascular no measurements, no staging g) 2/6/25 weekly skin assessment BLE vascular measurements included h) 2/11/25 weekly skin assessment BLE vascular no measurements, no staging i) 2/18/25 weekly skin assessment BLE vascular no measurements, no staging-last wound clinic visit 2/6/25 measurements obtained and entered into skin assessment on that day. Record review revealed it lacked orders for staff to not complete measurements of Resident #1's wounds while completing her weekly skin assessments. Review of Resident #1's December 2024 Treatment Administration Record (TAR) revealed the following orders were not signed out as being completed: a) Apply to BLE Xerofoam, ABD pad, rolled gauze and wrap with ace wraps daily, one time a day; not signed out as being completed on 12/16, 12/20, 12/23 b) Wound care to left lower extremity (LLE)-Xerofoam to LLE and left heal, cover with absorbent dressing then ace wrap, change daily; not signed out as being completed on 12/4, 12/15 c) Wound care to right lower extremity (RLE)- apply Santyl to necrotic and slough areas, Xerofoam to other open green areas (not over Santyl), apply absorbent dressing, ace wrap change daily; not signed out as being completed on 12/6, 12/15 d) Weekly skin assessment every Tuesday; not signed out as completed on 12/24 e) Elevated legs three times a day (TID) for at least 30 minutes every shift; order not signed out as being completed on 12/5, 12/9, 12/20 Review of Resident #1's January 2025 TAR revealed the following orders were not signed out as being completed: a) Apply to BLE Xerofoam, ABD pad, rolled gauze and wrap with ace wraps daily, one time a day; not signed out as being completed on 1/6, 1/23 b) Dressing applied to promote autolytic debridement, one time a day every Tuesday, Thursday, Saturday for wound care; not signed out as being completed on 1/23 (continued on next page)

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	165531	A. Building B. Wing	02/27/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c) Non pressure assessment to be completed weekly with skin assessment one time a day every Tuesday; not signed out as being completed on 1/21, 1/28 d) Santyl External ointment 250 unit/gram, apply to BLE topically one time a day every Tuesday, Thursday, and Saturday; not signed out as being completed on 1/23 e) Triamcinolone Acetonide External Cream 0.1%, apply to legs topically one time a day every Tuesday, Thursday, and Saturday; not signed out as being completed on 1/23 f) Weekly skin assessment one time a day every Tuesday for skin care; not signed out as being completed on 1/14, 1/21, 1/28 g) Offload heels with offloading boots every shift; not signed out as being completed on 1/23 h) Elevate BLE at heart level TID for at least 30 minutes daily; not signed out as being completed on 1/17 in the morning and lunch, 1/23 in the morning and lunch Review of Resident #1's February 2025 TAR revealed the following orders were not signed out as being completed: a) Apply to BLE Xerofoam, ABD pad, rolled gauze and wrap with ace wraps daily, one time a day; not signed out as being completed on 2/12, 2/13 b) Dressing applied to promote autolytic debridement, one time a day every Tuesday, Thursday, Saturday for wound care; not signed out as being completed on 2/13 c) Non-pressure assessment to be completed weekly with skin assessment one time a day every Tuesday; not signed out as being completed on 2/4 d) Santyl External ointment 250 unit/gram, apply to BLE topically one time a day every Tuesday, Thursday, and Saturday; not signed out as being completed on 2/13 e) Triamcinolone Acetonide External Cream 0.1%, apply to legs topically one time a day every Tuesday, Thursday, and Saturday; not signed out as being completed on 2/13 f) Offload heels with offloading boots every shift; not signed out as being completed on 2/12 g) Elevate BLE at heart level TID for at least 30 minutes daily; not signed out as being completed on: 2/12 at bed time, 2/13 in the morning and at lunch h) Weekly skin assessment one time a day every Tuesday: not signed out as being completed on 2/4, 2/18. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/2025 at 1:18 PM Resident #1's bilateral lower extremities appear to be wrapped in ace wraps. When asked if her dressings and treatments are getting completed every day, she stated most generally they get done. She added some times the nurses will skip them, at times they will skip 2 days at a time. Resident #1 indicated if the right staff are working they will get done and it varies on who will skip the treatments. She knows Staff C Licensed Practical Nurse (LPN) and Staff H completes the treatments and dressings. She does go to the wound clinic once a month where they assess her wounds and have told her they are looking good. Resident #1 was asked if the facility completes weekly skin assessments to her wounds and she indicated she was not sure if they do them but knows there are some that do not do the assessments. She acknowledged they do assess her wounds at the wound clinic. On 2/26/2025 at 11:45 AM the Director of Nursing (DON) stated they do not obtain measurements with her weekly skin assessments because they do them monthly at the wound clinic. The areas are all over the place on her lower legs, it would be hard to get accurate measurements. The nurses look at them every day with her treatments. The ADON added she was surprised they have not amputated her legs due to her vascular ulcers. When asked about her orders as not being signed out as being completed, the DON stated she refuses them often and denied being told that staff are just not doing them. The facility provided a document titled Pressure Ulcers/Skin Breakdown-Clinical Protocol with a revision date of April 2018. Assessment and Recognition: 2. The nurse shall describe and document/report the following: a) full assessment of pressure sore including location, state, length, width and depth, presence of exudates or necrotic tissue. Treatment/Management: 1. The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents. 2. The physician will help identify medical interventions related to wound management. The facility provided a procedure titled Wound Care with a revision date of October 2010. The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation: 1. Verify that there is a physician's order for this procedure. Documentation: The following information should be recorded in the resident's medical record: (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 02/27/2025
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. All assessment data (i.e. wound bed color, size, drainage, etc.) obtained when inspecting the wound. 9. If the resident refused the treatment and the reason(s) why. The facility provided a policy titled Administering Medications with a revision date of December 2012. The policy indicated: 21. Topical medications used in treatments must be recorded on the resident's TAR.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074 Based on clinical record review, staff interviews and facility policy review the facility failed to ensure a gait belt was used for 1 of 14 residents (Resident #5) reviewed for falls. The facility reported a census of 37 residents. Findings include: According to the significant change Minimum Data Set (MDS) assessment tool with a reference date of 1/24/2025 documented Resident #5 had a Brief Interview of Mental Status (BIMS) score of 3. A BIMS score of 3 suggested severe cognitive impairment. Resident #5 had one sided impairment to her upper and lower extremities and utilized a wheelchair. The MDS documented Resident #5 did not have any falls since her admission/entry or reentry or prior assessment. The following diagnoses were listed for the resident: stroke, diabetes mellitus, dementia, anxiety disorder, depression, bipolar disorder, lack of coordination, abnormalities of gait and mobility, and muscle weakness. The Care Plan focus area with a revision date of 10/22/2024 documented Resident #5 required assistance with Activities of Daily Living (ADL's) related to a history of a stroke with weakness and abnormal gait, dementia and bipolar disorder. The Care Plan documented she required extensive assistance of two staff for stand and pivot transfers. On 2/13/2025 at 1:36 PM Staff D was asked if anything happened during the time a nurse was not present that required them to notify the Administrator, she acknowledged Resident #5 had a fall. The Administrator went in and assessed Resident #5; asked her specific areas with pain, checked her legs, and hips. No pain was noted during the assessment. The Administrator and Staff B assisted the resident up off the floor into a wheelchair without the use of a gait belt. On 2/13/2025 at 1:46 PM Staff B CMA asked if anything happened during the time a nurse was not in the building on 2/12/2025, she stated Resident #5 fell shortly after Staff A left the building. It happened about 2:30 PM, she fell out of bed; her bed was in the lowest position but her fall mat was not in place. The Administrator came in, squeezed her calf, one of her knees, and thigh. They proceeded to stand her up with no gait belt by her and the Administrator placing an arm under her armpit, held on to Resident #5's pants, stood her up and placed her in the wheelchair. The Administrator asked her at about 3:00 PM to get her vitals, as she was trying to get report from Staff E. Staff D was asked since this was an unwitnessed fall, should vitals have been completed; she stated they should have been done. She added she did not know the frequency of them because that is a nurse's job. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/2025 at 3:46 PM the Administrator was asked if anything happened that required a nurse's attention, while there was no nurse in the building on 2/12/2025. He stated Resident #5 fell out of bed; he assessed her and got her in to her wheelchair. There were no injuries and follow-up vitals were done. The Administrator was asked what kind of assessment was completed he stated, he made sure the resident was not in pain, checked for bleeding and bruising. He felt confident that the fall was an easy fall, she slid off the bed. They were able to get her up without discomfort or pan. He had Staff B complete vitals on her. When asked who initiated the neurological assessments since it was an unwitnessed fall, he stated those did not happen. He indicated himself, Staff B and another staff member assisted Resident #5. Staff D was being Resident #5, Staff B and himself were on either side of her and they lifted her up. When asked if they had a gait belt on Resident #5 he acknowledged they did not. He did not notice any pain or discomfort. On 2/25/2025 at 10:30 AM Staff E Certified Medication Aide (CMA) stated gait belts are to be used when assisting residents off the floor. Before the new company took over they had a policy where they had to use a mechanical lift for anyone that was found on the floor, now staff are not sure what their new policy is. On 2/26/2025 at 11:45 AM the Director of Nursing (DON) could not speak of if the facility had a no lift policy or not. Would assume if the person that fell was a larger individual that required a two person assist, a lift would be use. Someone like Resident #5, staff could pick her up and put her to bed safely. A gait belt should have been used when assisting Resident #5 off the floor when she fell on [DATE]. She would expect staff to have gait belts with them at all times and to use them with every transfer that does not require a mechanical lift. The facility provided a policy titled Safe Lifting and Movement of Residents with a revision date of July 2017. In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. 1. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. 2. Manual lifting of residents shall be eliminated when feasible. 4. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices.

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074 Based on clinical record review, agency staff schedule, facility schedule, staff interviews and facility assessment the facility failed to provide nursing coverage on [DATE] from approximately 1:30 PM until approximately 4:30 PM. Staff indicated Staff A Agency LPN started her shift on [DATE] at 6:00 PM and worked until [DATE] at approximately 1:30 PM due to another staff member calling sick to work. The Administrator advised Staff A to go back to the hotel to nap and get her medications before her next shift started at 6:00 PM. The facility reported a census of 37 residents. Findings include: According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of [DATE], documented Resident #4 had a Brief Interview of Mental Status (BIMS) score of 14. A BIMS score of 14 suggested no cognitive impairment. The MDS documented Resident #4 had an indwelling catheter, ostomy and received tracheostomy care. The following diagnoses were listed for Resident #4: sepsis, renal failure, neurogenic bladder, multidrug-resistant organism, pneumonia, quadriplegia, multiple sclerosis, anxiety, respiratory failure, stage 4 pressure ulcer. The Care Plan focus area with a revision date of [DATE] documented Resident #4 required tube feeding related to water flushes, dysphagia, chewing problem, and swallowing problems. The Care Plan focus area with a revision date of [DATE] documented Resident #4 has (potential acute) pain related to chronic disability. The Care Plan focus area with a revision date of [DATE] documented Resident #4 has a tracheostomy related to impaired breathing mechanics, has as needed (PRN) oxygen to keep his saturations above 90%. Staff are to suction as necessary. Staff are also to keep an extra tracheotomy tube and obturator at the bedside. If the tube is coughed out, open the stoma with a hemostat. If the tube cannot be reinserted, monitor/document for signs of respiratory distress. If able to breathe spontaneously, elevate the head of bed to 45 degrees and stay with resident. Obtain medical help immediately. The Care Plan focus area with a revision date of [DATE] documented Resident #4 received an anticoagulant therapy due to a diagnosis of a pulmonary embolism. Record review revealed Resident #4 had the following hospital and emergency room (ER) visits: 1) [DATE]-[DATE] he was hospitalized for sepsis secondary to a urinary tract infection (UTI) 2) On [DATE] he went to the ER to be suctioned because he would not allow the nurse on duty to suction him 3) [DATE]-[DATE] he was hospitalized for sepsis due to pneumonia (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 02/27/2025
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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4) February 3, 2025-February 10, 2025 he was hospitalized for severe sepsis with acute organ dysfunction 5) February 14, 2024 he was sent to the ER for a possible seizure. Upon entrance into the facility the facility provided a document with the following Residents in Isolation: 1) Resident #9 went in to isolation on [DATE] for influzena A, was symptomatic 2) Resident #10 went in to isolation on [DATE] for COVID-19, was symptomatic On [DATE] at 4:57 PM Staff A's staffing agency account/payroll staff member emailed her timecard for the month. The timecard indicated Staff A went to work on [DATE] at 5:40 PM and worked until [DATE] at 1:38 PM. Review of the daily schedule dated [DATE] listed the following staff were scheduled to work Staff E Certified Medication Aide (CMA), Staff B CMA, Staff K CMA, Staff O Certfied Nurse Aide (CNA), Staff N CNA, Staff L CNA, Staff M CNA, Staff D CNA, and Staff S CNA. Staff H Licensed Practical Nurse (LPN) was on the schedule but called off sick. The Administrator was asked to send CPR certifications of staff that were CPR certified. He sent the following staff's certificates: Staff A, Staff C, Staff H, and the Assistant Director of Nursing (ADON). The Administrator later indicated the Director of Nursing's (DON) CPR certification had expired. The staff members on the schedule for [DATE] did not have their CPR certificates. The facility failed to have a CPR certified staff member on duty from 1:30 PM until 5:30 PM on [DATE]. On [DATE] at 11:43 AM Staff C LPN was asked to talk about staffing on [DATE]. Staff C stated oh boy, a nurse called in the night prior for the AM shift. Staff C indicated the DON sent her a text asking her to cover the AM shift on [DATE], but she told her she could not because she was sick. They were unable to find anyone which left Staff A stuck at work. Staff C was told the DON told Staff A to contact her agency to find her a replacement. Staff C got a call from a staff member on [DATE] stating the Administrator told Staff A to go back to hotel, take a nap, get her medications, and come back for her 6:00 PM shift. Staff K CMA told her this and that the Administrator took the medication cart keys at approximately 1:40 PM on [DATE] and Staff A left the building. Staff B took Staff A to her hotel. Staff C indicated Staff A reported to work at 6:00 PM on [DATE], stayed until roughly 2:00 PM on [DATE] and was scheduled to work at 6:00 PM on [DATE]. They had no nurse on duty from approximately 2:00 PM-4:30 PM until the DON arrived at the facility. In all the years she has been in this facility, this has never happened before. When asked who else was present at that time that would be able to discuss this she stated: Staff B, Staff E, Staff K and the Administrator was here too. Staff C added Staff A should not have left the building, she should have stayed in the building and napped or something. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:04 PM Staff K stated she went in to work at 6:00 AM on [DATE] and Staff A was to be there until noon because the scheduled day nurse called in sick at 8:00 PM the night prior ([DATE]). Management talked to several staff to see if they could come in. At 1:30 PM Staff A looked at her as she was getting her thinks gathered and packed up. She asked Staff K who she was supposed to give her medication cart keys to and Staff K told her she was unsure since there was no other nurse there. Staff A then went in to the Administrator's office and she gave him her keys. Staff K was at the medication cart across from where the Administrator's office was and she heard him tell Staff A to go get some rest and he would see her around 5:00 PM. Staff A left the building and Staff K stated when she left at the end of her shift at 2:00 PM there was no nurse replacement. Staff K stated she has never known there to not be a nurse in the building. Staff K was asked to list the staff members present during this time: herself, Staff E, Staff L, Staff M, Staff N, Staff O, Staff P, Staff Q Housekeeper, and Staff R Housekeeper. When asked if there were any high-risk residents in the facility at that time, she stated Resident #4 had to be suctioned regularly, residents with COVID and Influenza that could have a change at any time that only a nurse could provide. On [DATE] at 12:56 PM Staff P was asked to discuss staffing from yesterday, [DATE]. She stated she worked 6:00 AM-2:00 PM with Staff A, Staff E, Staff K, Staff L, Staff M, Staff N, Staff O. The DON and ADON were not working that day. Staff P indicated Staff A left the facility about 1:00 PM with no other nurse in the building. Staff P left the building at approximately 2:10 PM and there was still no nurse in the building. The Administrator told staff he is a nurse but not currently licensed. On [DATE] at 1:04 PM Staff O was asked to discuss staff on [DATE]. She stated Staff A come in to work on [DATE] at 6:00 PM and was there until [DATE] at 1:30 PM. Her Agency called the facility and stated she needed to go home. Staff A gave the Administrator her medication cart keys and left. The Administer said it was okay for her leave because he is a nurse but is not licensed. Staff O indicated she was unsure what time a nurse came in to the facility on [DATE] after Staff A left the building. When asked what staff were present for this she stated, Staff B, Staff D, Staff N, and Staff S. The ADON and DON were not in the building that day. Staff B took Staff A back to her hotel that day. On [DATE] at 1:19 PM Staff E was asked to discuss staffing on [DATE]. Staff E stated they had five CNA's on the floor, two CMAs, and one nurse. The one nurse had worked the night before, starting at 6:00 PM on [DATE] but was unsure when she left as she was in the dining room charting. Staff E thought someone told her the nurse left at 1:45 PM. When asked who the nurse was she stated Staff A. Staff E stated she left for the day at 3:03 PM and there was no nurse in the building at that time; the DON and ADON were not here either. Staff E was asked to who was working after 2:00 PM on [DATE], she stated: Staff B CMA, Staff D CNA, Staff N, and Staff S Agency CNA. Staff E stated they had high risk residents at that time: Resident #4, they just sent him back to the emergency room (ER) today, they have dialysis residents, residents with influenza and COVID-19, and several residents with frequent falls. She indicated Resident #5 fell that day when there was no nurse in the building, not even 30 minutes after Staff A left. Resident #5 did not get hurt. Staff E stated she felt bad for Staff A because she had worked a lot of hours. (continued on next page)

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:36 PM Staff D was asked to discuss staffing on [DATE]. She stated they had no nurse in the building for about 3 hours; from about 1:40 PM until about 5:,d+[DATE]:45 PM. Staff D stated she clocked in at 2:00 PM along with Staff N and Staff S. The Administrator was in the building and knew what was going on. He told staff if they had any issues he was a nurse and they needed to go. He was a nurse before he was an Administrator. Staff D was asked if anything happened during the time a nurse was not present that required them to notify the Administer, she acknowledged Resident #5 had a fall. The Administer went in and assessed Resident #5; asked her specific areas with pain, checked her legs, and hips. No pain was noted during the assessment. The Administrator and Staff B assisted the resident up off the floor into a wheelchair without the use of a gait belt. She indicated this was the only incident that happened in which the Administer was needed. The DON ended up coming in about 4:30 PM. Staff A returned for her scheduled 6:00 PM-6:00 AM shift about 5:,d+[DATE]:45 PM. Staff D stated it was crazy and scary that they did not have a nurse in the building, they were all worried; this had never happened before. On [DATE] at 1:46 PM Staff B CMA was asked to talk about staffing on [DATE]. Staff B stated yesterday was a sh*t show. Before she could clock in, Staff A was on duty then went outside, started walking then asked if she could give her a ride to her hotel. This was between 1:30 PM and 2:00 PM because Staff B was back at the facility by 2:00 PM. Staff B stated Staff A had been there all day, they did not have a nurse to relieve her. The Administrator has told her to go home for a few hours, get her medications, get a nap in and be back at about 5:30 PM; that's what Staff A told her. When Staff B got back to the facility there was no nurse working, at least not a licensed one. The Administer stated he has been a nurse in the past, just not licensed to practice. At the time there was only one CMA in the building and the nurse came in, she wants to say maybe about 5:30 PM. She added she was not sure because she was in the dining room. One of the CNAs told her the DON had come in. When asked if anything happened during the time a nurse was not in the building, she stated Resident #5 fell shortly after Staff A left the building. It happened about 2:30 PM, she fell out of bed; her bed was in the lowest position but her fall mat was not in place. The Administrator came in, squeezed her calf, one of her knees, and thigh. They proceeded to stand her up with no gait belt by her and the Administrator placing an arm under her armpit, held on to Resident #5's pants, stood her up and placed her in the wheelchair. The Administrator asked her at about 3:00 PM to get her vitals, as she was trying to get report from Staff E. Staff D was asked since this was an unwitnessed fall, should vitals have been completed; she stated they should have been done. She added she did not know the frequency of them because that is a nurse's job. (continued on next page)

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Garden View Care Center	1200 West Nishna Road Shenandoah, IA 51601

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 3:46 PM the Administrator stated on [DATE] the morning nurse, Staff H Licensed Practical Nurse (LPN) was schedule to work 6:00 AM-6:00 PM on [DATE]. Staff A was working the overnight shift on [DATE] and agreed to stay until noon. That morning they attempted to get another nurse to come in. The DON was ill, had a doctor's appointment so she was not in the facility. The ADON was stranded in the country because of the snow. They attempted to get agency staff but they were not able to provide coverage. The plan was to have Staff A get some sleep in the building so they had a nurse, but she needed her medications. She went to her hotel to get her medications; his understanding was she was going to come back but did not. There was a three-hour gap where they did not have a nurse; from about 1:00 PM until 4:00 PM. He had a medication aide here to pass medications. The Administrator stated he took charge of the keys for the medication cart Staff A was responsible for. He stated he has been an Administrator for 50 some years and was an LPN in Minnesota and North Dakota, but does not have a current license. He acted like a nurse and knew that set some people off. The Administrator indicated he spoke to someone at the Iowa Department of Inspections, Appeals, and Licensing about what was going on. He indicated if needed they would have been able to send residents to the hospital that needed attention. The ADON was working from home. With the combination of the weather, people being off sick it all hit at once yesterday. He added this never happened to him before. When asked if anything happened that required a nurse's attention he stated Resident #5 fell out of bed; he assessed her and got her in to her wheelchair. There were no injuries and follow-up vitals were done. The Administrator was asked what kind of assessment was completed he stated, he made sure the resident was not in pain, checked for bleeding and bruising. He felt confident that the fall was an easy fall, she slid off the bed. They were able to get her up without discomfort or pan. He had Staff B complete vitals on her. When asked who initiated the neurological assessments since it was an unwitnessed fall, he stated those did not happen. He indicated himself, Staff B and another staff member assisted Resident #5. Staff B and himself were on either side of her and they lifted her up. When asked if they had a gait belt on Resident #5 he acknowledged they did not. He did not notice any pain or discomfort. The Administrator added he told Staff A to go to her hotel to get her medications that she needed for sleep but she did not come back until 5:30 PM. He denied suggesting her to go take a nap then come back. He added he stayed in the facility until Staff A came back for her shift. On [DATE] at 4:23 PM the DON stated Staff A left on her own, no one told her to leave yesterday. When asked if she was in the facility when this all happened to verify that, she indicated she was not. She was in the hospital getting infusions. On [DATE] at 5:11 PM Staff A was asked to discuss what took place on [DATE]. She stated she came in at 6:00 PM on [DATE] and left at 1:30 PM on [DATE]. She indicated the Administrator told her agency that she could leave and she would be back at 5:30 PM when her next shift started. The Administrator used to be a nurse but did not have an active license. She wanted to work until noon and then wanted to go get some sleep before her next shift at 6:00 PM. She felt if she worked until noon that would give them plenty of time to find coverage. She added she had done this before but this time, management should have come in. Staff A stated her agency records their calls, so they should have the conversation with their staff and the Administrator recorded. Staff A stated she has severe narcolepsy and needed to go get sleep with her CPAP for a few hours. She needed her medications and wanted to go rest for ,d+[DATE] hours, she can't work straight through like that. She indicated she works a lot of hours there, usually ,d+[DATE]-hour shifts. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:08 AM spoke to staff at Staff A's staffing agency. Prior to the caller picking up the phone, a recording indicated the call will be record for training purposes. Staff indicated she called to speak with the Administrator because Staff A was scared to leave but she could not work that many hours, 36 hours in a row. The Administrator told Staff A to leave, the calls are recorded so she has that on file. She was not sure when he told Staff A to come back to the facility, he didn't specify that. She did call to see if Staff A left and she was told she left at approximately 1:00 PM. The agency staff member indicated Staff A had recently tested positive for Influenza A. Staff A started working in January the week of the 6th-12th and has not stopped working since. On [DATE] at 11:03 AM Staff F Registered Nurse (RN) stated she could not believe they allowed a nurse to leave the building without a nurse to cover her. Management should have been on top of that. Staff F stated she lives nearby but no one called to see if she could cover. When it snows like it did that day, her clinic will close. So, she could have come in so that nurse could have went home to nap, but no one called her. On [DATE] at 9:29 AM Staff T CNA stated they used to have to wear gait belts while they worked. Now gait belts are hardly used but a few staff members will always use a gait belt. She stated personally, she would use a gait belt to assist residents off the floor. She also knows some staff will two arm assist residents off the floor without a gait belt. On [DATE] at 2:15 PM Staff S Agency CNA stated she worked the day they had no nurse in the building. She was passing ice and waters when Staff D stated Resident #5 had fallen. They all were already panicking because there was no nurse on the floor; that has never happened. The Administrator came in the resident's room and stated he used to be a nurse but did not have an active license at the time. He started to assess Resident #5: asked if anything hurt, checked her hips. Resident #5 stated she was fine. Staff B, Staff D and the Administrator assisted the resident up from the floor to her wheelchair. They put her shoes on and noticed the fall mat was under her bed. They did not use a gait belt when transferring her from the floor to the wheelchair. They grabbed her pants and put their arms under her arms and lifted her up. They had no nurse in the building for three hours. The DON came in because Staff A could not work that many hours, it would have been unsafe either way. Staff S stated she was told the Administrator told Staff A to go home. On [DATE] at 11:45 AM the DON stated she knows the nurses are busy they have 40 residents to one nurse. She is working on getting that changed, they need another nurse on the day shift to split things up. It can be too much for one nurse to take on; if one thing happens, it all goes out the window. Staff A's staffing agency emailed a recording of the phone call between the staff agency and the Administrator on [DATE]: Staffing Agency: I am not sure who to speak with, I tried calling the ADON earlier. Our staff member, Staff A has been there since 6:00 PM last night and she really needs to go get her medications. The Administrator interrupted her and stated I told her three times to go. The Staffing Agency stated Staff A does not want to get in trouble for leaving, the Administrator interrupted her and stated I will go and tell her, did she just call you? Staffing Agency stated yes, she did, asked to call over, just wanted to make sure. The Administrator interrupted her and stated I am sorry they bothered you, I told her an hour ago to go. Staffing Agency stated she will call and let her know. The Administrator stated you call and tell her, tell her you talked to the Administrator. The call ended. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility Assessment with date(s) assessment or update of [DATE] documented: 1. The facility will utilize this facility assessment to consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. 2. Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. 3. Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. 4. Develop and maintain a plan to maximize recruitment and retention of direct care staff. Staffing Plan: Direct care staffing to include charge nurse, CMA and CNA. RN/LPN charge nurse: 1 nurse per shift (usually 12-hour shifts): a) weekday day shift-1 b) weekday night shift-1 c) weekend day shift-1 d) weekend night shift-1 e) if a nurse is schedule for 8 hours, there will be one nurse on each shift. Team Leaders that are licensed nurses/CNAs may periodically assist residents with Activities of Daily Living (ADL's). Contingency Planning: The organization implements a proactive and systematic approach involving regular review of staffing and other potential disruptions. The organization cross-trains staff members for work within the organization including on-call staff are available and the organization has established partnerships with staffing agencies to mitigate the impact of sudden staffing shortages.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074 Based on clinical record review, staff interviews, and facility assessment review the facility failed to ensure the appropriate licensed staff were competent to complete an assessment after Resident #5 had an unwitnessed fall. The facility also failed to ensure the appropriate certified staff assisted Resident #5 with a transfer after she sustained an unwitnessed fall. The facility reported a census of 37 residents. Findings include: According to the significant change Minimum Data Set (MDS) assessment tool with a reference date of [DATE] documented Resident #5 had a Brief Interview of Mental Status (BIMS) score of 3. A BIMS score of 3 suggested severe cognitive impairment. Resident #5 had one sided impairment to her upper and lower extremities and utilized a wheelchair. The MDS documented Resident #5 did not have any falls since her admission/entry or reentry or prior assessment. The following diagnoses were listed for the resident: stroke, diabetes mellitus, dementia, anxiety disorder, depression, bipolar disorder, lack of coordination, abnormalities of gait and mobility, and muscle weakness. The Care Plan focus area with a revision date of [DATE] documented Resident #5 required assistance with Activities of Daily Living (ADLs) related to a history of a stroke with weakness and abnormal gait, dementia and bipolar disorder. The Care Plan documented she required extensive assistance of two staff for stand and pivot transfers. On [DATE] at 1:36 PM Staff D was asked to discuss staffing on [DATE]. She stated they had no nurse in the building for about 3 hours; from about 1:40 PM until about 5:,d+[DATE]:45 PM. Staff D stated she clocked in at 2:00 PM along with Staff N and Staff S. The Administrator was in the building and knew what was going on. He told staff if they had any issues he was who they needed to go to. He was a nurse prior to being an Administrator. Staff D was asked if anything happened during the time a nurse was not present that required them to notify the Administrator, she acknowledged Resident #5 had a fall. The Administrator went in and assessed Resident #5; asked her specific areas with pain, checked her legs, and hips. No pain was noted during the assessment. The Administrator and Staff B assisted the resident up off the floor into a wheelchair without the use of a gait belt. She indicated this was the only incident that happened in which the Administrator was needed. The Director of Nursing (DON) ended up coming in about 4:30 PM. Staff A returned for her scheduled 6:00 PM-6:00 AM shift about 5:,d+[DATE]:45 PM. Staff D stated it was crazy and scary that they did not have a nurse in the building, they were all worried; this had never happened before. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:46 PM Staff B Certified Medication Aide (CMA) was asked to talk about staffing on [DATE]. Staff B stated yesterday was a sh*t show. Before she could clock in, Staff A was on duty then went outside, started walking then asked if she could give her a ride to her hotel. This was between 1:30 PM and 2:00 PM because Staff B was back at the facility by 2:00 PM. Staff B stated Staff A had been there all day, they did not have a nurse to relieve her. The Administrator had told her to go home for a few hours, get her medications, get a nap in and be back at about 5:30 PM; that's what Staff A told her. When Staff B got back to the facility there was no nurse working, at least not a licensed one. The Administrator stated he has been a nurse in the past, just not licensed to practice. At the time there was only one CMA in the building and the nurse came in, she wants to say maybe about 5:30 PM. She added she was not sure because she was in the dining room. One of the CNA's told her the DON had come in. When asked if anything happened during the time a nurse was not in the building, she stated Resident #5 fell shortly after Staff A left the building. It happened about 2:30 PM, she fell out of bed; her bed was in the lowest position but her fall mat was not in place. The Administrator came in, squeezed her calf, one of her knees, and thigh. They proceeded to stand her up with no gait belt by her and the Administrator placing an arm under her armpit, held on to Resident #5's pants, stood her up and placed her in the wheelchair. The Administrator asked her at about 3:00 PM to get her vitals, as she was trying to get report from Staff E. Staff D was asked since this was an unwitnessed fall, should vitals have been completed; she stated they should have been done. She added she did not know the frequency of them because that is a nurse's job. On [DATE] at 3:46 PM the Administrator was asked if anything happened that required a nurse's attention, while there was no nurse in the building on [DATE]. He stated Resident #5 fell out of bed; he assessed her and got her in to her wheelchair. There were no injuries and follow-up vitals were done. The Administrator was asked what kind of assessment was completed he stated, he made sure the resident was not in pain, checked for bleeding and bruising. He felt confident that the fall was an easy fall, she slid off the bed. They were able to get her up without discomfort or pain. He had Staff B complete vitals on her. When asked who initiated the neurological assessments since it was an unwitnessed fall, he stated those did not happen. He indicated himself, Staff B and another staff member assisted Resident #5. Staff B and himself were on either side of her and they lifted her up. When asked if they had a gait belt on Resident #5 he acknowledged they did not. He did not notice any pain or discomfort. On [DATE] at 2:15 PM Staff S Agency CNA stated she worked the day they had no nurse in the building. She was passing ice and waters when Staff D stated Resident #5 had fallen. They all were already panicking because there was no nurse on the floor; that has never happened. The Administrator came in the resident's room and stated he used to be a nurse but did not have an active license at the time. He started to assess Resident #5: asked if anything hurt, checked her hips. Resident #5 stated she was fine. Staff B, Staff D and the Administrator assisted the resident up from the floor to her wheelchair. They put her shoes on and noticed the fall mat was under her bed. They did not use a gait belt when transferring her from the floor to the wheelchair. They grabbed her pants and put their arms under her arms and lifted her up. They had no nurse in the building for three hours. The DON came in because Staff A could not work that many hours, it would have been unsafe either way. Staff S stated she was told the Administrator told Staff A to go home. On [DATE] at 11:45 AM the DON indicated the Administrator was a nurse but did not have an active license. When asked if he had his CNA certification, she was unable to confirm or deny if he was certified. (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a https://nurses.com search, the Administrator's Minnesota LPN license expired on [DATE]. A search to see if he held a license in Iowa, revealed there were not results for that search. The Facility Assessment with date(s) assessment or update of [DATE] documented: Team Leaders that are licensed nurses/CNAs may periodically assist residents with Activities of Daily Living (ADL's).

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 37074 Based on, facility nursing schedule review, facility staffing sheets, management call in logs, facility's Payroll Based Journal (PBJ), staff interviews and facility assessment review the facility failed to have Registered Nurse (RN) coverage daily for 8 consecutive hours, 7 days a week. The facility reported a census of 37 residents. Findings include: Review of the January 2025 nursing schedule and Facility Staffing sheets revealed the facility failed to have a Registered Nurse (RN) for 8 consecutive hours and 7 days a week on: 1/1 and 1/23. Review of the February 2025 nursing schedule and Facility Staffing sheets revealed the facility failed to have RN coverage daily for 8 consecutive hours, 7 days a week on: 2/1, 2/2, 2/4, 2/5, 2/7, 2/8, 2/9, 2/10, 2/11, 2/15, and 2/16. Review of the facility's PBJ report for October 1, 2024 - December 31, 2024 revealed the facility did not have RN coverage on 11/26/2024, 12/6/2024, 12/10/2024, 12/23/2024, 12/24/2024, and 12/25/2024. On 2/13/2025 at 11:43 AM Staff C Licensed Practical Nurse (LPN) laughed when asked how the RN coverage was, she added it's still an issue at the facility. On 2/13/2025 at 12:04 PM Staff K Certified Medication Aide (CMA) laughed when asked how the RN covered was there at the facility. She added she knew there were a lot of days without a RN. Staff K was asked in the last two weeks how many days has the Director of Nursing (DON) worked for RN coverage, she said maybe two times. On 2/13/2025 at 1:19 PM Staff E CMA stated when the DON is working they have RN coverage but she had been on vacation, sick or the hospital a lot lately. They have one RN, Staff F that works as needed (PRN) on the weekends but they have no coverage when the DON is gone during the week. They have two nurses that are facility nurses but they are LPN's. The Assistant Director of Nursing (ADON) is gone a lot too but she is an LPN. On 2/18/2025 at 2:16 PM Staff H LPN was asked how the RN coverage was here at the facility, she stated we don't have it. The DON will tell staff that they have it but it does not need to be consecutive hours. On 2/19/2025 at 11:03 AM Staff F RN stated the facility does not have a lot of RN's. She usually works 23 times a month because she has a full-time job elsewhere. She will usually work Friday night at 8:00 PM until 8:30 AM on a Saturday. She has not been there in a couple of weeks. On 2/19/2025 at 1:26 PM Staff C LPN was asked what RN's work at the facility, she stated the DON, Staff F RN, Staff U RN, and Staff V. Staff F works weekends but not every weekend. Staff U is not here anymore. Staff V has not picked up a shift in forever, wants to say 6 months. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/25/2025 at 9:14 AM Staff V RN stated she had not worked at the facility in a few months. She has not worked there since the new DON has been there. She reached out in October for shifts to be covered but there was nothing. She reached out again for open shifts but its always a battle to get any kind of response. The ADON reached out asking about dates of availability in March but she was out of time. When Staff V would reach out to management to pick up a shift, they will tell her it's been covered by agency staff. With her full-time job, she has some flexibility and can pick up shifts at the facility as long as it's not a last-minute request. In January she had a lot of flexibility and wanted to work, but no one returned her calls. On 2/25/2025 at 9:29 AM Staff T CNA laughed when asked if they have RN coverage at the facility. She stated she did not think they had an RN other than Staff F. She knew another nurse wanted to pick up hours but the ADON or DON would not answer that nurse's messages. She hears people saying they don't have RN coverage. On 2/26/2025 at 11:45 AM the DON stated their RN coverage is pretty good. She stated they had Staff U filling in on overnights, Staff F works 10:00 PM-8:00 AM on the weekends and Staff X agency RN will fill in on the weekends/holidays. The Facility Assessment with a date of assessment or update of 2/14/2025 documented the facility retains staffing to maintain 24-hour licensed nurse (8 hours of RN coverage, 7 days a week).

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 37074 Based on observations and staff interviews the facility failed to ensure the nurse staffing information was posted to include accurate required information and updated daily for residents and visitors to see. The facility reported a census of 37 residents. Findings include: On 2/13/2025 at 11:45 AM the daily staff posting was located at the front of the building to the left of the nurse's station, at the start of center hall dated 2/11/2025. At 2:25 PM the daily staff posting located where center, west and east halls met was dated 2/11/2025. On 2/14/2025 at 8:38 AM the daily staff postings was located at the front of the building to the left of the nurse's station; at the start of center hall and at where center, west and east halls met and was dated 2/14/2025. On 2/19/2025 at 9:56 AM the daily staff posting was located at the front of the building to the left of the nurse's station; at the start of center hall and at where center, west and east halls met and was dated 2/18/2025. On 2/26/2025 at 11:45 AM the Director of Nursing (DON) stated the night nurses fill out the staff postings that are present in the facility for residents and visitors to see.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 37074 Based on clinical record review, staff interviews, and facility policy review the facility failed to ensure 1 of 4 residents reviewed (Resident #7) was free from unnecessary medications. The facility reported a census of 37 residents. Findings include: According to the Annual Minimum Data Set (MDS) assessment tool with a reference date of 1/9/2025 documented Resident #7 had a Brief Interview of Mental Status (BIMS) score of 5. A BIMS score of 5 suggested severe cognitive impairment. The MDS documented he did not display physical, verbal, or other behavioral symptoms during the review period. Resident #7 did not exhibit rejection of care behaviors. The MDS documented he received scheduled pain medication regimen, did not receive an as needed (PRN) pain medications or was offered or declined, and he did not receive a non-medication intervention for pain. He did not receive an opioid during the 7-day review period. The following diagnoses were documented for Resident #7: stroke, cancer, heart failure, benign prostatic hyperplasia, renal failure, diabetes mellitus (DM), dementia, insomnia. The Care Plan focus area with a revision date of 2/27/2024 documented Resident #7 was at risk for pain related to decreased mobility and a cancer diagnosis. Staff were directed to: a) Administer his analgesic medications as ordered; b) anticipate the resident's need for pain relief and respond immediately to any complaint of pain. The Care Plan focus area with a revision date of 11/4/2024 documented #7 had a behavior problem related to him not wanting to have others care of him, having confusion and thinking he or his sister owns the facility. The resident refuses to go to bed unless his door is shut; will sleep in both beds in the room (does not have a roommate); smears stool onto clothing, his bed, and wheelchair; takes his brief off; self-transfers; gets agitated; mocks staff and residents; and does not listen when staff asks or suggests cares or interventions. The Care Plan directed staff to: a) Administer medications as ordered; b) Anticipate and meet the resident's needs; c) Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner, divert attention, remove from the situation and take to an alternative location as needed. Review of Resident #7's January 2025 Medication Administration Record (MAR) revealed the following orders: a) Tylenol 8-hour oral tablet extended release 650 milligrams (mg), give 1 tablet by mouth at bedtime at 8:00 PM. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b) Oxycodone HCL (narcotic pain relief) 5 mg, give 1 tablet every 6 hours as needed (PRN), with an order date of 1/20/2025. It was signed out as being given on 1/24/2025 at 2:57 AM with a pain rating of 7 out of 10, 1/26/2025 at 3:05 AM with a pain rating of 8 out of 10, 1/29/2025 at 4:18 AM with a pain rating of 6 out of 10, and 1/31/2025 at 4:09 AM with a pain rating of 5 out of 10. Signed out by Staff A Agency Licensed Practical Nurse (LPN). c) Assess pain on a scale of 0-10 two times a day for pain monitoring, with an order date of 4/9/2024. Staff documented his pain rating to be between 0 and 7, with 58 out of 62, ratings at a 0. Review of Resident #7's February 2025 MAR revealed the following: a) Tylenol 8-hour oral tablet extended release 650 milligrams (mg), give 1 tablet by mouth at bedtime at 8:00 PM. b) Oxycodone HCL 5 mg give 1 tablet every 6 hours PRN, with an order date of 1/20/2025. It was signed out as being given on 2/7/2025 at 2:16 AM with a pain rating of 5 out of 10, 2/9/2025 at 12:45 AM with a pain rating of 6 out of 10, 2/18/2025 at 8:50 PM with a pain rating of 5 out of 10, and 2/23/2025 at 12:12 AM with a pain rating of 6 out of 10. Signed out by Staff A. c) Assess pain on a scale of 0-10 two times a day for pain monitoring, with an order date of 4/9/2024. Staff documented his pain rating to be between 0 and 7, with 43 out of 48, ratings at a 0. On 2/18/2025 at 2:16 PM Staff H Licensed Practical Nurse (LPN) stated she has worked nights before. When asked if Resident #7 has pain at night, she indicated she has never given him a narcotic at night. He will moan and groan but she has never indicated he was in pain. There will be months where it's not signed out as being given but for some reason Staff A LPN is signing it out frequently as giving it to him. On 2/18/2025 at 3:21 PM Staff K Certified Medication Aide (CMA) stated Resident #7 does have a PRN order for pain. At one time they would give it to him at night to help him sleep. Since they have started him on a sleeping pill they do not give it to him anymore because he sleeps at night. He can tell you when he is in pain but not sure if he is agreeing with you or telling you he is in pain. He has non-verbal moans and groans but you can tell when he needs it. On 2/19/2025 at 7:05 AM Staff W (Certified Nursing Assistant) CNA stated Staff A gives Resident #7 his PRN narcotic without him being in pain. Staff A has been heard saying she gives it to him at night because she needs an okay night at work. Staff W was unsure who else Staff A has done this too but Staff A says if they have it, she will give it. Staff A made Staff W go with her one night while she administered the medication as a witness. Staff W indicated he was not in pain that night. He always makes noise, he grunts all the time and she still gave it to him. On 2/19/2025 at 11:03 AM Staff F RN stated Resident #7 is usually sleeping when she works the night shift. He will moan a lot, so she will ask if he wants his pain medication and he will say no. Staff F was asked to describe his behaviors, she stated he just hollers out during transfers, insulin shots, then he is fine. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/19/2025 at 1:26 PM Staff C LPN stated a couple years ago Resident #7 would be in pain at night, so they got the PRN order and he would get one at bed time. After a while he would not get it because they had ordered a sleeping pill for him. Since that sleeping pill has been ordered she has never had to give him his PRN medication. Resident #7 does not moan or groan, on occasion during the day he will get fidgety, will moan and groan. When asked if he is able to tell you if he is in pain, she stated he will tell you he is and where his pain is. On 2/25/2025 at 9:29 AM Staff T CNA stated Resident #7 does scream a lot especially when you are using the mechanical lift with him. As soon as you stand him up he starts screaming, the nurses give him his insulin he screams. Some days he does not scream, she denied thinking it was pain related and thought it was because she was agitated. On 2/25/2025 at 2:15 PM Staff S Agency CNA stated she Resident #7 some times will have pain while she is working with him, but he does not ask for medication to help with it. He will yell when they are using the mechanical lift with him, will ask if he is pain and he will say yes or no but he also just likes to yell. When asked if she felt his pain was enough to receive a narcotic medication she stated she is not sure if is in that much pain. She added she was unsure if he could tell you how much pain that would call for the use of a narcotic pain pill. On 2/26/2025 at 11:45 AM the Director of Nursing (DON) stated he has behaviors more than pain. When they do his blood sugar he will holler. She has taken care of him before and when she tells him I am going to do your blood sugar he will say I am going to scream. She will poke his finger and he will say ow. He is not a good historian and screams to get a reaction. Give him insulin, he screams. Any time you do anything with him, he screams. The believed he would be able to tell them if he was in pain and felt he could indicate where it is. She has worked at night with him and he does not yell out unless you are assisting him to bed or change him. If she felt he was in pain she would look to see what was causing his pain and go from there. She would do a physical assessment, look for guarding behavior. The facility provided a policy titled Administering Medications with a revision date of December 2012. The policy documented if a resident uses PRN medications frequently, the Attending Physician and Interdisciplinary Care Team, with support from the Consultant Pharmacist as needed, shall re-evaluate the situation, examine the individual as needed, determine if there is a clinical reason for the frequent PRN use, and consider whether a standing dose of medication is clinically indicated.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37074 Based on observations, staff interviews, and facility policy review the facility failed to appropriately store six medications after they were delivered to the facility from the pharmacy. The facility reported a census of 37 residents. Findings include: On 2/13/2025 at 5:03 PM an opened and unattended blue plastic bag sat on top of the counter at the nurse's station. Inside the bag were the following medication cards: sertraline (anti-depressant), oseltamivir (treatment of influenza), Lisinopril (treatment of hypertension), pyridostigmine (treatment of myasthenia gravis), Eliquis (anti-coagulant), and metoprolol (treatment of hypertension). At 5:30 PM the blue bag was behind the counter of the nurse's station, out of reach from passersby. On 2/25/2025 at 10:30 AM Staff E Certified Medication Aide (CMA) stated she tries to have the nurse put the delivered medications away when she is working. On 2/26/2025 at 11:00 AM Staff C Licensed Practical Nurse (LPN) and Staff J CMA stated when medications are delivered from the pharmacy they are usually in white or blue bags. The nurse or CMA that is present when they are delivered will put them away, they should not sit on the counter unattended. On 2/26/2025 at 11:45 AM the Director of Nursing (DON) stated when medications are delivered from the pharmacy she will open the package, take the packing slip out to check off what they have and compare it with the list. She will sign the forms, give them one, she keeps the other then she will take the medications to the cart and put them away. When she was made aware that a pharmacy bag was left opened and unattended on the nurse's station counter for 30 minutes she stated, no no, that should have been either given to the CMA to put them aware or not sitting on the counter. The facility provided a policy titled Medication Labeling and Storage with a revision date of February 2023. The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 37074 Based on observations, staff interviews, clinical record review, and facility assessment review the decisions in administering the facility contributed to deficient practice. The facility reported a census of 37 residents. Findings include: On 2/13/2025 at 11:43 AM Staff C Licensed Practical Nurse (LPN) stated last month residents reported they did not get their medications when the Assistant Director of Nursing (ADON) worked the floor. Staff C filled out medication error incident reports and the ADON grilled her about doing that. On 2/13/2025 at 12:04 PM Staff K Certified Medication Aide (CMA) stated on 2/12/2025 the Administrator approached her as she was at the nurse's station, basically ripping on her. She was not sure if the Administrator knew if she called with concerns about not having a nurse in the building. Staff K stated he agreed with her that it was not right but he felt like it should have been kept in the facility and not talked about. On 2/13/2025 at 1:36 PM Staff D Certified Nursing Assistant (CNA) was asked to discuss staff on 2/12/2025. She stated they had no nurse in the building for about 3 hours; from about 1:40 PM until about 5:30-5:45 PM. Staff D stated she clocked in at 2:00 PM along with Staff N and Staff S. The Administrator was in the building and knew what was going on. He told staff if they had any issues he was who they needed to go to. He was a nurse before he was an Administrator. Staff D was asked if anything happened during the time a nurse was not present that required them to notify the Administrator, she acknowledged Resident #5 had a fall. The Administrator went in and assessed Resident #5; asked her specific areas with pain, checked her legs, and hips. No pain was noted during the assessment. The Administrator and Staff B assisted the resident up off the floor into a wheelchair without the use of a gait belt. She indicated this was the only incident that happened in which the Administrator was needed. The DON ended up coming in about 4:30 PM. Staff A returned for her scheduled 6:00 PM-6:00 AM shift about 5:30-5:45 PM. Staff D stated it was crazy and scary that they did not have a nurse in the building, they were all worried; this had never happened before. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/13/2025 at 1:46 PM Staff B CMA was asked to talk about staffing on 2/12/2025. Staff B stated yesterday was a sh*t show. Before she could clock in, Staff A was on duty, then came outside, started walking she asked if she could give her a ride to her hotel. This was between 1:30 PM and 2:00 PM because Staff B was back at the facility by 2:00 PM. Staff B stated Staff A had been there all day, they did not have a nurse to relieve her. The Administrator had told her to go home for a few hours, get her medications, get a nap in and be back at about 5:30 PM; that's what Staff A told her. When Staff B got back to the facility there was no nurse working, at least not a licensed one. The Administrator stated he has been a nurse in the past, just not licensed to practice. At the time there was only one CMA in the building until the nurse came back in, she wants to say maybe about 5:30 PM. She added she was not sure because she was in the dining room. One of the CNAs told her the Director of Nursing (DON) had come in. When asked if anything happened during the time a nurse was not in the building, she stated Resident #5 fell shortly after Staff A left the building. It happened about 2:30 PM, she fell out of bed; her bed was in the lowest position but her fall mat was not in place. The Administrator came in, squeezed her calf, one of her knees, and thigh. They proceeded to stand her up with no gait belt by her and the Administrator placing and arm under her armpit, held on to Resident #5's pants, stood her up and placed her in the wheelchair. The Administrator asked her at about 3:00 PM to get her vitals, as she was trying to get report from Staff E. Staff D was asked since this was an unwitnessed fall, should vitals have been completed; she stated they should have been done. She added she did not know the frequency of them because that is a nurse's job. Staff B stated they only have three nurses and one is leaving, one agency nurse, besides the ADON and DON. The DON and ADON do not come out of their offices to help. (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 02/27/2025
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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/13/2025 at 3:46 PM the Administrator stated on 2/12/2025 the morning nurse, Staff H Licensed Practical Nurse (LPN) was schedule to work 6:00 AM-6:00 PM. Staff A was working the overnight shift on 2/11/2025 and agreed to stay until noon. That morning they attempted to get another nurse to come in. The DON was ill, had a doctor's appointment so she was not in the facility. The ADON was stranded in the country because of the snow. They attempted to get agency staff but they were not able to provide coverage. The plan was to have Staff A get some sleep in the building so they had a nurse, but she needed her medications. She went to her hotel to get her medications; his understanding was she was going to come back but did not. There was a three-hour gap where they did not have a nurse; from about 1:00 PM until 4:00 PM. He had a medication aide here to pass medications. The Administrator stated he took charge of the keys for the medication cart Staff A was responsible for. He stated he has been an Administrator for 50 some years and was a LPN in Minnesota and North Dakota, but does not have a current license. He acted like a nurse and knew that set some people off. The Administrator indicated he spoke to someone at the Iowa Department of Inspections, Appeals, and Licensing about what was going on. He indicated if needed they would have been able to send residents to the hospital that needed attention. The ADON was working from home, the DON got to the facility to get stuff done. With the combination of the weather, people being off sick it all hit at once yesterday. He added this never happened to him before. When asked if anything happened that required a nurse's attention he stated Resident #5 fell out of bed; he assessed her and got her in to her wheelchair. There were no injuries and follow-up vitals were done. The Administrator was asked what kind of assessment was completed he stated, he made sure the resident was not in pain, checked for bleeding and bruising. He felt confident that the fall was an easy fall, she slid off the bed. They were able to get her up without discomfort or pain. He had Staff B complete vitals on her. When asked who initiated the neurological assessments since it was an unwitnessed fall, he stated those did not happen. He indicated himself, Staff B and another staff member assisted Resident #5. Staff B and himself were on either side of her and they lifted her up. When asked if they had a gait belt on Resident #5 he acknowledged they did not. He did not notice any pain or discomfort. The Administrator added he told Staff A to go to her hotel to get her medications that she needed for sleep but she did not come back until 5:30 PM. He denied suggesting her to go take a nap then come back. He added he and the DON stayed in the facility until Staff A came back for her shift. On 2/13/2025 at 5:11 PM Staff A was asked to discuss what took place on 2/12/2025. She stated she came in at 6:00 PM on 2/11/2025 and left at 1:30 PM on 2/12/2025. She indicated the Administrator told her agency that she could leave and she would be back at 5:30 PM when her next shift started. The Administrator used to be a nurse but did not have an active license. She wanted to work until noon and then wanted to go get some sleep before her next shift at 6:00 PM. She felt if she worked until noon that would give them plenty of time to find coverage. She added she had done this before but this time, management should have come in. Staff A stated her agency records their calls, so they should have the conversation with their staff and the Administrator recorded. Staff A stated she has severe narcolepsy and needed to go get sleep with her CPAP for a few hours. She needed her medications and wanted to go rest for 2-3 hours, she's can't work straight through like that. She indicated she works a lot of hours there, usually 12-16 hour shifts. (continued on next page)

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

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/18/2025 at 2:16 PM Staff H LPN stated she can't believe this place is still open. She has put in her notice and is going to elsewhere to work. She indicated right now she is the only nurse on the floor with the CNAs because the two CMA's went home for the day. Staff H indicated she got here at 10:00 PM on 2/17/2025, worked an overnight shift and will be here until 6:00 PM today. She had to take her kids to school this morning so they called an agency nurse to come in while she took her kids to school. She questioned why would they pay an agency nurse to cover a couple hours while the ADON and DON sat in their office. Management will not help when their staff are struggling to get their tasks done, they just stay in their office. At one time Resident #4 needed suctioned but Staff H was really busy so the CNA asked the DON if she could do it. The DON told the CNA she's not f***ing doing it. She has told staff that she's not doing things because it not her problem. The DON will sit in her office and talk about staff, ADON will push everything off on to the nurses; they are creating a hostile work environment. There is not teamwork here, just toxic behaviors. She has voiced her concerns to Corporate and her reasons for leaving the facility. She was told to discuss them with the Administrator. She did that but it did not go anywhere, nothing has changed. The day they had no nurse here, why did the Administrator allow that? Management should have come in to cover it. A nurse left the building with coverage and he allowed it, he did not mandate someone to work. On 2/18/2025 at 3:21 PM Staff K Certified Medication Aide (CMA) stated since the survey started she stated the Administrator would usually walk by and say good morning to her. He did not acknowledge her being at work today. Staff and residents have told her the DON was saying a lot of things about Staff K. Other staff members told her the DON was overheard saying she was going to kick her a** for calling state. Staff K stated she is definitely getting the cold shoulder right now and they should not be doing that. On 2/19/2025 at 7:05 AM Staff W CNA stated staff are talking about how the DON is talking about kicking Staff K's butt for turning them in to state. She does not understand why no one is getting along here at the facility. The DON is not professional, she will stand up at the nurse's station and cuss and she will not come out of her office to assist with tasks. One time she went in to ask her to suction Resident #4, she refused to do because she has done it enough. She did not go in there an do it. Isn't that their job, to make sure he can breathe? On 2/19/2025 at 12:49 PM Transportation staff stated Resident #4 hollered that he needed suctioned and wanted the DON to do it. She went in to the DON's office and told her he asked that she do it. The DON said she was busy and the ADON said it's not her job. The Transportation staff member said her jaw dropped, but no one got up to do it. She went to the nurse and told her, she felt bad because the nurse was very busy. That bothers her, things like that. She knows the current staff care for their residents, but they are fed up with the management not stepping up to help. On 2/19/2025 at 11:03 AM Staff F Registered Nurse (RN) stated she feels like the whole place is going to crap. The DON does not care, she can never get ahold of her, they have no RN coverage and recently a nurse left the building for a few hours with no replacement. She has heard from a lot of staff that management is not willing to help, will not do a lot and can't get ahold of them when needed. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/25/2025 at 9:29 AM Staff T CNA stated the other day Staff H was the only nurse on the floor with no CMA's. The ADON or DON did not ask if she needed help before they left, just walked out. That is inappropriate because medications and insulin's were given late. Staff had asked how long the surveyor was going to be in the building and the Social Worker said if people would stop coming to talk with the surveyor, the survey would be over sooner. On 2/25/2025 at 2:15 PM Staff S Agency CNA stated she worked the day they had no nurse in the building. She was passing ice and waters when Staff D stated Resident #5 had fallen. They all were already panicking because there was no nurse on the floor; that has never happened. The Administrator came in the resident's room and stated he used to be a nurse but did not have an active license at the time. He started to assess Resident #5: asked if anything hurt, checked her hips. Resident #5 stated she was fine. Staff B, Staff D and the Administrator assisted the resident up from the floor to her wheelchair. They put her shoes on and noticed the fall mat was under her bed. They did not use a gait belt when transferring her from the floor to the wheelchair. They grabbed her pants and put their arms under her arms and lifted her up. They had no nurse in the building for three hours. The DON came in because Staff A could not work that many hours, it would have been unsafe either way. Staff S stated she was told the Administrator told Staff A to go home. On 2/26/2025 at 11:45 AM the DON stated she started at the facility Mid October of 2024. When asked how often she works the floor she stated twice, mostly because she has been sick. When asked how often the ADON works the floor she stated twice, as well. On 2/27/2025 during the exit conference with the department heads and corporate staff the ADON laughed when this deficiency and findings were discussed. The Facility Assessment with a date of assessment or update of 2/14/2025 documented the facility will utilize this facility assessment to: 1) inform staffing decisions to ensure there are enough staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and care plans. Staffing plan: Administrator-in charge of administrative duties, oversees the entire building's operations. Team leaders that are licensed Nurses/CNAs may periodically assist residents with ADLs. Team leaders may also assist residents with meals. Inform staffing decisions to ensure that they are enough staff with the appropriate competencies and skill sets necessary to care for it's residents' needs as identified through resident assessments and plans of care by daily staffing assignment sheets and hours posted. The facility proved a document titled Quality Assurance Performance Improvement (QAPI), Quality Assessment Assurance (QAA) Plan with a revision date of 1/2/2025. The facility expects areas for improvement to be identified and provides for an non-retaliatory process that promotes input from staff, residents, resident representatives, and family members.

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F 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.

37074

Based on clinical record review, staff interviews and facility policy review the facility failed to ensure Resident #5, #9, and #10's records were complete and accurate. Resident #5's clinical record did not contain an incident report after she sustained an unwitnessed fall nor did staff complete an assessment. Resident #9's clinical record did not contain information about his positive Influenza A status and Resident #10's clinical record did not contain information about his positive COVID-19 status. The facility reported a census of 37 residents.

Findings include:

1. According to the significant change Minimum Data Set (MDS) assessment tool with a reference date of 1/24/2025 documented Resident #5 had a Brief Interview of Mental Status (BIMS) score of 3. A BIMS score of 3 suggested severe cognitive impairment. Resident #5 had one sided impairment to her upper and lower extremities and utilized a wheelchair. The MDS documented Resident #5 did not have any falls since her admission/entry or reentry or prior assessment. The following diagnoses were listed for the resident: stroke, diabetes mellitus, dementia, anxiety disorder, depression, bipolar disorder, lack of coordination, abnormalities of gait and mobility, and muscle weakness.

The Care Plan focus area with a revision date of 10/22/2024 documented Resident #5 was at risk for falls related to medication side effects, incontinence, noncompliance with safety interventions and a history of falls prior to her admission. On 12/2/2024 resident was found lying on the mat by her bed. The Care Plan documented she required extensive assistance of two staff for a stand and pivot transfer.

Review of Resident #5's Progress Notes on 2/14/2025 at 10:17 AM revealed one progress note related to a fall that occurred on 2/11/2025 at approximately 9:00 PM.

On 2/18/2025 at 11:03 AM the Interim Administrator emailed a print out of incident reports from 1/22/2025 through 2/16/2025. The print out of incident reports listed Resident #5's last incident report related to a fall was dated 2/11/2025 at 9:00 PM.

On 2/21/2025 at 11:52 AM the Interim Administrator emailed an incident report documenting Resident #5's fall on 2/12/2025, that was completed by the Director of Nursing (DON).

On 2/21/2025 at 11:52 AM the Interim Administrator emailed an incident report documenting Resident #5's fall on 2/12/2025, that was completed by the Director of Nursing (DON).

Review of Resident #5's assessment tab in her Electronic Health Record (EHR) revealed it lacked a post fall assessment from her fall on 2/12/2025. The only post fall assessment full assessment was documented on 2/13/2025 by the DON.

The facility provided a document titled Falls-Clinical Protocol with a revision date of March 2018. The staff will evaluate and document falls that occur while the individual is in the facility: for example, when and where they happen, any observations of the events, etc.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/2025 at 3:46 PM the Administrator was asked if anything happened that required a nurse's attention, while there was no nurse in the building on 2/12/2025. He stated Resident #5 fell out of bed; he assessed her and got her in to her wheelchair. There were no injuries and follow-up vitals were done. The Administrator was asked what kind of assessment was completed he stated, he made sure the resident was not in pain, checked for bleeding and bruising. He felt confident that the fall was an easy fall, she slid off the bed. They were able to get her up without discomfort or pain. He had Staff B complete vitals on her. When asked who initiated the neurological assessments since it was an unwitnessed fall, he stated those did not happen. He indicated himself, Staff B and another staff member assisted Resident #5. Staff B and himself were on either side of her and they lifted her up. When asked if they had a gait belt on Resident #5 he acknowledged they did not. He did not notice any pain or discomfort. On 2/26/2025 at 11:45 AM the Director of Nursing (DON) stated the nurses are responsible for filling out the incident reports (IPs) when the event happens or as soon as it can get done. When asked when Resident #5's IR was filled out related to her fall on 2/12/2025, she stated that was her bad. At the time of the fall the she was in the hospital getting infusions then came in to the facility. She know better now and clarified the IR should have been filled out sooner then it was. 2. The facility provided a handwritten note that indicated Resident #9 went in to isolation on 2/10/2025 due to a positive Influenza A test. The note documented he was symptomatic. Review of Resident #9's Progress Notes on 2/13/2025 at 3:30 PM revealed it lacked documentation of a positive Influenza A test. 3. The facility provided a handwritten note that indicated Resident #10 went in to isolation on 2/10/2025 due to a positive COVID-19. The note documented he was symptomatic. Review of Resident #10's Progress Notes on 2/26/2025 at 9:50 AM revealed it lacked documentation of a positive COVID-19 test. On 2/26/2025 at 11:45 AM the DON stated staff should be charting the resident's test results in their chart; whether they are positive or negative. She knew Staff did not chart Resident #10's positive COVID-19 test results. She stated it was nursing 101 to document that. The facility provided a document titled COVID-19 Policy Guidelines that was updated on 9/1/2024. Recording of test results: 1) The facility will record all test results, both positive and negative, within the organization's tracking system. 2) Positive and negative test results will be recorded/maintained in the resident permanent medical record. 3) Document resident refusals and interventions that were implemented based on those refusals.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 37074 Based on previous CMS-2567 review, staff interview, and facility policy review the facility failed to ensure a comprehensive, effective Quality Assessment and Performance Improvement (QAPI) program. The facility reported a census of 37 residents. Findings include: Review of the Department of Inspections, Appeals and Licensing (DIAL) website under the facility's visit history revealed repeated deficient practices identified during the facility's complaint survey ending on on 2/2/2024: a) F725 Sufficient Nursing Staff b) F727 Sufficient Nursing Staff c) F732 Posted Nurse Staffing Information, The facility's complaint survey ending on 4/5/2024: a) F684 Quality of Care b) F842 Resident Records-Identifiable Information The facility's annual recertification survey ending on 7/25/2024: a) F684 Quality of Care b) F725 Sufficient Nursing Staff c) F727 Sufficient Nursing Staff d) F689 Free of Accidents/Hazards/Supervision/Devices e) F880 Infection Control The facility's complaint and facility report incident survey ending on 9/11/2024: a) F689 Free of Accidents/Hazards/Supervision/Devices b) F725 Sufficient Nursing Staff c) F842 Resident Records-Identifiable Information d) F865 QAPI Program/Plan Good Faith Attempt (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e) F880 Infection Control On 2/27/2025 at 8:41 AM the Administrator stated after a survey, the results are shared with the management team members and start their plan of correction of moving forward, work on meeting the standards to get back in compliance. When asked what is done to ensure items identified are not repeated in future surveys, he stated depends on the items identified. They may need to demote or remove staff, do more audits, provided education and see what training needs to be redone. They will do daily or weekly reports to see what has been done and what issues have come up that have not been addressed yet. The facility provided a document titled Quality Assurance Performance Improvement (QAPI), Quality Assessment Assurance (QAA) Plan with a revision date of 1/2/2025. The purpose of QAPI in our organization is to develop a culture of proactive leadership that solicits the input from employees in various departments, including contracted professionals, if indicated, as well as those we serve residents, resident representatives, and family members. Further, our purpose includes ongoing development of plans for improvement leading to systematic changes that support exceptional health care to seniors and operating excellence in every aspect of our business.

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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 37074

Based on observations, record review, staff and resident interviews, and facility policy reviews the facility failed to ensure all staff wore masks, and provided masks upon entry in to the facility while in outbreak status. Staff also failed to follow proper practices when obtaining a resident's blood sugar and prior to administering resident's insulin. The facility reported a census of 37 residents.

Findings include:

1. On 2/13/2025 at 11:45 AM on the front entrance door was a sign that notified visitors the facility was in outbreak status, masks are required. Once inside the main entrance double doors, no masks were available to put on. There were no masks and no one at the nurse's station at the start of center hall. One had to walk down center hall to the nurse's station where the three halls meet to ask for a mask.

On 2/13/2025 at 12:20 PM the Administrator walked in the surveyor's room with no mask on, there was no mask present around his neck or in his hands. At 2:25 PM the Administrator was at the back nurse's station with no mask on, no mask around his neck or chin. Once he saw the surveyor, he put on a mask. At 4:13 PM observed the Director of Nursing (DON) walking around behind the nurse's station with no mask on, she had been witnessed to be coughing throughout the day.

On 2/14/2025 at 8:30 AM the sign remained on the front door indicating masks required for staff and visitors. Once inside the facility through the front doors, no masks available at the main entrance. At 8:45 AM observed the DON and Administrator at the back nurse's station with no masks on. At 10:35 AM the DON walked from her office to the Administrators office without a mask on, she was observed coughing without covering her mouth.

On 2/18/2025 at 10:00 AM Staff I Dietary Aide (DA) walked from the kitchen to the front of the building. At 10:01 AM Staff I walked from the front of the building to the kitchen with a mask on. At 3:30 PM the Activity Director (AD) assisted 11 residents with an activity. The AD had his mask on his chin, not covering his nose and mouth. At 3:45 PM the AD remained in the dining room with residents assisting with an activity, 11 residents remain for the activity. Once he saw the surveyor he covered his mouth and nose with his mask. At 3:52 PM 11 residents remained in the dining room for the activity and the AD mask was off again.

On 2/19/2025 at 9:56 AM the Administrator placed masks on the table directly in front of the front entrance.

On 2/20/2025 at 11:07 AM the AD assisted 8 residents with an activity in the dining room with his mask down, not covering his face or nose. The Transportation staff member walked down [NAME] hall with her mask below her chin, not covering her mouth and nose. Staff A Licensed Practical Nurse (LPN) observed at the nurse's station with her mask on her chin, below her mouth and nose.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/25/2025 at 8:45 AM the DON reported they had 6 new cases of COVID-19 since the 21st. She reported none of the residents were showing signs and symptoms. At 10:41 AM the Social Worker walked down [NAME] hall from the dining room with her mask under her chin. Once she saw the surveyor she pulled the mask over her mouth and nose. At 1:19 PM the Social Worker walked down center hall, passing 3 residents and 2 staff members with her mask below her chin. Once she saw the surveyor she pulled her mask over her mouth and nose. On 2/26/2025 at 10:30 AM Staff J Certified Medication Aide (CMA) was at the medication cart at the beginning of East hall with her mask under her chin. Staff C LPN sat at the nurse's station with her mask below her chin. At 10:37 AM the AD walked out of resident room [ROOM NUMBER] with his mask under his chin, once he saw the surveyor he pulled his mask up to cover his nose and mouth. At 10:38 AM the Social Worker walked from her office on center hall, down east hall to the room where the vending machines were with her mask under her chin, not covering her mouth or nose. At 11:08 AM the AD was at the front of the facility with 6 residents assisting with an activity. His mask was under his chin, once he saw the surveyor he pulled the mask up to cover his nose and mouth. The facility provided a document titled Long Term Care (LTC) Respiratory Surveillance Line List dated 2/24/2025. The list documented the Transportation staff member tested positive for COVID-19 on 2/21/2025 with the following symptoms documented: fever, cough, body aches, headaches, and chills. On 2/23/2025 at 10:00 AM located behind the nurse's station, a print out was posted on the bulletin board. The ADON stated the Corporate Infection Control Nurse sent this via email at the start of their outbreak. The print out contained the following information: COVID-19 1 positive, 2 staff: 1. Resident isolation x 10 days with today being day 0, to come off isolation on 2/21/2025. They may only exit room for medical necessary reasons with source control in place. Full set of vitals and respiratory assessment completed every shift for monitoring for 10 days. 2. Roommate of positive resident (if they have one) should be tested every 48 hours for 3 days and monitored for symptoms every shift with full set of vitals for 10 days. If the roommate is able to wear source control they may come out of their room, but only if they are willing to be tested per the above schedule and war a mask when outside of their room. If they are unable and or unwilling to comply with that rule, they must be placed on contact/droplet isolation for 7 days until the final test confirms they are negative. An outbreak sign must be posted for both outbreaks at the front door. As well ensure there is a passive screen sign for COVID-19 posted at the front door at all times. It must remain in place always. Outbreak: now that you are in outbreak as far as COVID-19 goes, all staff are required to wear surgical masks at all times. You will be in outbreak status a minimum of 2 weeks. You must complete routine testing of all staff and residents a minimum of every 7 days. This will continue until you have no new positives for 14 days. On 2/19/2025 at 7:05 AM Staff W Certified Nursing Assistant (CNA) stated since they have been in outbreak status, staff are not wearing masks in the halls or in resident's rooms. She started to wear one once everyone started to get sick. (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 02/27/2025
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/19/2025 at 1:26 PM Staff C Licensed Practical Nurse (LPN) stated the facility used to have sheets that were filled out that included the time tested and whether the test was positive or negative. She indicated masks are worn when remembered to do so. They started in outbreak status once they had staff and residents test positive for COVID-19 plus an Influenza positive resident. On 2/21/2025 at 10:13 AM Staff D CNA stated the facility is not doing COVID-19 since they have been in outbreak status. She stated even for staff, they are doing them so she is doing them on her own at home. It's been a concern that they are not doing testing, people have been asking for guidance but they get told there is no protocol to follow. When the previous Administrator was in house, they were testing every 48 hours. Staff D stated they have not been testing residents either. When asked what their current protocol is she indicated she is unsure of it. They thought they should be following CDC guidelines but was told the facility makes up their own guidance. On 2/25/2025 at 2:15 PM Staff S Agency CNA stated masks are not getting worn. A lot of times they are on their neck or under staff's nose. They are not keeping track of COVID-19 testing; they test two days ago but before that they were tested the week prior. They used to have to fill out sheets when they would get tested to help keep track of things but they don't have that anymore. The facility provided a document titled COVID-19 Policy Guidelines with a revision date of 9/1/2024. The policy indicated the facility has established protocol for the prevention and spread of COVID-19 in accordance with the CDC, CMS, and State/Local Agencies. For residents and visitors, the safest practice is to wear masks. All employees, consultants, contractors should be educated related to virus, infection control, prevention, early detection, and monitoring. Resident close contact exposure: if a the resident or family report possible close contact to an individual with COVID-19 the facility testing should be as follows, test 24 hours after known exposure and if negative, again 48 hours after the first negative test and, if negative, 48 hours after the second negative test. The resident should be monitored for signs and symptoms and wear source control for 10 days. All residents experiencing a new onset of symptoms as outlined by the CDC consistent with that of COVID-19 should be placed on airborne transmission-based precautions and testing should be performed. 1) All symptomatic resident with a positive antigen test should be considered positive for COVID-19. 2) A symptomatic resident with a negative antigen test should have a confirmatory NAAT/PCR test completed, or a second antigen test performed 48 hours after the first negative test. Empiric Use of Transmission Based Precautions (quarantine): Residents who have experienced close contact and remain asymptomatic do not require empiric use of transmission-based precautions. 1) The resident should wear source control for 10 days following the exposure 2) The resident should be tested immediately but not sooner than 24 hours after known exposure and if negative, again 48 hours after the first negative test and, if negative, 48 hours after the second negative test. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) The resident should be monitored for signs and symptoms and wear source control. High risk exposure requiring testing with no work restriction: 1) The healthcare provider should wear source control for 10 days following the exposure, and 2) Perform COVID-19 testing immediately (but not earlier than 24 hours after the exposure) and, if negative, again in 48 hours after the first negative test, if negative, again 48 hours after the second negative test and 3) Follow all recommended infection prevention control practices including wearing well-fitting source control, monitoring themselves for fever or symptoms consistent with COVID-19 and not reporting to work when ill or if testing positive for COVID-19 infection. 2. According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 12/4/2024 documented Resident #2 had a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested no cognitive impairment. Resident did not refuse cares during the review period and received insulin. The following diagnoses were listed for Resident #2: type 2 diabetes mellitus, renal failure. The Care Plan focus area with a revision date of 6/16/2024 documented Resident #2 had diabetes mellitus type 2. Staff were directed to administer diabetes medications as ordered by her doctor and to monitor/document for side effects and effectiveness. Resident #2 had the following orders: a) Blood sugars four times a day (QID), with an order start date of 10/2/2023, b) Humalog (treatment of diabetes) injection solution 100 unit/milliliters (u/mL), inject per sliding scale. On 2/18/2025 at 10:35 AM Resident #2 stated Staff A has a habit of doing accuchecks and giving insulin without using alcohol wipes. Resident #2 would tell her she needed to use the wipes and Staff A would tell her she forgot the wipes. Resident#2 would tell Staff A she is not forgetting to use the alcohol wipes with her. Resident #2 stated it's just crazy to her that she would not use alcohol wipes before getting her blood sugar and before administering her insulin. 3. According to the annual MDS assessment tool with a reference date of 1/30/2025, Resident #6 had a BIMS score of 14. A BIMS score of 14 suggested no cognitive impairment. The MDS documented she received insulin 7 days of the 7-day review period. The MDS listed the following diagnoses: stage 5 kidney disease, hypertension, renal failure, diabetes mellitus, thyroid disease, Parkinson's disease, anxiety, and depression. The Care Plan focus area with a revision date of 11/19/2019 documented Resident #6 was insulin dependent due to her diagnosis of diabetes mellitus. She received Humalog sliding scale daily before meals. Staff were directed to administer insulin as ordered by doctor and to monitor/document for side effects and effectiveness. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #6 had the following orders: a) Lantus (treatment of diabetes) 100 u/mL, give 30 U two times a day (BID), with an order date of 2/3/2025 b) Lyumjev 100 u/mL, inject as per sliding scale, with an order date of 2/3/2025. On 2/25/2025 at 1:14 PM Resident #6 indicated she had a device placed on her upper arm that monitors her blood sugars. When staff replaces the device, they cleanse the area prior to placing a new device. When they administer her insulin in her abdomen or the back of her upper arms, not all staff cleanse the area prior to administering her insulin. 4. According to the Annual MDS assessment tool with a reference date of 2/13/2025 Resident #8 had a BIMS score of 15. A BIMS score of 15 suggested no cognitive impairment. Resident #8 received insulin 7 days during the 7 day review period. The MDS listed the following diagnoses for Resident #8: diabetes mellitus, depression, long term use of insulin and obesity. The Care Plan focus area with a revision date of 11/18/2024 documented he had diabetes mellitus and had an order to self-administer his insulin. The Care Plan directed staff to administer diabetic medications as ordered by the doctor. Resident #8 had the following orders: a) Tresiba (treatment of diabetes mellitus) inject 45u every day, with a start date of 11/5/2024, b) Lyumjev 100u/mL give 15 U before meals, with a start date of 4/20/2024, c) Lyumjev 100u/mL inject per sliding scale, with a start date of 4/9/2024, d) Accuchecks four times day, with a start date of 11/9/2022. On 2/18/2025 at 3:48 PM Resident #8 stated Staff A on the evening shift will check his blood sugars but does not cleanse his finger before checking it. She also does not cleanse the site before she gives him his insulin. She does this a lot and when asked why, Staff A would tell him she forgot the alcohol wipes. Resident #2 will argue with Staff A until she goes to get an alcohol wipe. Resident #8 stated he stopped asking her because it was the same excuse each time and nothing changed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/13/2025 at 11:43 AM Staff C Licensed Practical Nurse (LPN) stated residents have told her that Staff A does not cleanse sites before obtaining resident's blood sugars and before administering their insulin's. At one time Resident #8 made Staff A go get an alcohol wipe because she told him she forgot. During a follow up on 2/19/2025 at 1:26 PM Staff C stated prior to obtaining a resident's blood sugar, you must cleanse the site with an alcohol wipe, make sure the area is dry then use the lancet to obtain the sample. The same goes for when administering insulin, you let the resident know what you are doing, ask where they would like the insulin administered then cleanse the site then administer the insulin. During a follow up interview on 2/21/2025 at 9:39 AM Staff C stated two Mondays ago, the ADON printed off COVID-19 testing guidelines informing them they were in outbreak status, staff need to be in masks for two weeks, testing needed to be done every seven days, until there are no new positives for 14 days. Staff C stated there are residents that are currently sick so she is testing residents and as of current she has had four residents test positive. On 2/19/2025 at 11:03 AM Staff F Registered Nurse (RN) stated when obtaining a resident's blood sugar staff should cleanse the resident's finger with an alcohol wipe first. Same goes prior to administering their insulin; the site should be cleansed with an alcohol wipe first. On 2/25/2025 at 9:29 AM Staff T CNA stated depending on who is working depends on whether or not masks are being worn. They are not testing staff members, she does her own testing. On 2/25/2025 at 10:30 AM Staff E Certified Medication Aide (CMA) stated COVID-19 testing is not getting done. She stated when the previous Administrator was there, they were doing testing every 48 hours, but now that's not getting done. Staff used to have sheets to fill out when staff were tested but they don't have that anymore. The last time she had a COVID-19 test was last Wednesday (2/19/2025). Staff E was asked if masks are being worn at the facility, she laughed and said people are not wearing them like they were supposed to. On 2/26/2025 at 11:45 AM the DON stated while they are in outbreak status the protocol is supposed to be the residents are tested initially, then 48 hours later all residents are to be bested. The residents that are positive will be tested again at the end of the 10-day isolation period. Staff should be tested before coming in to work and that is offered onsite. When asked she was aware staff are not wearing their masks appropriately or at all, she indicated she knew. They should be worn at all times, unless staff are in their own personal space. The DON was asked to define personal space, she stated: in their office, bathroom. They should be worn when staff are within 6 feet of any human being, it should always be on during resident cares and should be worn appropriately over their mouth and nose. The DON indicated she will educate staff on wearing them appropriately. The DON indicated when obtaining a resident's blood sugar staff should cleanse the resident's finger with an alcohol wipe prior to getting their blood sugar. When staff administer the resident's insulin, they should cleanse the site prior to administration with an alcohol wipe. The facility provided a procedure titled Blood Sampling-Capillary (Finger Sticks) with a revision date of September 2014. The purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to prevent transmission of bloodborne diseases to residents and employees. Steps in the procedure: 5. Wipe the area to be lanced with an alcohol wipe (continued on next page)

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	165531	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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