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	12/08/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Records (EHR), document review, staff interviews, resident interview and policy review the facility failed to prevent neglect when Staff A refused to provide or delayed providing suctioning for Resident #34 who was dependent on staff assistance for his tracheostomy (breathing tube in the neck). Resident #34 stated Staff A, Licensed Practical Nurse (LPN) refused to suction him nearly nightly when he worked at the facility. The resident experienced psychosocial harm as evident by severe anxiety, fear of being unable to breath and dying. Staff A worked at the facility 9/17/25 - 11/12/25 on the overnight shift with the last day of training with a second nurse on 10/4/25. Schedule documented Staff A was the only nurse when working the overnight shift when scheduled. Resident #34 stated he would have to turn the call light on 3 or 4 times before Staff A would complete the suctioning. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of October 6, 2025 on December 3, 2025 at 11:15 a.m. The facility staff removed the immediacy of the IJ on December 4, 2025, and decreased the scope to G, through the following actions:a. All residents residing at the facility were interviewed to ensure they feel safe in their environment and free from abuse or exploitation on 12/3/25.b. All Department heads to include Administrator and DON were educated by the Director of Clinical Services to complete thorough investigations into all concerns brought to them including conducting root cause analysis to identify adequate and quantifiable interventions to prevent further abuse or exploitation 12/4/25.c. The DON and all staff nurses were immediately trained at the direction of the DCS on Tracheal Care and Suctioning to ensure competency in this skill. d. Administrator and DON were educated by the Director of Clinical Services on abuse policies to include timely reporting of all allegations of abuse and exploitation to the state agency as required on 12/4/25.The facility identified a census of 37 residents. Findings include:The Minimum Data Set (MDS) dated [DATE] documented Resident #34 had a Brief Interview for Mental Status (BIMS) of 14 indicating no cognitive impairment. MDS also indicated Resident #34 had diagnoses of acute and chronic respiratory failure with hypoxia, functional quadriplegia and presence of tracheostomy.Review of Resident #34's EHR titled, Orders documented a physician's order with a start date of 8/7/25 for deep suctioning if needed with 4-5 passes if resident needs every 20 minutes as needed.Review of Resident #34's EHR titled, Medication Administration Records/Treatment Administration Records documented a physician's order with a start date of 8/7/25 for deep suctioning if needed with 4-5 passes if resident needs every 20 minutes as needed. Further review of MAR/TAR for the months of October and November of 2025 revealed no documentation of the order being utilized by Staff A. On 12/2/25 at 1:36 PM Resident #34 stated Staff A would refuse to suction his tracheostomy frequently. Resident #34 explained he had to call the Certified Nursing Assistants (CNA) 3 or 4 times before Staff A completed the suctioning. Resident #34 said it would cause severe anxiety when Staff A worked because Staff A would not suction when he felt he needed it. Resident #34 stated when his tracheostomy was not suctioned it felt like he could not breathe and was dying. Resident #34 stated he felt he was being neglected when Staff A did not suction when he requested it. Resident #34 acknowledged all of the overnight CNA staff knew Staff A would refuse to suction his tracheostomy. Resident #34 stated basically every night Staff A worked he would refuse to suction his tracheostomy. Resident #34 said Staff C, CNA and Staff B, CNA could speak about Staff A and that he did not come in and suction his tracheostomy when requested and would frequently refuse to suction his tracheostomy. Resident #34 stated it did not seem like Staff A knew what he was doing. On 12/2/25 at 9:34 AM Staff C stated Staff A refused to suction Resident #34 even when Resident #34 requested. Staff C explained Staff A would say he had just been in Resident #34's room. Staff C stated she looked at Resident #34's orders and Resident #34 had as needed orders for suctioning his tracheostomy. Review of text message sent to the DON by Staff C documented on 11/9/25 another nurse checked on Resident #34 because Staff A would not. Text message sent to the DON on 11/10/25 at 1:47 AM Resident #34 was asking to be suctioned again but Resident #34 said he wanted the DON and did not want to say it out loud and upset Staff A. DON replied via text. Tell Staff A he was the nurse on the floor.On 12/2/25 at 6:15 AM Staff F, CNA said Resident #34 would request medication or to be suctioned. Staff F stated it doesn't happen too often through the night. Staff F explained she worked with Staff A a couple of times. Staff F expressed one night, Resident #34 had requested to have his tracheostomy suctioned and Staff F told Staff A. Staff F stated Staff A's response was that he had just done it one hour prior and Staff A refused to go in and Staff A refused suction Resident #34's tracheostomy. Staff A said she

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Records (EHR), document review, staff interviews, resident interview and policy review the facility failed to investigate the allegation of neglect, failed to separate Staff A, Licensed Practical Nurse (LPN) from Resident #34 and failed to take corrective actions to prevent further abuse/neglect of Resident #34. Resident #34 stated Staff A would refuse to provide or delayed providing suctioning to Resident #34 who was dependent on staff assistance for his tracheostomy (breathing tube in the neck) frequently. Resident #34 explained he would have to call the Certified Nursing Assistants (CNA's) with the call light 3 or 4 times before his tracheostomy would be suctioned by Staff A. Staff A worked at the facility from 9/17/25 - 11/12/25 on the overnight shift with the last day of training with a second nurse on 10/4/25. Schedule documented Staff A was frequently the only nurse who worked the overnight shift when scheduled. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of October 6, 2025 on December 3, 2025 at 11:15 a.m. The facility staff removed the immediacy of the IJ on December 4, 2025, and decreased the scope to D, through the following actions:a. Remove any staff implicated in abuse or failure to report from resident care immediately. Increase supervision and monitoring in all care areas.b. Ensure residents identified at risk are protected and monitored. Resident #34 was interviewed on 12/3/2025 to ensure the resident felt safe and cared for. c. All staff were educated on reporting allegations of abuse and exploitation to the Administrator (Abuse coordinator) or DON if abuse coordinator is absent immediately as well as immediate separation of alleged victim and perpetrator on 12/3/25 or before their next shift.d. All staff including the Administrator, DON and ADON were educated on Residents Rights.The facility identified a census of 37 residents. Findings include:The Minimum Data Set (MDS) dated [DATE] documented Resident #34 had a Brief Interview for Mental Status (BIMS) of 14 indicating no cognitive impairment. MDS also indicated Resident #34 had diagnoses of acute and chronic respiratory failure with hypoxia, functional quadriplegia and presence of tracheostomy.Review of Resident #34's EHR titled, Orders documented a physician's order with a start date of 8/7/25 for deep suctioning if needed with 4-5 passes if resident needs every 20 minutes as needed.Review of Resident #34's EHR titled, Medication Administration Records/Treatment Administration Records documented a physician's order with a start date of 8/7/25 for deep suctioning if needed with 4-5 passes if resident needs every 20 minutes as needed. Further review of MAR/TAR for the months of October and November of 2025 revealed no documentation of the order being utilized by Staff A. On 12/2/25 at 1:36 PM Resident #34 stated Staff A would refuse to suction his tracheostomy frequently. Resident #34 explained he had to call the Certified Nursing Assistants (CNA) 3 or 4 times before Staff A completed the suctioning. Resident #34 said it would cause severe anxiety when Staff A worked because Staff A would not suction when he felt he needed it. Resident #34 stated when his tracheostomy was not suctioned it felt like he could not breathe and was dying. Resident #34 stated he felt he was being neglected when Staff A did not suction when he requested it. Resident #34 acknowledged all of the overnight CNA staff knew Staff A would refuse to suction his tracheostomy. Resident #34 stated basically every night Staff A worked he would refuse to suction his tracheostomy. Resident #34 said Staff C, CNA and Staff B, CNA could speak about Staff A and that he did not come in and suction his tracheostomy when requested and would frequently refuse to suction his tracheostomy. Resident #34 stated it did not seem like Staff A knew what he was doing. On 12/2/25 at 9:34 AM Staff C stated Staff A refused to suction Resident #34 even when Resident #34 requested. Staff C explained Staff A would say he had just been in Resident #34's room. Staff C stated she looked at Resident #34's orders and Resident #34 had as needed orders for suctioning his tracheostomy. Staff C explained she reported to the Director of Nursing (DON) verbally, face to face and by text. Staff C repeated she notified the DON.Review of text message sent to the DON by Staff C documented on 11/9/25 another nurse checked on Resident #34 because Staff A would not. Text message sent to the DON on 11/10/25 at 1:47 AM Resident #34 was asking to be suctioned again but Resident #34 said he wanted the DON and did not want to say it out loud and upset Staff A. DON replied via text. Tell Staff A he was the nurse on the floor.On 12/2/25 at 6:15 AM Staff F, CNA said Resident #34 would request medication or to be suctioned. Staff F stated it doesn't happen too often through the night. Staff F explained she worked with Staff A a couple of times. Staff F expressed one night, Resident #34 had requested to have his tracheostomy suctioned and Staff F told Staff A. Staff F stated Staff A's response was that he had just done it one hour prior and Staff A refused to go in and Staff A refused suction Resident #34's

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility record review, legal record review, resident and staff interviews, and facility policy review, the facility failed to provide a licensed nurse on a 24-hour basis. The facility failed to have a licensed nurse on premises on the overnight shift from 11/11/25-11/12/25. The facility reported a census of 37 residents. Findings include: Review of the facility's master schedule for staffing assignments for 11/25 revealed Staff A, Licensed Practical Nurse (LPN) was scheduled for 12 hour overnight shifts on 11/3, 11/4, 11/8, 11/9 and 11/11/25. Review of Staff A's timecard revealed he clocked in at the facility on 11/11/25 at 7:59 PM and clocked out of the facility on 11/12/25 at 1:15 AM working 5.27 hours. Review of a legal document from [NAME] County Sheriff's Office revealed on 11/12/25 at approximately 1:19 PM a traffic stop was initiated for a vehicle traveling with no lights on. The Deputy followed the vehicle with his emergency lights activated. The driver continued driving in the oncoming lane of travel with no lights until it pulled into the parking lot of the facility. The driver was identified as Staff A. The staff volunteered that he worked at the facility and had left to get gas. Following a field investigation Staff A was placed under arrest, placed in the rear of the Deputy's car and the facility staff were notified.On 12/1/25 at 10:55 AM the [NAME] County Deputy stated he was the Narcotics Investigator for the county and after 1:00 AM on 12/12/25 he observed Staff A leaving a convenient store without his lights on. The Deputy stated he attempted to pull Staff A over, but he continued to drive at times on the wrong side of the road, stopping when he pulled into the facility's parking lot. The Deputy stated Staff A was apologetic and stated he was the nurse on duty for the facility. The Deputy stated when he contacted the staff inside the building that he was taking Staff A into custody, they responded that Staff A was the nurse on duty and he could not leave the building. The Deputy explained to the Certified Nursing Assistants (CNAs) that Staff A had left the building and they replied they were unaware he had left. The Deputy stated the CNAs contacted the Director of Nursing (DON) to advise her of the situation and the DON had asked whether Staff A could remain on the premises until she arrived. The Deputy advised the DON that he was not comfortable with that option based on his interactions with Staff A. The Deputy stated he contacted the hospital and requested an Emergency Medical Services (EMS) unit to be on site until the DON arrived. On 12/2/25 at 6:15 AM Staff F, CNA, stated she had worked with Staff A a few times. The staff stated Staff A would go out to his car for long periods of time and tell the staff to call him if they needed anything. Staff F stated Staff A would leave his phone at the nurses' station when he told the staff to call him. On 12/2/25 at 9:15 AM Staff B, CNA, stated Staff A acted weird when working overnights with the CNAs. The staff stated the CNA's never knew where Staff A was during the shift. The staff stated Staff A would leave his cell phone number at the nurses' station and told them to call him if there was a problem. Staff B stated on the overnight of 11/11/25 the last time she saw Staff A was around 12:30 AM when she was doing rounds and asked Staff A to check on an unidentified resident. Staff B stated she never saw Staff A after 12:30 AM until she was notified by the Deputy that Staff A was being taken into custody. The staff stated Staff A would frequently take breaks on the overnight shift and they would not know where he was. On 12/2/25 at 9:32 AM Staff C, CNA, stated on the overnight shift of 11/11/25 the last time she recalled seeing Staff A was around 12:30 AM when she was doing rounds with Staff B. Staff C stated during the course of rounds Resident #1 had a fever but she could not locate Staff A and figured she would find Staff A during the course of rounds. Staff B stated around 1:30 AM when completing rounds and noting she had not seen Staff A and thought he wasn't in the building, the Deputy entered the facility and notified them that Staff A was being taken into custody. Staff C stated she contacted the DON and the DON did ask if Staff A could remain on site until she arrived, but the Deputy declined. Staff C stated the EMS arrived and was present as a medical service until the DON arrived approximately 45 minutes later. Staff C stated she and other staff had reported to the DON that they could not always find Staff A and he was always taking breaks. The staff stated Staff A would leave his phone number for staff to use to contact him if there was a problem, but sometimes his phone(s) would be sitting at the nurses station when they could not find him. On 12/2/25 at 10:18 AM the Administrator stated if there were concerns about staff behaviors they were to contact her or the DON. The Administrator stated if there were repeat concerns then there would be documentation regarding the concerns, and teachable moments. The Administrator stated Staff A did not have a soft chart with documentation of disciplinary action or teachable moments. The Administrator stated the facility did not have cameras.On 12/2/25 at 10:35 AM the DON stated she had an electronic soft chart for Staff A. The documents provided by

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on staff interviews, personal record review, and facility policy review, the facility failed to ensure that nursing staff were adequately orientated and trained before they were scheduled to work independently with the residents for 2 of 2 nurse files reviewed. The facility reported a census of 37 residents. Findings include: On 12/3/25 at 6:20 AM, Staff D, Licensed Practical Nurse (LPN) stated that he didn't have any orientation or training before he worked with the residents on his own. Staff D said that he did not follow another nurse for a period of time, or have any orientation checklist to complete. A review of the file for Staff D revealed that the personal file lacked an orientation or training checklist. On 12/4/25 at 7:59 AM, Staff A, LPN said that he was not provided a check list for training when he started working at the facility. He said that he was trained on medication times and had some other paperwork, but he did not have any competency-based training on catheters, enteral tubes or tracheotomy cares. Staff A stated he was expected to suction a tracheostomy on a resident overnight. A review of the personal file for Staff A revealed that the file lacked an orientation or training checklist. On 12/4/25 at 12:47 PM, Staff CC, RN said that she no longer worked at the facility, and one of the reasons she moved on was because the facility hired inappropriate staff. Staff CC said that Staff A had followed her when he first started, but he thought he already knew everything and there was no checklist for her to use and sign off on. Staff CC said that she did not give Staff A the keys to the narcotic drawer because she didn't trust him. She said that there was a weekend shift that the Director of Nursing was trying to get filled, and she asked her to work. When Staff CC said that she could not work that day, the DON asked her if she thought that Staff A was ready to take a shift on his own. Staff CC told them that he was not, and she didn't trust him, but the DON had him work 4 hours on his own anyway. Staff CC said that she was particularly concerned that Staff A didn't seem to retain information and often appeared confused. On 12/2/25 at 12:27 PM, the Administrator said that a nurse that had been working on orientating Staff A, contacted the DON that he wasn't doing the medications correctly. She did not know of any formal orientation or training program at the facility. On 12/8/25 at 2:23 PM, the DON said that the facility was working on a process for orientating nurses. She said the new staff do their onboarding, watch some videos then they are orientated by another nurse for at least 2 weeks. She said that she would like spend some time with that new nurse before putting her/him on the floor alone. She said that if an orientating nurse communicated to her that the new nurse was not ready to work independently, she would not put that person on the floor unsupervised. She said they did not have a formal orientation list. A facility policy titled: Orientation Program for Newly Hired Employees, Transfers and Volunteers, dated, January 2008, showed that all newly hired personnel must attend a 10-hour orientation program within the first 5 days of employment. A checklist wound be used to record materials reviewed with each employee and a written record would be maintained of each employees orientation program.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interview, staff interview and policy review the facility failed to provide food at an appetizing temperature to 3 of 14 residents reviewed (Resident #28, #31 and #35). The facility reported a census of 37 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] for Resident #28 documented a Brief Interview for Mental Status (BIMS) of 14 indicating no cognitive impairment. On 12/1/25 at 1:57 PM Resident #28 said most of the time the food is okay. Resident #28 explained she ate meals in her room and she would be lucky if the food was still warm when she received her tray. Resident #28 said the facility does not have heated carts for room tray delivery. Resident #28 explained her biggest concern was that the food sits too long before being brought to the room. 2. The MDS dated [DATE] for Resident #31 documented a BIMS of 13 indicating no cognitive impairment. On 12/1/25 at 12:18 PM Resident #31 stated she had a room tray every meal and the meals were cold when the meal was dropped off. 3. The MDS dated [DATE] for Resident #35 documented a BIMS of 14 indicating no cognitive impairment. On 12/1/25 at 11:50 AM Resident #35 stated the food is served cold at times. Resident #35 stated if the food was something that she wanted reheated she would ask the staff. Observation on 12/3/25 at 12:38 PM of room trays loaded on cart. The room tray was dropped off at 12:46 PM. The sample tray temperature returned to the kitchen and checked at 12:47 PM revealed the temperature of the food on the sample tray was the peas 135.5 degrees, mashed potatoes 137.5 degrees and pepper steak 129 degrees.On 12/3/25 at 1:20 PM Staff T, Kitchen Manager acknowledged she had made an observation of most of the lunch service. Staff T stated the food on room trays should be 135 degrees or above when delivered to the residents room. Staff T acknowledged the pepper beef should have been 135 degrees or above. On 12/8/25 at 12:51 PM Staff V, Consulting Dietitian stated the food should reach the resident at 135 degrees. On 12/8/25 at 3:10 PM the Administrator stated the facility's expectation was the temperature of the food that was delivered to the resident as a room tray would have been higher than or equal to 135 degrees. Review of policy revised 10/17 titled, Food Preparation and Service documented food and nutrition services employees shall prepare and serve food in a manner that complies with safe food handling practices. The danger zone for food temperatures is between 41F and 135F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. Potentially hazardous foods include meats, poultry, seafood, cut melon, eggs, milk, yogurt and cottage cheese. The longer foods remain in the danger zone the greater the risk for growth of harmful pathogens. Therefore, PHF must be maintained below 41F or above 135F. Potentially hazardous foods held in the danger zone for more than 4 hours (if being prepared from ingredients at room temperature) or 6 hours (if cooked and then cooled) may cause foodborne illness.