STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165531	A. Building B. Wing	04/08/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on clinical record review, resident and staff interviews, and facility policy review the facility failed to treat 1 of 3 residents (Resident #1) with dignity when assisting with Activities of Daily Living (ADLs). The facility reported a census of 31 residents.Findings include:According to the quarterly Minimum Data Set (MDS) assessment with a reference date of 2/12/2026 documented Resident #1 had a Brief Mental Status (BIMS) score of 13. A BIMS score of 13 suggested no cognitive impairment. The MDS documented he did not exhibit rejection of care during the review period. Resident #1 had an impairment to bilateral extremities; he utilized a wheelchair. The MDS documented he was dependent on staff for toileting hygiene and toilet transfers. The MDS indicated Resident #1 was always incontinent of stool. The following diagnoses were documented for Resident #1: atrial fibrillation, heart failure, renal failure, retention of urine, insomnia, and acute pain.The Care Plan Focus Area with a revision date of 3/12/2025 documented Resident #1 had self-care deficit as evidenced by requiring assistance with Activities of Daily Living (ADLs), impaired balance during transitions, walking and requiring assistance while incontinent. The Care Plan documented he required assistance of one staff for toileting and requested a urinal at his bedside.A second Care Plan Focus Area with a revision date of 9/13/2025 documented Resident #1 was incontinent of his bowels. Staff were directed to check him every two hours and assist with toileting as needed. Staff were also instructed to provided peri-care after incontinent episodes.On 4/7/2026 at 11:05 AM Resident #1 sat in his motorized wheelchair in his room, watching television. Resident #1 stated there was one time a staff member told him to poop in his pants when he asked to use the bedpan. The staff member that told him that, no longer works at the facility. Resident #1 stated he had to go to the bathroom but the staff member could not find his bed pan so she told him to go in his adult brief; so, he did. Resident #1 indicated he would usually use the bed pan since his other leg was amputated. Before that he could use the toilet. When the staff member told him to poop his pants it did not make him feel very good. Resident #1 could not recall if he was told to sh*t himself.On 4/3/2026 at 11:52 AM the Assistant Director of Nursing (ADON) stated she was present when Staff A previous Director of Nursing (DON) interviewed Staff B Certified Nursing Assistant (CNA) about the incident involving Resident #1. Staff B acknowledged she did tell Resident #1 to soil his brief. Staff B then later stated she told him that because that is what the briefs are for. Staff B let them know there was a bed pan in Resident #1's bathroom but it was too big. Staff B did not go to the main storage to get a different pan. The ADON acknowledged Staff B should have assisted Resident #1 with using the bedpan. If she could not find one, she could have asked someone to help her look for one.On 4/3/2026 at 12:07 PM Staff A stated Staff C Certified Medication Aide (CMA) informed her Resident #1 needed to use the bedpan and Staff B told him he could sh*t himself. Resident #1 wanted to use the bedpan. Staff B stated she looked around to find a different bedpan but could not find one. When Staff D went in to the resident's bathroom there was a bedpan in his bathroom. Staff A stated she and the ADON interviewed Staff B together on the phone. Staff B stated there were no fracture bed pans in the building, after she looked in the storage closet up front. Staff A knew they had some in there. Staff A asked what Staff B did next, she acknowledged she told Resident #1 to go in his brief because that is what they are for; to (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	piss and sh*t in. Staff A acknowledged Staff B should not have told the resident to go his in pants. She should have used a bed pan, they have them in the building; either in the resident's bathrooms or in the storage closets.The facility provided a document titled Promoting/Maintaining Resident Dignity. It is the practice of this facility to protect and promote resident rights and treat each resident in a manner and in an environment, that maintains or enhances residents' quality of life by recognizing each resident's individuality. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. The resident's former lifestyle and personal choices will be considered when providing care and services to meet the resident's needs and preferences.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on clinical record review and staff interviews the facility failed to ensure 1 of 3 residents reviewed (Resident #2) were provided transportation services for their out-of-town appointment. The facility reported a census of 31 residents.Findings include:According to the Significant Change Minimum Data Set (MDS) assessment tool with a reference date of 3/7/2026 documented Resident #2 had a Brief Interview of Mental Status (BIMS) score of 9. A BIMS score of 9 suggested mild cognitive impairment. The MDS listed the following diagnoses for Resident #2: heart failure, renal insufficiency, non-Alzheimer's dementia, anxiety, depression, and left leg below the knee amputation.Record review revealed a document titled Doctor's Orders and Progress Notes, dated 3/27/2026. The documented listed the following: please complete dry dressing changes daily to left lower extremity with gauze and ace bandage, non-weight bearing to left leg, and follow up on 4/3/2026 at 9:30 AM.Record review of progress note on 4/7/2026 at 3:05 PM revealed no progress notes documented related to the follow-up appointment scheduled for 4/3/2026 at 9:30 AM.On 4/3/2026 at 12:07 PM Staff A previous Director of Nursing (DON) stated Resident #2 missed her appointment that was scheduled this morning. Staff A was unaware of this until 10 minutes before the resident was supposed to be at the clinic. Corporate had let go of the facility's transportation staff member this week and the Assistant Administrator was asked to take residents to their appointments. Staff A indicated the Assistant Administrator informed the Administrator that she did not feel comfortable driving to appointments that were scheduled out of town.On 4/3/2026 at 3:07 PM the Assistant Administrator acknowledged that she is now providing transportation for residents with scheduled appointments. She then stated she preferred not to do the out-of-town appointments because she does not feel comfortable driving that big of a van out in the bigger cities. She did indicate a resident missed their appointment this morning because it was out of town and she does not feel comfortable driving there. When she called the clinic to have it rescheduled, she asked the clinic if the appointment needed to be rescheduled sooner than 4/23/2026. The clinic was ok with the appointment being rescheduled. During a follow-up interview on 4/7/2026 at 2:45 PM she indicated since they let go of the staff member doing transportation and the Activities Director, she was the only left that was covered under their insurance to drive the transportation van for resident appointments. She did let the Administrator know she was not ok with driving out of town for appointments. Moving forward they have reached out resident's Managed Care Organizations (MCOs) to assist with out-of-town appointments so she can focus on the appointments in town. The Assistant Administrator and Social Worker are going to sit down at the end of the week to go over upcoming appointments and get MCOs involved for those out-of-town appointments.On 4/8/2026 at 10:15 AM Staff E Transportation stated starting today she will be assisting with residents to their appointments on an as needed (PRN) basis. She will assist with the out-of-town appointments.On 4/8/2026 at 11:20 AM the Administrator stated Resident #2 missed appointment had been rescheduled because the Assistant Administrator did not want to drive to Omaha. They are working on bringing back Staff E PRN to do those out-of-town appointments.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, and staff interviews the facility failed to ensure maintain a clean, safe, and sanitary homelike environment. The facility reported a census of 31 residents.Findings include:On 4/2/2026 at 10:10 AM observed Resident #5's window cracked and her closet doors broken. Resident #5 stated these things have been broken since she was admitted to the facility not quite a year yet. She added the window rattles when doors open and close. Her room will at times become chilly in the winter when the wind blows. The resident was sitting in her recliner that is positioned next to the window. Both closet doors do not open or close and are not secured on the track. The outside door has a half dollar hole in it. On 4/2/2026 at 12:00 PM observed the following environmental concerns:-between rooms [ROOM NUMBERS]: 5 ceiling tiles with brown to light brown circular stains of various sizes,-between rooms 50-52 and 53-55 by the fire extinguisher cubbie: 6 ceiling tiles with brown to light brown circular stains of various sizes,-by room [ROOM NUMBER] and the linen closet: 6 ceiling tiles with brown to light brown circular stains of various sizes,-by the bathhouse and rooms 42-44: 6 ceiling tiles with brown to light brown linear stains of various sizes,-20 hall ceiling: 1 ceiling tile beige in color with a large split in the tile. To the left of this tile is a one with a hole in it,-40 hall the ceiling tile bracket appeared to be bent downward,-60 hallway with paint chips on the wall,-70 hall has a long light black line on the wall above the grab bars, with paint chipping,-nurse's station ceiling has a tile with a hole in it, wall with paint chipping,-room [ROOM NUMBER] and 76 have paint chipping on the wallsOn 4/7/2026 at 1:55 PM the Maintenance Director stated he was not aware Resident #5's closet doors were in need of repair. At that time, he was able to get one door on the track so it could open and close. The other door will need a different wheel. He indicated he is aware of the ceiling tiles needing to be replaced, due to the leaking roof. He added has ran out of new(er) tile to replace the stained ones with. Buying new tiles is not within his current budget, so he tries to replace them with tiles from non-resident care areas. On 4/8/2026 at 9:45 AM during a follow-up interview with Resident #5, she stated her closet doors had been fixed. Both closet doors are on the track; both are able to close and open.On 4/8/2026 at 11:20 AM the Administrator stated he had identified the ceiling tiles in need of replaced. He added now that where they get their supplies from has a paid up account, they will be able be able to order things to get those replaced.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on clinical record review, facility investigative file review, resident and staff interviews, and facility policy review the facility failed to report an allegation of abuse within 2 hours of the alleged incident. The facility reported a census of 31 residents.Findings include:According to the quarterly Minimum Data Set (MDS) assessment with a reference date of 2/12/2026 documented Resident #1 had a Brief Mental Status (BIMS) score of 13. A BIMS score of 13 suggested no cognitive impairment. The MDS documented he did not exhibit rejection of care during the review period. Resident #1 had an impairment to bilateral extremities; he utilized a wheelchair. The MDS documented he was dependent on staff for toileting hygiene and toilet transfers. The MDS indicated Resident #1 was always incontinent of stool. The following diagnoses were documented for Resident #1: atrial fibrillation, heart failure, renal failure, retention of urine, insomnia, and acute pain.The Care Plan Focus Area with a revision date of 3/12/2025 documented Resident #1 had self-care deficit as evidenced by requiring assistance with Activities of Daily Living (ADLs), impaired balance during transitions, walking and requiring assistance while incontinent. The Care Plan documented he required assistance of one staff for toileting and requested a urinal at his bedside.A second Care Plan Focus Area with a revision date of 9/13/2025 documented Resident #1 was incontinent of his bowels. Staff were directed to check him every two hours and assist with toileting as needed. Staff were also instructed to provided peri-care after incontinent episodes.Review of the facility's investigative file revealed the following:Staff C Certified Medication Aide (CMA) wrote she worked on 2/19/2026 and heard Resident #1 ask Staff B Certified Nursing Assistant (CNA) to be taken to the bathroom to have a bowel movement. Staff B told him to just sh*t himself. She noticed his call light was on so she went in to help him. His adult brief was full, so she washed him up. Today, 2/20/2026 she talked to Staff A Director of Nursing (DON) as she felt and thought it was a dignity issue. She signed and dated her statement on 2/20/2026.On 2/20/2026 Staff A spoke with Staff B with the Assistant Director of Nursing (ADON) in attendance. They spoke with Staff B regarding Resident #1 and the incident on 2/19/2026. Staff A asked Staff B if she instructed the resident to have a bowel movement in his pants. Staff B reported the bed pan she had was too large and that there were no other in the building. The DON asked Staff B if she checked the main storage up front. Staff B stated she told him to go in his brief. Then stated that's what a brief is for to piss and sh*t in.On 2/20/2026 at 3:30 PM Resident #1 was interviewed by Staff A and the Scheduler. When asked if he requested to go to the bathroom last night (2/19/2026), he stated yes, she told me to go in my diaper (Staff B). Resident #1 denied this being his preference an stated the staff stated there were no bedpans and would have to go in my diaper. Resident #1 then pointed to a bedpan across the room and stated there's one right there.Timeline of Incident: on 2/20/2026 at approximately 3:30 PM Staff C reported this incident to Staff A, stating it took place on the evening of 2/19/2026 some time between 6:00 PM and 10:00 PM. The State Agency was notified via phone by the Administrator on 2/20/2026 at 4:08 PM.On 4/7/2026 at 11:05 AM Resident #1 sat in his motorized wheelchair in his room, watching television. Resident #1 stated there was one time a staff member told him to poop in his pants when he asked to use the bedpan. The staff member that told him that, no longer works at the facility. Resident #1 stated he had to go to the bathroom but the staff member could not find his bed pan so she told him to go in his adult brief; so, he did. Resident #1 indicated he would usually use the bed pan since his other leg was amputated. Before that he could use the toilet. When the staff member told him to poop his pants it did not make him feel very good. Resident #1 could not recall if he was told to sh*t himself.On 4/3/2026 at 11:20 AM Staff C stated on the evening shift of 2/19/2026 she thought she heard Staff B tell Resident #1 to sh*t his pants when he asked to go to the bathroom. The next day she told Staff A what she thought she heard Staff B tell Resident #1. She acknowledged she should have turned her concern in sooner.On 4/3/2026 at 11:52 AM the ADON stated she was present when Staff A previous (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (DON) interviewed Staff B about the incident involving Resident #1. Staff B acknowledged she did tell Resident #1 to soil his brief. Staff B then later stated she told him that because that is what the briefs are for. Staff B let them know there was a bed pan in Resident #1's bathroom but it was too big. Staff B did not go to the main storage to get a different pan. The ADON acknowledged Staff B should have assisted Resident #1 with using the bedpan. If she could not find one, she could have asked someone to help her look for one. The ADON stated Staff C should have reported this incident right away to the Abuse Coordinator and not waited until the next day. When asked who the facility Abuse Coordinator was, she stated the Administrator.On 4/3/2026 at 12:07 PM Staff A stated Staff C informed her Resident #1 needed to use the bedpan and Staff B told him he could sh*t himself. Resident #1 wanted to use the bedpan. Staff B stated she looked around to find a different bedpan but could not find one. When Staff D went in to the resident's bathroom there was a bedpan in his bathroom. Staff A stated she and the ADON interviewed Staff B together on the phone. Staff B stated there were no fracture bed pans in the building, after she looked in the storage closet up front. Staff A knew they had some in there. Staff A asked what Staff B did next, she acknowledged she told Resident #1 to go in his brief because that is what they are for; to piss and sh*t in. Staff A acknowledged Staff B should not have told the resident to go his in pants. She should have used a bed pan, they have them in the building; either in the resident's bathrooms or in the storage closets. Staff A acknowledged Staff C and Staff D CNA should have reported the incident to herself, the charge nurse or Administrator.On 4/8/2026 at 11:20 AM the Administrator stated staff should have immediately reported this incident.The facility provided a document titled Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy that was updated on 3/18/2026. All allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the Administrator. All allegations of resident abuse shall be reported to the appropriate state entity not later than two hours after the allegation is made.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on clinical record review, facility investigative file review, staff and resident interviews the facility failed to provide Activities of Daily Living (ADLs) care for 1 of 3 residents reviewed (Resident #1) for ADL care. The facility reported a census of 31 residents.Findings include:According to the quarterly Minimum Data Set (MDS) assessment with a reference date of 2/12/2026 documented Resident #1 had a Brief Mental Status (BIMS) score of 13. A BIMS score of 13 suggested no cognitive impairment. The MDS documented he did not exhibit rejection of care during the review period. Resident #1 had an impairment to bilateral extremities; he utilized a wheelchair. The MDS documented he was dependent on staff for toileting hygiene and toilet transfers. The MDS indicated Resident #1 was always incontinent of stool. The following diagnoses were documented for Resident #1: atrial fibrillation, heart failure, renal failure, retention of urine, insomnia, and acute pain.The Care Plan Focus Area with a revision date of 3/12/2025 documented Resident #1 had self-care deficit as evidenced by requiring assistance with Activities of Daily Living (ADLs), impaired balance during transitions, walking and requiring assistance while incontinent. The Care Plan documented he required assistance of one staff for toileting and requested a urinal at his bedside.On 4/7/2026 at 11:05 AM Resident #1 sat in his motorized wheelchair in his room, watching television. Resident #1 stated there was one time a staff member told him to poop in his pants when he asked to use the bedpan. The staff member that told him that, no longer works at the facility. Resident #1 stated he had to go to the bathroom but the staff member could not find his bed pan so she told him to go in his adult brief; so, he did. Resident #1 indicated he would usually use the bed pan since his other leg was amputated. Before that he could use the toilet. When the staff member told him to poop his pants it did not make him feel very good.On 4/3/2026 at 11:20 AM Staff C Certified Medication Assistant (CMA) stated she thought she heard Staff B tell Resident #1 to sh*t himself when he asked her to go to the bathroom. Resident #1 then had his call light on, so Staff C went in to see what he needed. Resident #1 had soiled his brief and needed to be cleaned up. She assisted him with cares and getting a new adult brief on. Staff C stated Resident #1 is usually not incontinent and could use a bedpan when he needed to.On 4/3/2026 at 11:52 AM the Assistant Director of Nursing (ADON) stated if Resident #1 asked Staff B for the bedpan, she should have assisted him with it. If she was unable to find one, she should have looked for one or asked someone to assist with finding one.On 4/3/2026 at 12:07 PM Staff A Director of Nursing (DON) stated Staff B should not have told Resident #1 to sh*t his pants. She should have assisted him with the bed pan per his request. They do have them available in the resident rooms or storage closets.On 4/7/2026 at 11:25 AM Staff D Certified Nursing Assistant (CNA) stated Resident #1 always asked for a bedpan, can be incontinent but sporadically. Staff D stated Resident #1 does know when he needs to go to the bathroom.The facility provided a document titled Supporting Activities of Daily Living (ADL) with a revision date of March 2018. Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Residents will be provided with care, treatment, services to ensure that their ADLs do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ALDs are avoidable. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with that consent of the resident and in accordance with the plan of care, including appropriate support and assistant with elimination (toileting).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observations, clinical record review, staff interviews and facility policy review the facility failed to secure resident's medical records. The facility also failed to ensure 1 of 3 resident's (Resident #2) medical file was complete and accurate. The facility reported a census of 31 residents. Findings include:1.On 4/2/2026 at 9:00 AM observed through an unlocked door (conference room) to the right of the main entrance after entering the facility. Once through the door, observed a file cabinet, with no locking mechanisms that contained resident medical records. At 1:39 PM to the west of the facility outside, a garage with two garage doors was observed. The garage door on the left was opened approximately 6 inches. The Maintenance Director opened both garage doors without needing to unlock them. Once through the garage door on the right, noted a grey 60-gallon trash can that was filled with resident documents. Resident identifiers visible. On 4/2/2026 at 3:26 PM the Administrator was asked where their medical records are stored. He stated in a building off campus. It's a storage unit company and he knew there was an issue with non-payment. At 3:32 PM observed with the Administrator the garage west of the facility the 60-gallon trash can with resident documents. He stated he had never been out to the garage and believe they are records that needed to be shredded. Acknowledged it was a problem since the documents are not secured. At 4:00 PM the Administrator had brought the 60-gallon trash can in to the building and placed in a locked room located on the west hall. He also stated the door to the conference room will have a lock installed today. On 4/3/2026 at 7:45 AM observed the doorknob to the conference room locked, however the door was not latched and was able to be opened. At 9:30 AM the Maintenance Director was able to fix the door, so it will shut all the way. At 10:30 AM observed the door to be shut and locked. 2. According to the Significant Change Minimum Data Set (MDS) assessment tool with a reference date of 3/7/2026 documented Resident #2 had a Brief Interview of Mental Status (BIMS) score of 9. A BIMS score of 9 suggested mild cognitive impairment. The MDS listed the following diagnoses for Resident #2: heart failure, renal insufficiency, non-Alzheimer's dementia, anxiety, depression, and left leg below the knee amputation.Record review revealed a document titled Doctor's Orders and Progress Notes, dated 3/27/2026. The documented listed the following: please complete dry dressing changes daily to left lower extremity with gauze and ace bandage, non-weight bearing to left leg, and follow up on 4/3/2026 at 9:30 AM.Record review of progress note on 4/7/2026 at 3:05 PM revealed no progress notes documented related to the follow-up appointment scheduled for 4/3/2026 at 9:30 AM.On 4/3/2026 at 12:07 PM Staff A previous Director of Nursing (DON) stated Resident #2 missed her appointment that was scheduled this morning. Staff A was unaware of this until 10 minutes before the resident was supposed to be at the clinic. Corporate had let go the facility's transportation staff member this week and the Assistant Administrator was asked to take residents to their appointments. Staff A indicated the Assistant Administrator informed the Administrator that she did not feel comfortable driving to appointments that were scheduled out of town. On 4/3/2026 at 3:07 PM the Assistant Administrator acknowledged that she is now providing transportation for residents with scheduled appointments. She then stated she preferred not to do the out-of-town appointments because she does not feel comfortable driving that big of a van out in the bigger cities. She did indicate a resident missed their appointment this morning because it was out of town and she does not feel comfortable driving there. When she called the clinic to have it rescheduled, she asked the clinic if the appointment needed to be rescheduled sooner than 4/23/2026. The clinic was ok with the appointment being rescheduled. During a follow-up interview on 4/7/2026 at 2:45 PM she indicated since they let go the staff member doing transportation and the Activities Director, she was the only left that was covered under their insurance to drive the transportation van for resident appointments. She did let the Administrator know she was not ok with driving out of town for appointments. Moving forward they have reached out resident's Managed Care Organizations (MCOs) to assist with (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	out-of-town appointments so she can focus on the appointments in town. The Assistant Administrator and Social Worker are going to sit down at the end of the week to go over upcoming appointments and get MCOs involved for those out-of-town appointments.The facility provided a document titled Charting and Documentation with a revision date of July 2017. All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165531	A. Building B. Wing	04/08/2026

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on review of previous Centers of Medicare and Medicaid Services (CMS) form 2567, staff interviews, and facility policy review the facility failed to ensure they provided a comprehensive, effective Quality Assessment and Performance Improvement (QAPI) program. The facility reported a census of 31 residents. Findings include:A review of the Department of Inspections, Appeals, and Licensing website revealed the facility had repeated deficient practices identified during complaint investigations and recertification surveys from 2/2/2024 to 12/8/2025. The repeated deficiencies cited include:-4/5/2024 during a complaint and incident investigation: 609 failure to report and 842 resident records-identifiable information,-7/24/2024 recertification survey and complaint investigation: 880 infection prevention and control,-9/11/2024 complaint and incident investigation: 584 safe/clean/comfortable/homelike environment, 609 failure to report, 842 resident records-identifiable information, 865 QAPI program/plan, disclosure/good faith attempt, and 880 infection prevention and control,-2/27/2025 complaint and incident investigation: 842 resident records-identifiable information, 865 QAPI program/plan, disclosure/good faith attempt, and 880 infection prevention and control,-4/10/2025 recertification survey and complaint survey: 865 QAPI program/plan, disclosure/good faith attempt, and 880 infection prevention and control,-10/21/2025 compliant and incident investigation: 677 ADL care provided for dependent residents,-12/8/2025 recertification survey, compliant and incident survey: 842 resident records-identifiable information, 865 QAPI program/plan, disclosure/good faith attempt.On 4/8/2026 at 11:20 AM the Administrator stated he started in the facility as their Interim Administrator in February this year. Stated he could only speak on what they have started working on as a Quality Assurance (QA) team since he started here. He plans to revamp QAPI. When asked what is completed after the facility receives their 2567 form from the State Agency (SA) he stated he would first review it, go through it with their QAPI team and individual departments to develop their plan of correction, review this information in their QAPI meetings initiate audits. The audits are important when working towards ensuring deficiencies are not repeated in further surveys. The audits have to put in place to see if they are effective. If they are not they will do an analysis and look at what can be done differently and look at it again.The facility provided a document titled Quality Assurance Performance Improvement (QAPI) updated 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. The facility will use a broad range of sources when monitoring and gathering data. Sources of this data may include but will not be limited to: input from employees, residents, resident representatives, families and other (satisfaction surveys, grievances, etc), adverse events-IDT review of risk management/quality conference: performance audit findings, survey findings (annual and complaint) and compliance findings and/or complaints. Findings will be reviewed by QAPI committee and compared with historical data, facility and company benchmarks and/or established targets to identify areas for improvement. Findings and action for the QAPI committee will be communicated following QAPI meetings and as often as deemed necessary to assure positive outcomes, through postings to relevant employees/departments, submission of QAPI plans to regional management team and all other methods as deemed necessary by QAPI committee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165531	A. Building B. Wing	04/08/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, staff interviews, previous Centers of Medicare and Medicaid Services (CMS) form 2567, and policy review the facility failed to provide appropriate infection prevention and control for residents in the facility. The facility failed to resolve water intrusion and black substance in the basement and back substance in the laundry room. The facility reported a census of 31 residents.Observation on 4/2/2026 at 1:12 PM revealed the wall between the washers and driers in the laundry to have various areas of cracks in the paint. Behind an area close to the floor board revealed a black fuzzy substance. Behind the water heater stagnate water present as well as to the left of the first washer once inside the dirty side of the laundry room. The Maintenance Director stated at times the drainage hoses become clogged and the water runs over the water compartment. The water present was observed to be on a flat surface above the slope to the drain. On 1:17 PM observed a heavy mildew/musty smell while in the basement. Also observed stagnate water in the basement where the walls meet the floor, with water draining from a sealed basement window. Some areas have mud present under the water. One room has a wooden work bench/storage shelf that is standing in the water. One room with the stagnate water had a wall that appeared to have been removed about half a foot off the basement floor; the area exposed has a large area of black substance. Another room has a wooden work bench/storage shelf that is standing in the water. The Maintenance Director stated he has been working on moving items from the areas of where the water seems to seep in from the walls/window. At 1:45 PM outside near the window and wall that seeps water during rainfall revealed the ground slopes towards the building not away. The Maintenance Director stated with heavy rainfall the rain has no place to go. He has tried to put downspout extensions on to help redirect the water but it's not enough.On 4/2/2026 at 4:00 PM informed the Administrator and Clinical Services Director of the water in the basement. They were not aware of there being water in the basement. On 4/3/2026 at 10:45 AM observation of the basement with the Administrator and Clinical Services Director. The heavy mildew/musty smell remained. The Clinical Services Director covered her mouth and nose with her cardigan while in the basement. Rain water remained but had receded, with mud present. The Administrator stated he was told this becomes an issue when they have a lot of rain. The Clinical Services Director thought if they were to get the court yard fixed up, this would help with the rain drainage. The facility provided a document titled Infection Prevention and Control Program Policy and Procedure dated 1/1/2026. This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards.