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	06/02/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interviews, staff interview, and policy review, the facility failed to provide dignity and respect to residents during interactions and care (Residents #8, #18, #20). The facility reported a census of 32 residents.Findings Include: 1. Resident #8's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating normal cognition. The MDS provided the resident did not have hallucinations, delusions, verbal/physical behaviors towards others or have rejection of care. The MDS documented diagnoses of anemia, hypertension-high blood pressure (HTN), and diabetes mellitus (DM). The MDS revealed the resident required no assistance with self care skills and ambulation. The resident's Care Plan revised 4/29/26 identified a problem area of potential for psycho-social well-being deficit initiated on 5/27/25 with staff interventions of encouraging the resident to express feelings and concerns and report additional needs to nursing. The document did not contain a problem area indicating the resident made false allegations or statements about or to staff. In an interview on 5/21/26 at 10:20 AM Resident #8 stated she felt 2 staff on the overnight shift did not treat her with dignity and she felt that if she spoke out about concerns she had with her care there would be retaliation. The resident stated she had brought up concerns during Resident Council and felt her concerns had been shared by the Administrator (previous) to the staff with her name being given to the staff as the complainant. Resident #8 stated since that time the staff had not treated her the same demonstrated by their mannerisms and care. 2. Resident #18's MDS dated [DATE] revealed a BIMS score of 15/15 indicating normal cognition. The MDS provided the resident did not have hallucinations, delusions, verbal/physical behaviors towards others or have rejection of care. The MDS documented diagnoses of renal insufficiency and DM. The MDS coded the resident was dependent on staff for toilet hygiene, transfers and required substantial/maximal assistance for rolling left and right. The document disclosed the resident was frequently incontinent of bladder and always continent of bowel. The Care Plan revised 4/29/26 identified self care deficits with a staff intervention for 1 person assist with bed mobility (revised 4/29/26), ensuring the call light was within reach (8/6/25) and provision of a grab bar x1 to assist with bed mobility (revised 1/19/26). The document did not contain a problem area indicating the resident made false allegations or statements about or to staff. In an interview on 5/21/26 at 3:00 PM Resident #18 stated that some staff on the overnight shift did not always assist her with her care and speak to her in a respectful manner. The resident stated the staff's tone when talking to her felt disrespectful. 3. Resident #20's MDS dated [DATE] revealed a BIMS score of 14/15 indicating normal cognition. The MDS provided the resident did not have hallucinations, delusions, verbal/physical behaviors towards others or have rejection of care. The MDS documented diagnoses of HTN and DM. The MDS revealed the resident required no assistance with self care skills and ambulation. The resident's Care Plan, revised 4/28/26, did not contain a problem area or staff intervention regarding the resident making false statements or accusations against staff. In an interview on 5/21/26 at 1:35 PM Resident's #20 stated there had been some problems with 2 CNAs on the overnight shift. The resident stated the CNAs had been notified of a concern raised during Resident Council and things had (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been better, but more recently the staff had not been speaking to him and he felt as though he was being ignored. The resident stated he was hesitant to bring it to the attention of administration due to fear of unnecessary retaliation. In an interview on 6/2/26 at 12:10 PM Staff K, Director of Nursing (DON), stated that residents should be treated with respect and not have fear of asking for assistance. The staff stated education needed to be provided to staff regarding interactions with and/or in front of residents. The facility's Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, undated, revealed all residents had the right to be free from abuse and neglect.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review the facility failed to protect a resident from misappropriation of property when a resident's medication became missing from the facility for 1 of 3 residents (Resident #2) reviewed. The facility reported a census of 32 residents. Findings include:Review of Resident #2's Minimum Data Set (MDS) dated [DATE] indicated that Resident #2 was taking opioid medications during the seven day look back period. The MDS further indicated that Resident #2 had diagnoses of heart failure, renal failure, diabetes mellitus, acquired absence of the right leg below the knee, and chronic pain. Review of the Electronic Healthcare Record (EHR) page titled, Clinical Physician Orders revealed an order for Hydrocodone-Acetaminophen 10-325 MG (Milligrams) to give one tablet by mouth every 4 hours as needed for increased pain with a start date of 2/15/26 and a discontinued date of 4/24/26. Further review revealed another order for Hydrocodone-Acetaminophen 5-325 MG to give one tablet by mouth every 6 hours as needed for pain with a start date of 4/24/26 and a discontinuation date of 5/7/26. Review of a facility provided document titled, Controlled Drug Record with a date of 4/23/26 revealed a narcotic count sheet for Resident #2's Hydrocodone-Acetaminophen 10-325 MG. Further review of the document revealed a count of 54 tablets left on 4/28/26 at 6:33 AM. The document further revealed an entry that was yellow highlighted on 4/28/26 at 2:00 PM the medication was discontinued. Interview 5/19/26 at 2:45 PM with Staff Q Certified Medication Aide (CMA) revealed that she was passing medications from the cart for Resident #2 on 4/28/26. Staff Q continued that Resident #2's Hydrocodone-Acetaminophen 10-325 MG tablets were discontinued, but were still on the medication cart. Staff Q revealed that she would not give the medication as it did not match the current order for Hydrocodone-Acetaminophen 5-325 MG. Staff Q then revealed that she took the medication along with the narcotic count sheet for the medication and placed them at the nurses station on the desk to be destroyed. Staff Q further indicated that she did not hear anything for 3 days, until Staff D Registered Nurse (RN) informed her that the medications were missing. Staff Q then revealed no one found the missing medications. Staff Q continued that she had never been part of destroying medications as the facility requires 2 staff. Staff Q further revealed that she believed Staff D had destroyed the medication. Interview 5/27/26 at 1:24 PM with Staff H Licensed Practical Nurse (LPN) revealed that the nurse practitioner had come through the facility to complete rounds and had written an order for a frequency change on Resident #2's Hydrocodone-Acetaminophen 10-325 MG, but the order did not have the milligrams specified. Staff then revealed that she assumed it was for a dosage decrease to 5-325 MG. Staff H then confirmed she should have clarified the order instead of just changing the dosage from 10-325 MG to 5-325 MG. Staff H continued that she was not working on 4/28/26 when the medication went missing. Interview 5/27/26 at 1:49 PM with Staff D confirmed she was working on 4/28/26 when the medication for Resident #2 went missing. Staff D revealed that she did not see the Hydrocodone at the nurses station, and that she was the nurse on the floor that day. Staff D further revealed that she did find the count sheet in a pile of paperwork several days later. Staff D continued that she did notify Staff S the previous Regional Clinical Director of the missing medication, as well as Staff P the previous Administrator at the same time. Interview 5/27/26 at 2:06 PM with Staff S revealed that she was notified several days after the medication for Resident #2 had gone missing. Staff S then revealed that the staff did look all over for the medications when she was notified on 5/7/26, but could not locate the 54 missing tablets. Interview 6/1/26 at 12:25 PM with Staff K the current Director of Nursing (DON) revealed that she would have liked to have seen that when medications are discontinued that the medications stay on the cart. Staff K further revealed that she would like to have these medications continue to be counted until 2 staff, with one being a nurse, can destroy the narcotics in the drug buster solution. Review of a facility provided policy titled, Nursing Facility Abuse Prevention, Identification, Investigation and Reporting with an updated date of 3/18/26 indicated that (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility will identify, through ongoing assessment, high-risk situations where abuse, neglect, or misappropriation of resident property may occur and provide appropriate intervention in such occasions.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, law enforcement interview, staff interviews, and policy review the facility failed to report possible abuse in a timely manner related to the misappropriation of residents medications for 1 of 1 resident's (Resident #2) reviewed. The facility reported a census of 32 residents. Findings include:Review of Resident #2's Minimum Data Set (MDS) dated [DATE] indicated that Resident #2 was taking opioid medications during the seven day look back period. The MDS further indicated that Resident #2 had diagnoses of heart failure, renal failure, diabetes mellitus, acquired absence of the right leg below the knee, and chronic pain. Review of the Electronic Healthcare Record (EHR) page titled, Clinical Physician Orders revealed an order for Hydrocodone-Acetaminophen 10-325 MG (Milligrams) to give one tablet by mouth every 4 hours as needed for increased pain with a start date of 2/15/26 and a discontinued date of 4/24/26. Further review revealed another order for Hydrocodone-Acetaminophen 5-325 MG to give one tablet by mouth every 6 hours as needed for pain with a start date of 4/24/26 and a discontinuation date of 5/7/26. Review of a facility provided document titled, Controlled Drug Record with a date of 4/23/26 revealed a narcotic count sheet for Resident #2's Hydrocodone-Acetaminophen 10-325 MG. Further review of the document revealed a count of 54 tablets left on 4/28/26 at 6:33 AM. The document further revealed an entry that was yellow highlighted on 4/28/26 at 2:00 PM the medication was discontinued. Interview 5/19/26 at 2:45 PM with Staff Q Certified Medication Aide (CMA) revealed that she was passing medications from the cart for Resident #2 on 4/28/26. Staff Q continued that Resident #2's Hydrocodone-Acetaminophen 10-325 MG tablets were discontinued, but were still on the medication cart. Staff Q revealed that she would not give the medication as it did not match the current order for Hydrocodone-Acetaminophen 5-325 MG. Staff Q then revealed that she took the medication along with the narcotic count sheet for the medication and placed them at the nurses station on the desk to be destroyed. Staff Q further indicated that she did not hear anything for 3 days, until Staff D Registered Nurse (RN) informed her that the medications were missing. Staff Q then revealed no one found the missing medications. Staff Q continued that she had never been part of destroying medications as the facility requires 2 staff. Staff Q further revealed that she believed Staff D had destroyed the medication. Interview 5/26/26 at 11:58 AM with the local Chief of Police revealed that the facility did call to inform them of the missing Hydrocodone for Resident #2 on 5/8/26. Interview 5/26/26 at 12:25 PM with Staff P the previous Administrator revealed he had an incident number from the police department. Staff P then revealed that he did not have a police report at this time. Staff P further revealed that he still needed to send some information to the local police department. Staff P continued that he would follow up with the police department and wait for their investigation. Follow up interview 5/26/26 at 12:47 PM with the police department officer conducting the investigation into the missing narcotics revealed that Staff P had sent him the requested information to conduct their investigation. Interview 5/26/26 at 1:05 PM with Staff P confirmed that the investigation was turned into the State Agency on 5/8/26 when the medications went missing on 4/28/26. Staff P then revealed that Staff S had completed the investigation and no longer works with the facility. Staff P continued that he believed the missing narcotics was a criminal thing, and was unsure if this would be an abuse issue. Staff P then confirmed the missing narcotics would be a reportable concern. Staff P continued this situation should have been turned in quicker than the 11 days that it was turned in. Staff P further indicated that it was 54 tablets of Hydrocodone-Acetaminophen 10-325 MG that had gone missing. Follow up interview 5/26/26 at 2:05 PM with Staff P confirmed that Staff D was the Director of Nursing (DON) at the time of the medications going missing. Staff P further revealed that he was not notified of the missing narcotics by Staff D until 5/7/26, and he then turned it into the police department, and the State Agency on (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/8/26. Interview 5/27/26 at 1:24 PM with Staff H Licensed Practical Nurse (LPN) revealed that the nurse practitioner had come through the facility to complete rounds and had written an order for a frequency change on Resident #2's Hydrocodone-Acetaminophen 10-325 MG, but the order did not have the milligrams specified. Staff then revealed that she assumed it was for a dosage decrease to 5-325 MG. Staff H then confirmed she should have clarified the order instead of just changing the dosage from 10-325 MG to 5-325 MG. Staff H continued that she was not working on 4/28/26 when the medication went missing. Interview 5/27/26 at 1:49 PM with Staff D confirmed she was working on 4/28/26 when the medication for Resident #2 went missing. Staff D revealed that she did not see the Hydrocodone at the nurses station, and that she was the nurse on the floor that day. Staff D further revealed that she did find the count sheet in a pile of paperwork several days later. Staff D continued that she did notify Staff S the previous Regional Clinical Director of the missing medication, as well as Staff P the previous Administrator at the same time. Staff D further revealed that she was the interim Director of Nursing (DON) at the time, and confirmed that she did not report the missing narcotics to Staff S, Staff P, the local police department, or the State Agency until 5/7/26. Staff D continued that she was not trained on what to do in this situation with the missing narcotics. Staff D then revealed that she should have reported to the appropriate people within 24 hours. Interview 5/27/26 at 2:06 PM with Staff S revealed that she was notified several days after the medication for Resident #2 had gone missing. Staff S then revealed that the staff did look all over for the medications when she was notified on 5/7/26, but could not locate the 54 missing tablets. Staff S continued that the missing narcotics were not reported to the State Agency, or the police department until 5/8/26. Staff S then revealed that she would have liked to have seen the police department investigate this prior to 5/26/26 when the State Agency notified the police department to inquire about their investigation. Staff S further revealed the DON at the time did not notify the appropriate persons in a timely manner. Interview 6/1/26 at 12:25 PM with Staff K the current Director of Nursing (DON) revealed she would expect missing narcotics to be reported to the police department, and the State Agency as soon as medications are discovered missing. Review of a facility provided policy titled, Nursing Facility Abuse Prevention, Investigation and Reporting with an updated date of 3/18/26 indicated all allegations of misappropriation should be reported immediately to the Administrator. The policy further indicated all allegations of resident neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the appropriate state entity not later than 2 hours after the allegation is made, if the events that cause the allegation result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not result in serious bodily injury.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, law enforcement interview, staff interviews, and policy review the facility failed to investigate the misappropriation of resident medications that went missing for 1 of 1 residents (Resident #2) reviewed. The facility reported a census of 32 residents. Findings include:Review of Resident #2's Minimum Data Set (MDS) dated [DATE] indicated that Resident #2 was taking opioid medications during the seven day look back period. The MDS further indicated that Resident #2 had diagnoses of heart failure, renal failure, diabetes mellitus, acquired absence of the right leg below the knee, and chronic pain. Review of the Electronic Healthcare Record (EHR) page titled, Clinical Physician Orders revealed an order for Hydrocodone-Acetaminophen 10-325 MG (Milligrams) to give one tablet by mouth every 4 hours as needed for increased pain with a start date of 2/15/26 and a discontinued date of 4/24/26. Further review revealed another order for Hydrocodone-Acetaminophen 5-325 MG to give one tablet by mouth every 6 hours as needed for pain with a start date of 4/24/26 and a discontinuation date of 5/7/26. Review of a facility provided document titled, Controlled Drug Record with a date of 4/23/26 revealed a narcotic count sheet for Resident #2's Hydrocodone-Acetaminophen 10-325 MG. Further review of the document revealed a count of 54 tablets left on 4/28/26 at 6:33 AM. The document further revealed an entry that was yellow highlighted on 4/28/26 at 2:00 PM the medication was discontinued. Interview 5/19/26 at 2:45 PM with Staff Q Certified Medication Aide (CMA) revealed that she was passing medications from the cart for Resident #2 on 4/28/26. Staff Q continued that Resident #2's Hydrocodone-Acetaminophen 10-325 MG tablets were discontinued, but were still on the medication cart. Staff Q revealed that she would not give the medication as it did not match the current order for Hydrocodone-Acetaminophen 5-325 MG. Staff Q then revealed that she took the medication along with the narcotic count sheet for the medication and placed them at the nurses station on the desk to be destroyed. Staff Q further indicated that she did not hear anything for 3 days, until Staff D Registered Nurse (RN) informed her that the medications were missing. Staff Q then revealed no one found the missing medications. Staff Q continued that she had never been part of destroying medications as the facility requires 2 staff. Staff Q further revealed that she believed Staff D had destroyed the medication. Interview 5/26/26 at 11:58 AM with the local Chief of Police revealed that the facility did call to inform them of the missing Hydrocodone for Resident #2 on 5/8/26. The Chief of Police then revealed that the facility was hesitant to have the police department come to investigate, but he informed the facility that if they were reporting to the State Agency then they would want the police to complete an investigation. He continued that they have been unable to complete their investigation as they were not supplied the staff's names and phone numbers that were working on the day the medications had gone missing. Interview 5/26/26 at 12:25 PM with Staff P the previous Administrator revealed he had an incident number from the police department. Staff P then revealed that he did not have a police report at this time. Staff P further revealed that he still needed to send some information to the local police department. Staff P continued that he would follow up with the police department and wait for their investigation. Follow up interview 5/26/26 at 12:47 PM with the police department officer conducting the investigation into the missing narcotics revealed that Staff P had sent him the requested information to conduct their investigation. Interview 5/26/26 at 1:05 PM with Staff P confirmed that the investigation was turned into the State Agency on 5/8/26 when the medications went missing on 4/28/26. Staff P then revealed that Staff S had completed the investigation and no longer works with the facility. Staff P continued that he believed the missing narcotics was a criminal thing, and was unsure if this would be an abuse issue. Staff P then confirmed the missing narcotics would be a reportable concern. Staff P continued this situation should have been turned in quicker than the 11 days that it was turned in. Staff P further indicated that it was 54 tablets of Hydrocodone-Acetaminophen 10-325 MG that had gone missing. Follow up interview 5/26/26 at 2:05 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM with Staff P confirmed that Staff D was the Director of Nursing (DON) at the time of the medications going missing. Staff P further revealed that he was not notified of the missing narcotics by Staff D until 5/7/26, and he then turned it into the police department, and the State Agency on 5/8/26. Interview 5/27/26 at 1:24 PM with Staff H Licensed Practical Nurse (LPN) revealed that the nurse practitioner had come through the facility to complete rounds and had written an order for a frequency change on Resident #2's Hydrocodone-Acetaminophen 10-325 MG, but the order did not have the milligrams specified. Staff then revealed that she assumed it was for a dosage decrease to 5-325 MG. Staff H then confirmed she should have clarified the order instead of just changing the dosage from 10-325 MG to 5-325 MG. Staff H continued that she was not working on 4/28/26 when the medication went missing. Interview 5/27/26 at 1:49 PM with Staff D confirmed she was working on 4/28/26 when the medication for Resident #2 went missing. Staff D revealed that she did not see the Hydrocodone at the nurses station, and that she was the nurse on the floor that day. Staff D further revealed that she did find the count sheet in a pile of paperwork several days later. Staff D continued that she did notify Staff S the previous Regional Clinical Director of the missing medication, as well as Staff P the previous Administrator at the same time. Staff D further revealed that she was the interim Director of Nursing (DON) at the time, and confirmed that she did not report the missing narcotics to Staff S, Staff P, the local police department, or the State Agency until 5/7/26. Staff D continued that she was not trained on what to do in this situation with the missing narcotics. Staff D then revealed that she should have reported to the appropriate people within 24 hours. Interview 5/27/26 at 2:06 PM with Staff S revealed that she was notified several days after the medication for Resident #2 had gone missing. Staff S then revealed that the staff did look all over for the medications when she was notified on 5/7/26, but could not locate the 54 missing tablets. Staff S continued that the missing narcotics were not reported to the State Agency, or the police department until 5/8/26. Staff S then revealed that she would have liked to have seen the police department investigate this prior to 5/26/26 when the State Agency notified the police department to inquire about their investigation. Staff S further revealed the DON at the time did not notify the appropriate persons in a timely manner. Interview 6/1/26 at 12:25 PM with Staff K the current Director of Nursing (DON) revealed she would expect the facility to properly investigate when narcotics go missing. Review of a facility provided policy titled, Nursing Facility Abuse Prevention, Investigation and Reporting with an updated date of 3/18/26 indicated that should an incident or suspected incident of resident abuse be reported or observed, the Administrator must be notified immediately. The policy further indicates the Administrator will complete documentation of the allegation of Resident abuse and collect any supporting documents relative to the alleged incident. Following investigation, the Administrator or designated agent will be responsible for forwarding the results of the investigation to the Department of Inspections & Appeals. This written report shall be forwarded to the Department within five days of the initial report.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, family interviews, staff interviews, and policy review the facility failed to hold Care Conferences for 4 of 4 residents reviewed (Residents #6, #11, #12, #16). The facility failed to hold and document Care Plan Conferences that included the resident and/or the resident representative. The facility reported a census of 32 residents. Findings include: 1. Resident #6's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 2/15 indicating severe cognitive impairment. The document included diagnoses of Non-Alzheimer's Dementia and anxiety. The Care Plan revised 5/15/26 included focus area and staff interventions for risk for falls, diversional activity deficit, communication deficit, psychotropic medications, hospice, behaviors, impaired cognitive function and self care. Review of the clinical record documentation revealed a Care Conference had not been held that included the resident's family and/or representative. The clinical record census revealed the resident was admitted on [DATE]. In an interview on 5/28/26 at 11:00 AM Resident #6's family stated they were contacted by the facility for the need of a Care Conference within the first 3 days of admission due to the resident's behaviors and were going to kick him out. The family stated they agreed to the need for a Care Conference and stated they had been asking for a conference since that time and one had not been held. 2. Resident #11's MDS assessment dated [DATE] revealed the resident had a BIMS score of 2/15 indicating severe cognitive impairment. The document included diagnoses of diabetes mellitus (DM), cerebrovascular accident (stroke), Non-Alzheimer's Dementia, anxiety, depression and bipolar. The Care Plan revised 5/26/26 included focus areas and staff interventions for risk bleeding, self care deficits, activities, nutritional problems, skin integrity, restorative nursing, and medications. Review of the clinical record Progress Notes revealed a Care Conference had been held on 1/14/26 with dietary, social services, activities, charge nurse and the resident in attendance. The entry revealed the resident's representative was not present or involved in the Care Conference. Review of the Progress Notes revealed no notification to the resident's representative prior to the Care Conference. The Progress Notes revealed no additional Care Conferences were held since 1/14/26. On 5/21/26 at 1:01 PM Resident #11's family member indicated he was also the resident's Power of Attorney (POA). The POA stated he had not been involved in a Care Conference and did not know what that was. On 5/20/26 at 10:40 AM Staff P, prior Administrator, stated the Care Plans were managed by the offsite MDS Coordinator for the initial Care Plan and the Director of Nursing (DON) for updates. Staff (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	P stated Social Services set up the Care Conferences, but that staff had resigned over a week ago. Staff P stated a formal plan for scheduling Care Conferences was not set but it would likely be up to himself and the DON. 3. Review of Resident #12's MDS dated [DATE] revealed Resident #12 was admitted to the facility from the community on 10/9/17. The MDS further revealed a BIMS score of 8 indicating moderate cognitive impairment. Review of Resident #12's Electronic Healthcare Record (EHR) page titled, Progress Notes revealed an entry dated 1/14/26 at 10:58 AM indicated that Resident #12 last had a care conference on 1/13/26 attended by dietary, social services, activities, a charge nurse, and Resident #12. The record lacked any documentation of a care conference held since then. 4. Review of Resident #16's MDS dated [DATE] revealed Resident #16 was admitted to the facility 4/18/23. The MDS further revealed a BIMS score of 15 indicating intact cognitive functioning. Review of Resident #16's EHR page titled, Progress Notes revealed an entry dated 12/22/25 at 2:57 PM indicated that Resident #16 last had a care conference on 12/22/25 at 11:30 AM with dietary, social services, activities, and Resident #16. Interview 6/1/26 at 12:25 PM with Staff K the current Director of Nursing (DON) revealed the facility did just hire a new social services employee. The DON further revealed she was unaware as to when the old social services worker left their position, and was unaware if care conferences were being completed. Follow up interview 6/1/26 with Staff K revealed she would expect care conferences to be completed appropriately and quarterly. Interview 6/1/26 at 2:01 PM with Staff L revealed the facility did just hire a new social services employee, but this new employee was still in the paperwork process. Staff L then revealed that care conferences had not been conducted. Review of a facility provided policy titled, Care Planning- Interdisciplinary Team with a revised date of September 2013 indicated that the resident, the resident's family and/or legal representative/guardian are encouraged to participate in the development of and revision of the resident's care plan. The policy further indicated that the facility will make every effort to schedule care plan meetings at the best time of the day for the resident and family.

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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** Based on clinical record review, facility audit review, observations, resident interviews, staff interviews, and policy review the facility failed to provide professional standards of care by not providing treatments per physician orders, documenting treatments before completion, documenting provision of medications when not available, and providing medications outside of parameters for 4 of 5 residents reviewed (Residents #2, #3, #8, #20). The facility reported a census of 32 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #2, dated 3/25/26, included diagnoses of acquired absence of right leg below the knee and diabetes. The MDS indicated the resident had a surgical wound and a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment for decision-making. Resident #2's Treatment Administration Record (TAR) for 5/1/26 – 5/31/26 revealed a physician's order for left anterior knee distal, left medical knee, left below the knee amputation(BKA) (surgical wound): Cleanse area with wound cleaner soaked gauze, apply skin prep to peri wound (area around edges of wound), apply hydrofera blue ready (antibacterial foam dressing used to promote healing in various wounds) to wound bed, cover with silicone bordered foam, change 3 times weekly on Monday, Wednesday, Friday on day shift and as needed for soiling. Interview and observation on 5/12/26 at 5PM, Resident #2 stated he recently had a left BKA amputation and was receiving treatments to his surgical site. The resident had three dressings, dated 5/11/26, on his left BKA surgical site area. Observation on 5/13/26 at 11:00 AM, Resident #2 outside for scheduled activity. Resident with two dressings on his left BKA surgical site area and one uncovered wound approximately 4 centimeters (cm) X 3 cm. with a yellow-colored surface and yellowish/red drainage on the pillowcase in his wheelchair where the uncovered wound is touching. Observation on 5/13/26 at 4:52 PM, Resident #2 in wheelchair and two dressings dated 5/11/26 remain on left BKA surgical area and one wound remains open. On 5/13/26 at 4:49 PM, Resident #2's TAR for 5/1/26 – 5/31/26, revealed the treatment for the resident's left anterior knee distal, left medial knee, and left BKA (surgical wound) was documented as completed by Staff H, Licensed Practical Nurse (LPN). A facility's Medication Admin Audit Report for Resident #2, dated 5/21/26, revealed on 5/13/26 at 1:47 PM the treatment for the resident's left anterior knee distal, left medial knee, and left BKA (surgical wound) was documented as completed by Staff H, LPN. Interview on 5/14/26 at 8:00 AM, Staff A, Certified Nurse Aide (CNA) stated yesterday morning when she got Resident #2 up, his dressing was off the open wound. Staff A stated after getting the resident up, she reported to Staff H that the wound was open without a dressing. Staff A further stated that she knows the wound remained without a dressing until at least 2:00 PM when she laid the resident down. Observation on 5/19/25 at 3:10 PM, Resident #2 in the dining room participating in group activity. The resident had no dressing on his left BKA wound area. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2's TAR for 5/1/26 – 5/31/26 documented left anterior knee, left lateral knee treatment of cleanse with saline and swab with betadine completed by Staff F, Registered Nurse (RN). Interview on 5/19/26 at 3:15 PM, Staff F stated she completed Resident #2's treatment for the lateral and anterior knee this morning and the wound was covered at that time. Staff F further stated Staff G, CNA assisted her to complete the treatment. Interview on 5/19/26 at 3:30 PM, Staff G denied she assisted Staff F with completing Resident #2's treatments today as Staff G is not even working down that hall. Interview on 5/19/26 at 3:35 PM, queried Staff F that Staff G denied assisting Staff F with Resident #2's leg/knee treatment this morning. Staff F stated that is why she asked if the resident had gone to activities as Staff F was insinuating that the dressing could have fallen off when the resident went to activities. Staff F further stated the left BKA wound area was wrapped and Staff F will just have to do it again. 2. The MDS for Resident #3, dated 4/7/26, included diagnoses of acquired absence of left leg below knee, encounter for orthopedic aftercare following surgical amputation, and diabetes. The MDS the resident had a BIMS score of 12, indicating mild cognitive impairment for decision-making. Resident #3's TAR for 5/1/26 – 5/31/26 revealed a physician's order, start date of 4/10/26, for surgical incision to left lower extremity- cleanse area with wound cleanser, idoform packing (medicated gauze to pack open wounds to combat infection) to open area, cover with gauze, wrap with kerlix (gauze wrapping), and wrap with ace bandage, change daily and as needed for soiling, every day shift for wound care. The TAR revealed the treatment was signed as completed every day from 5/1/26 – 5/19/26 except for 5/16/26. Resident's hospital after visit summary dated 5/11/26 revealed diagnosis of wound of left leg, wound dehiscence (a surgical wound that has reopened) with instructions to leave the dressing on, keep it dry and intact until the next visit on 5/29/26. Observation and interview on 5/14/26 at 9:00 AM, Resident #3 sitting on the side of the bed, with stocking over her left BKA. The resident stated she has a new amputation of her left leg below the knee and recently had to return to the hospital for surgical treatment of her amputation. The resident further stated she is supposed to have a treatment every day to her BKA but depends on which staff is on, sometimes the treatment only gets done every other day. Observation on 5/18/26 at 1:33 PM, Resident #3 with a dressing partially attached to her left BKA dated 5/17. The resident stated a nurse had changed the dressing and threw away the stocking cover due to blood on the stocking. Observation on 5/19/26 at 2:40 PM Staff F assisted Resident #3 to activities and Staff F told the resident she will do her BKA treatment after the activity. The resident's left BKA site with stitches visible and no dressing. Interview on 5/19/26 at 2:45 PM, Staff F stated she had not completed Resident #3's left BKA treatment for the day. Queried Staff F about treatment already signed off as completed. Staff F reviewed the resident's electronic health record and confirmed the left BKA treatment was (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented as completed by herself at 11:26 AM. Staff F stated she thinks she may have accidentally signed off the treatment when she administered and signed off the resident's insulin. Observation 5/20/26 at 1:50 PM, Resident #3 sitting in a wheelchair, left BKA site with stitches not covered, yellowish-red fluid dripping from stitched area. Observation and interview on 5/20/26 at 2:15 PM, Staff J, RN entered Resident #3's room and cleansed suture site with wound cleanser, placed Iodoform on top of the sutures, wrapped the BKA with kerlix and then ace wrap. Staff J stated that was the current ordered treatment for the resident's BKA suture site. Interview on 5/21/26 at 11:40AM, Staff K, Director of Nursing (DON) stated her expectation for treatments to be completed per physician orders and not document treatments as done before they are completed. 3. Resident #8's MDS dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating normal cognition. The MDS documented diagnoses of anemia, hypertension -high blood pressure (HTN), and diabetes mellitus (DM). The document included the resident during 6 of the last 7 days of the reporting period the resident received an injection and hypoglycemic medication. The Care Plan revised 4/29/26 revealed a problem area related to DM and risk for frequent infections, visual impairment, hyper/hypoglycemia revised on 3/17/25 with staff interventions including all concerns with DM to be addressed with the primary care physician (PCP), diabetes medications as ordered by PCP with monitoring and documented side effects and effectiveness, and monitor/checks blood glucose levels as ordered. The document included a problem area related to altered cardiovascular status and risk for shortness of breath, chest discomfort, pain/numbness/weakness in extremities with diagnoses of peripheral vascular disease (PVD), HTN, and hyperlipidemia revised 4/29/26 with staff interventions of notification to PCP of signs/symptoms of complications of diagnoses, altered vascular status and side effects of medications. The clinical record's Medication Administration Record (MAR) for 4/26 revealed the following orders: Amlodipine Besylate Oral Tablet 10 milligram (mg); give 1 tablet in the morning related to HTN, hold if systolic blood pressure - top/first number (SBP) is less than 100 with a start date of 5/20/25. On 4/1 blood pressure 86/42 medication administered. On 4/7 blood pressure 96/48 medication administered. Metoprolol Succinate Extended Release (ER) Oral Tablet 24 hour 100 mg; give 100 mg in the morning related to HTN, hold if SBP is less than 100 with a start date of 5/20/25. On 4/1 blood pressure 86/42 medication administered. On 4/7 blood pressure 96/48 medication administered. Hydralazine HCl Oral Tablet 50 mg; give 1 tablet three times a day (TID) related to HTN, hold if SBP is less than 100 with a start date of 3/4/25. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/1 morning blood pressure 86/42 medication administered. On 4/7 morning blood pressure 96/48 medication administered. On 4/10 morning blood pressure 98/54 medication administered. The clinical record's MAR for 5/26 revealed the following orders: Amlodipine Besylate Oral Tablet 10 milligram (mg); give 1 tablet in the morning related to HTN, hold if SBP is less than 100 with a start date of 5/20/25. On 5/4 blood pressure 90/50 medication administered. On 5/9 blood pressure 96/66 medication administered. On 5/14 blood pressure 98/36 medication administered. On 5/15 blood pressure 90/40 medication administered. Metoprolol Succinate Extended Release (ER) Oral Tablet 24 hour 100 mg; give 100 mg in the morning related to HTN, hold if SBP is less than 100 with a start date of 5/20/25. On 5/4 blood pressure 90/50 medication administered. On 5/9 blood pressure 96/66 medication administered. On 5/14 blood pressure 98/36 medication administered. On 5/15 blood pressure 90/40 medication administered. Hydralazine HCl Oral Tablet 50 mg; give 1 tablet TID related to HTN, hold if SBP is less than 100 with a start date of 3/4/25. On 5/4 morning blood pressure 90/50 medication administered. On 5/9 morning blood pressure 96/66 medication administered. On 5/15 morning blood pressure 90/40 medication administered. On 5/19 mid day blood pressure 94/46 medication administered. On 5/20 evening blood pressure 94/65 medication administered. On 5/28 evening blood pressure 92/74 medication administered. On 5/29 mid day blood pressure 94/48 medication administered. Mounjaro Subcutaneous Solution Auto-injector 10 mg/0.5milliliters (ml); inject 1 syringe subcutaneously every Monday related to Type 2 DM without complications with a start date 4/27/26. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/4 medication not available. On 5/11 medication administered. On 5/18 medication administered. On 5/25 medication not available. The clinical record's Progress Notes revealed the following entries: 4/21/26 the resident returned from appointment with new orders: lower Mounjaro to 10mg weekly with the resident and pharmacy notified and the MAR updated. 5/4/26 Mounjaro 10 mg/0.5 ml waiting on prior authorization. 5/25/26 notification to PCP that Mounjaro not available; medication has been reordered. Requested a one-time order to give when medication arrives. 6/1/26 call placed to PCP regarding need for prior authorization for Mounjaro. Per pharmacy the medication has needed a prior authorization since March and has not been filled. On 6/2/26 at 10:50 AM Staff R, pharmacy representative, stated the pharmacy last attempted to fill Resident #8's Mounjaro prescription on 5/25 and was denied for insurance reasons. The staff stated the last time the medication was delivered to the facility was on 3/30 and 3/31, they had to send partial dosages for a total of 4 doses of 15 mg Mounjaro. Staff R stated the 4 dosages equaled a 4 week supply. Staff R stated the pharmacy received a new order for decreasing Mounjaro to 10 mg on 4/21/26 and has not been able to fill the new dose secondary to insurance and preauthorization. The facility failed to hold hypertensive medications when Resident #8's blood pressure was below the physician ordered parameter. The facility failed with documentation of the resident's Mounjaro, documenting the medication had been provided when the medication had not been filled by the pharmacy. 4. Resident #20's MDS dated [DATE] revealed a BIMS score of 14/15 indicating normal cognition. The MDS documented diagnoses of HTN and DM. The document included during 7 of the last 7 days of the reporting period the resident received an insulin injection, took diuretic and hypoglycemic medications. The Care Plan revised 4/28/26 revealed a focus area risk for altercations in cardiovascular status revised on 4/28/26 with interventions to administer medications as ordered and monitor blood pressure as ordered revised 5/8/25. The document contained a problem area for nutrition revised on 4/28/26 with interventions for staff including: notification to PCP signs of altered mental status, HTN, chest pain and signs of malnutrition. A problem area of diuretic therapy revised on 8/5/25 provided staff interventions of administering medication as ordered with medications interacting with hypertensive medications, obtaining and reporting any orders to PCP, and reporting any adverse effects to PCP. The Care Plan provided a problem area related to DM revised on 7/9/25 with interventions to provide medications as ordered, dietitian to follow nutritional regimen, observe for side effects and signs of hypo/hyperglycemia, and provide with meal times, dietary restrictions and snacks revised 7/2/25. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The clinical record's Clinical Physician Orders revealed an order for daily weight every day shift for use of Torsemide with a start date of 3/31/26. The clinical record's MAR for 4/26 revealed the following orders: Accuchecks TID related to Type 2 DM without complications with a start date of 1/2/25 had no documentation on the evening of 4/23/26. Humalog KwikPen Subcutaneous Solution Pen Injector 100 unit/ml per parameters related to Type 2 DM with a start date of 1/2/25 had no documentation on the evening of 4/23/26. The clinical record's MAR for 5/26 revealed the following orders: Lantus SoloStar Subcutaneous Solution Pen Injector 100 unit/ml; inject 18 units at bedtime related to Type 2 DM with a start date of 3/12/26 had no documentation on 5/10/26. Accuchecks TID related to Type 2 DM without complications with a start date of 1/2/25 had no documentation on the evening of 5/19/26. Humalog KwikPen Subcutaneous Solution Pen Injector 100 unit/ml per parameters related to Type 2 DM with a start date of 1/2/25 had no documentation on the evening of 5/19/26. The clinical record's Weight Log revealed lack of documentation on 4/1, 5/7, 5/8, 5/11, 5/18, 5/28, and 5/29. The facility failed to document and/or provide care, treatment and medication per physician orders. On 6/1/26 at 4:45 PM Staff K, Director of Nursing (DON), stated if a physician ordered parameters with a medication then the medication should not be administered outside of those parameters. The staff stated if a Certified Medication Aide (CMA) was providing medications then that staff needed to make contact with the nurse regarding the medication. Staff K stated if there was a blank on a MAR it would indicate that the medication/treatment had not been provided. The facility's undated Charting and Documentation Policy revealed all services a resident receives shall be documented in the resident's medical record which included medications, treatments and services. The policy included entries will document the date and time of the procedure/treatment was provided, refusal, notification of the family/physician if indicated, and must be accurate. The facility's undated Provision of Physician Ordered Services Policy revealed care and all services are provided according to accepted standards of clinical practice. The facility's Wound Care Policy, revised 10/10, provided guidelines for the care of wounds to promote healing. The document disclosed the steps necessary when completing the treatment and for documentation. The policy revealed documentation included: documenting the dressing with initials/ time/date, documenting in the medical record the type of wound care, date/time when the wound care was provided, assessment data, and documentation/notifications of refusal of treatment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, resident interviews, staff interviews, and facility policy review the facility failed to provide oral care for 4 of 4 residents (Residents #1, #6, #2, #12) reviewed. The facility reported a census of 32 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating normal cognition. The MDS documented diagnoses of atrial fibrillation, heart failure, and diabetes mellitus (DM). The document coded the resident required setup for grooming/hygiene tasks. The Care Plan revised 4/30/26 identified a problem area of self care deficit as evidenced by requiring assistance with activities of daily living (ADLs) revised on 4/30/26 with a staff intervention of need for 1 person assistance for oral care including encouraging care in the morning, afternoon and hour of sleep. The document included the resident had own teeth with some broken and for staff to assist with oral care revised on 9/15/25. Observed on 5/27/26 at 7:40 AM Staff C, Certified Nursing Assistant (CNA) and Staff G, CNA, assist Resident #1 with personal care. Observed the resident's emesis basin, dated 5/2, contained a toothbrush sealed in plastic, sealed mouthwash and unused toothpaste. Following a dependent transfer to her recliner, Staff G asked Resident #1 if she would like to brush her teeth and provided set up for the resident to complete the task. On 5/27/26 at 8:40 AM Resident #1 stated she never brushed her teeth as she was over here indicating seated in her recliner, and the water and all of the stuff was over there gesturing to the sink/counter area across the room. 2. Resident #6's MDS Assessment Resident #6's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a BIMS score of 2/15 indicating severe cognitive impairment. The document coded the resident was dependent upon staff for oral care. The document included diagnoses of Non-Alzheimer's Dementia and anxiety. The Care Plan revised 5/15/26 identified a problem area with self care deficit by requiring assistance with ADLs revised on 5/7/26 with a staff intervention of 1 person assistance encouraging care in the morning, afternoon and at hour of sleep, and the resident had his own teeth revised on 5/7/25. Observed on 5/27/26 at 7:08 AM Staff C and Staff G assist Resident #6 with peri care, dressing, transfer to a wheelchair and combing hair. Staff G pushed the resident to the nurse's station. Observed the resident's spit basin dated 5/2 contained an unopened sealed in plastic toothbrush, sealed mouthwash, and unused toothpaste. On 5/27/26 at 7:35 AM Staff C stated staff should be completing oral care with residents. On 5/27/26 at 7:45 AM Staff G acknowledged Resident #6 should have had oral care and face washed prior to leaving his room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #2's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognitive functioning. The MDS further indicated that Resident #2 was dependent on staff assistance for oral hygiene, toileting hygiene, upper body dressing, and lower body dressing. Further review of the MDS indicated that Resident #2 had diagnoses of coronary artery disease, heart failure, renal insufficiency, diabetes mellitus, and blindness in the left eye. Review of Resident #2's Care Plan with a revision date of 4/28/26 indicated that Resident #2 required the assistance of 1 staff to encourage oral care in the morning, afternoon, and at bedtime. The care plan further indicated that Resident #2 has his own teeth with some that are broken. Observation 5/26/26 at 1:45 PM revealed Resident #2's toothbrush was still wrapped in plastic and unopened in a spit basin labeled 5/2/26. Interview 5/26/26 at 3:00 PM with Resident #2 revealed that staff do not help brush his teeth as he has no teeth to brush. Resident #2 further revealed that staff do not offer to help brush his gums either, and confirmed that his toothbrush is still in the plastic by his sink. 4. Review of Resident #12's MDS dated [DATE] revealed a BIMS score of 8 indicating moderate cognitive impairment. The MDS further indicated that Resident #2 required substantial assistance with oral hygiene, upper and lower body dressing, and personal hygiene. Further review of the MDS indicated Resident #2 had diagnoses of coronary artery disease, renal insufficiency, and non-Alzheimer's dementia. Observation 5/26/26 at 1:50 PM of Resident #12's toothbrush still wrapped in plastic and unopened in a spit basin labeled 5/2/26. Interview 5/26/26 at 3:58 PM with Staff N Certified Nursing Assistant (CNA) revealed night shift changes out the toothbrushes for the residents monthly at the beginning of the month. Staff N then revealed she knows toothbrushing is not getting completed twice a day as staff seem to be running all the time due to call ins. Interview 5/26/26 at 4:06 PM with Staff K the current Director of Nursing (DON) revealed that she would expect oral care and toothbrushing to be completed twice a day or more depending on orders. Review of a facility provided policy titled, Oral Care with an implementation date of 5/27/26 indicated the facility is to provide oral care to residents in order to prevent and control plaque-associated oral diseases.

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	165531	A. Building B. Wing	06/02/2026

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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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. Based on observation, resident electronic health record review, staff interview, and policy review the facility failed to provide safe ambulation/transfer techniques by not using a gait belt to ambulate a resident that required assistance for 1 of 3 (Resident #14) residents reviewed. The facility reported a census of 32 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #14, dated 5/12/26, included diagnoses of cancer and anxiety disorder. The MDS identified the resident required substantial/maximal assistance of staff for sit to stand, transfers, and walking. The MDS identified the resident was occasionally incontinent of bladder and bowel and a Brief Interview for Mental Status score of 9, indicated moderate cognitive impairment for decision-making.Resident #14's Care Plan, with revision date 5/23/25, documented the following problems and interventions:a. Self-care deficit as evidenced by requiring assistance with activities of daily living, impaired balance during transitions requiring assistance and /or walking with an intervention for mobility of assist of 1 staff with front-wheeled walker and wheelchair with revision date 2/18/26.b. At risk for falls related to impaired balance, poor safety awareness, neuromuscular functional impairment and the use of medications that may increase falls risks, revised 5/1/26, with interventions of educated resident to utilize call light for assistance and encourage resident to ask for assistance when wanting to transfer/ambulate.Observation on 5/14/26 at 7:30 AM, Resident #14 walked down the hall and to the dining room with a wheeled walker and Staff C, Certified Nurse Aide (CNA), with Staff C's hand on resident's lower back, no gait belt on resident.Interview on 5/14/26 at 11:40 AM, Staff E, CNA stated Resident #14's care plan revealed the resident is an assist of 1 staff with a walker which would require a gait belt to be used when transferring or walking with the resident. The facility Use of Gait Belt Policy, undated, revealed it is the policy of this facility to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety.Interview on 5/21/26 at 11:40 AM, Staff K, Director of Nursing stated expectation for staff to use a gait belt for transfers and ambulating residents that need assistance and as documented in the resident's care plan.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, resident interview, staff interview, and policy review the facility failed to meet professional standards for ostomy care by not releasing the build up of gas in the ostomy bag, which caused the appliance to spill the contents for 1 of 1 (Resident #13) reviewed. The facility reported a census 32.Findings include:Review of Resident #13's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS further indicated Resident #12 had diagnoses of functional quadriplegia, ileostomy status, noninfective gastroenteritis (inflammation of the stomach and intestines) and colitis (inflammation of the inner lining of the large intestine), and Ogilvie syndrome (sudden paralysis and massive dilation of the colon). Review of Resident #13's Care Plan with a revision date of 4/28/26 indicated that Resident #13 requires an assist of 1 staff with colostomy care and emptying. Observation 5/26/26 at 3:20 PM revealed Resident #13's ostomy bag completely filled with air, after bingo.Interview 5/26/26 at 3:30 PM with Resident #13 revealed that staff are not always the best about burping or draining his ostomy bag. Resident #13 further revealed that if staff don't burp his ostomy bag it will make a mess as the sides of the appliance will blow out and everything that is inside will spill out. Resident #13 continued that this has happened several times. Observation 5/27/26 at 9:28 AM revealed Resident #13 sitting by the nurses station on the west hall with his ostomy appliance full of air at this time. Interview 6/1/26 at 9:40 AM with Staff A Certified Nursing Assistant (CNA) revealed that she completes the task of burping Resident #13's ostomy appliance, but she believes that not all staff are completing this. Staff further revealed that when charting the task of burping the appliance that the system will not always record correctly that it is being done. Staff A further continued that Resident #13's ostomy appliance fills with air pretty quickly, and that it really does need to be burped or it will pop and come apart. Interview 6/1/26 at 10:15 AM with Staff G CNA revealed that ostomy outputs are to be charted twice a day, and that Resident #13 does have a task for Resident #13 to have his ostomy appliance burped every 2 hours. Staff G further revealed that if the ostomy is not emptied of the air then the ostomy will pop and will be a mess. Staff G continued that if Resident #13's ostomy is getting burped when she is working, but does not think that all the staff are completing this task. Interview 6/1/26 at 1:13 PM with Staff K the current Director of Nursing (DON) revealed that she would expect staff to empty and burp ostomy appliances at the appropriate times. Review of a facility provided policy titled, Ostomy Care-Colostomy, Urostomy, and Ileostomy with and implementation date of 5/27/26 indicated residents who required colostomy, urostomy, or ileostomy services will receive care consistent with professional standards of practice.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, resident interview, electronic health record review, policy review, and staff interview the facility failed to provide a respiratory treatment timely for 1 (Resident #17) of 1 residents reviewed. The facility reported a census of 32 residents. Findings include:The Minimum Data Set (MDS) assessment for Resident #17, dated 2/24/26, included diagnoses of Panlobular Emphysema (a severe form of chronic obstructive pulmonary disease (COPD) with widespread lung damage) and COPD. The MDS identified a Brief Interview for Mental Status score of 9, indicated no cognitive impairment for decision-making.Resident #17's Care Plan documented a problem of resident has COPD and is at risk for shortness of breath, impaired breathing, and respiratory infections with the intervention to administer medications/inhalers as ordered.Observation on 5/14/26 starting at 10:00 AM, Resident #17 walked down the hall, leaning on the wall and holding the hand rail, was able to hear the resident wheezing and the resident appeared short of breath, and resident stated he needed a vial of medication for his nebulizer (breathing treatment) now. Staff I, Certified Medication Aide replied to the resident that she had notified the nurse as she was no longer able to do his breathing treatments. Staff D, Registered Nurse came and walked to the resident's room with the resident, listened to the resident's lungs, and started a breathing treatment. Interview on 5/14/26 at 10:25 AM, after Resident #17's breathing treatment completed, Resident #17 stated he had been waiting for at least 40 minutes for his breathing treatment and had been having a hard time breathing prior to the treatment. The resident stated he turned on his call light at 9:10 AM, according to the clock on his wall, and approximately 10 minutes later an unknown staff member came in, which he reported to her that he needed a breathing treatment and she said she would tell the nurse, and nobody has ever come back. The resident stated this happens frequently that he has to wait way over 15 minutes when he asks for a breathing treatment and has had to wait up to 2 hours before. Resident #17 stated the staff can be late with his other medications but he can't wait that long for his breathing treatments as he needs to be able to breathe.Resident #17's Medication Administration Record, 5/1/26 - 5/31/26, revealed a physician's order for Ipratropium-Albuterol Inhalation Solution, (medication administered in a breathing treatment) inhale orally every 6 hours as needed for shortness of breath related to COPD.Resident #17's electronic health record Progress Note, dated 5/14/26 at 10:08 AM, created by Staff D, documented: Resident complaining of shortness of breath, audible wheezing noted. Upon auscultation (listening to lungs with a stethoscope) wheezing noted throughout.The facility Nebulizer Therapy policy, not dated, documented it is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed.Interview on 5/21/26 at 11:40AM, Staff K, Director of Nursing stated expectation for staff to evaluate a resident's breathing status and administer ordered breathing treatments timely when needed by a resident.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and policy review the facility failed to provide nursing staff to assure residents safety by not responding to call lights in a timely manner for 4 of 4 residents (Residents #10, #19, #21, #1) reviewed. The facility reported a census of 32. Findings include: 1. Resident #10's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating normal cognition. The document coded the resident was dependent upon staff for all self care activities including dressing, toileting hygiene, transfers, eating and grooming/hygiene. The document revealed the resident had an indwelling catheter and was always incontinent of bowel. The MDS Assessment documented a diagnosis of quadriplegia (paralysis of 4 limbs). The Care Plan revised on 4/29/26 identified a problem area of self care deficit revised on 4/29/26 with staff interventions of ensuring the call light was within reach and bed mobility/transfers/dressing required the assistance of 2 staff. On 5/21/26 at 2:15 PM Resident #10 stated he has waited for over an hour for his call light to be answered, especially later evenings and overnight. The resident stated in the past couple of days there had been only 1 Certified Nursing Assistant and 1 Certified Medication Aide (CMA) getting people ready for bed. The resident stated when this happens the CMA has to help with transfers and then medications may be late. 2. Resident #19's MDS assessment dated [DATE] revealed a BIMS score of 15/15 indicating normal cognition. The assessment coded the resident as requiring partial/moderate assistance for toilet hygiene. The MDS Assessment documented diagnoses of spinal stenosis of lumbar region (narrowing of space of the spine in the lower back causing pain and pressure), and diabetes mellitus (DM). The Care Plan revised on 4/30/26 identified a problem area related to DM revised 3/17/25 with staff interventions of snacks and monitoring of blood glucose levels. The document disclosed a problem area of chronic pain and decreased function related to spinal stenosis, and DM with polyneuropathy revised 8/5/25 with staff interventions of provision of scheduled and as needed (PRN) medications. The Care Plan's problem area of self care deficit revised 4/30/26 instructed staff to ensure call light was within reach. On 5/21/26 at 1:20 PM Resident #19 stated he turned his call light on at approximately 3:00 AM and it was not answered until after 6:00 AM when the next shift came on duty. The resident stated he didn't think there was enough staff on the overnight shift. 3. Resident #21's MDS assessment dated [DATE] revealed a BIMS score of 15/15 indicating normal cognition. The assessment coded the resident as requiring total assistance from staff for toileting hygiene, transfers, dressing, and bed mobility. The document included the resident had an indwelling catheter and was always incontinent of bowel. The MDS Assessment documented diagnoses of stroke, paraplegia, and anxiety. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan revised on 4/29/26 contained a problem area for risk for falls revised on 8/6/25 with a directive for staff to ensure the call light was within reach and encourage the resident to use it for assistance. The document revealed a self care deficit revised on 8/6/25 with staff interventions of 2 person assist for bed mobility, toileting and transfers using a Hoyer lift. Continuous observation on 5/20/26 beginning at 1:44 PM Resident #21 turned his call light on, at 2:00 PM Staff E, CNA, asked the resident what he wanted and left the area. At 2:02 PM Staff E, donned PPE and entered the room with a Hoyer lift and turned the call light off. 4. Resident #1's MDS assessment dated [DATE] revealed a BIMS score of 15/15 indicating normal cognition. The document coded the resident was dependent on staff for toilet hygiene, transfers, and lower body dressing. The document revealed the resident was incontinent of bowel and bladder. The MDS Assessment documented diagnoses of atrial fibrillation, heart failure, and diabetes mellitus (DM). The Care Plan revised on 4/30/26 identified a problem area of self care deficit revised on 4/30/26 with staff interventions of 2 person assist with bed mobility, 2 person assist for dressing, resident's call light is within reach, 2 person assist for toileting, and 2 person assist with transfers using a Hoyer (dependent mechanical non weight bearing lift). On 5/20/26 at 3:57 PM Resident #1 stated she has had to wait up to an hour for her call light to be answered. The resident stated she knows how long as she watches the time on her phone. Resident #1 stated she thought it was due to lack of staff rather than staff themselves. During continuous observation 5/26/26 from 3:33 PM until 3:57 PM (24 Minutes) Resident #1's call light was observed to be on with Resident #1 waiting by the door of the room watching her phone. Interview 5/26/26 at 4:06 PM with Staff K the current Director of Nursing (DON) revealed she would like to see call lights answered within 15 minutes or less. Review of a facility provided policy titled, Call Lights: Accessibility and Timely Response with an implementation date of 5/27/26 indicated call lights will directly relay to a staff member to ensure appropriate response.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, staff interviews, and policy review, the facility failed to provide appropriate treatment and services to meet a resident's highest practicable physical, mental, and psychosocial well-being for residents diagnosed with dementia for 2 of 2 residents reviewed (Resident #6, #11). The facility had a census of 32.Findings include:1. Resident #6's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a BIMS score of 2/15 indicating severe cognitive impairment. The document revealed the resident displayed fluctuating inattention, physical behaviors directed towards other 4-6 days of the last 7 days of the reporting period, verbal behavioral symptoms towards other 1-3 days of the last 7 days of the reporting period and those behaviors significantly interfered with the resident's care, social interaction and significantly impacted the privacy, care, and living environment of others. The document disclosed the resident required significant assistance or was dependent upon staff for self care and transfers. The document included diagnoses of Non-Alzheimer's Dementia and anxiety. The document revealed the resident took antipsychotic, antianxiety, and opioid medications. The clinical record's Medical Diagnoses identified the resident had a diagnosis of vascular dementia, severe, with agitation (5/1/26). The Care Plan revised 5/15/26 identified a problem area related to fall risk revised on 5/7/26 with staff interventions of low bed and safe environment with even floors and personal items within reach. A problem area identified the potential or diversional activity deficit due to cognitive impairment with staff interventions of encouragement of resident's family/friends to attend special activities, invite to attend activities, 1:1 bedside/in-room activities, and provide social interaction activities. A problem area of impaired cognitive function revised on 5/7/26 identified staff interventions of cue/orient/supervise as needed, report changes in cognitive function, and use of task segmentation. The Care Plan failed to identify Resident #6's specific diagnosis of vascular dementia and specific interventions related to that diagnosis. The Care Plan failed to provide individualized interventions to provide the resident related to activities, behaviors and non-pharmalogical interventions for behaviors. The document failed to provide revisions to the Care Plan with individualized behaviors. The Care Plan did not identify Resident #6 required 1:1.The clinical record's Physician Orders identified to monitor behaviors every shift with 0 = no behaviors, 1 = physical aggression, 2 = hallucinations, 3 = verbal aggression, 4 = resisting care, 5 = attention seeking, 6 = paranoia, 7 = wandering, 8 = agitation, and 9 = see nurse notes. The Physician Orders neither contained an order for 1:1 nor individualized behaviors. Observed on 5/20/26 at 1:00 PM Resident #6 seated in a w/c at the nurses' station with no activity present; staff present without interaction with the resident. Observed on 5/20/26 at 2:15 PM Resident #6 seated in a w/c at the nurses' station without activity and without interaction with staff.Observed on 5/20/26 at 2:55 PM Resident #6 seated in a w/c at the nurses' station with no activity; staff present at the nurse's station but not engaging with the resident. Observed on 5/20/26 at 4:15 PM Resident #6 seated in a w/c at the nurses' station in a wheelchair (w/c) with no activity and no interaction from staff. Observed on 5/20/26 at 4:45 PM Resident #6 seated in a w/c at the nurses' station, appearing restless demonstrated by moving leg rests and shifting in the w/c - no staff present. Oberved on 5/20/26 at 5:15 PM a visitor stating Resident #6, seated at the nurses' station, had urinated on himself and urine was running onto the floor. Observed no staff present. As the visitor stated urine all over the floor, Staff P, Previous Administrator, walked up, observed the urine on the floor, the resident's wet pants, and attempted to find staff to assist the resident. Oberved on 5/21/26 at 9:59 AM Resident #6 seated in his w/c sleeping at the nurses' station. Oberved on 5/27/26 at 9:35 AM Resident #6 seated at the nurses' station in his w/c with a blanket across his lap with no activity for engagement.Observed on 5/27/26 at 10:10 AM Resident #6 seated at the nurses' station seated in a recliner with the leg rest extended. Observed the resident moving around in the (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recliner with no activity and no staff in the area. Observed on 6/1/26 at 1:45 PM Resident #6 seated at the nurses' station seated in a w/c without any activity.On 5/27/26 at 12:50 PM Staff O, Certified Nursing Assistant (CNA), stated Resident #6 was a 1:1.On 5/27/26 at at 3:14 PM Staff T, CNA, stated Resident #6 was 1:1. 2. Resident #11's MDS assessment dated [DATE] revealed the resident had a BIMS score of 2/15 indicating severe cognitive impairment. The document disclosed the resident was dependent upon staff for all self care activities, transfers and wheelchair (w/c) mobility. The document included diagnoses of diabetes mellitus (DM), cerebrovascular accident (stroke), Non-Alzheimer's Dementia, anxiety, depression and bipolar.The clinical record's Medical Diagnoses identified Resident #11 had a diagnosis of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (10/9/15).The Care Plan revised 5/26/26 revealed a problem area that the resident chose not to participate in many activities, revised 4/29/26, with staff interventions to encourage the resident to attend activities, the resident enjoyed cornhole and animal visits, enjoys listening to music and provide 1:1 as needed, all revised 4/28/26. The Care Plan failed to identify Resident #11's specific diagnosis of unspecified dementia and specific interventions related to that diagnosis. On 5/21/26 at 11:15 AM Resident #11 seated in w/c at the nurses' station without any activity. On 5/27/26 at 9:35 AM Resident #11 seated at the nurses' station seated in her w/c without any activity or staff engagement. On 5/27/26 at 10:10 AM Resident #11 seated at the nurses' station without activity or staff present.In an interview on 5/20/26 at 10:47 AM Staff P stated the facility did not have a full time Activity Director, but did have a shared Activity Director with another facility who was present 3 days a week. In an interview on 6/2/26 at 12:10 PM Staff K, current Director of Nursing (DON), concurred there needed to be more education to staff on interactions with residents with diagnosis of dementia and activities available to them. The staff stated that Resident #6 was not identified as a 1:1 needing to be at the nurses' station, but did exhibit numerous behaviors and was a fall risk. Staff K stated if residents were at the nurses' station, activities/stimuli should be available. The facility did not have a policy related to dementia care and activities.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, resident interviews, staff interview, and policy review the facility failed to order and dispense medications per physician orders for 3 of 7 residents reviewed (Residents #1, #16, #19). The facility reported a census of 32 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15/15 indicating normal cognition. The MDS Assessment documented diagnoses of atrial fibrillation, heart failure, hyperlipidemia (high cholesterol), and diabetes mellitus (DM). The document revealed the resident received 1 injection, antibiotics, diuretics, and hypoglycemic medications during the past 7 days of the reporting period. The clinical record's Medical Diagnoses included: Type 2 diabetes mellitus without complications, hyperlipidemia, and hypokalemia (lower than normal potassium in blood that helps regulate heart rhythms, muscle contractions, and nerve signals). Resident #1's Care Plan, revised 4/30/26, revealed a problem area of DM revised 8/12/25 with staff interventions of diabetic medication as ordered by physician (revised 5/8/25), and to monitor/document/report episodes of hyper/hypoglycemia (high/low blood sugars). A problem area related to altered cardiovascular status and risk for shortness of breath, chest discomfort and diagnosis of hypokalemia (revised 4/30/26) with staff interventions for monitoring signs/symptoms of congestive heart failure/altered vascular status and lunch sounds, and observe for side effects of beta blockers (revised 4/30/26). Resident #1's Medication Administration Record (MAR) 4/26 revealed the following: Potassium Chloride Extended Release (ER) Oral Tablet Extended Release 20 MEQ. Give 1 tablet by mouth in the afternoon for electrolyte replacement related to Hypokalemia to be given after lunch start date 3/27/26 - medication not available 4/29/26.Potassium Chloride ER Oral Tablet Extended Release 20 MEQ. Give 1 tablet every day (QD) for electrolyte replacement start date 2/26/25 - medication not available 4/29/26. Resident #1's [DATE]/26 revealed the following:Potassium Chloride ER Oral Tablet Extended Release 20 MEQ.Give 1 tablet by mouth in the afternoon for electrolyte replacement related to Hypokalemia to be given after lunch start date 3/27/26 - medication not available 5/20/26.Potassium Chloride ER Oral Tablet Extended Release 20 MEQ. Give 1 tablet every day (QD) for electrolyte replacement start date 2/26/25 - medication not available 5/20/26.The clinical record's Progress Notes revealed the following:4/29/26 12:27 PM Potassium Chloride ER Oral Tablet Extended Release 20 MEQ. Give 1 tablet by mouth in the afternoon for electrolyte replacement related to Hypokalemia to be given after lunch medication on order.5/20/26 1:34 PM Potassium Chloride ER Oral Tablet Extended Release 20 MEQ. Give 1 tablet by mouth in the afternoon for electrolyte replacement related to Hypokalemia to be given after lunch - medication unavailable pharmacy notified.Potassium Chloride ER Oral Tablet Extended Release 20 MEQ. Give 1 tablet every day - medication not available, nurse and Director of Nursing (DON) notified. The clinical record lacked documentation of physician notification of medication unavailability. On 5/20/26 at 1:51 PM Staff Q stated there had been a lack of medication again for residents. The staff stated Resident #1's order for potassium had been faxed and the facility still did not have the medication. On 5/20/26 at 3:57 PM Resident #1 stated there had been a couple of instances where she did not receive all of her medications as they were not available. The resident stated some staff had spoken to her about it and told her the medication had not been ordered. The resident stated she could not remember the exact name of her medication as she took several of them. 2. Resident #16's MDS assessment dated [DATE] revealed a BIMS score of 15/15 indicating intact cognition. The MDS included the diagnoses of hypertension, traumatic brain injury (TBI), and depression. The MDS revealed the resident received antidepressant, diuretic, opioid, hypoglycemic, and anticonvulsant medications during the last 7 days of the reporting period. The clinical record's Medical Diagnoses included diagnoses of personal history of TBI, essential hypertension, and depression.Resident #16's (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care Plan, revised 4/29/26, revealed a problem area related to pain/discomfort and increased risk for injury from decreased function from TBI and history of skull/facial bone fractures and shingles revised on 8/5/25 with staff interventions of administer scheduled/PRN pain medications as ordered, attempt and document any non-pharmalogical interventions, and observe for side effects of narcotic medications (all initiated 8/5/25). Resident #16's [DATE]/26 revealed documentation had been completed that all medications were dispensed as ordered. Resident #16's [DATE]/26 revealed an order for Wellbutrin XL Oral Tablet Extended Release 24 Hour 150 MG. Give 150 mg QD with documentation indicating the medication had been provided every day until the last date reviewed 5/26/26. On 5/19/26 at 2:45 PM Staff Q, Certified Nursing Assistant (CNA)/Certified Medication Aide (CMA), stated there had been multiple times when medications had not been available for residents. The staff stated she had notified Staff S, Previous Regional Clinical Director, of medications not being available. Staff Q stated a new process had been developed with the use of the medication stickers, placing in the ordering book, and marking when the pharmacy was faxed. On 5/20/26 at 1:51 PM Staff Q stated there had been a lack of medication again for residents. The staff stated she had borrow from the day shift to provide Resident #16's Wellbutrin as the night shift was out. 3. Resident #19's MDS assessment dated [DATE] revealed a BIMS score of 15/15 indicating normal cognition. The MDS Assessment documented diagnoses of hypertension, DM, hyperlipidemia, and depression. The document included the resident received 7 insulin injections, antidepressant, diuretic, antiplatelet, hypoglycemic, and anticonvulsant medications in the last 7 days of the reporting period. The clinical record's Medical Diagnoses included: other specified diabetes mellitus with diabetic neuropathy, unspecified (3/8/24), Type 2 DM with mild non- proliferative diabetic retinopathy without macular edema, unspecified eye (4/23/18), diverticulitis of intestine, part unspecified without perforation or abscess without bleeding (3/4/21), hyperlipidemia (4/23/18), and hypothyroidism (4/23/18).Resident #19's Care Plan, revised 4/30/26, revealed a DM problem area (revised 3/17/25) with staff interventions to provide with meal times, portion sizes, snacks, monitor/document signs/symptoms of high/low blood sugars, sliding scale as ordered, and observe for anti-diabetic medications. A problem area related to altered cardiovascular status and risk for shortness of breath, chest discomfort and diagnosis of hypokalemia (revised 4/28/26) with staff interventions for monitor/document/report PRN with signs/symptoms of altered vascular status, monitor PRN changes in lung sounds, and monitor sign/symptoms of changes of skin conditions (revised 4/28/26). A problem area related to hypothyroidism (revised 9/15/25) provided staff interventions to give thyroid replacement therapy as ordered and monitor for signs/symptoms of hypothyroidism (initiated 9/15/25). Resident #19's [DATE]/26 revealed the following:Levothyroxin Sodium Oral Tablet 175 MCG. Give 1 tablet QD related to hypothyroidism, unspecified start date 2/5/26 - medication not available on 4/22.Resident #19's [DATE]/26 revealed the following:Atorvastatin Calcium Oral Tablet 40 MG. Give 1 tablet QD related to hyperlipidemia, unspecified start date 6/10/25 - medication not available 5/11/26.Lactobacillus Oral Tablet. Give 1 tablet in the morning related to diverticulitis of intestine, part unspecified without perforation or abscess without bleeding, start date 1/29/26 - medication not available 5/13/26. The facility failed to document the medications not available, pharmacy, DON/charge nurse, and physician notification. On 5/19/26 at 2:45 PM Staff Q, Certified Nursing Assistant (CNA)/Certified Medication Aide (CMA), stated there had been multiple times when medications had not been available for residents. The staff stated she had notified Staff S, Previous Regional Clinical Director, of medications not being available. Staff Q stated a new process had been developed with the use of the medication stickers, placing in the ordering book, and marking when the pharmacy was faxed. On 5/21/26 at 1:20 PM Resident #19 stated he has had episodes in the past 2 months of medications not being available. The resident stated he was notified by nursing staff during medication administration of unavailability.On 6/1/26 at 4:45 PM Staff K, Current DON, acknowledged there had been a problem with the availability of medications. The staff stated if a medication was not available and was a prescribed medication the primary provider should be notified and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented. The staff stated if the medication was an over-the-counter medication, then she (current DON) should be notified so the medication could be purchased and provided to the resident. The facility's Medication Orders Policy, revised 12/12, revealed a current list of orders must be maintained in the clinical record of each resident, and orders must be written and maintained in chronological orders. The facility did not provide a policy specific to ordering/refilling medications.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, resident interview and policy review the facility failed to regulate a resident's medication to treat the resident's medical condition for 1 of 3 residents (Resident #16) reviewed. The facility failed to provide a current diagnosis for a narcotic medication. The facility reported a census of 32 residents. Findings include: Resident #16's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating intact cognition. The MDS included the diagnoses of traumatic brain injury (TBI), and other psychoactive substance abuse, uncomplicated. The MDS provided the resident did not receive scheduled pain medication or non-pharmalogical pain medication, but did receive as needed (PRN) pain medication during the last 5 days of the reporting period. The MDS revealed the resident received opioid medication during the last 7 days of the reporting period. The clinical record's Medical Diagnoses included a diagnosis of other psychoactive substance abuse, uncomplicated created 9/22/25. The Medical Diagnoses did not include a current diagnosis of shingles. Resident #16's Care Plan, revised 4/29/26, revealed a problem area related to pain/discomfort and increased risk for injury from decreased function from TBI and history of skull/facial bone fractures and shingles revised on 8/5/25 with staff interventions of administer scheduled/PRN pain medications as ordered, attempt and document any non-pharmalogical interventions, and observe for side effects of narcotic medications (all initiated 8/5/25). The facility's Physician Order document revealed an order for Tramadol HCl Tablet 50 mg by mouth every (Q) 6 hours as needed for pain PRN related to shingles with a date and time of 11/27/23 1:47 AM. Resident #16's Medication Administration Review (MAR) 4/26 revealed an order for Tramadol HCl 50 mg Q 6 hours PRN related to shingles - start date 11/27/23 with 33 doses provided during the month with no medication provided on 4/5, 4/17, and 4/30. Resident #16's [DATE]/26 revealed an order for Tramadol HCl 50 mg Q 6 hours PRN related to shingles - start date 11/27/23 with 21 doses provided until 5/25 at 9:07 PM with no medication provided on 5/1, 5/2, 5/4, 5/9, 5/11, 5/12, and 5/14. Review of Resident #16's Narcotic Count Sheet for Tramadol HCL 50 mg tablet revealed the following: 4/4/26 Amount Given 1, Amount Remaining 124/5/26 Amount Given 1, Amount Remaining 11 - MAR not documented 4/6/26 Amount Given 1, Amount Remaining 10 No discrepancies from 4/6 to 4/16/26 between the MAR and Narcotic Count Sheet.4/17/26 Amount Given 1, Amount Remaining 22 4/17/26 Amount Given 1, Amount Remaining 21 - MAR not documentedNo discrepancies from 4/17 to 4/30 between the MAR and Narcotic Count Sheet. 4/30/26 Amount Given 1, Amount Remaining 8 - MAR not documented5/1/26 Amount Given 1, Amount Remaining 7 - MAR not documented5/3/26 Amount Given 1, Amount Remaining 6 5/4/26 Amount Given 1, Amount Remaining 5 - MAR not documentedNo discrepancies from 5/5 to 5/8 between the MAR and Narcotic Count Sheet.5/9/26 No documentation on the Narcotic Count Sheet.5/10/26 Amount Given 1, Amount Remaining 0 5/11/26 Amount Given 1, Amount Remaining 29 - MAR not documented5/12/26 Amount Given 1, Amount Remaining 28 - MAR not documented5/13/26 Amount Given 1, Amount Remaining 27 5/14/26 Amount Given 1, Amount Remaining 26 - MAR not documentedThe clinical record's Progress Notes revealed the following entries:On 1/9/26 at 6:13 AM the order noted a drug interaction between Wellbutrin XL Oral Tablet Extended Release 24 hour 150 mg related to major depressive disorder, single episode, unspecified and Tramadol HCl Oral Tablet 50 mg related to shingles with moderate severity.On 1/28/26 at 10:06 PM resident requested Tramadol 50 mg and 2 Tylenol 500 mg for right leg discomfort. The resident provided a dose of Augmentin 500/125. The noted included observation of right anterior food was bright red, no pitting edema, right ankle and above to mid leg is dusky gray in color.On 3/8/26 at 10:57 PM the resident's BLEs were purple, red in color, turgor is good, tops of both feet were bright red, right foot has 2+ edema. The resident indicated pain 3/10 and requested PRN Tramadol 50 mg PRN and 2 Tylenol 500 mg PRN.On 3/31/26 at 11:10 AM resident required 2 Tylenol 500 mg and 1 Tramadol 50 mg for pain in BLE, rating (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain a 3/10.On 4/19/26 at 10:50 PM resident requested 1Tramadol mg PRN and 2 Tylenol mg PRN for pain in bilateral lower extremities (BLE). The Progress Notes failed to provide documentation related to the treatment of shingles since 11/30/23 with the exception of entries related to the dispensing of Tramadol.The facility's Physician Nursing Home Visit document dated 11/5/23 at 11:20 AM revealed the resident expressed some boredom at the facility and wished he could have some more pain medications. The document included diagnoses of TBI and history of polysubstance abuse. The document disclosed the resident was not a good candidate for pain medications and would attempt non-pharmaceutical management of his pain. The facility's Consultant Pharmacist Recommendation to Physician dated 9/28/24 revealed the pharmacy request for discontinuation or lowering the order of PRN Tramadol with no justification provided by the physician other than no change to current medication. On 5/20/26 at 1:35 PM Resident #16 stated he took Tramadol for pain in his legs. On 6/1/26 at 4:45 PM Staff K, current Director of Nursing (DON, stated she was unable to find any signed pharmacy driven Gradual Drug Reduction (GDR) recommendations from the physician for the past year for Resident #16 regarding the use of Tramadol. The staff acknowledged she had read the documentation from the physician regarding the recommendation of not using pain medications dated 11/5/23 due to the diagnosis of polysubstance abuse. Staff K stated the use of a narcotic was not uncommon for the treatment of pain associated with shingles, but she was not aware of Resident #16's Tramadol order had a related diagnosis of shingles dated 11/27/23. Staff K stated the diagnosis needed to be current for the use of any medication. Staff K acknowledged she had become aware of discrepancies in documentation for individualized narcotic count sheets and the residents MARs. The facility's Controlled Substances Policy, revised 12/12, revealed the individual resident controlled count sheet must contain the date and time of medication administered and by whom. The document must also contain the number on hand of each controlled medication. The facility's Medication Orders Policy, revised 12/12, revealed Physician Orders/Progress Notes must be signed and dated every 30 days (may be changed to every 60 days after the first 90 days of the resident's admission). The document included PRN orders must include the type, route, dosage, frequency, strength, and reason for administration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, resident interview, staff interviews, and policy review the facility failed to properly secure and store medications to minimize loss or access by storing medication in a resident's room for 1 of 5 residents (Resident #13) reviewed. The facility further failed to properly secure medications for 1 of 4 medication carts. The facility reported a census of 32 residents. Findings include:1. Review of Resident #13's MDS dated [DATE] revealed a BIMS score of 12 indicating moderated cognitive impairment. Review of Resident #13's Electronic Healthcare Record (EHR) page titled, Clinical Physician Orders revealed an order dated 3/10/26 for Lidocaine-Prilocaine external cream 2.5-2.5% to be applied topically to the right foot/ankle twice daily related to pain. Observation 5/26/26 at 10:45 AM revealed Resident #13's lidocaine cream sitting on top of the bedside nightstand. No staff or residents were observed around the medication at this time. Interview 5/26/26 at 11:15 AM with Resident #13 revealed that he keeps his cream next to his bed just in case he needs it. Observation 5/27/26 at 9:28 AM revealed Resident #13's lidocaine cream was sitting in the top drawer of the bedside nightstand. Review of a facility provided document titled, Self Administration Medication assessment dated [DATE] for Resident #13 indicated that Resident #13 did not want to self administer medications. Interview 6/1/26 at 12:25 PM with Staff K the current Director of Nursing (DON) revealed she would like to see lidocaine stored in the medication cart unless there was an assessment, an order from the physician for the resident to self administer the medication. 2. Continuous observation 6/1/26 from 1:05 PM until 1:10 PM revealed the treatment medication cart on the west hallway was unlocked. This cart was observed to have insulin pens and needles in the cart. During this observation period multiple nursing assistants, laundry staff, and residents passed the medication cart. At 1:10 PM Staff M Licensed Practical Nurse (LPN) came out of a resident's room and took the treatment cart. Interview 6/1/26 at 1:10 PM with Staff M revealed that she normally locks the cart when it is unattended and must have forgotten this time. Follow up interview 6/1/26 at 2:01 PM with Staff K revealed she would expect medication carts to be locked when not being accompanied. Review of a facility provided policy titled, Medication Storage with a copyright date of 2025 indicated all drugs and biologicals will be stored in locked compartments. The policy further indicates all medications housed at the facility will be stored appropriately to ensure proper security.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interviews, staff interviews, and facility policy review the facility failed to provide snacks to 3 of 4 residents (Residents #8, #19, #20) who wanted to eat at non-traditional times or outside of scheduled meal service times. The facility reported a census of 32 residents.Findings include: 1. Resident #8's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating normal cognition. The MDS documented diagnoses of anemia, hypertension -high blood pressure (HTN), and diabetes mellitus (DM). The document included the resident during 6 of the last 7 days of the reporting period the resident received an injection and hypoglycemic medication. The Care Plan revised 4/29/26 revealed a problem area related to DM and risk for frequent infections, visual impairment, hyper/hypoglycemia revised on 3/17/25 with staff interventions including all concerns with DM to be addressed with the primary care physician (PCP), diabetes medications as ordered by PCP with monitoring and documented side effects and effectiveness, monitor/checks blood glucose levels as ordered, and snacks allowed. The clinical records titled Physician Orders contained an order for the resident to have a mid afternoon snack dated 10/4/23 at 3:30 PM. The clinical records Task Documentation for Snacks for the past 30 days (5/4 - 6/1/26) revealed the following:19 total entries for 13 days. 13 entries completed for times between 7:02 AM and 10:17 AM indicated snacks provided.6 entries for snacks provided between noon and evening meals. 0 entries for evening (after supper) snacks provided.The facility failed to offer and document that Resident #8 was offered snacks as per physician orders. On 5/21/26 at 10:20 AM Resident #8 stated she did not consistently get snacks as she needed due to her blood sugars and diabetes. The resident stated not receiving evening snacks was worse than not receiving afternoon snacks. The resident stated her concerns had been voiced to the Administrator and at Resident Council. 2. Resident #19's MDS assessment dated [DATE] revealed a BIMS score of 15/15 indicating normal cognition. The MDS Assessment documented diagnoses of HTN, DM, hyperlipidemia, and depression. The document included the resident received 7 insulin injections and hypoglycemic medications in the last 7 days of the reporting period. The clinical records titled Medical Diagnoses contained other specified diabetes mellitus with diabetic neuropathy and diverticulitis (inflammation or infection in the colon) of the intestine, part unspecified, without perforation or abscess without bleeding. Resident #19's Care Plan, revised 4/30/26, revealed a DM problem area (revised 3/17/25) with staff interventions to provide with meal times, portion sizes, snacks, monitor/document signs/symptoms of high/low blood sugars, sliding scale as ordered, and observe for anti-diabetic medications.The clinical records Task Documentation for Snacks for the past 30 days (4/29 - 5/24/26) revealed the following:21 total entries for 13 days.11 entries completed for times between 6:30 AM and 8:30 AM indicated snacks provided.1 entry for mid morning snack provided.8 entries for snacks provided between noon and evening meals.0 entries for evening snacks provided. On 5/21/26 at 1:20 PM Resident #19 stated he was supposed to get food 6 times/daily due to his diabetes and diverticulitis. The resident stated he never gets snacks in the morning between breakfast and lunch. The resident stated snacks were available in the afternoon. Resident #19 stated evening snacks and snacks on the weekend were not provided.3. Resident #20's MDS dated [DATE] revealed a BIMS score of 14/15 indicating normal cognition. The MDS documented diagnoses of HTN and DM. The document included during 7 of the last 7 days of the reporting period the resident received an insulin injection, took diuretic and hypoglycemic medications. The Care Plan revised 4/28/26 revealed a problem area for nutrition revised on 4/28/26 with interventions for staff including: notification to PCP signs of altered mental status, HTN, chest pain and signs of malnutrition. The Care Plan provided a problem area related to DM revised on 7/9/25 with (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions to provide medications as ordered, dietitian to follow nutritional regimen, observe for side effects and signs of hypo/hyperglycemia, and provide with meal times, dietary restrictions and snacks revised 7/2/25.The clinical records Task Documentation for Snacks for the past 30 days (5/4 - 6/2/26) revealed the following:78 total entries with documentation every day.25 entries documented as not applicable for snacks provided with times between 12:00 AM and 6:00 AM.3 entries documented as not applicable for snacks provided in the morning between breakfast and lunch.1 entry documented as not applicable for snacks provided in the afternoon between noon and evening meals.1 entry documented as not applicable for snacks provided in the evening.10 entries documented snacks provided between 6:00 AM and 10:30 AM.18 entries documented snacks provided between noon and evening meals. 19 entries documented snacks provided in the evening. 1 entry documented snacks not taken in the evening. On 5/21/26 at 1:35 PM Resident #20 stated concerns regarding inconsistent snacks in the evening and they had been discussed at Resident Council. The resident stated that the snack cart may be available in the hallway and he has to obtain his own snacks rather than staff delivering the snacks in the evening. Resident #20 stated snacks were not always available. On 5/27/26 at 11:28 AM Staff P, Previous Administrator, stated he was aware of the concerns regarding lack of evening snacks and had worked with staff to correct the problem. Staff P stated the facility provided the residents snacks around 2:30 PM and 7:30 PM. Staff P stated the facility did not provide morning snacks. On 5/27/26 at 12:50 PM Staff O, Certified Nursing Assistant (CNA), stated there had been times when it was difficult to get the snacks passed in the evenings due to the needs of the residents regarding toileting, fall risk and 2 staff required for transfers. The staff stated the evening staff try to deliver snacks while completing care and attending residents' needs. On 5/27/26 at 3:14 PM Staff T, CNA, stated there had been problems with snacks in the evening, but staff were trying their best to provide them in a timely manner. On 6/2/26 at 12:10 PM Staff K, current Director of Nursing (DON), stated staff should be providing snacks to residents. The staff expected snacks to be provided in the afternoons and evenings. When asked about documentation of snacks offered between the times of 6:00 AM and 8:00 AM, the staff stated she suspected staff were documenting what they planned to do rather than what had been completed. The facility provided document for meal times indicated the following:Breakfast served at 7:30 AM Lunch served at 12:00 PMDinner served at 5:30 PM The facility's Snacks (Between Meal and Bedtime) Serving Policy, undated, revealed the purpose was to provide the resident with adequate nutrition. The document contained steps for providing the resident snacks which included bringing the snacks into the resident's room and ensuring the resident was able to manage without further assistance. The document disclosed documentation should include date, time, amount of snack consumed, and 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. Based on facility record review, staff interview, and facility policy review the facility failed to have an effective Quality Assurance and Performance Improvement (QAPI) program in place to provide quality care for residents. The facility failed to make good faith attempts to correct quality deficiencies, and maintain and implement a comprehensive QAPI program and plan, The facility identified a census of 32 residents.Findings include: The Department of Health and Human Services/Centers for Medicare and Medicaid Services (CMS) 2567 documents revealed the facility had repeated deficient practices in the years 2025 and 2026 as exhibited by the following:F550 Resident Rights/Exercise of Rights (4/8/26, 6/2/26) F609 Reporting of Alleged Violations (4/8/26, 6/2/26)F610 Investigate/Prevent/Correct Alleged Violations (12/8/25, 6/2/26)F656 Develop/Implement Comprehensive Care Plan (4/10/25, 12/8/25)F657 Care Plan Timing and Revision (2/27/25, 12/8/25, 6/2/26)F658 Services Provided Meet Professional Standards (2/27/25, 12/8/25, 6/2/26)F677 Activities of Daily Living (ADL) Care Provided for Dependent Residents (10/21/25, 4/8/26, 6/2/26)F684 Quality of Care (2/27/25, 12/8/25) F686 Treatment for Healing/Prevention of Pressure Ulcers (2/27/25, 12/8/25, F688 Increase/Prevent Decrease Range of Motion/Mobility (4/10/25, 12/8/25)F689 Free of Accident Hazards/Supervision/Devices (2/27/25, 6/2/26) F695 Respiratory/Tracheostomy Care and Suctioning (12/8/25, 6/2/26)F725 Sufficient Nursing Staff (2/27/25, 12/8/25, 6/2/26)F726 Competent Nursing Staff (2/27/25, 12/8/25) F755 Pharmacy Services/Procedures/Pharmacist Records (4/10/25, 12/8/25, 6/2/26)F757 Drug Regimen is Free from Unnecessary Drugs (2/27/25, 6/2/26)F804 Nutritive Value/Appearance/Palatable/Preferred Temperature (12/8/25, 4/10/25F842 Resident Records - Identifiable Information (4/8/26, 12/8/25, 2/27/25, F865 QAPI Program/Plan, Disclosure/Good Faith Attempt (2/27/25, 4/10/25, 12/8/25, 4/8/26, 6/2/26)F880 Infection Prevention and Control (2/27/25, 4/10/25, 4/8/26, 6/2/26)On 6/2/26 at 2:50 PM Staff U, current Administrator, stated the facility had held QAPI meetings in April and May that he had not been a part of. The staff stated moving forward the facility will be holding standup and standdown meetings daily for everyone in the building, and the interdisciplinary team (IDT) will be meeting daily, and the Clinical Leadership Team will be meeting daily once the new Assistant Director of Nursing (ADON) begins. Staff U stated the facility had Performance Improvement Plans (PIPs) in place and would be developing additional plans related to the current survey as there were repeat deficiencies. The facility's QAPI Quality Assessment Assurance (QAA) Plan updated on 1/2/2025 revealed the purpose of QAPI is to develop a culture of proactive leadership and includes ongoing development of plans for improvement leading to systemic changes that support exceptional health care to seniors.

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	06/02/2026

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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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** Based on clinical record review, observations, staff interviews, and policy review, the facility failed to provide infection prevention measures to ensure the use of Enhanced Barrier Precautions (EBP) when required, hand hygiene during wound care, and hand hygiene during dependent activities of daily living (ADLs) for 4 of 4 residents (Residents #15, #2, #6, #1) reviewed. The facility reported a census of 32 residents.Findings include: 1. The Minimum Data Set (MDS) for Resident #15, dated 5/12/26, included diagnoses of encounter for other orthopedic aftercare following surgical amputation, Multidrug-Resistant Organism (MDRO) (bacteria that resist treatment with more than one antibiotic) and diabetes. The MDS identified the resident was dependent on staff for toileting hygiene and transfers and a Brief Interview for Mental Status (BIMS) Score of 15, indicating no cognitive impairment for decision-making. Resident #15's Care Plan with revision date 4/28/26, revealed the resident required EBP related to the presence of a wound and EBP will be instituted during completion of high contact activities. Observation on 5/13/26 at 12:31 PM, Staff B, Certified Nurse Aide (CNA) was in Resident #15's room and Staff A, CNA entered the room with a full body mechanical lift. Staff A and Staff B, with only gloves on and no gowns on, proceeded to transfer the resident from her bed to a wheelchair with the lift. Interview on 5/13/26 at 12:40 PM, Staff B stated she had just finished with getting Resident #15 off the bed pan before she and Staff A transferred the resident. Staff B further stated that she did not wear a gown when she assisted the resident with the bedpan and she should have and that both staff should have worn a gown also when transferring the resident as the resident is on EBP due to the resident has a wound and EBP requires a gown and gloves with any care of the resident. 2. The MDS for Resident #2, dated 3/25/26, included diagnoses of acquired absence of right leg below the knee and diabetes. The MDS identified the resident had a surgical wound and a BIMS score of 15, indicating no cognitive impairment for decision-making. Resident #2's Treatment Administration Record for 5/1/26 – 5/31/26 revealed a physician's order for left anterior knee distal, left medical knee, left below the knee amputation(surgical wound): Cleanse area with wound cleaner soaked gauze, apply skin prep to periwound (area around edges of wound), apply hydrofera blue ready (antibacterial foam dressing used to promote healing in various wounds) to wound bed, cover with silicone bordered foam, change 3 times weekly on Monday, Wednesday, Friday and as needed for soiling. Observation on 5/14/26 at 10:40 AM, Staff D, Registered Nurse (RN) applied a gown and gloves and removed 3 old dressings from Resident #2's left below the knee amputation wound areas. Staff D proceeded to cleanse the open wounds with wound cleanser, changed gloves without completing hand hygiene and then applied the new wound treatment and dressing as ordered. Facility Enhanced Barrier Precautions Policy dated 3/25/24 revealed EBPs are utilized to prevent the spread of MDROs to residents and are indicated for residents with chronic wounds. EBPs employ targeted gown and glove use during high-contact resident care activities with examples of high-contact resident care activities requiring the use of a gown and gloves include transferring and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	changing briefs or assisting with toileting. Interview on 5/21/26 at 11:40 AM, Staff K, Director of Nursing (DON) stated expectation for staff to wear gowns and gloves for residents on EBP when providing care. Staff K further stated when staff complete wound treatments and after removing the old wound dressings and cleansing wounds her expectation to change gloves and complete hand hygiene before applying the new treatment and dressing. 3. Resident #6's MDS assessment dated [DATE] revealed the resident had a BIMS score of 2/15 indicating severe cognitive impairment. The document coded the resident was dependent upon staff for all dressing, toileting hygiene, oral care, and transfers. The document revealed the resident was frequently incontinent of bladder and bowel continence was not rated. The document included diagnoses of Non-Alzheimer's Dementia and anxiety. The Care Plan revised 5/15/26 identified a problem area with self care deficit by requiring assistance with ADLs revised on 5/7/26 with a staff intervention of 1 person assistance for dressing, bed mobility, oral care, grooming/hygiene, and 1-2 person assistance for transfers. Continuous observation on 5/27/26 at 7:08 AM of Staff C, Certified Nursing Assistant (CNA)/bath aide, and Staff G, CNA, providing morning ADL care to Resident #6 revealed the following: Both staff entered the room, completed hand hygiene, and donned gloves. Staff observed the floor/fall mats were covered in urine. Staff C utilized wipes to remove urine from the mats and stated she would take them to the shower room to clean when they were finished with the resident. Staff removed gloves, completed hand hygiene, and donned new gloves. Staff G removed gloves, left the room without completing hand hygiene. Staff G returned to the room with a mop bucket due to urine on the floor, completed hand hygiene, donned gloves and worked with Staff C to assist the resident with putting on a shirt. Staff G removed gloves, left the room without completing hand hygiene. Staff G returned to the room with socks, completed hand hygiene, donned gloves and assisted the resident with putting on socks. Staff C noted the resident's sheets were wet. Staff C and G set the resident up for standing with a front wheeled walker (FWW), gait belt, and initiating an adult dependent brief and pants. Both staff assisted the resident with moving to a standing position. Staff C maintained physical contact with verbal cues for standing, while Staff G utilized wipes for peri care using her left gloved hand. Staff G then used both gloved hands to fasten the dependent brief and pull the resident's pants up. Staff C and G worked together to assist the resident using the FWW to his w/c. The resident required (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	total assistance for positioning in the w/c. Staff C gathered dirty items and placed them in plastic bags for removal from the room. Gloves removed and hand hygiene completed. Staff G removed gloves, completed hand hygiene, and combed the resident's hair. 4. Resident #1's MDS assessment dated [DATE] revealed a BIMS score of 15/15 indicating normal cognition. The document coded the resident required setup for grooming/hygiene tasks and dependent upon staff for toilet hygiene, transfers, and dressing. The document revealed the resident was incontinent of bowel and bladder. The MDS included diagnoses of atrial fibrillation, heart failure, and diabetes mellitus (DM). The Care Plan revised 4/30/26 identified a problem area of self care deficit as evidenced by requiring assistance with ADLs revised on 4/30/26 with a staff intervention for 1 person assistance for oral care, 2 person assistance for dressing, bed mobility, and dependent for transfers. Continuous observation on 5/27/26 at 7:40 AM of Staff C and Staff G complete ADL care with Resident #1 revealed the following: Staff entered the room with Staff C bringing a shower chair and Staff G bringing a dependent mechanical lift. Note the dependent mechanical lift did not have disinfectant wipes on it. Both staff completed hand hygiene and donned gloves. Both staff working together assisted the resident with rolling to remove the wet brief, place a sling, and transferred the resident to the shower chair using the dependent mechanical lift. Staff C left the room with Resident #1. Staff G removed her gloves, and prepared the bed for the resident's return. Staff G donned gloves and assisted Staff C transfer Resident 1 from the shower chair to the bed. Staff C and G completed lower body dressing, bed mobility, placement of the lift sling and transferred the resident to the recliner. Staff C removed gloves, completed hand hygiene, and removed the shower chair from the room. Staff G removed gloves, completed hand hygiene, and provided the resident with setup for oral care. Staff G moved the dependent mechanical lift to the hallway and left it. Neither Staff C nor Staff G returned to disinfect the mechanical lift. Observed on 5/27/26 at 6:55 AM Staff C disinfecting the shower chair. On 6/2/26 at 12:10 PM Staff K, current Director of Nursing (DON) stated the expectation was for hand hygiene to be completed with glove changes either with hand sanitizer or washing hands. Staff K (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated the dependent mechanical lift should be disinfected between use with residents and acknowledged she had observed the bracket on the lift for holding disinfecting wipes was empty. The facility's Handwashing/Hand Hygiene Policy, revised 8/19, revealed the primary means to prevent the spread of infections with hand hygiene. The document included single-use gloves that should be utilized when anticipating contact with bodily fluids and when in contact with a resident who is on contact precautions. The document disclosed hand hygiene should be completed before donning gloves, after glove removal, and is the final step after removing and disposing of personal protective equipment.