STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165531	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/08/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 Ok ✓ Lg	INITIAL COMMENTS Correction date: 1-8-26 The following deficiencies resulted from the facility's annual recertification survey and investigation of complaints # 1770688-C, # 2668583-C, # 2686903-A, and facility reported incident # 2668603-I conducted December 1, 2025 to December 8, 2025. Complaint # 1770688-C resulted in a deficiency. Compliant # 2668583-C resulted in a deficiency. Complaint # 2686903-C resulted in a deficiency. Facility reported incident #2668603-I resulted in a deficiency. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000		
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F0600		

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 reverse for further 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 ✓
Richard Rebhardt	Administration	1-8-26

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F0600 SS = SQC-J	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on Electronic Health Records (EHR), document review, staff interviews, resident interview and policy review the facility failed to prevent neglect when Staff A refused to provide or delayed providing suctioning for Resident #34 who was dependent on staff assistance for his tracheostomy (breathing tube in the neck). Resident #34 stated Staff A, Licensed Practical Nurse (LPN) refused to suction him nearly nightly when he worked at the facility. The resident experienced psychosocial harm as evident by severe anxiety, fear of being unable to breath and dying. Staff A worked at the facility 9/17/25 - 11/12/25 on the overnight shift with the last day of training with a second nurse on 10/4/25. Schedule documented Staff A was the only nurse when working the overnight shift when scheduled. Resident #34 stated he would have to turn the call light on 3 or 4 times before Staff A would complete the suctioning. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of October 6, 2025 on December 3, 2025 at 11:15 a.m. The facility staff removed the immediacy of the IJ on December 4, 2025, and decreased the scope to "G", through the following actions: a. All residents residing at the facility were interviewed to ensure they feel safe in their environment and free from abuse or exploitation on 12/3/25. b. All Department heads to include Administrator and DON were educated by the Director of Clinical Services to complete thorough investigations into all concerns brought to them including conducting root cause analysis to identify adequate and quantifiable interventions to prevent further abuse or exploitation 12/4/25. c. The DON and all staff nurses were immediately trained at the direction of the DCS on Tracheal Care and Suctioning to ensure competency in this skill. d. Administrator and DON were educated by the Director of Clinical Services on abuse policies to include timely reporting of all allegations of abuse and exploitation to the state agency as required on 12/4/25. The facility identified a census of 37 residents. Findings include:	F0600		

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F0600 SS = SQC-J	Continued from page 2 The Minimum Data Set (MDS) dated 10/10/25 documented Resident #34 had a Brief Interview for Mental Status (BIMS) of 14 indicating no cognitive impairment. MDS also indicated Resident #34 had diagnoses of acute and chronic respiratory failure with hypoxia, functional quadriplegia and presence of tracheostomy. Review of Resident #34's EHR titled, Orders documented a physician's order with a start date of 8/7/25 for deep suctioning if needed with 4-5 passes if resident needs every 20 minutes as needed. Review of Resident #34's EHR titled, Medication Administration Records/Treatment Administration Records documented a physician's order with a start date of 8/7/25 for deep suctioning if needed with 4-5 passes if resident needs every 20 minutes as needed. Further review of MAR/TAR for the months of October and November of 2025 revealed no documentation of the order being utilized by Staff A. On 12/2/25 at 1:36 PM Resident #34 stated Staff A would refuse to suction his tracheostomy frequently. Resident #34 explained he had to call the Certified Nursing Assistants (CNA) 3 or 4 times before Staff A completed the suctioning. Resident #34 said it would cause severe anxiety when Staff A worked because Staff A would not suction when he felt he needed it. Resident #34 stated when his tracheostomy was not suctioned it felt like he could not breathe and was dying. Resident #34 stated he felt he was being neglected when Staff A did not suction when he requested it. Resident #34 acknowledged all of the overnight CNA staff knew Staff A would refuse to suction his tracheostomy. Resident #34 stated basically every night Staff A worked he would refuse to suction his tracheostomy. Resident #34 said Staff C, CNA and Staff B, CNA could speak about Staff A and that he did not come in and suction his tracheostomy when requested and would frequently refuse to suction his tracheostomy. Resident #34 stated it did not seem like Staff A knew what he was doing. On 12/2/25 at 9:34 AM Staff C stated Staff A refused to suction Resident #34 even when Resident #34 requested. Staff C explained Staff A would say he had just been in Resident #34's room. Staff C stated she looked at Resident #34's orders and Resident #34 had as needed orders for suctioning his tracheostomy. Review of text message sent to the DON by Staff C documented on 11/9/25 another nurse checked on Resident #34 because Staff A would not. Text message sent to the DON on 11/10/25 at 1:47 AM Resident #34 was asking to	F0600		

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F0600 SS = SQC-J	Continued from page 3 be suctioned again but Resident #34 said he wanted the DON and did not want to say it out loud and upset Staff A. DON replied via text. Tell Staff A he was the nurse on the floor. On 12/2/25 at 6:15 AM Staff F, CNA said Resident #34 would request medication or to be suctioned. Staff F stated it doesn't happen too often through the night. Staff F explained she worked with Staff A a couple of times. Staff F expressed one night, Resident #34 had requested to have his tracheostomy suctioned and Staff F told Staff A. Staff F stated Staff A's response was that he had just done it one hour prior and Staff A refused to go in and Staff A refused suction Resident #34's tracheostomy. Staff A said she called the DON and then the other nurse that was on duty (it was earlier in the evening) went in and suctioned Resident #34's tracheostomy. On 12/4/25 at 4:18 PM Staff B stated she was never in the room when Staff A completed tracheostomy cares for Resident #34. Staff B explained she would answer Resident #34's call light 2 or 3 times over a length of time and continue to tell Staff A before he completed the tracheostomy suctioning. Staff B stated Resident #34 would get angry sometimes when he wanted his tracheostomy suctioned because Staff A would not come to his room to suction him. Staff B said Resident #34 appeared more scared than mad most of the time when he requested his tracheostomy to be suctioned. Staff B explained refusal by Staff A to complete the tracheostomy suctioning occurred every time Staff A worked. Staff B restated Staff A refusing to complete suction when requested by Resident #34 and Resident #34 had to turn his light on 2-3 times with the CNA's telling Staff A that Resident #34's requests for his tracheostomy to be suctioned occurred every night Staff A worked. On 12/2/25 at 2:08 PM the DON stated she received a call on her cell phone asking how many times Resident #34 could be suctioned. The DON stated she forgot about the call but she had documented the call from the CNA (Staff F) somewhere. The DON explained sometimes Resident #34 obsessed over his tracheostomy suctioning and it is the one thing Resident #34 had control of in his life. The DON explained Resident #34 had been suctioned but the aide wanted to know how often Resident #34 could be suctioned. The DON said the call occurred in the evening between 6:00 pm and 10:00 pm and there also was a 2nd nurse (Staff O) at the facility. The nurse that was working with Staff A that evening that completed the suctioning was Staff O, LPN. The DON stated Staff O left at 10 PM and she contacted	F0600		

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F0600 SS = SQC-J	Continued from page 4 Staff O to see if there were any issues. The DON elaborated that Staff O explained Resident #34 was fine. The DON explained Staff O checked on Resident #34 because Staff A was doing something with another resident. The DON stated she came in according to the master schedule on 11/9/25 at 11:00 PM or 11:30 PM. The DON explained she frequently came into work on the overnight shift. The DON said any time the staff reaches out to her with questions or concerns she would come to the building and that she did not go to the facility because Resident #34 had requested to be suctioned at that time. The DON said she was at the building so she might as well make an observation of Staff A while he completed tracheostomy suctioning on Resident #34. The DON stated Staff A spoke to Resident #34 that night and explained to Resident #34 why Staff A was there. The DON stated Staff A did an excellent job with the task. The DON stated Resident #34 would request to be suctioned a couple times during the night. The DON explained Staff F did not have any concerns with Resident #34 not being suctioned enough. The DON stated she thought that Staff F just wanted to know for her own information about suctioning. The DON stated no staff had brought to her any concerns about Staff A's treatment of Resident #34. The DON stated she asked Resident #34 pretty routinely about concerns and Resident #34 was not one that was shy about saying anything. The DON stated Resident #34's grandmother would also let them know about concerns. The DON stated if staff reported any concerns with residents she would investigate. Review of document provided by the DON dated 11/9/25 documented the DON received a call from Staff F asking how many times Resident #34 could be suctioned. The DON explained Resident #34's orders to her and questioned if there was a concern. Staff F voiced she was asking because Resident #34 had requested to be suctioned frequently and had requested Staff A. The DON attempted to contact Staff A but was told he was busy at the moment. Staff O in the facility at the time. DON contacted her to see if there was an issue. Staff O stated she had just come from Resident #34's room and there were no issues. The DON arrived at the building and shadowed Staff A the rest of the shift. The DON stated Staff A was observed suctioning Resident #34 without issues. No concerns with Staff A's ability to perform his job duties at that time. On 12/8/25 at 12:00 PM the DON explained Staff A was in training until 10/4/25. The DON acknowledged Staff A's first day on the overnight shift by himself from 10:00 PM - 6:00 AM was on 10/5/25.	F0600		

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F0600 SS = SQC-J	Continued from page 5 Review of document titled, Staff A's payroll provided by the Administrator documented Staff A worked the overnight shift on 10/5, 10/6, 10/7, 10/9, 10/13, 10/15, 10/19, 10/22, 10/24, 10/26, 10/27, 10/29, 10/30, 11/4, 11/8, 11/9 and 11/11. Review of Resident #34's EHR titled, Census documented Resident #34 was out of the facility 9/29 - 10/6 and 10/15 - 10/20. On 12/4/25 at 7:59 AM Staff A, LPN stated he started working at the facility a couple months ago. Staff A stated he was terminated 11/12/25. Staff A acknowledged that he worked the overnight shift from 6:00 PM - 6:00 AM. Staff A explained he had to suction a tracheostomy while at the facility as part of his job duties. Staff A said Resident #34 had a tracheostomy. Stated he worked from 6pm - 6AM. Staff A stated he did not usually have a second nurse on his shift. Staff A stated he had to suction Resident #34 a lot during his shift. Staff A said he would suction Resident #34 multiple times a night, sometimes every hour. Staff A explained he would suction Resident #34's tracheostomy at least 2 or 3 times before he went to sleep. Staff A revealed Resident #34's suction order was as needed. Staff A said he did not recall having to sign out the suctioning on the MAR. Staff A said Resident #34 did not have an order for suctioning. Staff A explained he would stop in and ask Resident #34 if he needed to be suctioned. Staff A stated the CNA's would come and tell him that Resident #34 needed suctioned on the overnight shift all the time. Staff A stated he would go and suction Resident #34 immediately unless he was in the middle of something and then would go suction right afterwards. Staff A stated the CNA never had to come and remind him multiple times to suction Resident #34. Staff A revealed he never refused to suction Resident #34. Staff A stated Resident #34 had never died on him and Resident #34 could breathe. Staff A elaborated he never had to be told twice to suction Resident #34. Staff A stated Resident #34 would panic and whip himself up into a frenzy. Staff A stated at times when Resident #34 had to be suctioned; he did appear to have anxiety. Staff A acknowledged the DON came in on her own late at night one time to make an observation. Staff A said the DON stated she was worried about what was going on at the facility. Staff A revealed he thought one of Resident #34's family members, possibly the grandmother had called the DON and told her that he was not suctioning Resident #34 when it was requested. Staff A stated Resident #34 never went more than a few minutes after requesting to be suctioned. Staff A said he worked 3 nights a week but not a set schedule.	F0600		

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F0600 SS = SQC-J	Continued from page 6 Review of policy updated 7/8/24 titled, Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy documented all Residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This includes prohibiting nursing facility staff from taking acts that result in personal degradation* including the taking or using photographs or recordings in any manner that would demean or humiliate a resident, and prohibits using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep, or distribute photographs and/or recordings on social media or through multimedia messages. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. It shall be the policy of this facility to implement written procedures that prohibit abuse, neglect, exploitation, and misappropriation of resident property. Any of the following as a result of the willful misconduct or gross negligence or reckless acts or omissions of a caretaker, taking into account the totality of the circumstances: Neglect of a dependent adult. "Neglect of a dependent adult" means deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a dependent adult's life or physical or mental health.	F0600		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12	F0605		

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F0605 SS = D	Continued from page 7 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which	F0605		

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F0605 SS = D	Continued from page 8 indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews, policy review and clinical record review the facility failed to ensure that the residents had rational for continued use of psychotropic medications and attempted Gradual Dose Reduction (GDR) of psychotropic medications for 3 of 5 resident reviewed (Residents #4, #6, #32). The facility reported a census of 37 residents.	F0605		

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F0605 SS = D	Continued from page 9 Findings include: 1) The Minimum Data Set (MDS), dated 10/28/25 for Resident #4, showed that he had a Brief Interview for Mental Status (BIMS) score of 12 (moderate cognitive deficits.) Resident #4 was totally dependent of staff for dressing, toileting hygiene. Resident #4 had antipsychotic medications reviewed on a regular basis and a GDR had not been attempted because the physician documented as clinically contraindicated on 1/2/25. His diagnoses included: diabetes mellitus, non-Alzheimer's dementia, seizure disorder, depression and schizophrenia. The Care Plan for Resident #4, showed that the resident was at risk for adverse side effects due to use of anti-psych medication to aide with the diagnosis of schizophrenia. The GDR review would be completed by the pharmacy/physician per facility protocol. A Note to Attending Physician/Prescriber showed that in July of 2025 the pharmacy requested that the resident's current dose of antidepressant, Zoloft 50 milligrams (mg). be reviewed for GDR. The response from the physician indicated that "the resident with good response, maintain the current dose" "See physician progress notes for clinical rationale." Dated 7/23/25. The chart lacked a corresponding physician progress note with rationale. 2) According to the MDS dated 9/23/25, Resident #6 had a BIMS score of 13 (moderate cognitive deficits.) He was independent with hygiene and eating. His diagnoses included non-Alzheimer dementia, depression, unspecified mood disorder The Care Plan updated on 10/28/25 for Resident #6, showed that the resident was at risk for adverse medication side effects due to use of anti-psych medication to aid with treatment of diagnosis of unspecified mood disorder. A GDR review would be completed by pharmacy/physician per facility protocol. Resident #6 had the potential for behaviors and was at	F0605		

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F0605 SS = D	Continued from page 10 risk for being combative. At times, the resident would refuse medications, by screaming out. A Note to Attending Physician/Prescriber showed that in July of 2025 the pharmacy requested that the residents dose of Depakote 250 mg. be evaluated, and consider a dose reduction. The physician's response was; "The resident with good response, maintain the current dose" "See physician progress notes for clinical rationale." Dated 7/23/25. The chart lacked a corresponding physician progress note with rationale. 3) The MDS for Resident #32 dated 11/18/25 a BIMS score of 6/15 indicating severe cognitive impairment. The MDS included diagnoses of stroke, heart failure, hypertension (HTN), peripheral vascular disease (PVD) and depression. The document identified no concerns with mood or behaviors during the reporting period. The MDS identified Resident #32 took antipsychotic, antidepressant, hypnotic, anticoagulant, diuretic, antiplatelet and anticonvulsant medications during the last 7 days of the assessment period. The document revealed the resident received antipsychotic medication on a regular basis with no gradual dose reduction (GDR). Resident #32's Care Plan dated 8/26/25 contained focus areas and goals related anti-depressant, anticonvulsant, sedative/hypnotic and antipsychotic medications including target behaviors, side effects, and GDR completed by pharmacy/physician per facility protocol (6/4/25). Review of Resident #32's Clinical Physician Orders identified the resident was prescribed: Eliquis Oral Tablet 5 mg (oral anticoagulant/blood thinner) Escitalopram Oxalate Oral Tablet 20 mg (antidepressant) Quetiapine Fumarate 100 mg (antipsychotic) Zolpidem Tartrate 7.5 mg (sedative/hypnotic)	F0605		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0605 SS = D	Continued from page 11 Hydrocodone-Acetaminophen 5-325 mg (pain relief) Duloxetine HCl Delayed Release 60 mg (antidepressant) The document further identified the resident was prescribed hypnotic medication with side effects, anticonvulsant medication with side effects, anticoagulant therapy with side effects, antipsychotic medication with side effects and anti-depressant medication with side effects. The Electronic Medical Record (EMR) Progress Note contained an entry on 7/23/25 indicating a pharmacy recommendation for a GDR of Quetiapine Fumarate (antipsychotic) with a fax sent to the Primary Care Physician (PCP). A Pharmacy Progress Note dated 8/25/25 revealed the chart was reviewed and to consider a dose reduction for Zolpidem Tartrate (hypnotic). A Pharmacy Progress Noted dated 10/17/25 provided the chart was reviewed and to evaluate Zolpidem for a dose reduction. A Pharmacy Progress Note dated 11/23/25 revealed a recommendation for a GDR for Duloxetine (antidepressant). The facility document, Note to Attending Physician/Prescriber, with a printed date of 7/16/25 revealed the resident had been taking an antipsychotic, Seroquel, 100 mg daily since November and to evaluate the current dose and consider a dose reduction. The document provided general identifiers for the physician to check off including “resident with good response, maintain the current dose” and to provide resident specific documentation to support the above action or to check below for information provided on the physician progress note. The PCP selected to maintain the current dose of medication, refer to the physician progress note and was signed on 7/23/25. The facility documents and EMR did not contain any further justification for declining a GDR for Seroquel (antipsychotic). The facility failed to provide documents pertaining to the recommendation of a dose reduction for Zolpidem (hypnotic) 8/25/25 and 10/17/25 and Duloxetine (antidepressant) 11/23/25. On 12/3/25 at 11:00 AM the Director of Nursing (DON) and Regional Nurse Consultant (RNC) stated they were acknowledging the facility lacked signed GDR documentation. The RNC stated the DON had been in the position since 8/25 and the facility had just hired an Assistant Director of Nursing (ADON). The RNC stated the facility recognized the concern and the deficient	F0605		

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F0605 SS = D	Continued from page 12 practice. On 12/3/25 at 1:00 PM the Administrator stated if the Consulting Pharmacist made a recommendation for a GDR, the recommendation needed to be implemented with justification and signature by the PCP. On 12/8/25 at 10:19 AM the DON stated she expected a declination for a GDR should have an explanation detailing why the refusal for GDR. The DON acknowledged the GDR forms were not completed for all dose reductions. The facility's policy Tapering Medications and Gradual Drug Dose Reduction revised 7/22 disclosed all medications shall be considered for possible tapering. The document further provided that tapering should be considered when a resident's clinical condition has improved or stabilized. The document revealed that continued use of an antipsychotic medication without a GDR may be clinically contraindicated if the continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale why a GDR would likely impair the resident's function or cause psychiatric instability or a previous GDR caused the resident's target behaviors returned or worsened after the most recent GDR.	F0605		
F0610 SS = SQC-J	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F0610		

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F0610 SS = SQC-J	Continued from page 13 This REQUIREMENT is NOT MET as evidenced by: Based on Electronic Health Records (EHR), document review, staff interviews, resident interview and policy review the facility failed to investigate the allegation of neglect, failed to separate Staff A, Licensed Practical Nurse (LPN) from Resident #34 and failed to take corrective actions to prevent further abuse/neglect of Resident #34. Resident #34 stated Staff A would refuse to provide or delayed providing suctioning to Resident #34 who was dependent on staff assistance for his tracheostomy (breathing tube in the neck) frequently. Resident #34 explained he would have to call the Certified Nursing Assistants (CNA's) with the call light 3 or 4 times before his tracheostomy would be suctioned by Staff A. Staff A worked at the facility from 9/17/25 - 11/12/25 on the overnight shift with the last day of training with a second nurse on 10/4/25. Schedule documented Staff A was frequently the only nurse who worked the overnight shift when scheduled. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of October 6, 2025 on December 3, 2025 at 11:15 a.m. The facility staff removed the immediacy of the IJ on December 4, 2025, and decreased the scope to "D", through the following actions: a. Remove any staff implicated in abuse or failure to report from resident care immediately. Increase supervision and monitoring in all care areas. b. Ensure residents identified at risk are protected and monitored. Resident #34 was interviewed on 12/3/2025 to ensure the resident felt safe and cared for. c. All staff were educated on reporting allegations of abuse and exploitation to the Administrator (Abuse coordinator) or DON if abuse coordinator is absent immediately as well as immediate separation of alleged victim and perpetrator on 12/3/25 or before their next shift. d. All staff including the Administrator, DON and ADON were educated on Residents Rights. The facility identified a census of 37 residents. Findings include: The Minimum Data Set (MDS) dated 10/10/25 documented Resident #34 had a Brief Interview for Mental Status	F0610		

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F0610 SS = SQC-J	Continued from page 14 (BIMS) of 14 indicating no cognitive impairment. MDS also indicated Resident #34 had diagnoses of acute and chronic respiratory failure with hypoxia, functional quadriplegia and presence of tracheostomy. Review of Resident #34's EHR titled, Orders documented a physician's order with a start date of 8/7/25 for deep suctioning if needed with 4-5 passes if resident needs every 20 minutes as needed. Review of Resident #34's EHR titled, Medication Administration Records/Treatment Administration Records documented a physician's order with a start date of 8/7/25 for deep suctioning if needed with 4-5 passes if resident needs every 20 minutes as needed. Further review of MAR/TAR for the months of October and November of 2025 revealed no documentation of the order being utilized by Staff A. On 12/2/25 at 1:36 PM Resident #34 stated Staff A would refuse to suction his tracheostomy frequently. Resident #34 explained he had to call the Certified Nursing Assistants (CNA) 3 or 4 times before Staff A completed the suctioning. Resident #34 said it would cause severe anxiety when Staff A worked because Staff A would not suction when he felt he needed it. Resident #34 stated when his tracheostomy was not suctioned it felt like he could not breathe and was dying. Resident #34 stated he felt he was being neglected when Staff A did not suction when he requested it. Resident #34 acknowledged all of the overnight CNA staff knew Staff A would refuse to suction his tracheostomy. Resident #34 stated basically every night Staff A worked he would refuse to suction his tracheostomy. Resident #34 said Staff C, CNA and Staff B, CNA could speak about Staff A and that he did not come in and suction his tracheostomy when requested and would frequently refuse to suction his tracheostomy. Resident #34 stated it did not seem like Staff A knew what he was doing. On 12/2/25 at 9:34 AM Staff C stated Staff A refused to suction Resident #34 even when Resident #34 requested. Staff C explained Staff A would say he had just been in Resident #34's room. Staff C stated she looked at Resident #34's orders and Resident #34 had as needed orders for suctioning his tracheostomy. Staff C explained she reported to the Director of Nursing (DON) verbally, face to face and by text. Staff C repeated she notified the DON. Review of text message sent to the DON by Staff C documented on 11/9/25 another nurse checked on Resident #34 because Staff A would not. Text message sent to the DON on 11/10/25 at 1:47 AM Resident #34 was asking to	F0610		

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F0610 SS = SQC-J	Continued from page 15 be suctioned again but Resident #34 said he wanted the DON and did not want to say it out loud and upset Staff A. DON replied via text. Tell Staff A he was the nurse on the floor. On 12/2/25 at 6:15 AM Staff F, CNA said Resident #34 would request medication or to be suctioned. Staff F stated it doesn't happen too often through the night. Staff F explained she worked with Staff A a couple of times. Staff F expressed one night, Resident #34 had requested to have his tracheostomy suctioned and Staff F told Staff A. Staff F stated Staff A's response was that he had just done it one hour prior and Staff A refused to go in and Staff A refused suction Resident #34's tracheostomy. Staff A said she called the DON and then the other nurse that was on duty (it was earlier in the evening) went in and suctioned Resident #34's tracheostomy. On 12/4/25 at 4:18 PM Staff B stated she was never in the room when Staff A completed tracheostomy cares for Resident #34. Staff B explained she would answer Resident #34's call light 2 or 3 times over a length of time and continue to tell Staff A before he completed the tracheostomy suctioning. Staff B stated Resident #34 would get angry sometimes when he wanted his tracheostomy suctioned because Staff A would not come to his room to suction him. Staff B said Resident #34 appeared more scared than mad most of the time when he requested his tracheostomy to be suctioned. Staff B explained refusal by Staff A to complete the tracheostomy suctioning occurred every time Staff A worked. Staff B stated the concern was brought up to the DON. Staff B restated Staff A refusing to complete suction when requested by Resident #34 and Resident #34 had to turn his light on 2-3 times with the CNA's telling Staff A that Resident #34's requests for his tracheostomy to be suctioned occurred every night Staff A worked. On 12/2/25 at 2:08 PM the DON stated she received a call on her cell phone asking how many times Resident #34 could be suctioned. The DON stated she forgot about the call and she documented the call from the CNA somewhere. The DON explained sometimes Resident #34 obsessed over his tracheostomy suctioning. The DON stated it is the one thing Resident #34 had control of his life. The DON explained the CNA's was Staff F. The DON explained Resident #34 had been suctioned but wanted to know how often Resident #34 could be suctioned. The DON said the call occurred in the evening between 6:00 pm and 10:00 pm and there was a 2nd nurse at the facility on a medication cart. The nurse that was working with Staff A that evening that	F0610		

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F0610 SS = SQC-J	Continued from page 16 completed the suctioning was Staff O, LPN. The DON stated Staff O left at 10 PM and she contacted Staff O to see if there were any issues. The DON elaborated that Staff O explained Resident #34 was fine. The DON explained Staff O checked on Resident #34 because Staff A was doing something with another resident. The DON stated she came in according to the master schedule on 11/9/25 at 11:00 PM or 11:30 PM. The DON explained she frequently came into work on the overnight shift. The DON said any time the staff reaches out to her with questions or concerns she would come to the building. The DON stated she did not go to the facility because Resident #34 had requested to be suctioned at that time. The DON said she was at the building so she might as well make an observation of Staff A while he completed tracheostomy suctioning on Resident #34. The DON stated Staff A spoke to Resident #34 that night and explained to Resident #34 why Staff A was there. The DON stated Staff A did an excellent job with the task. The DON stated Resident #34 would request to be suctioned a couple times during the night. The DON explained Staff F did not have any concerns with Resident #34 not being suctioned enough. The DON stated she thought that Staff F just wanted to know for her own information about suctioning. The DON stated no staff had brought to her any concerns about Staff A's treatment of Resident #34. The DON stated she asked Resident #34 pretty routinely about concerns and Resident #34 was not one that was shy about saying anything. The DON stated Resident #34's grandmother would also let them know about concerns. The DON stated if staff reported any concerns with residents she would investigate. Review of document provided by the DON dated 11/9/25 documented the DON received a call from Staff F asking how many times Resident #34 could be suctioned. The DON explained Resident #34's orders to her and questioned if there was a concern. Staff F voiced she was asking because Resident #34 had requested to be suctioned frequently and had requested Staff A. The DON attempted to contact Staff A but was told he was busy at the moment. Staff O in the facility at the time. DON contacted her to see if there was an issue. Staff O stated she had just come from Resident #34's room and there were no issues. The DON arrived at the building and shadowed Staff A the rest of the shift. The DON stated Staff A was observed suctioning Resident #34 without issues. No concerns with Staff A's ability to perform his job duties at that time. Review of the clinical record revealed the record lacked a thorough investigation of the allegations of neglect to Resident #34 by Staff A.	F0610		

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F0610 SS = SQC-J	Continued from page 17 On 12/8/25 at 12:00 PM the DON explained Staff A was in training until 10/4/25. The DON acknowledged Staff A's first day on the overnight shift by himself from 10:00 PM - 6:00 AM was on 10/5/25. Review of document titled, Staff A's payroll provided by the Administrator documented Staff A worked the overnight shift on 10/5, 10/6, 10/7, 10/9, 10/13, 10/15, 10/19, 10/22, 10/24, 10/26, 10/27, 10/29, 10/30, 11/4, 11/8, 11/9 and 11/11/25. Review of Resident #34's EHR titled, Census documented Resident #34 was out of the facility 9/29 - 10/6 and 10/15 - 10/20/25. On 12/4/25 at 7:59 AM Staff A, LPN stated he started working at the facility a couple months ago. Staff A stated he was terminated 11/12/25. Staff A acknowledged that he worked the overnight shift from 6:00 PM - 6:00 AM. Staff A explained he had to suction a tracheostomy while at the facility as part of his job duties. Staff A said Resident #34 had a tracheostomy. Stated he worked from 6pm - 6AM. Staff A stated he did not usually have a second nurse on his shift. Staff A stated he had to suction Resident #34 a lot during his shift. Staff A said he would suction Resident #34 multiple times a night, sometimes every hour. Staff A explained he would suction Resident #34's tracheostomy at least 2 or 3 times before he went to sleep. Staff A revealed Resident #34's suction order was as needed. Staff A said he did not recall having to sign out the suctioning on the MAR. Staff A said Resident #34 did not have an order for suctioning. Staff A explained he would stop in and ask Resident #34 if he needed to be suctioned. Staff A stated the CNA's would come and tell him that Resident #34 needed suctioned on the overnight shift all the time. Staff A stated he would go and suction Resident #34 immediately unless he was in the middle of something and then would go suction right afterwards. Staff A stated the CNA never had to come and remind him multiple times to suction Resident #34. Staff A revealed he never refused to suction Resident #34. Staff A stated Resident #34 had never died on him and Resident #34 could breathe. Staff A elaborated he never had to be told twice to suction Resident #34. Staff A stated Resident #34 would panic and whip himself up into a frenzy. Staff A stated at times when Resident #34 had to be suctioned; he did appear to have anxiety. Staff A acknowledged the DON came in on her own late at night one time to make an observation. Staff A said the DON stated she was worried about what was going on at the facility. Staff A revealed he thought one of Resident #34's family members, possibly	F0610		

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F0610 SS = SQC-J	Continued from page 18 the grandmother had called the DON and told her that he was not suctioning Resident #34 when it was requested. Staff A stated Resident #34 never went more than a few minutes after requesting to be suctioned. Staff A said he worked 3 nights a week but not a set schedule. Review of policy updated 7/8/24 titled, Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy documented all Residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This includes prohibiting nursing facility staff from taking acts that result in personal degradation* including the taking or using photographs or recordings in any manner that would demean or humiliate a resident, and prohibits using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep, or distribute photographs and/or recordings on social media or through multimedia messages. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Any of the following as a result of the willful misconduct or gross negligence or reckless acts or omissions of a caretaker, taking into account the totality of the circumstances: Neglect of a dependent adult. "Neglect of a dependent adult" means deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a dependent adult's life or physical or mental health. Should an incident or suspected incident of resident abuse (as defined above) be reported or observed, the Administrator must be notified immediately. (If the Administrator is on vacation, then a designee must be named as the temporary Abuse Coordinator until the Administrator returns) The Administrator will complete documentation of the allegation of Resident abuse and collect any supporting documents relative to the alleged incident. The Administrator will review documentation in the resident record (including review of assessment if resident injury). Assess the resident for injury if the allegation involves physical or sexual abuse. Provide proper notifications to the primary care provider, responsible party, etc. Attempt to obtain witness statements (oral and/or written) from all known witnesses. If there is physical evidence that can be preserved, attempt to do so, and maintain it in a safe location to minimize risk of evidence being tampered with. The facility will establish and enforce	F0610		

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F0610 SS = SQC-J	Continued from page 19 an environment that encourages individuals to report allegations of abuse without fear of recrimination or intimidation.	F0610		
F0636 SS = D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures.	F0636		

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F0636 SS = D	Continued from page 20 (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is NOT MET as evidenced by: Based on record review, resident interview, staff interviews, and policy review the facility failed to accurately complete a comprehensive Minimum Data Set (MDS) as directed by the Centers for Medicaid and Medicare Services (CMS) Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025 assessment for 1 out of 14 residents reviewed (Resident #10). The facility census was 37. Findings include: Resident #10's MDS Assessment dated 9/23/25 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 indicating normal cognition. The document revealed the resident had diagnoses of traumatic spinal cord dysfunction, neurogenic bladder and quadriplegia. The resident had an impairment on bilateral upper extremities (BUE) and bilateral lower extremities (BLE) range of motion (ROM). The document provided that the resident received 2 days of restorative program (for at least 15 minutes/day) in	F0636		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0636 SS = D	Continued from page 21 the last 7 days for passive range of motion (PROM). The Care Plan dated 10/6/25 revealed a focus of an altercation of musculoskeletal status related to C-5 paralysis injury, contractures of BUE and BLE initiated 5/21/25. Interventions included use of supportive devices (braces for use with eating as recommended by Occupational Therapy (OT) evaluation for restorative care program initiated 5/21/25 and follow Physical Therapy (PT) recommendation per doctor order for contracture management/treatment plan initiated 5/21/25. A focus area of inability to have independent ROM and is at risk for contractures dated 5/19/25 contained a goal of tolerating PROM exercises as written in their individualized restorative programs with a revision on 8/6/25 with a goal date of 12/22/25. Resident #10's Electronic Medical Record (EMR) Point of Care (POC) (documentation by aide when care provided) provided a Restorative Task PROM Lower Extremities (LEs) focusing on ankles, knees, and hips towards all planes to ensure joint mobility and prevention of contractures - 10 repetitions x1 set each joint. The document provided from 8/3/25 to 12/1/25 that the resident received service 12 times with the last date of service 9/19/25. A Restorative Tasks PROM passive stretching - bilateral shoulders/elbows/forearms/wrist, finger digits 1-5 -10 repetitions x1 on each area. The document provided from 8/3/25 to 12/1/25 that the resident received 13 times with the last date of service 10/27/25. On 12/1/25 at 1:09 PM Resident #10 stated he had not been receiving ROM for UEs and LEs. The resident stated he had received ROM, but that stopped when OT stopped working with him. The resident indicated he had not been receiving Restorative Nursing services. Resident #10 stated he had not had received Restorative Nursing for quite some time and was concerned about contracture management. On 12/3/25 at 10:08 AM the Director of Nursing (DON) stated the Therapy Department wrote the restorative programs. The DON stated the facility has a Restorative Nurse Aide (RNA) who worked 5 days a week. The staff stated the Restorative Nursing Plan would spell out specifics on what the resident would receive and that was in POC. The staff stated the RNA may have her own documentation that she kept. The DON stated the Therapy Department would write a Restorative Nursing Plan at the end of the therapy services and would determine the frequency. On 12/3/25 at 10:30 AM Staff P, RNA, stated the MDS	F0636		

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F0636 SS = D	Continued from page 22 Coordinator would review and revise the Restorative Nursing Plans as needed. The staff stated she would see residents 3-4 times per week. The staff stated she completed her own paper documentation as she was unable to document in the EMR. The staff stated the previous Assistant Director of Nursing (ADON) was putting things into POC but she could not access due to not having a computer to access. Staff P stated she came back to the Restorative Nursing Program in 6/25; prior to that there was no Restorative Nursing Program as she was pulled to the floor as Certified Nurse Assistant (CNA) or Certified Medication Aide (CMA). Staff P stated Resident #10 was not receiving restorative services as he had been receiving therapy services. The staff stated Resident #10 had approached her about Restorative Nursing and stated he was no longer receiving therapy services. The staff stated the resident had not been on Restorative Nursing services since she returned in June. On 12/4/25 at 10:41 AM Staff U, MDS Coordinator, stated she did not oversee the Restorative Nursing Program. The staff stated she used the data that was put in POC and pulled that data into the MDS Assessment. Staff U stated that a lot of Restorative Nursing data did not pull through into the assessment from the facility and had not spoken with anyone regarding the problem of data not pulling through. On 12/4/25 at 11:20 AM the DON declined to answer whether a Registered Nurse should be over or was over the Restorative Nursing program. The DON stated the previous Assistant Director of Nursing (ADON) was over the program, but the facility had not had an ADON for a while until this week. On 12/4/25 at 12:20 PM the Administrator stated the time that was entered in POC would be the time the MDS Coordinator would utilize. The Administrator stated she was unaware the RNA was completing paper documentation for Restorative Nursing and not POC. The CMS RAI Version 3.0 Manual dated October 2025 Chapter 3 revealed restorative nursing program interventions focus on achieving and maintaining optimal physical, mental and psychosocial functioning. The document disclosed there was a 7 day look-back period during which the program was provided at least 15 minutes during the 24-hour period. The criteria required for inclusion in the MDS included:Measurable objectives and interventions must be documented in the Care Plan and medical record with revisions of the Restorative Nursing Program at the same time the Care Plan was revised. Evidence of periodic evaluation by	F0636		

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F0636 SS = D	Continued from page 23 the licensed nurse must be in the medical record. RNAs must be trained in the techniques that promote the resident involvement in the activity.A registered or licensed nurse must supervise the activities in a restorative nursing program.The facility's MDS 3.0 Completion Policy dated 2025 revealed all disciplines need to follow the guidelines in Chapter 3 of the current RAI Manual for each assessment.	F0636		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F0656		

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F0656 SS = D	Continued from page 24 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interviews, clinical record review, and policy review, the facility failed to develop and implement a Comprehensive Care Plan for 1 of 14 residents (Resident #22) reviewed. The Care Plans failed to identify resident centered interventions for a resident who used continuous oxygen. The facility reported a census of 37 residents. Findings include: The Minimum Data Set (MDS) for Resident #22 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 indicating normal cognition. The document revealed diagnoses of dependence on supplemental oxygen, diabetes mellitus, anxiety disorder, depression, chronic obstructive pulmonary disease (COPD) and respiratory failure. The document disclosed the resident received oxygen therapy, and was prescribed antidepressant, diuretic, antiplatelet and hypoglycemic medications. Resident #22's Care Plan dated 11/3/25 contained a problem area that it was the resident's preference to smoke while at the facility and did not want a smoking cessation program revised 7/22/25. The goal revealed the resident would smoke with appropriate safety precautions and experience no injury or cause injury to others when smoking through the next review date revised 11/3/25 and target date 1/19/26. Interventions included continuous observation while smoking, Smoking Assessment quarterly and as needed (PRN), observe to be sure the Smoking Policy is being followed correctly and smoking material was not allowed to be kept in room with revision on 7/22/25. A problem area identified continuous use of oxygen and was at risk for alterations in oxygen levels due to COPD, asthma and obstructive sleep apnea revised 4/23/25. The identified goal was to remain free from signs/symptoms of respiratory infections through the next review revised 11/3/25 with a target date of 1/19/25. Interventions for staff to follow included: give medications as	F0656		

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F0656 SS = D	Continued from page 25 ordered by physician with monitoring for side effects and effectiveness, history of noncompliance with using oxygen while ambulating, oxygen settings via nasal cannula as ordered and monitoring for signs/symptoms of respiratory distress and report to physician with initiation date of 4/23/25. The Care Plan failed to identify interventions related to the resident's continuous use of oxygen in relationship to the resident's desire for smoking. The interventions did not include who was responsible for management of the resident's oxygen prior to/after smoking and where it should be placed when smoking. The Interdisciplinary Team Nicotine/Smoking Safety Assessment - v5 dated 10/28/25 revealed the resident required a smoking apron and supervision. The document did not reference the resident's continuous use of oxygen. Resident #22's Clinical Physician Orders printed 12/4/25 revealed the resident required continuous oxygen at 3 L related to COPD. On 12/4/25 at 8:50 AM Staff X, Housekeeping, stated residents who smoke take their oxygen off and leave in the building. The staff stated Housekeeping/Laundry staff were responsible to take residents out for smoking. The staff stated Resident #22 took her own oxygen off when going outside to smoke. On 12/8/25 at 10:19 AM the DON stated she expected all interventions for a resident to be included on the Care Plan, including what a resident should do with their oxygen when smoking and who was responsible for management of the oxygen. The facility's Care Plans, Comprehensive Person-Centered Policy, revised 3/22, revealed the interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The document further revealed the Care Plan interventions were chosen after careful consideration of the relationship between the resident's problem areas, causes and relevant clinical decision making.	F0656		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F0657		

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F0657 SS = D	Continued from page 26 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, resident interview, staff interviews, and facility policy review the facility failed to revise a Comprehensive Care Plan for 1 of 14 residents (Resident #10) reviewed. The facility failed to revise the interventions and goals for a resident who was not receiving a Restorative Nursing Program. The facility reported a census of 37 residents. Findings include: Resident #10's MDS Assessment dated 9/23/25 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 indicating normal cognition. The document revealed the resident had diagnoses of traumatic spinal cord dysfunction, neurogenic bladder and quadriplegia. The resident had an impairment on bilateral upper extremities (BUE) and bilateral lower extremities (BLE) range of motion (ROM). The document provided that the resident received 2 days of restorative program (for at least 15 minutes/day) in the last 7 days of the assessment period for passive	F0657		

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F0657 SS = D	Continued from page 27 range of motion (PROM). The Care Plan dated 10/6/25 revealed a focus of altercation of musculoskeletal status related to C-5 paralysis injury, contractures of BUE and BLE initiated 5/21/25. The goal revealed the resident would remain free of complications related to contracture formation revised on 8/6/25 with a target date of 12/22/25. Interventions included use of supportive devices (braces for use with eating as recommended by Occupational Therapy (OT) evaluation for restorative care program initiated 5/21/25 and follow Physical Therapy (PT) recommendation per doctor order for contracture management/treatment plan initiated 5/21/25. A focus area of inability to have independent ROM and is at risk for contractures dated 5/19/25 contained goals of tolerating PROM exercises as written in their individualized restorative programs and tolerating PROM (which limbs, which days, and how many reps) with no complaints of pain to joints through the next review date with a revision on 8/6/25 with a goal date of 12/22/25. The interventions included notifying the charge nurse/therapy of declines in ability to complete PROM, notifying the charge nurse of complaints of pain to joints during or after performing PROM and nurse to review programs routinely addressing progress towards goals all initiated on 5/19/25. On 12/1/25 at 1:09 PM Resident #10 stated he has not been receiving PROM for UEs and LEs. The resident stated he had received ROM, but stopped when OT stopped working with him. The resident indicated he had not been receiving Restorative Nursing services. Resident #10 stated he had not had received Restorative Nursing for quite some time and was concerned about contracture management. On 12/3/25 at 10:30 AM Staff P, Restorative Nurse Aide (RNA), stated Resident #10 was not receiving restorative services as he had been receiving therapy services. The staff stated Resident #10 had approached her about Restorative Nursing and stated he was no longer receiving therapy services. The staff stated the resident had not been on Restorative Nursing services since she returned in 6/25. On 12/3/25 at 10:40 AM Staff R, Physical Therapist Assistant/Director of Rehabilitation (PTA/DOR) and Staff S, Occupational Therapist Registered/Licensed (OTR/L), they had not written Restorative Nurse Plans for Resident #10. On 12/4/25 at 12:20 PM the Administrator stated she expected the documentation in EMR regarding Restorative	F0657		

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F0657 SS = D	Continued from page 28 Nursing Plans to be the plans that were being completed. On 12/8/25 at 10:19 AM the DON stated she expected the Care Plan to match the Restorative Nursing Plans that were being completed. The DON stated the MDS Coordinator completed the basic and initial Care Plans, and then she and the Administrator completed Care Plan revisions based on Risk Management items. The facility's Care Plans, Comprehensive Person-Centered Policy, revised 3/22, revealed the interdisciplinary team reviewed and updated the Care Plan when an outcome was not met, at least quarterly in conjunction with the required quarterly MDS assessment, and a significant change in the resident's condition. The document provided that assessments of residents were ongoing and Care Plans were revised as information about the residents changed.	F0657		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, staff interviews and policy review, the facility failed to follow physician orders for 1 of 3 residents reviewed (Resident #32). The facility reported a census of 37 residents. Findings include: The Minimum Data Set (MDS) for Resident #32 dated 11/18/25 documented a Brief Interview of Mental Status (BIMS) score of 6/15 indicating severe cognitive impairment. The MDS included diagnoses of stroke, heart failure, hypertension (HTN), peripheral vascular disease (PVD) and depression. The document identified no concerns with mood or behaviors during the reporting period. The MDS identified Resident #32 took antipsychotic, antidepressant, hypnotic, anticoagulant, diuretic, antiplatelet and anticonvulsant medications during the last 7 days of the assessment period. The document revealed the resident had 4 venous and arterial ulcers, had application of nonsurgical	F0658		

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F0658 SS = D	Continued from page 29 dressings other than to the feet, applications of ointments/medications other than to feet and application of dressings to feet. Resident #32's Care Plan dated 8/26/25 contained a potential for infection. Interventions for this problem included monitor/document/report to physician for signs/symptoms of infection. A problem area for impaired skin integrity and risk for edema, skin/tissue color changes, swelling, pain and pressure ulcers. Interventions for the problem area included administration of treatments as ordered and monitor for effectiveness (treatments as per orders/facility protocol) 6/4/25, apply protective ointment to prevent skin breakdown 6/4/25, and monitor/document location, size and treatment of skin injury 6/4/25. Resident #32's Treatment Administration Record (TAR) revealed the following: -Left LE (lower extremity): Cleanse with soap and water and pat dry, Eucerin or equivalent emollient lotion to peri wound; apply layer or Xeroform to open wound bed; apply non bordered foam dressing over Xeroform, cover with ABD pad, secure with gauze wrap and tape. Wrap from toe to knee with 6" ACE wrap; change daily and as needed (PRN) in the morning for wound care-Start Date 10/29/25 and discharge (D/C) Date 11/25/25. No documentation on 11/16 and 11/25/25 to indicate the treatments were completed. -Medi honey Wound/Burn Dressing External Gel (Wound Dressings) Apply to right great and 2nd toes topically every day shift for venous ulcers-Start Date 7/30/25. No documentation on 11/16/25. -Right 2nd toe Dorsal: Cleanse with wound cleaner and wipe wound bed with gauze, apply Medi honey to wound bed, apply Calcium Alginate over Medi honey, cover with gauze, secure with tape, change daily and PRN soiling; May substitute bordered gauze dressing if gauze doesn't stay in place. in the morning for Wound care-Start Date 10/29/25 and D/C Date 11/19/25. No documentation on 11/16/25. -Right great toe planter: Cleanse with soap and water and dry well, apply Lac Hydrin lotion to peri wound, apply Eucerin over Lac Hydrin apply Calcium Alginate to wound bed, cover with Duoderm secure with gauze wrap and tape change daily and PRN soiling. in the morning for Wound care-Start Date 10/26/25 and D/C Date 11/19/25. No documentation on 11/16/25. -Right Lateral foot: Cleanse with soap and water and	F0658		

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F0658 SS = D	Continued from page 30 pat dry; apply Lac Hydrin lotion and crusted areas on foot and leg, apply Eucerin over Lac Hydrin to foot and leg, apply Calcium Alginate to open wound bed. Cover with ABD pad, secure with gauze wrap from toe to knee with 6" ACE wrap, change daily and PRN soiling in the morning for wound care-Start Date10/29/25 and D/C Date11/25/2025. No documentation on 11/16 and 11/20/25. -Weekly weight related to skin breakdown in the morning every Monday-Start Date 6/23/25. No documentation on 11/24/25. -Encourage the resident to elevate legs 2-3x daily for 30min each time two times a day-Start Date 5/02/2025. No documentation on 11/16 AM and midday and 11/20/25 AM and midday. -A hypnotic has been ordered for this resident. Observe closely for significant side effects. Click N (no)if monitored and any of the above was observed, select chart code "Other/See Nurses Notes" and record findings in nurses note. No documentation on 11/13 evening, 11/16 days and 11/30/25 evening. -Anticonvulsant Medication Use: Observe closely for significant side effects. Click Y (yes) if monitored and none of the above observed. Click N (no) if monitored and any of the above was observed, select chart code "Other/See Nurses Notes" and record findings every shift-Start Date 8/07/25. No documentation on 11/13 evening, 11/16 day and 11/30/25 evening. -Anti-Psychotic Medication Use: Observe closely for significant side effects. Click Y (yes) if monitored and none of the above observed. Click N (no)if monitored and any of the above was observed, select chart code "Other/See Nurses Notes" and record findings every shift-Start Date 8/07/25. No documentation on 11/13 evening, 11/16 day and 11/30/25 evening. -Encourage protein intake. Consider supplement if needed with meals for wound healing-Start Date 4/11/25. No documentation on 11/13 5:00 PM, 11/16 8:00 AM, 12:00 PM, 11/20 12:00 PM, 5:00 PM, 11/21 5:00 PM, 11/24 5:00 PM and 11/30/25 5:00 PM. -Encourage the resident to wear a Darco boot or something similar shoe/slipper to the right foot to prevent injury to toes when self propelling. every shift for wound prevention-Start Date 10/26/25 and D/C Date 12/02/25. No documentation 11/13 evening, 11/16 day and 11/30/25 evening. -Encourage the resident to wear a Darco boot or similar	F0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165531	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/08/2025

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F0658 SS = D	Continued from page 31 shoe/slipper to the right foot to prevent injury to toes when self-propelling. every shift for pressure relief-Start Date 11/22/25 and D/C Date 12/02/25. No documentation 11/30/25 at evening. -Monitoring for signs of bleeding every shift when receiving anticoagulant therapy. Start Date 8/7/25. No documentation 11/13 evening, 11/16 day, and 11/30/25 evening. The facility failed to follow physician orders for providing treatments to the lower extremities on 7 occasions, obtaining a weight once/week, encouraging elevation of lower extremities on 4 occasions, documentation of side effects for hypnotics 3 occasions, side effects of anticonvulsants on 3 occasions, documentation of side effects for antipsychotics on 3 occasions, protein intake on 8 occasions, use of a Darco boot on 3 occasions, revised Darco boot order documentation on 1 occasion and monitoring of bleeding on 3 occasions. On 12/8/25 at 3:02 PM Staff Z, Licensed Practical Nurse (LPN), stated Resident #32 would refuse treatments at times, but the refusals should be documented as such in the TAR. The staff stated there should not be blanks on the TAR. On 12/8/25 at 10:19 AM the Director of Nursing (DON) stated orders should be completed as ordered by the physician. The DON stated if there was no documentation she would assume the medication/treatment had not been completed. The DON stated the expectation was to complete orders as written. If orders were not followed the physician should be notified or parameters should be set for not needing to contact physician due to frequent refusals. The facility's Medication Therapy Policy, revised 4/07, revealed all medication orders will be supported by appropriate care processes and practices. The document further indicated medication use shall be consistent with an individual's condition, prognosis and responses to treatments and circumstances that require a need to alter treatment. The facility's Notification of Changes Policy, revised 2025, to ensure the facility promptly consults with the resident's physician and notify the resident's representative when there is a change requiring notification. The facility did not have a specific policy for following physician orders.	F0658		

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F0658 F0684 SS=D SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews, provider interview, hospital reports and clinical record review the facility failed to ensure that residents received accurate and timely assessment and intervention for 1 of 2 residents reviewed (Resident #1). Early in November 2025, Resident #1 was found to have a Urinary Tract Infection (UTI) and was put on an antibiotic. He continued to be febrile (elevated temperature) off and on throughout the month. Staff failed to provide timely and consistent assessments to include vital signs, and failed to contact the doctor with continued fever. On December 1, 2025, Resident #1 was admitted to the hospital with urosepsis (severe life threatening infection in the blood that originated from a UTI). The facility reported a census of 37 residents. Findings include: The Minimum Data Set (MDS) dated 11/13/25, showed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive deficits.) He was totally dependent on staff for dressing, eating, hygiene, transfers and toileting. The resident had an indwelling catheter and tube feedings. His diagnoses included urinary tract infection in last 30 days, diabetes mellitus, aphasia (difficulty speaking), cerebrovascular accident (CVA/stroke), and hemiplegia (paralysis one side of the body). The Care Plan for Resident #1, updated on 11/14/25, showed that he had the potential for infection related to history of UTI. Staff were to monitor daily for dehydration, pain/discomfort and report to the physician. Staff were directed to monitor temperature, pulse during active administration of antibiotics report signs of sepsis, rapid breathing, heart rate, shortness of breath, extreme pain, fever/shivering.	F0658 F0684		

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F0684 SS = G	Continued from page 33 According to the Medication/Treatment Administration Record (MAR/TAR), Resident #1 was put on an antibiotic; Cefpodoxime Proxetil, 100 milligrams (mg) two times a day for UTI started on 11/6/25 at 8:00 PM and the treatment was completed on 11/17/25 at 9:53 AM. The following documentation was found in the Nursing Progress Notes (NPN) and the Vitals Tab (VT) of the electronic chart: a. NPN: on 11/6/25 at 1:30 PM readmitted to the facility from the hospital b. On 11/7/25, 11/10 and 11/11 the chart lacked vitals in the VT or NPN c. NPN: on 11/12/25 at 3:24 AM, T 99.7 and Tylenol was given. d. VT: on 11/12 at 8:51 PM, T 99.2 (the chart lacked follow up temperature check) e. On 11/13/25, the chart lacked any vitals in the VT or NPN. f. NPN: On 11/14 at 9:55 AM, T 100.2 and Tylenol was given g. VT: on 11/14 at 8:03 PM, T 99.4 the chart lacked documentation of follow up assessment. h. NPN: on 11/15 at 11:55 PM 100.2 i. VT: 11/16 at 8:23 PM, T 96.0 j. 11/17/25 chart lacked vitals k. NPN: 11/18 at 8:24 PM, T 100.1 l. 11/19/25 chart lacked vitals m. VT: 11/20 at 8:04 PM. T 98 temp n. NPN: 11/21 at 6:52 PM, T 100.7 Tylenol given o. NPN: 11/21 at 10:00 PM, T 99.2 p. 11/22 the chart lacked vitals. q. NPN: 11/22 at 9:33 PM left arm swollen, elevated on pillow r. VT: 11/23 at 4:53 PM, T 98.2	F0684		

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F0684 SS = G	Continued from page 34 s. 11/25, chart lacked vitals t. 11/27, chart lacked vitals u. VT: on 11/28 at 7:21 PM, T 98 v. NPN: on 11/29 at 4:30 AM, T 102 w. VT: on 11/30 at 6:28 PM, T 99.0 x. NPN: on 12/1 at 2:30 AM, T 102, edema, called the doctor y. VT: on 12/1/25 at 3:06 AM, T 102 From 11/6/25 through 11/30/25, the chart lacked documentation that the doctor had been contacted regarding the on-going fever. A hospital report progress note for Resident #1, dated 12/1/25, showed that the chief complaint upon admission was; infection and fever. The Assessment and Plan included: 1. Multifocal bilateral pulmonary infiltrates, questionable pneumonia. 2. Urinary tract infection. On 12/2/25 at 6:15 AM, Staff F, Certified Nurse Aide (CNA) said that Resident #1 was running a Temperature (T) for several nights and she told Staff A, Licensed Practical Nurse (LPN) that the resident could use a medication for the fever, but Staff A refused to give the resident a Tylenol because “babies run that temp.” Staff F said that this was shortly before the resident had been sent to the hospital. The Discharge Summary from the hospital, dated 12/4/25 at 3:43 PM, showed that the Emergency department findings included urine analysis with three plus bacteria and epithelial cells present. Xray showed multifocal bilateral pulmonary infiltrates. He was admitted for management of UTI and pneumonia. Hospital Course: admitted with sepsis due to UTI. He was treated with multiple antibiotics, however, he did not improve, likely due to multiple comorbidities. The family made the decision to for-go further lifesaving treatment and make him comfortable. Transferred back to nursing home on hospice care. On 12/8/25 at 9:09 AM, Staff G, Licensed Practical Nurse (LPN) said she came in on a Sunday and had taken the blood sugar for Resident #1 and noticed increased edema. She said she took his temp and he was a-febrile	F0684		

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F0684 SS = G	Continued from page 35 with a lower blood pressure and his lungs sounded like he had phlegm stuck. He didn't seem in distress and she passed it onto the next shift. She did not get anything reported to her at shift change that he'd been having high temps. On 12/8/25 at 7:51 AM, Staff E, Registered Nurse (RN) said that she was told that Resident #1 had a stroke that caused brain stem damage, so he wasn't having normal temp control. She didn't see this information on any of his paperwork, but that was what the other nurses were saying. She remembered that Resident #1 was having temps around 99 and his skin looked okay. She had given him some Tylenol several times. Staff E said that she had him sent to the hospital, when his temperature got up to 102. She said that the prior nurse had reported that he had edema, and she became concerned that he could have been septic. Staff E said that the expectation was to provide full assessments at least twice a day because Resident #1 he was on skilled care. On 12/8/25 at 9:15 AM, the Primary Care Physician (PCP) said that he thought that Resident #1 had gone to the hospital with the diagnoses of UTI and pneumonia. The PCP remembered that the resident had been on an antibiotic early in November for a UTI but he was not aware that the resident continued to have high temperatures on and off before the hospitalization. The PCP looked through the notes for Resident #1, and saw that he had been contacted on Nov 11th with a concern of high blood pressures. That was right around the time they started him on an antibiotic for a UTI. The PCP said that he was contacted about some blood sugars and for authorization for skilled services, but did not see any communication about high temperatures until Nov 30/Dec 1st. He said that he would have liked to know about continued high temps so they could have done repeat labs or urine cultures. The PCP said that it could possibly have made the difference in the outcome of the resident having to go to the hospital. The doctor was not aware of any brain injury that Resident #1 had that would cause him to have continued higher temperatures. On 12/08/2025 at 2:29 PM, the Director of Nursing (DON) said that when a resident had an infection, the staff should have been taking "at least a temp" per shift, and they should have notified the doctor of elevated temps. Facility policy titled: Notification of Change The purpose of the policy was to ensure the facility promptly informed resident, consults with resident's	F0684		

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F0684 SS = G	Continued from page 36 physician when there was a change requiring notification. Clinical complication defined examples include recurrent UTIs. The facility must inform the resident, consults with the resident's physician when there was a change requiring notification. Circumstances requiring notification include significant change in the resident physical condition including clinical complications. The facility's Notification of Changes Policy, revised 2025, to ensure the facility promptly consults with the resident's physician and notify the resident's representative when there is a change requiring notification.	F0684		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview and record review the facility failed to provide wound treatments as ordered for 2 of 2 residents reviewed with pressure ulcers. Resident's #2 and #34 were admitted with a history of severe skin breakdown and required consistent treatments. The clinical record showed that in September and October 2025, staff failed to document the treatments had been administered as ordered, and failed to document why the resident refused the treatments and that the doctor had been notified. The facility reported a census of 37 residents. Findings include:	F0686		

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F0686 SS = D	Continued from page 37 The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. 1) According to the Minimum Data Set (MDS) dated 9/9/25, Resident #2 had a Brief Interview for Mental Status (BIMS) score of 13. He was totally dependent on staff for dressing, toileting, hygiene, transfers and turning in bed. He had an indwelling catheter and was always incontinent of bowel. His diagnoses included peripheral vascular disease, diabetes mellitus, paraplegia. The Care Plan for Resident #2 updated on 2/27/25, showed that he was at risk for frequent infections, alteration of skin, monitor for changes; redness, breakdown and report to physician as necessary. History of pressure area to coccyx, bilateral buttocks, bilateral heels. Staff were to administer treatments as ordered and monitor for effectiveness On 12/01/2025 at 12:34 PM, Resident #2 was sitting up in bed eating his lunch. He had a catheter bag hanging from the bed and he was very thin. The resident said that he did not want to talk. On 12/04/2025 at 6:23AM, Staff E, Registered Nurse (RN) stated the nurses are responsible for wound assessments weekly to include measurements. The nurses were to	F0686		

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F0686 SS = D	Continued from page 38 document any refused treatments, and to contact the doctor about refusals. A Weekly Pressure Wound Assessment (WPWA) dated 9/23/25 at 3:08 AM, showed that Resident #2 had more than 5 wounds. The pressure on his sacrum measured 7.2 centimeters (cm) length x 5.9 cm width x 0.5 cm depth. The wound had moderate drainage with a slight odor. The Medication/Treatment Administration Record (MAR/TAR) showed an order dated 9/26/25 for treatment to the sacrum; cleanse with cleaner or saline, apply triad paste to peri-wound, apply Vashe (wound cleanser) soaked gauze to the wound bed and in undermined areas, and cover with ABD (gauze pad used to absorb discharge from draining wounds) pad, secure with tape, change twice a day (BID) and as needed (PRN) soiling. The following was found on the MAR/TAR for Resident #2: In September 2025, the treatment was not completed on the 6th, 11th, 17th, 18th, 19th, 20th and 28th In October 2025, the treatment was not completed on the 1st, 2nd, 7th, 9th, 13th, 16th, 17th, 18th, 19th, 23rd, 24th and 27th. A Pressure Wound Assessment, dated 10/31/25 at 6:30 PM, showed that the sacrum pressure measured 8 cm. x 3 cm. x 2.2 depth, Stage IV. In November, the treatment was not completed on the 13th, 20th. The WPWA dated 11/27/25 at 6:03 PM showed the sacral wound measured 6 cm. x 4 cm. x 2.2 cm. described at a Stage IV. The only documented refusal of wound treatment was on 9/8 and 9/24, and the chart lacked documentation that the doctor had been notified of the refusals. 2) The MDS for Resident #34, dated 10/10/25, showed that he had a BIMS score of 14 (intact cognitive ability) The resident was totally dependent on staff for all care areas. The resident had an indwelling urinary catheter, ostomy, Diagnosis included anemia, renal insufficiency, neurogenic bladder, pneumonia, septicemia, urinary tract infections, and quadriplegia. The Care Plan for Resident #34, updated on 8/13/25, showed that he had a feeding tube for water flushed and medications related to diagnosis of dysphagia, Multiple Sclerosis and Bechet's disease. Staff were to complete	F0686		

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F0686 SS = D	Continued from page 39 weekly skin/treatment documentation in accordance to wound nurse assessment and plan of care recommended. He had the potential for infection related to a history of sepsis. An order dated 9/15/25 at 7:00 PM, showed staff were to cleanse the scrotum with soap and water apply thin layer of Silvadene to xeroform and apply to wound bed, cover with ABD pad and secure with cloth every Monday and Thursday. The MAR/TAR showed that he refused on the 6th and the 9th. The chart lacked corresponding documentation of why the resident refused, or communication with the doctor. An order dated 10/12/25 7:00 PM, directed staff to treat the bilateral groin: 1) cleanse area well 2) apply Triad paste twice a day and PRN two times a day for wound care. The treatment was not completed on October 24th or the 27th. An order dated 10/15/25 at 6:00 AM, showed that staff were to provide wound care to the left lateral foot right lateral ankle, left medial ankle, right posterior heel 1) cleanse with saline 2) swab with betadine every day for wound care. The MAR/TAR showed that it was not completed on October 24th 25th or 28th. On 12/4/25 at 10:00 AM, the Nurse Consultant for the facility said that if a resident missed a wound care treatment, there should have been documentation of why he refused, and that the doctor had been contacted. A facility policy titled: Wound Care, dated October 2010, showed that the purpose of the policy was to provide guideline for the care of wounds to promote healing. Information on wounds was to be recorded in the resident medical record included; any changes in the resident's condition, assessment data such as color, size drainage, if the resident refused the treatment and the reason why. Staff were to notify the supervisor if the resident refused the wound care and report other information in accordance with facility policy and professional standards of practice.	F0686		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a	F0688		

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F0688 SS = D	Continued from page 40 reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, resident interview, staff interview, and policy review the facility failed to provide range of motion (ROM) services to a resident with limited ROM to prevent further decrease in range of motion or development of contractures for 1 of 14 residents reviewed (Resident #10). The facility reported a census of 37. Findings include: Resident #10's Minimum Data Set (MDS) Assessment dated 9/23/25 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 indicating normal cognition. The document revealed the resident had diagnoses of traumatic spinal cord dysfunction, neurogenic bladder and quadriplegia. The resident had an impairment on bilateral upper extremities (BUE) and bilateral lower extremities (BLE) range of motion (ROM). The document provided that the resident received 2 days of restorative program (for at least 15 minutes/day) in the last 7 days of the assessment period for passive range of motion (PROM). The Care Plan dated 10/6/25 revealed a focus of altercation of musculoskeletal status related to C-5 paralysis injury, contractures of BUE and BLE initiated 5/21/25. The goal revealed the resident would remain free of complications related to contracture formation revised on 8/6/25 with a target date of 12/22/25. Interventions included use of supportive devices (braces for use with eating as recommended by Occupational Therapy (OT) evaluation for restorative care program initiated 5/21/25 and follow Physical Therapy (PT) recommendation per doctor order for contracture management/treatment plan initiated 5/21/25. A focus area of inability to have independent ROM and is at risk for contractures dated 5/19/25	F0688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165531	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/08/2025

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

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F0688 SS = D	Continued from page 41 contained goals of tolerating PROM exercises as written in their individualized restorative programs and tolerating PROM (which limbs, which days, and how many reps) with no complaints of pain to joints through the next review date with a revision on 8/6/25 with a goal date of 12/22/25. The interventions included notifying the charge nurse/therapy of declines in ability to complete PROM, notifying the charge nurse of complaints of pain to joints during or after performing PROM and nurse to review programs routinely addressing progress towards goals all initiated on 5/19/25. Resident #10's Electronic Medical Record (EMR) Point of Care (POC) provided a Restorative Task PROM Lower Extremities (LEs) focusing on ankles, knees, and hips towards all planes to ensure joint mobility and prevention of contractures - 10 repetitions x1 set each joint. The document provided from 8/3/25 to 12/1/25 that the resident received the service 12 times with the last date of service 9/19/25. A Restorative Tasks PROM passive stretching - bilateral shoulders/elbows/forearms/wrist, finger digits 1-5 -10 repetitions x1 on each area. The document provided from 8/3/25 to 12/1/25 that the resident received the task 13 times with the last date of service 10/27/25. On 12/1/25 at 1:09 PM Resident #10 stated he has not been receiving PROM for UEs and LEs. The resident stated he had received ROM, but stopped when OT stopped working with him. The resident indicated he had not been receiving Restorative Nursing services. Resident #10 stated he had not had received Restorative Nursing for quite some time and was concerned about contracture management. On 12/3/25 at 10:08 AM the Director of Nursing (DON) stated the Therapy Department wrote the restorative programs. The DON stated the facility has a Restorative Aide who worked 5 days a week. The staff stated POC is where the documentation should be and provide the details of the program(s), but the Restorative Nurse Aide (RNA) may have her own documentation. The DON stated the Therapy Department would write a Restorative Nursing Plan at the end of the therapy services and would determine the frequency. On 12/3/25 at 10:30 AM Staff P, RNA, stated the MDS Coordinator would review and revise the Restorative Nursing Plans as needed. The staff stated she would see residents 3-4 times per week. The staff stated she completed her own paper documentation as she was unable to document in the EMR. The staff stated the previous Assistant Director of Nursing (ADON) was putting things into POC but she could not document due to not having a	F0688		

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F0688 SS = D	Continued from page 42 computer to access. Staff P stated she came back to the Restorative Nursing Program in 6/25; prior to that there was no Restorative Nursing Program as she was pulled to the floor as a Certified Nurse Assistant (CNA) or Certified Medication Aide (CMA). The staff stated she did not see residents while they were receiving OT or PT services, but once a resident was not receiving therapy then would come back to restorative. Staff P stated Resident #10 was not receiving restorative services as he had been receiving therapy services. The staff stated Resident #10 had approached her about Restorative Nursing and stated he was no longer receiving therapy services. The staff stated the resident had not been on Restorative Nursing services since she returned in 6/25. On 12/3/25 at 10:40 AM Staff R, Physical Therapist Assistant/Director of Rehabilitation (PTA/DOR) stated she was new to the facility and did not know the process of residents transitioning to the Restorative Nursing Program. The staff stated Resident #10 last received PT services on 10/12/25. Staff R stated she had not written a Restorative Nursing Program for Resident #10. Staff R stated she was unaware of the process for Restorative Nursing in the facility and how to refer a resident to Restorative Nursing. Staff S, Occupational Therapist Registered/Licensed (OTR/L), stated she was not familiar with Resident #10 and had not written a Restorative Nursing Program for him. Staff R and Staff S stated a resident could receive Restorative Nursing services while the resident was on Medicare Part B therapy services for unrelated reasons. On 12/3/25 at 10:45 AM the DON stated a resident could receive Restorative Nursing services while receiving therapy if the services were unrelated. The DON stated the PTA/DOR was new to the facility and had begun attending the facility's Morning Meeting. The DON stated if a resident had been receiving Restorative Nursing services prior to therapy then she would expect the resident to receive services after therapy. On 12/4/25 at 10:41 AM Staff U, MDS Coordinator, stated she did not oversee the Restorative Nursing Program. On 12/4/25 at 10:50 AM Staff P stated she wrote the Restorative Nursing Programs for the residents who were receiving services. The staff stated upon return to the Restorative Nursing Program in 6/25 she was directed to "bring residents down and start their programs back up". When asked about the length of time between the last restorative programs and 6/25, the staff acknowledged it could have been close to a year. Staff P stated she wrote just basic active range of motion	F0688		

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F0688 SS = D	Continued from page 43 (AROM) and PROM programs based on what she thought the residents could handle. Staff P stated once she wrote the programs they would go to the Assistant Director of Nursing (ADON) for a signature. When asked about who that would be when no ADON, the staff stated it would be the DON or someone. Staff P stated the programs would be in their offices with signatures as the programs the staff was using did not have a nurse signature. On 12/4/25 at 11:20 AM the DON stated a registered nurse (RN) should be over the Restorative Nursing Program. When asked whether a RN was over the Restorative Nursing Program, the DON stated she was not going to answer that. When asked if she had reviewed any Restorative Nursing Programs, the DON stated she had not seen any programs. The DON stated she was not aware the RNA was writing the programs and not using POC. The DON stated the ADON was supposed to be in charge of Restorative Nursing, but they had not had an ADON for a while. On 12/4/25 at 12:20 PM the Administrator stated the Restorative Nursing Programs were in the EMR. The Administrator stated the nurse who put the programs in POC was the nurse who wrote them and those were the programs that were completed. The Administrator stated the documents the RNA was referencing should be the same as the one in PCC. The Administrator stated she did know the RNA had written the programs she was completing and not documenting in POC. On 12/9/25 at 1:11 PM the DON stated the RNA was completing 16 programs that she had written. The facility's Restorative Nursing Services Policy revised 7/17 revealed restorative nursing care consists of nursing interventions that may or may not be accompanied by OT, PT or speech therapy. The document further provided that restorative goals and objectives are individualized and resident-centered, and outlined in the Care Plan.	F0688		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F0690		

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F0690 SS = D	Continued from page 44 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, observations, staff interview, and facility policy review the facility failed to provide a professional standard of quality of care by not completing catheter cares for 1 of 1 residents reviewed (Resident #10). The facility reported a census of 37 residents. Findings include: Resident #10's Minimum Data Set (MDS) Assessment dated 9/23/25 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 indicating normal cognition. The document revealed the resident had diagnoses of traumatic spinal cord dysfunction, neurogenic bladder and quadriplegia. The document disclosed the resident had an indwelling catheter. The Care Plan dated 10/6/25 revealed a focus area for a supra pubic catheter due to diagnosis of neuromuscular dysfunction of the bladder and C5 spinal cord injury revised 10/6/25. The goal disclosed the catheter will be managed appropriately and not exhibit signs of infection or urethral trauma through the next review	F0690		

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F0690 SS = D	Continued from page 45 date revised 8/6/25 and target date 12/22/25. Interventions for the focus area included providing catheter care as per facility policy, catheter change as ordered, and monitor/document intake and output as per facility policy initiated 6/25/25. Resident #10's Medication Administration Record/Treatment Administration Record (MAR/TAR) 11/25 revealed an order for Acetic Acid Irrigation Solution 0.25%. Use 60 ml via irrigation at bedtime for flushing with 30 ml with catheter care at nighttime (HS) related to quadriplegia, unspecified with a start date of 9/3/25. The document disclosed no documentation for following the physician order on 11/11 and 11/13/25. The resident's Point of Care (POC/documentation at time of care) response history for monitoring output from 8/3/25 - 12/3/25 revealed the following: -5 days with 0 entries for output. -28 days with 1 entry for output. -55 days with 2 entries for output. -25 days with 3 entries for output. -3 days with 4 entries for output. On 12/3/25 at 10:15 AM the Director of Nursing (DON) stated if there were a blank on the MAR/TAR it would indicate that the treatment or medication was not given. The DON expected catheter cares to be managed as ordered and/or as indicated on the Care Plan. The facility's Medication Orders Policy, revised 2025, revealed medications should be administered upon the signed order of a person lawfully authorized to prescribe. The facility's Medication Therapy Policy, revised 4/07, revealed all medication orders will be supported by appropriate care processes and practices. The facility's Catheter Care Policy did not provide guidance for the frequency of emptying a catheter bag.	F0690		
F0695 SS = G	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F0695		

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F0695 SS = G	Continued from page 46 The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, electronic medical record (EMR) reviews, staff interviews, and facility policy review, the facility failed to provide respiratory care and services in accordance with professional standards of practice for 1 of 2 residents (Resident #22) reviewed, requiring the use of oxygen and nebulizer treatments. The facility reported a census of 37 residents. Findings include: The Minimum Data Set (MDS) for Resident #22 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 indicating normal cognition. The document revealed diagnoses of dependence on supplemental oxygen, diabetes mellitus, anxiety disorder, depression, chronic obstructive pulmonary disease (COPD) and respiratory failure. The document disclosed the resident received oxygen therapy, and was prescribed antidepressant, diuretic, antiplatelet and hypoglycemic medications. Resident #22's Care Plan dated 11/3/25 contained a problem area with continuous use of oxygen and was at risk for alterations in oxygen levels due to COPD, asthma and obstructive sleep apnea revised 4/23/25. The identified goal was to remain free from signs/symptoms of respiratory infections through the next review revised 11/3/25 with a target date of 1/19/26. Interventions for staff to follow included: give medications as ordered by physician with monitoring for side effects and effectiveness, history of noncompliance with using oxygen while ambulating, oxygen settings via nasal cannula as ordered and monitoring for signs/symptoms of respiratory distress and report to physician with initiation date of 4/23/25. A problem of altered respiratory status with a history of respiratory failure and risk for respiratory rate increases/decreased, nose flaring, grunting, sweating, wheezing, color changes, continuous oxygen and diagnoses of COPD, asthma and obstructive sleep apnea. The goal area showed no signs of respiratory failure/distress revised on 11/3/25 with a target date of 1/19/26. Interventions for staff to follow included administration of medications as ordered with monitoring of effectiveness and side effects,	F0695		

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F0695 SS = G	Continued from page 47 administration of medications/puffers as ordered with monitoring of effectiveness and side effects, oxygen via nasal cannula as ordered, monitor/document an signs/symptoms of respiratory distress to physician and monitor/document any abnormal breathing patterns to physician all dated 4/23/25. A problem area identified a diagnosis of COPD and risk for shortness of breath, impaired breathing and respiratory infections revised on 4/23/25. The goal related to the problem was to maintain adequate air exchange daily with no signs/symptoms of distress with a revision date of 11/3/25 and target date of 1/19/26. The interventions identified included administration of medications/puffers as ordered with monitoring for effectiveness and side effects, administration of supplemental oxygen as ordered by physician, monitor for signs/symptoms of acute respiratory insufficiency and monitor for signs of respiratory infections/distress, adventitious lung sounds, shortness of breath, coughing and elevated temperature with notification to the physician - all initiated 4/23/25. Resident #22's Clinical Physician Orders included the following orders: -Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) mg/3 ml 1 vial inhale 3 times/day. -Oxygen 3 L continuous every shift related to COPD. Observed on 12/1/25 at 1:13 PM Resident #22 walking down the hallway pulling an E-tank using a nasal cannula for supplemental oxygen. The resident walked into her room, took the cannula off and continued to her bed. The resident stated she was having increased difficulties with her breathing this week. Observed the resident reach over to the bedside table, obtain a nebulizer mask, place it on her face and turn the machine on. The resident then stopped and stated "did that wrong", removed the mask, obtained Albuterol solution from the bedside table, opened the vial, put it in the medicine cup, and placed the mask back on her face. The Electronic Medical Record (EMR) Progress Notes revealed a Nurse's Note on 12/3/25 at 12:01 PM that at 11:00 AM Resident #22 was complaining of an increase in shortness of breath with oxygen saturations of 85% with 3 L oxygen via nasal cannula. The note further contained lung sounds revealed rubs in the upper lobes and the resident was very lethargic. An order was received for transport to the hospital via ambulance. A	F0695		

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F0695 SS = G	Continued from page 48 Nurse's Note on 12/3/25 at 2:41 PM disclosed Resident #22 was admitted for COPD exacerbation. A General Progress Note on 12/4/25 at 11:06 AM revealed the resident was returning to the facility with continuation of oxygen per previous orders, the resident was provided Levofloxacin (antibiotic) via IV, and will have a new diabetic medication, Zituvimet. The Hospital Discharge Summary revealed Resident #22 was brought to the Emergency Department on 12/3/25. The resident presented with a one-week history of worsening dyspnea and productive cough with thick mucus shortness of breath with subjective fevers associated with hot and cold sensations. The document indicated the resident was given DuoNeb treatment and Solu-Medrol (Methylprednisolone Sodium Succinate) in the Emergency Department. The resident was admitted with a diagnosis of COPD with acute exacerbation. The resident was also treated with Levofloxacin 750 mg during her hospitalization. The EMR did not contain an assessment for self administration of medications. The Clinical Physician Orders did not contain an order for the resident to self administer her medications or manage her own oxygen. On 12/3/25 at 4:15 PM Staff H, Certified Medication Aide, stated Resident #22 did have a nebulizer treatment. The staff stated she would provide the resident with her Albuterol vial and let the resident set it up herself when she was ready. Staff H stated she recognizes she is not supposed to do that but the resident "is very independent". On 12/3/25 at 4:25 PM Staff Z, Licensed Practical Nurse (LPN) stated Resident #22 did have a nebulizer treatment. The staff stated she would put the Albuterol in the medication cup of the nebulizer and let the resident turn it on when she was ready. On 12/3/25 at 4:30 PM Staff AA, CMA, stated she would set the nebulizer up for the resident by putting the Albuterol in the medication cup and if the resident wasn't ready for the medication she would leave it for the resident to complete when she was ready. On 12/8/25 at 10:15 AM the Director of Nursing (DON) stated she expected the nurses and/or CMAs to provide medications as ordered. The DON stated Resident #22's Albuterol should not be left for the resident to administer herself. The DON stated Resident #22's nebulizer should not be set up and left for the	F0695		

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F0695 SS = G	Continued from page 49 resident to turn on herself. The DON stated the facility did have an assessment for self administration of medication but Resident #22 did not have this. The DON acknowledged Resident #22 was admitted to the hospital for COPD exacerbation and self administration of a medication that was not prescribed as self administration could be a contributing factor. On 12/8/25 at 5:17 PM the physician stated he could not “envision” Resident #22 self administering her nebulizer treatments. The physician stated the resident could be extremely difficult. The physician stated there should be better documentation on medication administration. The physician stated if an assessment were given for self administration of medication, the assessment would say she could. However the physician stated he was unsure if she actually would give herself the medication as prescribed. The physician stated it would be much better if the nursing staff set up the nebulizer treatment and started it when the resident was ready for it rather than leaving it for the resident to self administer. The facility’s Medication Therapy Policy, revised 4/07, revealed medication orders will be supported by appropriate care processes and practices. It further stated medication use shall be consistent with an individual’s condition, prognosis and responses to treatments. The facility’s Medication Orders Policy, dated 2025, disclosed medications should be administered only under the order of a person lawfully authorized to prescribe.	F0695		
F0725 SS = F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff.	F0725		

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F0725 SS = F	Continued from page 50 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on facility record review, legal record review, resident and staff interviews, and facility policy review, the facility failed to provide a licensed nurse on a 24-hour basis. The facility failed to have a licensed nurse on premises on the overnight shift from 11/11/25-11/12/25. The facility reported a census of 37 residents. Findings include: Review of the facility's master schedule for staffing assignments for 11/25 revealed Staff A, Licensed Practical Nurse (LPN) was scheduled for 12 hour overnight shifts on 11/3, 11/4, 11/8, 11/9 and 11/11/25. Review of Staff A's timecard revealed he clocked in at the facility on 11/11/25 at 7:59 PM and clocked out of the facility on 11/12/25 at 1:15 AM working 5.27 hours. Review of a legal document from Fremont County Sheriff's Office revealed on 11/12/25 at approximately 1:19 PM a traffic stop was initiated for a vehicle traveling with no lights on. The Deputy followed the vehicle with his emergency lights activated. The driver continued driving in the oncoming lane of travel with no lights until it pulled into the parking lot of the facility. The driver was identified as Staff A. The staff volunteered that he worked at the facility and had left to get gas. Following a field investigation Staff A was placed under arrest, placed in the rear of the Deputy's car and the facility staff were notified. On 12/1/25 at 10:55 AM the Fremont County Deputy stated he was the Narcotics Investigator for the county and	F0725		

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F0725 SS = F	Continued from page 51 after 1:00 AM on 12/12/25 he observed Staff A leaving a convenient store without his lights on. The Deputy stated he attempted to pull Staff A over, but he continued to drive at times on the wrong side of the road, stopping when he pulled into the facility's parking lot. The Deputy stated Staff A was apologetic and stated he was the nurse on duty for the facility. The Deputy stated when he contacted the staff inside the building that he was taking Staff A into custody, they responded that Staff A was the nurse on duty and he could not leave the building. The Deputy explained to the Certified Nursing Assistants (CNAs) that Staff A had left the building and they replied they were unaware he had left. The Deputy stated the CNAs contacted the Director of Nursing (DON) to advise her of the situation and the DON had asked whether Staff A could remain on the premises until she arrived. The Deputy advised the DON that he was not comfortable with that option based on his interactions with Staff A. The Deputy stated he contacted the hospital and requested an Emergency Medical Services (EMS) unit to be on site until the DON arrived. On 12/2/25 at 6:15 AM Staff F, CNA, stated she had worked with Staff A a few times. The staff stated Staff A would go out to his car for long periods of time and tell the staff to call him if they needed anything. Staff F stated Staff A would leave his phone at the nurses' station when he told the staff to call him. On 12/2/25 at 9:15 AM Staff B, CNA, stated Staff A acted "weird" when working overnights with the CNAs. The staff stated the CNA's never knew where Staff A was during the shift. The staff stated Staff A would leave his cell phone number at the nurses' station and told them to call him if there was a problem. Staff B stated on the overnight of 11/11/25 the last time she saw Staff A was around 12:30 AM when she was doing rounds and asked Staff A to check on an unidentified resident. Staff B stated she never saw Staff A after 12:30 AM until she was notified by the Deputy that Staff A was being taken into custody. The staff stated Staff A would frequently take breaks on the overnight shift and they would not know where he was. On 12/2/25 at 9:32 AM Staff C, CNA, stated on the overnight shift of 11/11/25 the last time she recalled seeing Staff A was around 12:30 AM when she was doing rounds with Staff B. Staff C stated during the course of rounds Resident #1 had a fever but she could not locate Staff A and figured she would find Staff A during the course of rounds. Staff B stated around 1:30 AM when completing rounds and noting she had not seen Staff A and thought he wasn't in the building, the	F0725		

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F0725 SS = F	Continued from page 52 Deputy entered the facility and notified them that Staff A was being taken into custody. Staff C stated she contacted the DON and the DON did ask if Staff A could remain on site until she arrived, but the Deputy declined. Staff C stated the EMS arrived and was present as a medical service until the DON arrived approximately 45 minutes later. Staff C stated she and other staff had reported to the DON that they could not always find Staff A and he was always taking breaks. The staff stated Staff A would leave his phone number for staff to use to contact him if there was a problem, but sometimes his phone(s) would be sitting at the nurses station when they could not find him. On 12/2/25 at 10:18 AM the Administrator stated if there were concerns about staff behaviors they were to contact her or the DON. The Administrator stated if there were repeat concerns then there would be documentation regarding the concerns, and “teachable moments”. The Administrator stated Staff A did not have a soft chart with documentation of disciplinary action or “teachable moments”. The Administrator stated the facility did not have cameras. On 12/2/25 at 10:35 AM the DON stated she had an electronic soft chart for Staff A. The documents provided by the DON were related to a medication observation on 10/8/25 and the incident on 11/12/25. The DON stated she expected the nurse on duty to manage problems related with CNA to CNA interactions and to be contacted if the concern was related to a nurse. The DON stated if there were on-going concerns, “teachable moments” and documentation would occur. On 12/2/25 at 12:27 PM the Administrator acknowledged Staff A should not have left the premises on the overnight shift of 11/11/25. The Administrator stated the expectation was nurses can leave the building as long as they stay on the premises. When asked about how long a nurse could leave she first responded not longer than an hour, and then stated that over 30 minutes and in the car if it is on the premises. The Administrator stated that some CNAs had expressed concerns that Staff A was taking long breaks and the DON came in a couple of times and shadowed him with no problems. On 12/2/25 at 12:30 PM the DON stated she did not keep concerns or notifications by staff regarding concerns about other staff. The staff stated she was not aware of Staff A not being in the building or staff being able to find him. The DON stated Staff A might go to various parts of the building for a break or thought he was a smoker. The DON was aware that Staff A would leave his phone number posted for staff to contact him	F0725		

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F0725 SS = F	Continued from page 53 for concerns. The DON stated she was notified on 11/12/25 at approximately 1:34 AM of Staff A being detained by law enforcement. The DON stated she did speak with the Deputy regarding the concerns of residents not having access to medical care. The DON acknowledged she did ask if Staff A could stay on the property, not necessarily wanting him to do resident care, but wasn't sure what to do. The DON stated the Deputy dispatched the EMS unit and it was staged at the facility until she arrived. The DON stated she arrived at the facility around 2:00 AM. On 12/2/25 at 1:04 PM the Clinical Services Director stated she expected a nurse to be in the building every moment of every day. The staff stated if there was only 1 nurse in the facility the staff cannot leave the building for their lunch break On 12/2/25 at 1:36 PM Resident #34 stated staff (CNAs) would tell him frequently that Staff A was not inside the building but outside in the parking lot. On 12/2/25 at 3:00 PM Staff H, Certified Medication Aide (CMA) stated she required Staff A's assistance with a resident and could not find him. The staff stated she paged for him and he did not respond. Staff H stated she observed Staff A come into the building and when asked where he was, Staff A indicated he had been in his car. On 12/4/25 at 7:59 AM Staff A acknowledged he was terminated on 11/12/25 as he broke a rule when he left the facility to get gas. The staff acknowledged he worked the overnight shift and was the only nurse on duty on the night of 11/12/25. Staff A stated he would leave his phone number for staff to contact him if they needed him. The staff stated he left for the gas station around 1:00 AM on the morning of 11/12/25. The staff acknowledged he was taken into custody for not having his lights on while driving. The Facility Assessment, updated 9/5/25, disclosed the facility would retain sufficient staffing to maintain a 24 hour licensed nurse. The document revealed there would be a Registered Nurse (RN) or LPN Charge Nurse 1 for each unit daily and 1 on the night shift (12 hour shifts). The facility's Staffing Policy, revised 10/17, disclosed licensed nurses were available 24 hours a day to provide direct resident care services.	F0725		
F0726 SS = F	Competent Nursing Staff	F0726		

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F0726 SS = F	Continued from page 54 CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(d) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews, personal record review, and facility policy review, the facility failed to ensure that nursing staff were adequately orientated and trained before they were scheduled to work independently with the residents for 2 of 2 nurse files reviewed. The facility reported a census of 37 residents. Findings include: On 12/3/25 at 6:20 AM, Staff D, Licensed Practical Nurse (LPN) stated that he didn’t have any orientation	F0726		

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F0726 SS = F	Continued from page 55 or training before he worked with the residents on his own. Staff D said that he did not follow another nurse for a period of time, or have any orientation checklist to complete. A review of the file for Staff D revealed that the personal file lacked an orientation or training checklist. On 12/4/25 at 7:59 AM, Staff A, LPN said that he was not provided a check list for training when he started working at the facility. He said that he was trained on medication times and had some other paperwork, but he did not have any competency-based training on catheters, enteral tubes or tracheotomy cares. Staff A stated he was expected to suction a tracheostomy on a resident overnight. A review of the personal file for Staff A revealed that the file lacked an orientation or training checklist. On 12/4/25 at 12:47 PM, Staff CC, RN said that she no longer worked at the facility, and one of the reasons she moved on was because the facility hired inappropriate staff. Staff CC said that Staff A had followed her when he first started, but he thought he already knew everything and there was no checklist for her to use and sign off on. Staff CC said that she did not give Staff A the keys to the narcotic drawer because she didn't trust him. She said that there was a weekend shift that the Director of Nursing was trying to get filled, and she asked her to work. When Staff CC said that she could not work that day, the DON asked her if she thought that Staff A was ready to take a shift on his own. Staff CC told them that he was not, and she didn't trust him, but the DON had him work 4 hours on his own anyway. Staff CC said that she was particularly concerned that Staff A didn't seem to retain information and often appeared confused. On 12/2/25 at 12:27 PM, the Administrator said that a nurse that had been working on orientating Staff A, contacted the DON that he wasn’t doing the medications correctly. She did not know of any formal orientation or training program at the facility. On 12/8/25 at 2:23 PM, the DON said that the facility was working on a process for orientating nurses. She said the new staff do their onboarding, watch some videos then they are orientated by another nurse for at least 2 weeks. She said that she would like spend some time with that new nurse before putting her/him on the floor alone. She said that if an orientating nurse communicated to her that the new nurse was not ready to	F0726		

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F0726 SS = F	Continued from page 56 work independently, she would not put that person on the floor unsupervised. She said they did not have a formal orientation list. A facility policy titled: Orientation Program for Newly Hired Employees, Transfers and Volunteers, dated, January 2008, showed that all newly hired personnel must attend a 10-hour orientation program within the first 5 days of employment. A checklist wound be used to record materials reviewed with each employee and a written record would be maintained of each employees orientation program.	F0726		
F0730 SS = F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(e)(7) §483.35(e)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews, staff file review and policy review, the facility administration failed to conduct annual staff evaluations for 3 of 3 personnel files reviewed. The facility reported a census of 37 residents. Findings include: A review of personnel files revealed the following: Staff N, Certified Nurse Aide (CNA) was hired on 11/22/21. Staff M, CNA, was hired on 8/20/21. Staff L, CNA, was hired on 8/23/21 The personnel files for Staff L, Staff M and Staff N lacked any annual evaluations. On 12/03/25 at 1:20 PM, the Administrator said that they have not been doing evaluations for staff because no one has had a raise for 5 years. She said that they have a plan in place to begin implementation of annual evaluations.	F0730		

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F0730 SS = F	Continued from page 57 Facility policy titled: Performance Evaluations dated September 2020. The job performance of each employee would be reviewed and evaluated at least annually. Performance evaluations may be used in determining employee promotions, shift/position transfers, demolitions, terminations, way increase and to improve the quality of the employee's work performance.	F0730		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interviews and clinical record review the facility failed to ensure they did not store unnecessary narcotics and failed to maintain	F0755		

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F0755 SS = D	Continued from page 58 accurate accounting for narcotics for 1 of 3 residents reviewed (Resident #38). The facility reported a census of 37 residents. Findings include: According to the Minimum Data Set (MDS) dated 11/25/25, Resident #38 had a Brief Interview for Mental Status (BIMS) score of 14 (intact cognitive ability) The resident was independent in all care areas and received scheduled pain medications. He did not receive As Needed (PRN) pain medication or interventions for pain. The Care Plan for Resident #38, updated on 8/5/25, showed that he was at risk for pain/discomfort and was at increased risk for injury from decreased function related to pain and staff were directed to administer pain medications as ordered. In an observation of the medication carts on 12/1/25 at 12:20 PM, it was discovered that Resident #38 had three separate blister pack cards of PRN tramadol, 50 milligrams (mg). The sticker from the pharmacy indicated that the order on each of the cards was from 2/17/25. One card had 30 tabs remaining, one card had 29 tabs and one card had just 3 tabs remaining. On 12/8/25 at 9:09 AM, a pharmacy representative said that they delivered three separate cards with 30 tabs each from this order: on 2/18/25, 5/3/25 and 5/15/25. A Controlled Drug Administration (CDA) document showed that the tramadol was last used on 10/16/25 with 3 tabs remaining. Another CDA document had one entry for medication administration, on 10/13/25. In the month of August, the CDA showed that 7 tabs of tramadol were administered. The Medication Administration Record (MAR) showed that it was given 6 times. The CDA showed that in the month of September, the tramadol was used 6 times and the MAR showed 5 administrations of the medication. The MAR for Resident #38 showed that in October, the PRN tramadol was used one time and the CDA documents showed that 3 tabs had been used that month. On 12/4/25 at 10:00 AM, the Nurse Consultant (NC) said that she looked through the narcotic drawer with the Director of Nursing (DON) and asked her why Resident #38 had three medication cards of tramadol. She said	F0755		

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F0755 SS = D	Continued from page 59 that she and the DON destroyed the pills from two of the three cards. The NC said she understood that the order was from February, and there should not have been so many extra packages. On 12/2/25 at 3:00 PM, Staff H, Certified Medication Aide (CMA) said that they reorder medications electronically and when she went to reorder an inhaler medication for Resident #38 it popped up as tramadol. She thought it was a glitch in the system, and that was why he had so many packs in the drawer. On 12/08/2025 at 2:27 PM, the DON said that the narcotics in the drawer for Resident #38 should have been destroyed "a long time ago." She said they were working on a process to review narcotics weekly to ensure they didn't have unnecessary narcotics stored. A facility policy titled: Medication Therapy, dated December 2012, showed that the physician would identify situations where medications should be tapered, discontinued, or changed to another medication, for example: a. When a medication was being given in excessive doses, for excessive periods of time, without adequate monitoring, or in the absence of a valid clinical rationale; b. When the results of ongoing assessment, or the presence of clinically significant adverse consequences monitoring, suggest that a medication should be reduced or discontinued entirely; and c. When a medication was being prescribed to treat, or in anticipation of, an adverse consequence of another prescribed drug.	F0755		
F0803 SS = E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance;	F0803		

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F0803 SS = E	Continued from page 60 §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is NOT MET as evidenced by: Based on observations, clinical record review, facility document review, policy review and staff interviews, the facility failed to follow the menu and prepare food to meet the nutritional needs for 7 of 37 residents reviewed (#9, #12, #17, #21, #23, #26 and #30). The facility reported a census of 37 residents. Findings include: 1. The Minimum Data Set (MDS) dated 9/1/25 for Resident #9 documented a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. The MDS also documented a diagnosis of dysphagia, oropharyngeal phase. Review of Resident #9's EHR titled, Orders documented an order for mechanical soft diet, regular texture and regular consistency. 2. The MDS dated 12/3/25 for Resident #12 documented a BIMS of 1 indicating severe cognitive impairment. The MDS also documented a diagnosis of dysphagia, oropharyngeal phase. Review of Resident #12's EHR titled, Orders documented an order for regular diet, mechanical soft texture, regular consistency. 3. The MDS dated 10/10/25 for Resident #17 documented a BIMS of 4 indicating severe cognitive impairment. The	F0803		

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F0803 SS = E	Continued from page 61 MDS also documented a diagnosis of dysphagia following unspecified cerebrovascular disease. Review of Resident #17's document titled, Speech Evaluation documented an order for mechanical soft with ground texture on 11/10/25. 4. The MDS dated 10/7/25 for Resident #21 documented a BIMS of 2 indicating severe cognitive impairment. The MDS also documented a diagnosis of dysphagia, oropharyngeal phase. Review of Resident #21's EHR titled, Orders documented an order for regular diet, mechanical soft texture, nectar consistency. 5. The MDS dated 10/7/25 for Resident #23 documented a BIMS of 4 indicating severe cognitive impairment. The MDS also documented a diagnosis of dysphagia, oropharyngeal phase. Review of Resident #23's EHR titled, Orders documented an order for regular diet mechanical soft texture regular fluid consistency. 6. The MDS dated 9/9/25 for Resident #26 documented a BIMS of 4 indicating severe cognitive impairment. Review of Resident #26's EHR titled, Orders documented an order for mechanical soft diet, mechanical soft texture regular consistency. 7. The MDS dated 9/23/25 for Resident #30 documented a BIMS of 8 indicating moderate cognitive impairment. The MDS also documented a diagnosis of dysphagia, oropharyngeal phase. Review of Resident #30's EHR titled, Orders documented an order for mechanical soft/ground meat diet, mechanical soft texture, regular fluid consistency. A continuous observation of lunch meal service on 12/3/25 from 12:06 PM - 12:38 PM revealed during lunch service an observation of Staff Q, Cook scooping 1/2 of a 3oz scoop of mechanical soft pepper steak, placing the mechanical pepper steak on plate and then scooping a smaller portion 1/4 scoop or less onto the plate. This occurred with all mechanical soft pepper steaks that were served that meal. On 12/3/25 at 12:55 PM Staff Q measured leftover mechanical soft pepper steak resulting with a total of 1.25 cups (10 oz.) of mechanical soft pepper steak left in a steam table pan.	F0803		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0803 SS = E	Continued from page 62 On 12/3/25 at 12:58 PM Staff Q explained the serving size for each resident with a mechanical diet should be 1 pepper steak per resident. Staff Q acknowledged she utilized a 3 oz. scoop for each mechanical soft resident as a serving size. Staff Q explained the menu usually had how many oz to serve but only documented one each today on the menu for the mechanical soft diets. Staff Q stated she thought 1 pepper steak would equal a 3 oz. scoop. Staff Q stated she typically had a little mechanical soft meat leftover after meal service. Staff Q acknowledged she processed 7 servings of pepper steak for serving 7 residents at lunch. Review of document titled, Diet Spreadsheet Week 5 Wednesday documented at noon meal for mechanical soft diets 1 each ground pepper steak. On 12/3/25 at 1:20 PM Staff T, Kitchen Manager acknowledged she had made an observation of most of the lunch service. Staff T explained when serving mechanical soft diets Staff Q was to follow the menu. Staff T acknowledged the spreadsheet for the lunch menu that day documented 1 pepper steak per serving. Staff T said she was not sure how to determine the scoop size for mechanical soft diets if the size of the scoop was not documented on the spreadsheet/menu. Staff T stated the meat usually had 3 oz. for the size of the scoop. Staff T stated there should not have been any leftover mechanical soft meat. Staff T explained if Staff Q processed 7 pepper steaks for 7 residents there should not have been any left. On 12/8/25 at 12:51 PM Staff V, Consulting Dietitian stated if there were 7 servings prepared for 7 mechanical diets then there should not be any leftovers. Staff V explained the serving size should be either on the spreadsheet or on the recipes. Staff V stated if the serving size was not on either one of those then it should be a volume method. Staff V stated she had done in-services on the volume method at the facility. Review of recipe dated winter 2025-2026 titled, Pepper Steak documented portion as 1 each. On 12/8/25 at 3:10 PM the Administrator stated if 7 servings were processed for 7 mechanical soft diets the expectation was there would be no mechanical soft meat leftover after service. Review of undated policy titled, Portion Control documented food will be served according to standard portion sizes to ensure adequate servings of food and	F0803		

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F0803 SS = E	Continued from page 63 to provide portions that are equal in size for those residents that do not require specialized diet modifications. Residents on diets that require portion variations will have the required information either stated on their tray card or it can be found on the diet spreadsheet under the diet they are on.	F0803		
F0804 SS = D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observations, resident interview, staff interview and policy review the facility failed to provide food at an appetizing temperature to 3 of 14 residents reviewed (Resident #28, #31 and #35). The facility reported a census of 37 residents. Findings include: 1. The Minimum Data Set (MDS) dated 9/2/25 for Resident #28 documented a Brief Interview for Mental Status (BIMS) of 14 indicating no cognitive impairment. On 12/1/25 at 1:57 PM Resident #28 said most of the time the food is okay. Resident #28 explained she ate meals in her room and she would be lucky if the food was still warm when she received her tray. Resident #28 said the facility does not have heated carts for room tray delivery. Resident #28 explained her biggest concern was that the food sits too long before being brought to the room. 2. The MDS dated 9/23/25 for Resident #31 documented a BIMS of 13 indicating no cognitive impairment. On 12/1/25 at 12:18 PM Resident #31 stated she had a room tray every meal and the meals were cold when the meal was dropped off. 3. The MDS dated 10/21/25 for Resident #35 documented a	F0804		

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F0804 SS = D	Continued from page 64 BIMS of 14 indicating no cognitive impairment. On 12/1/25 at 11:50 AM Resident #35 stated the food is served cold at times. Resident #35 stated if the food was something that she wanted reheated she would ask the staff. Observation on 12/3/25 at 12:38 PM of room trays loaded on cart. The room tray was dropped off at 12:46 PM. The sample tray temperature returned to the kitchen and checked at 12:47 PM revealed the temperature of the food on the sample tray was the peas 135.5 degrees, mashed potatoes 137.5 degrees and pepper steak 129 degrees. On 12/3/25 at 1:20 PM Staff T, Kitchen Manager acknowledged she had made an observation of most of the lunch service. Staff T stated the food on room trays should be 135 degrees or above when delivered to the residents room. Staff T acknowledged the pepper beef should have been 135 degrees or above. On 12/8/25 at 12:51 PM Staff V, Consulting Dietitian stated the food should reach the resident at 135 degrees. On 12/8/25 at 3:10 PM the Administrator stated the facility's expectation was the temperature of the food that was delivered to the resident as a room tray would have been higher than or equal to 135 degrees. Review of policy revised 10/17 titled, Food Preparation and Service documented food and nutrition services employees shall prepare and serve food in a manner that complies with safe food handling practices. The "danger zone" for food temperatures is between 41F and 135F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. Potentially hazardous foods include meats, poultry, seafood, cut melon, eggs, milk, yogurt and cottage cheese. The longer foods remain in the "danger zone" the greater the risk for growth of harmful pathogens. Therefore, PHF must be maintained below 41F or above 135F. Potentially hazardous foods held in the danger zone for more than 4 hours (if being prepared from ingredients at room temperature) or 6 hours (if cooked and then cooled) may cause foodborne illness.	F0804		
F0805 SS = E	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink	F0805		

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F0805 SS = E	Continued from page 65 Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, observations, document review, policy review and staff interviews the facility failed to prepare food in a form designed to meet individual needs by processing an incorrect consistency for modified diet ordered for 7 of 7 residents reviewed (Resident #9, #12, #17, #21, #23, #26 and #30). The facility reported a census of 37 residents. Findings include: 1. The Minimum Data Set (MDS) dated 9/1/25 for Resident #9 documented a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. The MDS also documented a diagnosis of dysphagia, oropharyngeal phase. Review of Resident #9's EHR titled, Orders documented an order for mechanical soft diet, regular texture and regular consistency. 2. The MDS dated 12/3/25 for Resident #12 documented a BIMS of 1 indicating severe cognitive impairment. The MDS also documented a diagnosis of dysphagia, oropharyngeal phase. Review of Resident #12's EHR titled, Orders documented an order for regular diet, mechanical soft texture, regular consistency. 3. The MDS dated 10/10/25 for Resident #17 documented a BIMS of 4 indicating severe cognitive impairment. The MDS also documented a diagnosis of dysphagia following unspecified cerebrovascular disease. Review of Resident #17's document titled, Speech Evaluation documented an order for mechanical soft with ground texture on 11/10/25. 4. The MDS dated 10/7/25 for Resident #21 documented a BIMS of 2 indicating severe cognitive impairment. The MDS also documented a diagnosis of dysphagia, oropharyngeal phase. Review of Resident #21's EHR titled, Orders documented an order for regular diet, mechanical soft texture, nectar consistency.	F0805		

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F0805 SS = E	Continued from page 66 5. The MDS dated 10/7/25 for Resident #23 documented a BIMS of 4 indicating severe cognitive impairment. The MDS also documented a diagnosis of dysphagia, oropharyngeal phase. Review of Resident #23's EHR titled, Orders documented an order for regular diet mechanical soft texture regular fluid consistency. 6. The MDS dated 9/9/25 for Resident #26 documented a BIMS of 4 indicating severe cognitive impairment. Review of Resident #26's EHR titled, Orders documented an order for mechanical soft diet, mechanical soft texture regular consistency. 7. The MDS dated 9/23/25 for Resident #30 documented a BIMS of 8 indicating moderate cognitive impairment. The MDS also documented a diagnosis of dysphagia, oropharyngeal phase. Review of Resident #30's EHR titled, Orders documented an order for mechanical soft/ground meat diet, mechanical soft texture, regular fluid consistency. An observation on 12/3/25 at 11:56 AM of mechanical soft diet process completed by Staff Q, Cook revealed Staff Q completed hand hygiene, utilized tongs to place 7 pepper steaks in the food processor, turned on the processor, removed the lid from food processor, removed the blade with bare hand from food processor, removed food from processor with spatula, a slice of onion larger than an inch in length (unprocessed) noted when mechanical meat place in steam table pan, temperature obtained with thermometer that was removed from the shelf unsanitized, mechanical meat was determined to be at too low of a temperature and placed in the oven, mechanical soft meat removed from the oven, thermometer cleansed, temperature checked again for mechanical soft meat, temperature of 166 revealed and steam table pan placed in steam table. On 12/3/25 at 12:03 PM Staff Q stated she was looking for shredded consistency for the mechanical soft meat when placed in the food processor. On 12/3/25 at 12:55 PM an observation revealed Staff Q measured the leftover mechanical soft beef with a total of 1.25 cups of beef left in the steam table pan with a slice of onion larger than an inch in length (unprocessed) present in the measuring cup when measured.	F0805		

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F0805 SS = E	Continued from page 67 On 12/3/25 at 12:45 PM the sample plate of lunch meal revealed pepper steak still tender with onion very crisp with temperature warm not hot, mashed potatoes creamy with no lumps, and buttered peas soft in texture. On 12/3/25 at 1:20 PM Staff T, Kitchen Manager acknowledged she had made an observation of most of the lunch service. Staff T explained when serving mechanical soft diets the cook was to follow the menu. Staff T stated when mechanical soft meat was processed today there should not have been an onion or any whole piece of food remaining when the mechanical soft meat was served. On 12/8/25 at 12:51 PM Staff V, Consulting Dietitian stated would question if the onion was crisp or not. Staff V stated if the onions were soft and cooked then it would probably be adequate for the mechanical soft diet. Staff V explained if the onion was crisp she would like to have seen the onion processed with the meat. Review of policy dated 2025 titled, Therapeutic Diet Orders documented the facility provides all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences. Therapeutic diets, including mechanically altered diets where appropriate, will be based on the resident's individual needs as determined by the resident's assessment. The reason for a therapeutic diet is to be documented in the medical record and/or indicated on the resident's comprehensive plan of care. All diet orders are to be communicated to the dietary department in accordance with facility procedures. Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive content as prescribed.	F0805		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F0812		

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F0812 SS = E	Continued from page 68 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interviews and policy review the facility failed to prepare food in accordance with professional standards by not completing appropriate hand hygiene during meal service to prevent cross contamination, not dating open food items and not disposing of expired food items. The facility reported a census of 37 residents. Findings include: During initial kitchen observation on 12/1/25 at 10:15 AM the walk-in refrigerator had a 5 lbs. container of sour cream, a 5 lbs. container of cottage cheese, a 1 gallon container of barbecue sauce, a 1 gallon container of salad dressing, a quart of coffee creamer and a 24 oz. container of chocolate syrup open and undated. The walk-in refrigerator also had 2 clear storage containers of salad dressing dated 11/17 and a clear storage container labeled ketchup dated 11/12. The walk-in freezer had a bag of dinner rolls and a bag of cookies open and undated. On 12/1/25 at 10:45 AM Staff T, Kitchen Manager stated the clear storage containers with salad dressing and ketchup should have had the contents disposed of and containers washed after 7 days. Staff T stated all open food items should have an open date on the packaging. Staff T acknowledged none of the items discussed in the walk-in refrigerator and freezer during the observation were dated appropriately. An observation on 12/3/25 at 11:56 AM of mechanical soft diet process completed by Staff Q, Cook revealed Staff Q completed hand hygiene, utilized tongs to place	F0812		

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F0812 SS = E	Continued from page 69 7 pepper steaks in the food processor, turned on the processor, removed the lid from food processor, removed the blade with bare hand from food processor, removed food from processor with spatula, a slice of onion larger than an inch in length (unprocessed) noted when mechanical meat place in steam table pan, temperature obtained with thermometer that was removed from the shelf unsanitized, mechanical meat was determined to be at too low of a temperature and placed in the oven, mechanical soft meat removed from the oven, thermometer cleansed, temperature checked again for mechanical soft meat, temperature of 166 revealed and steam table pan placed in steam table. On 12/3/25 at 12:06 PM observed lunch meal service started. Staff Q observed touching/wiping her face, picking up the resident's plates from the plate warmer with thumb on the serving surface of the plates several times throughout the lunch service without completing hand hygiene. Observation on 12/3/25 at 12:30 PM revealed Staff Q completed hand hygiene, apply gloves, pick up tongs with right hand, hold the bread bag with left hand, receive knife from Staff W, Cook in Training, knife placed in left hand then passed to right hand, bread buttered on parchment paper, 2 slices of bread picked up with gloved hands, bread slices placed butter side together with gloved hands and bread placed in plastic baggie with gloved hands. On 12/3/25 at 1:20 PM Staff T, Kitchen Manager acknowledged she had made an observation of most of the lunch service. Staff explained she had a concern with cross contamination when Staff Q frequently touched her face and touched serving objects such as plates and serving spoons. Staff T stated she would like to have seen Staff Q utilize tongs to place the buttered bread together and the place in the baggie. On 12/8/25 at 12:51 PM Staff V, Consulting Dietitian stated she would have liked to see the thermometer sanitized unless she knew it was sanitized before putting the thermometer away. Staff V said the thermometer probably should have been sanitized. Staff V stated the Staff Q should be always completing hand hygiene after touching her face. Staff V explained she should use tongs or gloves when touching the bread. Staff V stated Staff Q should not be touching anything prior to touching the bread. Staff V stated if Staff Q did touch anything else she needed to remove the gloves, complete hand hygiene and reapply the gloves. Staff V explained the condiments should be dated when opened or have a use by date. Staff V said everything	F0812		

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F0812 SS = E	Continued from page 70 in the kitchen should be dated when it was opened. Staff V stated if the condiment is not in the original container it should be disposed of after 3 days. On 12/8/25 at 3:10 PM the Administrator stated all of the open food items should be dated. The Administrator stated she does not have a concern with the thermometer and would assume Staff Q cleansed the thermometer prior to putting the thermometer away originally. The Administrator stated the facility's expectation is that hand hygiene would be completed appropriately. Review of policy revised 7/14 titled, Food Receiving and Storage documented foods shall be received and stored in a manner that complies with safe food handling practices. All foods stored in the refrigerator or freezer will be covered, labeled and dated ("use by" date). Review of policy revised 10/17 titled, Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices documented food and nutrition services employees will follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. All employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents. Employees must wash their hands before coming in contact with any food surfaces, after handling soiled equipment or utensils, during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks and/or after engaging in other activities that contaminate the hands.	F0812		
F0835 SS = F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is NOT MET as evidenced by: Based on government record review, facility record review, resident interview, staff interview, policy review, and current survey results, the facility	F0835		

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F0835 SS = F	Continued from page 71 administration failed to provide effective administrative oversight. The facility failed to conduct further research on a national nurse license verification that documented a revoked nursing license in another state in 08/2025, failed to conduct reference checks prior to hire, and failed to investigate reported performance concerns for 1 of 1 employee records reviewed (Staff A, Licensed Practical Nurse [LPN]). The facility also failed to ensure quality improvement measures were taking place after being designated a Special Focus Facility in 07/2025. The facility reported a census of 37 residents. Findings include: 1. The State of Nebraska Department of Health and Human Services (NE DHHS) Findings of Fact and Conclusions of Law: Order dated and filed Jul 23 2025, recommended defendant's (Staff A, Licensed Practical Nurse [LPN]) privilege to practice as a Practical Nurse in the State of Nebraska be REVOKED, effective 10 days following the signed order. A NE DHHS hearing record dated 7/23/25 showed a hearing was held on 7/9/25. The record documented NE DHHS may discipline the defendant's multistate licensure privilege to practice nursing in Nebraska. On or about March 13, 2024, the County Health Center (CHC) terminated defendants employment for violation of workplace drug use policy, unlawful use of a controlled substance in the workplace or reporting for work while under the influence of alcohol or unlawful drugs, incompetence in performing assigned duties and engaging in conduct prejudicial to his employers reputation. The defendant failed to report his termination to NE DHHS withing 30 days as required by law. The State Of Nebraska Dept. of Health and Human Services Nursing License Verification website detailed the following for Staff A's nursing license:License Type-LPN-Compact PrivilegeLicense Status -RevocationEffective Date of Status 8/2/2025An undated New Hire Information Form for Staff A showed that he was interviewed on 9/8/25 for LPN position. The form documented Verbal offer accepted. Staff A provided at least two references from Nebraska; one from a homecare service and another from a nursing home. The personnel file for Staff A lacked documentation to reflect the references were contacted. According to facility payroll records, Staff A worked	F0835		

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F0835 SS = F	Continued from page 72 his first shift in the facility on 9/17/25. A License Verification Report from the Nursys® website, checked by the facility on 10/2/2025, showed that Staff A had an active, unencumbered Iowa Practical Nurse (PN) license. It also documented a history of adverse action taken against Staff A's nursing license in Nebraska. The personnel file for Staff A lacked documentation to reflect further research or review conducted on the nurse's history or that measures were developed or implemented to monitor the newly hired nurse's performance. Review of text message sent to the Director of Nursing (DON) by Staff C, Certified Nurse Aide (CNA), documented on 11/9/25 another nurse checked on Resident #34 because Staff A would not. Text message sent to the DON on 11/10/25 at 1:47 AM Resident #34 was asking to be suctioned again but Resident #34 said he wanted the DON and did not want to say it out loud and upset Staff A. DON replied via text. Tell Staff A he was the nurse on the floor. On 12/2/25 at 6:15 AM Staff F, CNA said Resident #34 would request medication or to be suctioned. Staff F stated it doesn't happen too often through the night. Staff F explained she worked with Staff A a couple of times. Staff F expressed one night, Resident #34 had requested to have his tracheostomy suctioned and Staff F told Staff A. Staff F stated Staff A's response was that he had just done it one hour prior and Staff A refused to go in and Staff A refused suction Resident #34's tracheostomy. Staff A said she called the DON and then the other nurse that was on duty (it was earlier in the evening) went in and suctioned Resident #34's tracheostomy. On 12/2/25 at 1:36 PM Resident #34 stated Staff A would refuse to suction his tracheostomy frequently. Resident #34 explained he had to call the Certified Nursing Assistants (CNA) 3 or 4 times before Staff A completed the suctioning. Resident #34 said it would cause severe anxiety when Staff A worked because Staff A would not suction when he felt he needed it. Resident #34 stated when his tracheostomy was not suctioned it felt like he could not breathe and was dying. Resident #34 stated he felt he was being neglected when Staff A did not suction when he requested it. Resident #34 acknowledged all of the overnight CNA staff knew Staff A would refuse to suction his tracheostomy. Resident #34 stated basically every night Staff A worked he would refuse to suction his tracheostomy. Resident #34 said Staff C, CNA and Staff B, CNA could speak about Staff A and that he did not come in and suction his tracheostomy when	F0835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165531	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/08/2025

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F0835 SS = F	Continued from page 73 requested and would frequently refuse to suction his tracheostomy. Resident #34 stated it did not seem like Staff A knew what he was doing. On 12/4/25 at 4:18 PM Staff B stated she was never in the room when Staff A completed tracheostomy cares for Resident #34. Staff B explained she would answer Resident #34's call light 2 or 3 times over a length of time and continue to tell Staff A before he completed the tracheostomy suctioning. Staff B stated Resident #34 would get angry sometimes when he wanted his tracheostomy suctioned because Staff A would not come to his room to suction him. Staff B said Resident #34 appeared more scared than mad most of the time when he requested his tracheostomy to be suctioned. Staff B explained refusal by Staff A to complete the tracheostomy suctioning occurred every time Staff A worked. Staff B stated the concern was brought up to the DON. Staff B restated Staff A refusing to complete suction when requested by Resident #34 and Resident #34 had to turn his light on 2-3 times with the CNA's telling Staff A that Resident #34's requests for his tracheostomy to be suctioned occurred every night Staff A worked. On 12/2/25 at 2:08 PM the DON stated she received a call on her cell phone asking how many times Resident #34 could be suctioned. The DON stated she forgot about the call and she documented the call from the CNA somewhere. The DON explained sometimes Resident #34 obsessed over his tracheostomy suctioning. The DON stated it is the one thing Resident #34 had control of his life. The DON explained the CNA's was Staff F. The DON explained Resident #34 had been suctioned but wanted to know how often Resident #34 could be suctioned. The DON said the call occurred in the evening between 6:00 pm and 10:00 pm and there was a 2nd nurse at the facility on a medication cart. The nurse that was working with Staff A that evening that completed the suctioning was Staff O, LPN. The DON stated Staff O left at 10 PM and she contacted Staff O to see if there were any issues. The DON elaborated that Staff O explained Resident #34 was fine. The DON explained Staff O checked on Resident #34 because Staff A was doing something with another resident. The DON stated she came in according to the master schedule on 11/9/25 at 11:00 PM or 11:30 PM. The DON explained she frequently came into work on the overnight shift. The DON said any time the staff reaches out to her with questions or concerns she would come to the building. The DON stated she did not go to the facility because Resident #34 had requested to be suctioned at that time. The DON said she was at the building so she might as well make an observation of Staff A while he	F0835		

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F0835 SS = F	Continued from page 74 completed tracheostomy suctioning on Resident #34. The DON stated Staff A spoke to Resident #34 that night and explained to Resident #34 why Staff A was there. The DON stated Staff A did an excellent job with the task. The DON stated Resident #34 would request to be suctioned a couple times during the night. The DON explained Staff F did not have any concerns with Resident #34 not being suctioned enough. The DON stated she thought that Staff F just wanted to know for her own information about suctioning. The DON stated no staff had brought to her any concerns about Staff A's treatment of Resident #34. The DON stated she asked Resident #34 pretty routinely about concerns and Resident #34 was not one that was shy about saying anything. The DON stated Resident #34's grandmother would also let them know about concerns. The DON stated if staff reported any concerns with residents she would investigate. Review of document provided by the DON dated 11/9/25 documented the DON received a call from Staff F asking how many times Resident #34 could be suctioned. The DON explained Resident #34's orders to her and questioned if there was a concern. Staff F voiced she was asking because Resident #34 had requested to be suctioned frequently and had requested Staff A. The DON attempted to contact Staff A but was told he was busy at the moment. Staff O in the facility at the time. DON contacted her to see if there was an issue. Staff O stated she had just come from Resident #34's room and there were no issues. The DON arrived at the building and shadowed Staff A the rest of the shift. The DON stated Staff A was observed suctioning Resident #34 without issues. No concerns with Staff A's ability to perform his job duties at that time. Review of the clinical record revealed the record lacked a thorough investigation of the allegations of neglect to Resident #34 by Staff A. Review of Staff A's timecard revealed he clocked in at the facility on 11/11/25 at 7:59 PM and clocked out of the facility on 11/12/25 at 1:15 AM working 5.27 hours. Review of a legal document from Fremont County Sheriff's Office revealed on 11/12/25 at approximately 1:19 PM a traffic stop was initiated for a vehicle traveling with no lights on. The Deputy followed the vehicle with his emergency lights activated. The driver continued driving in the oncoming lane of travel with no lights until it pulled into the parking lot of the facility. The driver was identified as Staff A. The staff volunteered that he worked at the facility and had left to get gas. Following a field investigation	F0835		

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F0835 SS = F	Continued from page 75 Staff A was placed under arrest, placed in the rear of the Deputy's car and the facility staff were notified. On 12/2/25 at 12:27 PM, the Administrator said that Staff A was the only overnight nurse and he should not have left the premises. Staff A told her that the methamphetamine pipe did not belong to him and that a family member used his car and probably left the pipe there. He denied that it was his or that he was using drugs. The Administrator said that the overnight nurses were allowed to leave the building as long as they were on the premises and are not be out of the building for over 30 minutes. The Administrator said that she had conducted the initial interview with Staff A for the nursing job. She said that he had been a nurse for over 30 years, mostly in Iowa. The Administrator said that she asked Staff A about the note on his Nebraska nursing license that indicated he had an "adverse action" against him, preventing him from practicing in that state. Staff A explained to her that his girlfriend took a picture of him smoking pot and then sent that picture to his workplace. His workplace wanted him to do a drug test but he had refused and that was when he was terminated. The Administrator said that since she started in July, they had not been doing any reference checks before hire, and that they were looking at different options for forms. She said that a couple of Certified Nurse Aides (CNA) had expressed concerns that Staff A was going to his car throughout the shift and was taking long breaks. The Director of Nursing (DON) came in a couple of the times and shadowed him and she didn't see any problems with his job performance. The DON told the Administrator that he had gone out for a break while she was there, and he hadn't been gone very long. The Administrator said that another LPN had contacted the DON that Staff A wasn't doing the medications correctly, but this particular nurse was fussy about how she did the medication pass and they hadn't observed any concerns On 12/4/25 at 12:47 PM, Staff J, Registered Nurse (RN) said she worked at the facility for just a couple of months and she quit because of lack of leadership, poor management and inappropriate staff. Staff J said that she worked with Staff A a couple of times, he would leave the building and not come back for long periods of time and when he did come back he was "hyped up". He was supposed to be training with her but he thought he already knew it all. She was concerned about his ability to suction a tracheotomy, and he would "pre-pop" the residents' pills and leave them in the cup in the med cart. He often made comments about begin accused of stealing narcotics at his last job, and she said that she did not give him the keys to the narcotic	F0835		

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F0835 SS = F	Continued from page 76 drawer when she was working with him because she didn't trust him. Staff J said that there was a weekend shift they needed filled and the DON asked her to work. Staff J said she could not work that day and the DON asked her if she thought that Staff A was ready to take a shift on his own. She told them that he was not and she didn't trust him. The facility did have him work 4 hours on his own anyway. She was particularly concerned that he didn't seem to retain the information and often appeared confused. According to the facility policy titled: Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, dated 7/8/24, the facility would make reasonable attempts to request and obtain information from previous employers and/or current employers that may be indicative of a history of abuse, neglect or mistreating residents. The facility would conduct a check with the appropriate licensing boards to assure that there were no disciplinary actions in effect against the applicants professional licenses by any state licensure body as a result of finding of abuse, neglect, exploitation or mistreatment of residents. 2. On 7/30/25 the facility was selected by the State Survey Agency (SSA) as a federal Special Focus Facility (SFF). On 8/5/25 the SSA met with the facility owners to review the SFF selection, SFF implications, and importance of quality improvement efforts that needed to occur as per Centers for Medicare and Medicaid Services (CMS) QSO-23-01-NH memo. Review of CMS Form 2567 with a date the survey was completed as 2/27/25 documented F-657 care plan revision, F-684 Quality Care, F-686 treatment of pressure ulcer, F-725 sufficient nursing staff, F-726 competent nursing staff, F-835 administration, F-842 resident records and F-865 good faith attempt Quality Assurance Performance Improvement (QAPI) program. 8 repeated deficiencies identified during the current survey. Review of CMS Form 2567 with a date the survey was completed as 4/10/25 documented F-656 care plan development, F-688 prevent decrease in ROM/Mobility, F-755 pharmacy services/records, F-804 palatable/prefer temperature of food and F-865 good faith attempt QAPI program. 5 repeated deficiencies identified during the current survey.	F0835		

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F0835 SS = F	Continued from page 77 Review of document with implementation date of 10/16/25 titled, Quality Assessment and Assurance Action Plan Area of Concern: Skin Assessment documented 8 action/interventions developed all with target dates of 11/15/25. 2 of the 8 areas documented progress/evaluation. One area documented on 11/18/25 and the second on 11/28/25. A goal completion date of 12/31/25 documented. The last page of the document contained: the project, what's the best results, what's the worst result, what's the biggest difference this plan will make, what do we want to accomplish and how will we know when the project is completed. All of these areas on the document are blank. Review of document with implementation date of 10/16/25 titled, Quality Assessment and Assurance Action Plan Area of Concern: documentation in PCC documented 6 action/interventions developed all with target dates of 11/15/25. 0 of the 6 areas documented any progress/evaluation. A goal completion date of 12/31/25 documented. The last page of the document contained: the project, what's the best results, what's the worst result, what's the biggest difference this plan will make, what do we want to accomplish and how will we know when the project is completed. All of these areas on the document are blank. Review of document with implementation date of 10/16/25 titled, Quality Assessment and Assurance Action Plan Area of Concern: bowel elimination and constipation management documented 8 action/interventions developed all with target dates of 11/15/25. 0 of the 8 areas documented any progress/evaluation. A goal completion date of 12/31/25 documented. The last page of the document contained: the project, what's the best results, what's the worst result, what's the biggest difference this plan will make, what do we want to accomplish and how will we know when the project is completed. All of these areas on the document are blank. Review of document with implementation date of 10/16/25 titled, Quality Assessment and Assurance Action Plan Area of Concern: MARS/TARS documented 8 action/interventions developed all with target dates of 11/15/25 except one that did not have a team member or target date documented. 0 of the 8 areas documented any progress/evaluation. A goal completion date of 12/31/25 documented. The last page of the document contained: the project, what's the best results, what's the worst result, what's the biggest difference this plan will make, what do we want to accomplish and how will we know when the project is completed. All of these areas	F0835		

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F0835 SS = F	Continued from page 78 on the document are blank. Review of document with implementation date of 10/16/25 titled, Quality Assessment and Assurance Action Plan Area of Concern: baths documented 7 action/interventions developed all with target dates of 11/15/25 except one that did not have a team member or target date documented. 0 of the 7 areas documented any progress/evaluation. A goal completion date of 12/31/25 documented. The last page of the document contained: the project, what's the best results, what's the worst result, what's the biggest difference this plan will make, what do we want to accomplish and how will we know when the project is completed. All of these areas on the document are blank. On 12/8/25 5:22 PM the Administrator stated they talked about the Quality Assessment and Assurance Action Plans during QAPI then medication errors occurred and treatment errors happened. The Administrator stated it did not seem like the plans were making any progress. The Administrator stated different education was provided for the Quality Assessment and Assurance Action Plans. The Administrator acknowledged the alternative education was not documented on the Quality Assessment and Assurance Action Plans. The Administrator also acknowledged there were no updates or documentation on the action plans after development to measure the success of the actions and track the performance but that was the goal moving forward. The Administrator stated the action plans are developed from self identified concerns, mock surveys and state surveys. The Administrator stated having consistent management will help in these processes and concerns. The Administrator stated when the facility switched over from the previous DON it did not help and adding an ADON will help moving forward. The current survey ending 12/8/25 resulted in citing of the following deficient practices: F600 Free from Abuse and Neglect F605 Right to be Free from Chemical Restraints F610 Investigate/Prevent/Correct Alleged Violation F636 Comprehensive Assessments & Timing F656 Develop/Implement Comprehensive Care Plan F657 Care Plan Timing and Revision F658 Services Provided Meet Professional Standards	F0835		

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F0835 SS = F	Continued from page 79 F684 Quality of Care F686 Treatment/Services to Prevent/Heal Pressure Ulcer F688 Increase/Prevent Decrease in Range of Motion/Mobility F690 Bowel/Bladder Incontinence, Catheter, Urinary Tract Infection F695 Respiratory/Tracheostomy Care and Suctioning F725 Sufficient Nursing Staff F726 Competent Nursing Staff F730 Nurse Aide Perform Review-12 hour/year In-Service F755 Pharmacy Services/Procedures/Pharmacist/Records F803 Menus Meet Resident Needs/Prep in Advance/Followed F804 Nutritive Value/Appearance, Palatable/Preferred Temperatures food F805 Food in Form to Meet Individual Needs F812 Food Procurement/Store/Prepare/Serve-Sanitary F835 Effective Administration F842 Resident Records - Identifiable Information F865 QAPI Program/Plan, Disclosure/Good Faith Attempt F867 QAPI/QAA Improvement Activities	F0835		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F0842		

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F0842 SS = D	Continued from page 80 §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F0842		

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F0842 SS = D	Continued from page 81 §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on Electronic Health Records (EHR) review, staff interviews, and document review the facility failed to provide complete and accurately documented records when a resident inventory list was not completed upon admission for 1 of 5 resident reviewed (Resident #19). The facility reported a census of 37 residents. Findings include: The Minimum Data Set (MDS) dated 11/18/25 for Resident #19 documented a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. Review of Resident #19's EHR documented only an inventory list from 7/7/23. Review of Resident #19's EHR titled, Census documented facility admission 5/19/25. Review of Resident #19's EHR faxed 5/20/25 titled, discharge summary documented Resident #19 was discharged from the hospital to the facility on 5/19/25. On 12/4/25 at 12:05 PM Staff Y, Social Services stated a friend took Resident #19 to the emergency room and the facility admitted Resident #19 on 5/19/25. Staff Y stated Resident #19 should have had an inventory list completed on 5/19/25 when she was admitted to the facility. Staff Y acknowledged there was no inventory list completed at that time.	F0842		

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F0842 SS = D	Continued from page 82 On 12/4/25 12:25 PM the Administrator stated the facility's expectation was an inventory list would have been completed upon admission to the facility. Request for policy for resident inventory list. No policy provided.	F0842		
F0865 SS = F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care	F0865		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0865 SS = F	Continued from page 83 and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and	F0865		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165531	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/08/2025

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

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F0865 SS = F	Continued from page 84 §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is NOT MET as evidenced by: Based on document review, staff interviews, and facility plan review the facility failed to demonstrate good faith attempts to correct quality deficiencies based on issues that were identified with repeat deficiencies in 12 areas over the last year and monitoring / tracking of performance improvement plans that remained incomplete in a reasonable time frame. The facility reported a census of 37 residents. Findings include: Review of CMS Form 2567 with a date the survey was completed as 2/27/25 documented F-657 care plan revision, F-684 Quality Care, F-686 treatment of pressure ulcer, F-725 sufficient nursing staff, F-726 competent nursing staff, F-835 administration, F-842 resident records and F-865 good faith attempt Quality Assurance Performance Improvement (QAPI) program. 8 repeated deficiencies identified during the current survey. Review of CMS Form 2567 with a date the survey was completed as 4/10/25 documented F-656 care plan development, F-688 prevent decrease in ROM/Mobility, F-755 pharmacy services/records, F-804 palatable/prefer temperature of food and F-865 good faith attempt QAPI program. 5 repeated deficiencies identified during the current survey. Review of document with implementation date of 10/16/25 titled, Quality Assessment and Assurance Action Plan Area of Concern: Skin Assessment documented 8	F0865		

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F0865 SS = F	Continued from page 85 action/interventions developed all with target dates of 11/15/25. 2 of the 8 areas documented progress/evaluation. One area documented on 11/18/25 and the second on 11/28/25. A goal completion date of 12/31/25 documented. The last page of the document contained: the project, what's the best results, what's the worst result, what's the biggest difference this plan will make, what do we want to accomplish and how will we know when the project is completed. All of these areas on the document are blank. Review of document with implementation date of 10/16/25 titled, Quality Assessment and Assurance Action Plan Area of Concern: documentation in PCC documented 6 action/interventions developed all with target dates of 11/15/25. 0 of the 6 areas documented any progress/evaluation. A goal completion date of 12/31/25 documented. The last page of the document contained: the project, what's the best results, what's the worst result, what's the biggest difference this plan will make, what do we want to accomplish and how will we know when the project is completed. All of these areas on the document are blank. Review of document with implementation date of 10/16/25 titled, Quality Assessment and Assurance Action Plan Area of Concern: bowel elimination and constipation management documented 8 action/interventions developed all with target dates of 11/15/25. 0 of the 8 areas documented any progress/evaluation. A goal completion date of 12/31/25 documented. The last page of the document contained: the project, what's the best results, what's the worst result, what's the biggest difference this plan will make, what do we want to accomplish and how will we know when the project is completed. All of these areas on the document are blank. Review of document with implementation date of 10/16/25 titled, Quality Assessment and Assurance Action Plan Area of Concern: MARS/TARS documented 8 action/interventions developed all with target dates of 11/15/25 except one that did not have a team member or target date documented. 0 of the 8 areas documented any progress/evaluation. A goal completion date of 12/31/25 documented. The last page of the document contained: the project, what's the best results, what's the worst result, what's the biggest difference this plan will make, what do we want to accomplish and how will we know when the project is completed. All of these areas on the document are blank. Review of document with implementation date of 10/16/25 titled, Quality Assessment and Assurance Action Plan	F0865		

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F0865 SS = F	Continued from page 86 Area of Concern: baths documented 7 action/interventions developed all with target dates of 11/15/25 except one that did not have a team member or target date documented. 0 of the 7 areas documented any progress/evaluation. A goal completion date of 12/31/25 documented. The last page of the document contained: the project, what's the best results, what's the worst result, what's the biggest difference this plan will make, what do we want to accomplish and how will we know when the project is completed. All of these areas on the document are blank. On 12/8/25 5:22 PM the Administrator stated they talked about the Quality Assessment and Assurance Action Plans during QAPI then medication errors occurred and treatment errors happened. The Administrator stated it did not seem like the plans were making any progress. The Administrator stated different education was provided for the Quality Assessment and Assurance Action Plans. The Administrator acknowledged the alternative education was not documented on the Quality Assessment and Assurance Action Plans. The Administrator also acknowledged there were no updates or documentation on the action plans after development to measure the success of the actions and track the performance but that was the goal moving forward. The Administrator stated the action plans are developed from self identified concerns, mock surveys and state surveys. The Administrator stated having consistent management will help in these processes and concerns. The Administrator stated when the facility switched over from the previous DON it did not help and adding an ADON will help moving forward. Review of policy updated 1/2/25 titled, Quality Assurance Performance Improvement (QAPI) Quality Assessment Assurance (QAA) Plan documented the purpose of QAPI in our organization is to develop a culture of proactive leadership that solicits the input from employees in various departments, including contracted professionals, if indicated, as well as those we serve Residents, Resident Representatives, and family members. Further, our purpose includes ongoing development of plans for improvement leading to systematic changes that support exceptional health care to seniors and operating excellence in every aspect of our business. The facility will use a broad range of sources when monitoring and gathering data. Sources of this data may include but will not be limited to input from employees, Residents, Resident Representatives, Families and others (satisfaction surveys, grievances, etc…). Also from adverse events – IDT review of Risk Management/Quality Conference, performance audit findings, survey findings (Annual and Complaint) and	F0865		

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F0865 SS = F	Continued from page 87 compliance findings and/or complaints. Findings will be reviewed by the QAPI committee and compared with historical data, facility & company benchmarks and/or established targets to identify areas for improvement. Findings and action of the QAPI committee will be communicated following QAPI meetings and as often as deemed necessary to assure positive outcomes, through postings to relevant employees/ departments, submission of QAPI plans to the regional management team and all other methods as deemed necessary by the QAPI committee. Prioritization of Performance Improvement Plans will be based on the scope and severity of the identified issue and the potential impact the issue has on Resident safety, clinical outcomes, and satisfaction. Performance Improvement Plans will be communicated as often as deemed necessary to assure positive outcomes, through postings to relevant employees/departments, submission of plans to regional management team (if requested) and QAPI committee and all other methods as deemed necessary by PIP and/or QAPI committee. PIP teams will be established when the need for PIP is identified. PIP teams will be interdisciplinary in nature and will include those individuals with the most knowledge, ability and/ or commitment to positive outcomes. Systematic action will be analyzed by the PIP committee not only for the desired outcome but also for any unintended outcomes. A root cause analysis (RCA) will be completed when a significant event or practice that may negatively impact a Residents safety or reception of quality care is identified through the Quality Assurance Performance Improvement (QAPI) process. The root cause is defined as 1-3 key factors that if were changed would have prevented or will prevent an undesirable outcome. The RCA will be conducted by an interdepartmental team. The RCA will be comprehensive in nature and will include the impact of; human, equipment, environmental, information, communication and Policy & Procedure factors that may have been attributed to the identified event or practice. The RCA will utilize the “5 Why” protocol when determining the root cause of the event or practice. The findings of the RCA will be maintained as part of the facility’s internal Quality Assurance and Performance Improvement program. The facility may utilize the “Root Cause Analysis Template” when complete root cause analyses. The QAPI committee will review all Performance Improvement Plans and outcomes to assure efficacy and sustainability. The purpose of evaluating the QAPI program is to provide for improved skills in the QAPI process and promotion of improved systematic outcomes. The plan shall be initiated by the QAPI committee to assure positive quality outcomes. Performance Improvement Plans formulated subsequent to this plan will be reviewed no less often than quarterly	F0865		

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F0865 SS = F	Continued from page 88 and as deemed necessary by the QAPI committee and/or PIP committee. Revisions or updates to this plan shall be documented within the QAPI Committee minutes.	F0865		
F0867 SS = E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action.	F0867		

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F0867 SS = E	Continued from page 89 §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and	F0867		

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F0867 SS = E	Continued from page 90 (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is NOT MET as evidenced by: Based on document review, staff interview, and policy review the facility failed to properly monitor and measure its success and track performance to ensure that improvements are realized and sustained for the Quality Assurance and Performance Improvement (QAPI) plan. The facility reported a census of 37 residents. Findings include: Review of document with implementation date of 10/16/25 titled, Quality Assessment and Assurance Action Plan Area of Concern: Skin Assessment documented 8 action/interventions developed all with target dates of 11/15/25. 2 of the 8 areas documented progress/evaluation. One area documented on 11/18/25 and the second on 11/28/25. A goal completion date of 12/31/25 documented. The last page of the document contained: the project, what's the best results, what's the worst result, what's the biggest difference this plan will make, what do we want to accomplish and how will we know when the project is completed. All of these areas on the document are blank. Review of document with implementation date of 10/16/25 titled, Quality Assessment and Assurance Action Plan Area of Concern: documentation in PCC documented 6 action/interventions developed all with target dates of 11/15/25. 0 of the 6 areas documented any progress/evaluation. A goal completion date of 12/31/25 documented. The last page of the document contained:	F0867		

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F0867 SS = E	Continued from page 91 the project, what's the best results, what's the worst result, what's the biggest difference this plan will make, what do we want to accomplish and how will we know when the project is completed. All of these areas on the document are blank. Review of document with implementation date of 10/16/25 titled, Quality Assessment and Assurance Action Plan Area of Concern: bowel elimination and constipation management documented 8 action/interventions developed all with target dates of 11/15/25. 0 of the 8 areas documented any progress/evaluation. A goal completion date of 12/31/25 documented. The last page of the document contained: the project, what's the best results, what's the worst result, what's the biggest difference this plan will make, what do we want to accomplish and how will we know when the project is completed. All of these areas on the document are blank. Review of document with implementation date of 10/16/25 titled, Quality Assessment and Assurance Action Plan Area of Concern: MARS/TARS documented 8 action/interventions developed all with target dates of 11/15/25 except one that did not have a team member or target date documented. 0 of the 8 areas documented any progress/evaluation. A goal completion date of 12/31/25 documented. The last page of the document contained: the project, what's the best results, what's the worst result, what's the biggest difference this plan will make, what do we want to accomplish and how will we know when the project is completed. All of these areas on the document are blank. Review of document with implementation date of 10/16/25 titled, Quality Assessment and Assurance Action Plan Area of Concern: baths documented 7 action/interventions developed all with target dates of 11/15/25 except one that did not have a team member or target date documented. 0 of the 7 areas documented any progress/evaluation. A goal completion date of 12/31/25 documented. The last page of the document contained: the project, what's the best results, what's the worst result, what's the biggest difference this plan will make, what do we want to accomplish and how will we know when the project is completed. All of these areas on the document are blank. On 12/8/25 at 5:22 PM the Administrator stated they talk about the PIPs during QAPI then medication errors and treatment errors happen and it does not seem they are making any progress. The Administrator stated different education was provided for the PIPs. The Administrator acknowledged there was not a measure of	F0867		

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F0867 SS = E	Continued from page 92 action plans after development to measure the success of the actions and track the performance but that is the goal moving forward. The Administrator stated having a consistent management would help in those processes and concerns. The Administrator stated when the facility switched over from the previous DON it did not help and adding an ADON will help moving forward. Review of policy updated 1/2/25 titled, Quality Assurance Performance Improvement (QAPI) Quality Assessment Assurance (QAA) Plan documented the purpose of QAPI in our organization is to develop a culture of proactive leadership that solicits the input from employees in various departments, including contracted professionals, if indicated, as well as those we serve Residents, Resident Representatives, and family members. Further, our purpose includes ongoing development of plans for improvement leading to systematic changes that support exceptional health care to seniors and operating excellence in every aspect of our business. The facility will use a broad range of sources when monitoring and gathering data. Prioritization of Performance Improvement Plans will be based on the scope and severity of the identified issue and the potential impact the issue has on Resident safety, clinical outcomes, and satisfaction. Performance Improvement Plans will be communicated as often as deemed necessary to assure positive outcomes, through postings to relevant employees/departments, submission of plans to regional management team (if requested) and QAPI committee and all other methods as deemed necessary by PIP and/or QAPI committee. PIP teams will be established when the need for PIP is identified. PIP teams will be interdisciplinary in nature and will include those individuals with the most knowledge, ability and/ or commitment to positive outcomes. Systematic action will be analyzed by the PIP committee not only for the desired outcome but also for any unintended outcomes. A root cause analysis (RCA) will be completed when a significant event or practice that may negatively impact a Residents safety or reception of quality care is identified through the Quality Assurance Performance Improvement (QAPI) process. The root cause is defined as 1-3 key factors that if were changed would have prevented or will prevent an undesirable outcome. The RCA will be conducted by an interdepartmental team. The RCA will be comprehensive in nature and will include the impact of; human, equipment, environmental, information, communication and Policy & Procedure factors that may have been attributed to the identified event or practice. The RCA will utilize the “5 Why” protocol when determining the root cause of the event or practice. The findings of the RCA will be maintained as	F0867		

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F0867 SS = E	Continued from page 93 part of the facility's internal Quality Assurance and Performance Improvement program. The facility may utilize the "Root Cause Analysis Template" when complete root cause analyses. The QAPI committee will review all Performance Improvement Plans and outcomes to assure efficacy and sustainability. The purpose of evaluating the QAPI program is to provide for improved skills in the QAPI process and promotion of improved systematic outcomes. The plan shall be initiated by the QAPI committee to assure positive quality outcomes. Performance Improvement Plans formulated subsequent to this plan will be reviewed no less often than quarterly and as deemed necessary by the QAPI committee and/or PIP committee. Revisions or updates to this plan shall be documented within the QAPI Committee minutes.	F0867		

Gardenview Care Center

Plan of Correction

Recertification Survey

Provider # 165531

Plan and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with State and Federal Law.

F600 Abuse and Neglect

The facility does ensure that the residents are free from neglect by providing timely suctioning.

A. All residents residing at the facility were interviewed to ensure they feel safe in their environment and free from abuse or exploitation.
B. All department heads, including the administrator and DON were educated by the director of clinical services to complete thorough investigations into all concerns brought to them, including conducting root cause analysis to identify adequate and quantifiable interventions to prevent further abuse or exploitation. The administrator and DON were educated by the director of clinical services on abuse policies and timely reporting of all allegations of abuse and exploitation.
C. All nurses immediately trained by the DCS or designee on tracheal care and suctioning to ensure adequate competency.
D. Social Services/Designee will audit weekly x4, and monthly x2 to ensure they remain free from abuse and with results forwarded to the QAPI/QA Committee for further review and recommendations.

Responsible Party: Social Services/Designee

Compliance Date: 12/3/25

F605 Free from Restraints

The facility does ensure that all residents are treated with respect and dignity, and have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. They have the right to be free from any chemical restraints

A. Resident # 4, 6 and 32 GDR's have been addressed and are current
B. All similar resident's have the ability to be affected. All residents that take psychoactive meds have charts have been reviewed, and GDR's have been issued on all resident's taking psychoactive meds.
C. DON/Adon have been educated on reviewing returned GDR's for not only a signature, but a rationale for decision and tapering medications.
D. DON/Designee will audit through the use of behavior management meeting weekly, order changes, new admission, and the routine GDR cycle to ensure resident's completion with results forwarded to the QAPI/QA Committee for further review and recommendations

Responsible Party: DON/Designee

Compliance Date: 1/8/25

F610 Investigation of Abuse

The facility does ensure that all alleged violations are thoroughly investigated and prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in process as well as reporting the results of all investigations to the administrator or designee. The facility ensures that any staff implicated will be removed from the care area immediately.

A. Resident #34 was interviewed on 12/3/25 and reported he felt safe and cared for and had no concerns with his care.
B. All similar residents have the ability to be affected have been interviewed to make sure they felt safe and cared for and have no concerns with their care. A lock box was placed at the nursing station for anonymous reporting by staff and the corporate hotline number is posted throughout the facility
C. All staff were educated on resident rights and reporting allegations of exploitation or abuse to the administrator or don if administrator is absent, immediately as well as immediate separation of victim and perpetrator on 12/3/25.
D. ADON/Designee will audit the lock box at the nurses station for anonymous reporting weekly x4, monthly x2 with results forwarded to the QAPI/QA Committee for further review and recommendations

Responsible Party: ADON/Designee

Compliance Date: 12/3/25

F636 Comprehensive Assessment

The facility does ensure that they conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity by using measurable objectives

A. Resident #10 was evaluated by OT and restorative program was initiated
B. All other residents have the potential to be affected. All restorative plans were reviewed, therapy evaluations identified, restorative plans then updated to ensure MDS accuracy.
C. Education was completed with facility leadership, restorative and clinical staffing. Clinical leadership and staffing on the process for putting restorative programs in the care plan to push to the task section for documentation accuracy.
D. DON/Designee will audit restorative program weekly x4, and monthly x2 to ensure residents are receiving restorative care. results forwarded to the QAPI/QA Committee for further review and recommendations.

Responsible Party: DON/Designee

Compliance Date: 1/8/25

F 656 Develop/Implement Comprehensive Care Plan

The facility does identify resident centered interventions for residents with continuous oxygen

A. Resident #22 care plan was updated to reflect oxygen use and required interventions related to the oxygen use and smoking.

B. All residents have the potential to be affected. All residents with continues oxygen orders that smoke have had their care plan and orders reviewed and updated.

C. All staff have been educated on the smoking process, and policy as it relates to residents that have oxygen needs.

D. The DON/Designee will audit any new orders for oxygen, assessing smoking needs weekly x 4, and monthly x 2 and with results forwarded to the QAPI/QA Committee for further review and recommendations.

Responsible Party: DON/Designee

Compliance Date: 1/8/25

F 657 Care Plan Timing and Revision

The facility does ensure that comprehensive care plans are reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

A. Resident #10 was evaluated by OT and restorative program was initiated
B. All other residents have the potential to be affected. All restorative plans were reviewed, therapy evaluations identified, restorative plans then updated to ensure MDS accuracy.
C. Education was completed with facility leadership, restorative and clinical staffing. Clinical leadership and staffing on the process for putting restorative programs in the care plan to push to the task section for documentation accuracy.
D. DON/Designee will audit restorative program weekly x4, and monthly x2 to ensure residents are receiving restorative care. results forwarded to the QAPI/QA Committee for further review and recommendations

Responsible Party: DON/Designee

Compliance Date: 1/8/25

F658 Services Provided Meet Professional Standards

The facility does follow doctor's orders to meet professional standards for

A. Resident #32 assessed and no adverse outcomes related to undocumented medication and treatment orders
B. All other residents have the potential to be affected.
C. All nurses educated on importance of following all physician orders as written and carrying out processes to ensure quality of care provided with these orders

D. The DON/Designee will audit new orders to ensure accuracy and delivery of quality of care weekly x4, and then monthly x2 with results forwarded to the QAPI/QA Committee for further review and recommendations.

Responsible Party: DON/Designee

Compliance Date: 1/8/25

F684 Quality of Care

The facility does ensure that resident's receive treatment and care in accordance with professional standards of practice, the comprehensive person centered care plan and the resident's choices

A. Resident #1 is deceased
B. All residents have the potential to be affected. A review was completed by clinical staff.
C. Education done with all clinical staff, skills held for annual competencies to include to change of condition and recognizing sepsis.
D. DON/Designee will audit for change of condition and conduct appropriate follow-up weekly x4, then monthly x2 with results forwarded to the QAPI/QA Committee for further review and recommendations.

Responsible Party: DON/Designee

Compliance Date: 12/29/25

F686 Treatment/Svcs to Prevent/Heel Pressure Ulcer

The facility does ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and treatment to promote healing, prevent infection and does not develop pressure ulcers unless unavoidable

A. Resident # 2 and #34's wound orders and care plan reviewed for accuracy and currently showing improvement
B. All other resident's who could be similarly affected have been reviewed. A skin sweep was completed on every resident
C. Education done with licensed nursing during staff Inservice and skills fair
D. DON/Designee will audit wound assessments and weekly skin assessments to ensure nursing compliance and continued wound improvement weekly x4, and monthly x2 to with results forwarded to the QAPI/QA Committee for further review and recommendations.

Responsible Party: DON/Designee

Compliance Date: 1/8/25

F688 Increase/Prevent Decrease in ROM/Mobility

The facility does range of motion exercises; the facility does provide range of motion services to resident with limited range of motion or contractures.

A. Resident #10 was evaluated by OT and restorative program was initiated
B. All other residents have the potential to be affected. All restorative plans were reviewed, therapy evaluations identified, restorative plans then updated to ensure MDS accuracy.
C. Education was completed with facility leadership, restorative and clinical staffing. Clinical leadership and staffing on the process for putting restorative programs in the care plan to push to the task section for documentation accuracy
D. DON/Designee will audit restorative program weekly x4, and monthly x2 to ensure residents are receiving restorative care. results forwarded to the QAPI/QA Committee for further review and recommendations

Responsible Party: DON/Designee

Compliance Date: 1/8/25

F 690 Bowel/Bladder Incontinence, Catheter, UTI

The facility does complete catheter care per physician

A. Resident #10's is receiving catheter care per physician orders
B. All other residents have the potential to be affected all residents with catheters were reviewed for order accuracy and care plan updated
C. Clinical staff were trained on completion of catheter care
D. DON/Designee will review residents with catheters weekly x4, monthly x2 to ensure residents have appropriate catheter care. Results forwarded to QA/QAPI Committee for review

Responsible Party: DON/Designee

Compliance Date: 1/8/25

F695 Respiratory/Tracheostomy Care and Suctioning

The facility does provide respiratory care and services with in accordance with professional standards of practice

A. Resident #22's was deemed unsafe to self administer, all meds stored in med cart and medications given by staff per order
B. All other residents have the potential to be affected. No other residents have been identified to have the desire or capability to self administer medications
C. Clinical staff was educated on safe medication administration practices
D. DON/Designee will for safe nebulizer administration practices weekly x4, monthly x2 to ensure proper medication nebulizer medication treatment. Results forwarded to QA/QAPI Committee for review

Responsible Party: DON/Designee

Compliance Date: 12/29/25

F725 Sufficient Nursing Staff

The facility does have licensed nurses on premises at all times

A. No Resident identified
B. All residents have the ability to be affected
C. Education provided with all staff on a nurse staying in the building 24 hours a day. Staff interviews conducted on if nurses are staying on facility grounds 24 hours a day
D. DON/Designee will conduct interviews with staff daily x30, and prn to ensure adequate nurse coverage. Results forwarded to QA/QAPI Committee for review

Responsible Party: DON/Designee

Compliance Date: 1/8/25

F726 Competent Nursing Staff

The facility does ensure that nursing staff have adequate orientation and training before they are scheduled to work independently with residents

A. No Resident Identified
B. All residents have the ability to be affected
C. A skills fair was held to ensure all staff are competent to work with residents independently. All new hired nursing staff will complete an orientation and competencies prior to working independently with residents.
D. DON/Designee will review all new hires for completion of orientation packet before independently working with residents weekly x4, and monthly x2 to ensure all nurses have completed a competency checklist and orientation packet upon hire. Results forwarded to QA/QAPI Committee for review

Responsible Party: DON/Designee

Compliance Date: 1/8/25

F730 Nurse Aide Performance Review 12 hour/Yr. In-service

The facility does conduct annual staff evaluations. The facility did complete a performance review of all nurses aides.

A. No resident identified
B. All residents have the ability to be affected
C. All nurses aides had a performance review completed
D. DON/Designee to review performance reviews to aide in identifying any performance issues auditing weekly x4, and monthly x2 and then prn to ensure performance reviews are completed. Results forwarded to QA/QAPI committee for review.

Responsible Party: DON/Designee

Compliance Date: 1/8/25

F 755 Pharmacy Services/Procedures/Pharmacist Records

The facility does maintain accurate accounting for narcotics and does ensure meds are destroyed appropriately

A. Resident #38 narcotic medication was destroyed by the facility according to standards of practice
B. All residents have the potential to be affected
C. Education with Medication aides and licensed nurses completed on disposition of drugs/timeliness. Pharmacy representative came to facility to audit medication room, medication carts and the mediation administration record.
D. DON/Designee will audit destructions of medications as weekly x4, and monthly x4 to ensure narcotics are destroyed per standards of practice. Results to be forwarded to QA/QAPI for review.

Responsible Party: DON/Designee

Compliance Date: 1/8/25

F803 Menus Meet Resident Nees/Prep in Av/Followed

The facility does ensure that menus meet the nutritional needs of residents in accordance with the established national guidelines

A. 7 residents on mechanical soft diets
B. All similar residents have the potential to be affected. All diets reviewed for accuracy
C. Education and training done with dietary on using scoops size for meals
D. The CDM/Designee will audit 3x weekly x 4 weeks, and than monthly x2 and prn with results forwarded to the QA/QAPI Committee

Responsible Party: CDM/Designee

Compliance Date: 1/8/25

F804 Nutritive Value/Appearance, Palatable/Prefer Temp

The facility does ensure that each resident receives, and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance

A. 3 residents affected from Peppered Beef served at 129 degrees. No acute findings or ill effect from it
B. All residents have the potential to be affected, but temperature was approved for the mashed potatoes and peas served with the meal
C. Dietary staff was educated on proper temping and adding foil to room trays before delivering
D. The CDM/Designee will monitor proper food temp 3x a week x4, and than monthly x2 and prn with results forwarded to the QA/QAPI Committee for further review and recommendations

Responsible Party: CDM/Designee

Compliance Date: 1/8/25

F805 Food in Form to Meet Individual Needs

The facility does ensure that food is prepared in a form designed to meet individual needs

A. 7 residents affected from processing an incorrect consistency for an onion in a modified diet.
B. All similar residents have the potential to be affected, but no other residents were affected
C. Dietary staff was educated to ground the onions in with the meat to meet the individual needs of the modified diet
D. The CDM/Designee will audit consistency of the modified diets 3x weekly x 4 weeks, then monthly x2 and than prn with results forwarded to QA/QAPI Committee for further review and recommendations

Responsible Party: CDM/Designee

Compliance Date: 1/8/25

F812 Food Procurement, Store/Prepare/Serve-Sanitary

The facility does ensure that food is stored, prepared, distributed and served in accordance with professional standards for food service safety

A. No specific resident identified
B. All residents have the potential to be affected
C. Hand hygiene education done with all Kitchen staff, as well as dating food opened and disposing of expired food
D. The CDM/Designee will audit food safety compliance 3x weekly x4, than monthly x2 and then prn with results forwarded to the QAPI/QA Committee for further review an recommendations

Responsible Party: CDM/Designee

Compliance Date: 1/8/25

F835 Administration

The facility does ensure that it is administered in a manner that enables it to use it's resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident

A. No staff identified no longer works at the facility
B. All residents have the potential to be affected by reference checks and performance concerns not being completed and followed up on by the facility.
C. Employee files for all nurse were audited for reports of adverse events on their license, reference checks and performance concerns. Education completed with HR on doing reference checks prior to hire and license checks prior to hire. Don was educated that all concerns regarding an employee's performance must be thoroughly investigated and documented. The Facility has a complaint box now established for any anonymous concerns to be followed up on by nursing leadership or appropriate department.
D. A new employee checklist will be completed by the HR director or designee on all new nursing team members and acknowledged by the administrator, prior to their first day of employment to ensure all proper steps have been followed. Identified concerns will be addressed prior to starting and outcome of the audits will be reviewed monthly at the QA meeting. All employee performance investigation/outcomes will be acknowledged by the administrator and trends identified will be discussed at the monthly QA meeting.

Responsible Party: HR director/Designee

Compliance Date: 1/8/25

F842 Resident Records- Identifiable Information

The facility does provide complete and accurately documented records for resident inventory lists.

A. Residents #19's inventory list completed by the facility
B. All similar residents have the ability to be affected
C. Inventory sheet audit on each resident completed. Education done with housekeeping and laundry that each resident must have an inventory sheet upon admission
D. SS/Designee will audit all new admissions for a completed inventory sheet and inventory sheet will be reviewed at care conferences with each residents. Audits to be done weekly x4, and monthly x2, and than prn to ensure completion of resident inventory and discussion at care conference. Results to be forwarded to QA/QAPI committee for review and recommendations

Responsible Party: SS/Designee

Compliance Party: 1/8/25

F865 QAPI Program/Plan, Disclosure/Good Faith Attempt

The facility does demonstrate a good faith attempt to correct quality deficiencies based on issues identified, including monitoring, tracking of performance improvement plan

A. No residents were specifically identified
B. All residents have the potential to be affected by care concerns not being identified and performance improvement plans not being monitored and tracked for completion
C. Leadership staff were educated by the AHCA QAPI Certified, Director of Quality LNHA regarding the implementation of a Quality Assurance Program that identifies aeras of concern utilizing data, implements performance improvement plans and tracks progress towards identified goals.
D. Weekly QAPI meetings implemented surrounding the most recent identified care concerns for 12 weeks, then monthly QAPI meetings support for 3 months with PIP progression monitored by the Director of Quality

Responsible Party: Admin/Designee

Compliance Party: 1/8/25

F867 QAPI/QAA Improvement Activities

The facility does properly monitor and measure its success and track performance to ensure that improvements are made and sustained

A. No residents were specifically identified
B. All residents have the potential to be affected by performance improvement plans not being monitored and tracked for completion
C. Leadership educated by the AHCA QAPI Certified, Director of Quality LNHA regarding the implementation of a Quality Assurance Program that identifies areas of concerns utilizing data, implements performance improvement plans and tracks progress towards identified goals.
D. Weekly QAPI meetings implemented surrounding the most recent identified care concerns for 24 weeks, then monthly QAPI meetings support for 6 months with PIP progression monitored by the Director of Quality

Responsible Party: Admin/Designee

Compliance Date: 1.8.25

Administrator: Rachael Gebhardt

Date: 1-8-26