

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2020
NAME OF PROVIDER OR SUPPLIER GARDEN VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WEST NISHNA ROAD SHENANDOAH, IA 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	
F 000	INITIAL COMMENTS Correction Date _____ The following deficiencies relate to the investigation of facility reported incident 89297-M completed March 10-October 12, 2020. Additional findings related to 89297-M will be sent to the facility at a later date under separate cover.	F 000			
F 684 SS=D	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 record review and staff interviews, the facility failed to meet professional standards of care when they failed to follow physician orders. (Resident #5). The facility reported census was 59 residents. Findings include: According to the Minimum Data Set (MDS) assessment with assessment reference date of 2/6/20, Resident #5 had a brief interview for mental status (BIMS) score of 15 indicating an intact cognitive status. Resident #5 is independently mobile, toilets independently and requires limited assistance with dressing and personal hygiene needs. Resident #5's diagnosis	F 684			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2020
NAME OF PROVIDER OR SUPPLIER GARDEN VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WEST NISHNA ROAD SHENANDOAH, IA 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	
F 684	<p>Continued From page 1</p> <p>included Non-Alzheimer's Dementia, diabetes mellitus, congestive heart failure, chronic obstructive pulmonary disease and anxiety.</p> <p>Review of Resident #5's Medication Administration Records (MAR) for December 2019 notes Resident #5 takes Ativan (Lorazepam) 0.5 milligrams routinely twice daily, in the morning and again in the evening. Resident #5 does not have an order for Ativan as needed (prn). According to the controlled medication utilization record (CMUR) for Resident #5's Ativan 0.5 milligrams, Staff G removed, an extra dose at times not consistent with Resident #5's scheduled routine administration times of morning and evening. Staff G removed doses on 12/1 at 12:00 p.m., 12/8 at 3:00 p.m. and 12/31 at 12:00 p.m.</p> <p>Review of Resident #5's Medication Administration Records (MAR) for January 2020 notes Resident #5 takes Ativan (Lorazepam) 0.5 milligrams routinely twice daily, in the morning and evening, until changed to daily on 1/8 which continued through 1/13 when it was changed back to twice per day at 9:00 a.m. and 6:00 p.m. Resident #5 does not have an order for Ativan as needed (prn). According to the controlled medication utilization record (CMUR) for Resident #5's Ativan 0.5 milligrams, Staff G removed an extra dose at times not consistent with her scheduled routine administration times. Staff G removed doses on 1/1 at 1:00 p.m., two doses on the morning of 1/9 at 8:00 a.m. and again at 9:00 a.m., 1/14 at 12:00 p.m., 1/23 at 12:00 p.m. and 1/27 at 1:50 p.m. Staff A also removed an evening dose on 1/11 when Resident #5 had received her routine daily dose at 7:55 a.m. that morning.</p>	F 684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2020
NAME OF PROVIDER OR SUPPLIER GARDEN VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WEST NISHNA ROAD SHENANDOAH, IA 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	
F 684	Continued From page 2 Review of Resident #5's Medication Administration Records (MAR) for February 2020 notes Resident #5 takes Ativan (Lorazepam) 0.5 milligrams routinely twice daily at 9:00 a.m. and 6:00 p.m. Resident #5 does not have an order for Ativan as needed (prn). According to the controlled medication utilization record (CMUR) for Resident #5's Ativan 0.5 milligrams, Staff G removed, an extra dose at times not consistent with Resident #5's scheduled routine administration times of 9:00 a.m. and 6:00 p.m. Staff G removed doses on 2/1 at 12:00 p.m., 2/2 at 12:00 p.m., 2/7 at 1:00 p.m., 2/11 at 12:00 p.m. and 2/24 at 1:00 p.m. Additionally, Staff A also removed an extra dose from Resident #5's Ativan supply on 2/8 at 11:00 p.m., 2/9 at 9:00 p.m. 2/18 at 9:00 p.m. and 2/25 at 10:00 p.m. In an interview on 3/12/20 at 6:15 a.m. Staff A, a licensed practical nurse, was asked why she had removed extra doses of Ativan from Resident #5's supply at times inconsistent with her scheduled routine times and not in accordance with physician orders. Staff A stated they were given prn. Staff A was asked where she would have documented this since Resident #5 does not have an order for prn Ativan. Staff A stated on the CMUR. Staff A stated she thought the computer was wrong. Staff A failed to obtain a physician order, transcribe it to the MAR, and complete follow-up documentation. Staff A administered medication without a physician order.	F 684			
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2020
NAME OF PROVIDER OR SUPPLIER GARDEN VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WEST NISHNA ROAD SHENANDOAH, IA 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	
F 755	<p>Continued From page 3</p> <p>§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(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>§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.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§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</p> <p>§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, facility policy review and staff interviews, the facility failed to ensure drug records are in order and that account of all controlled medications is maintained and periodically reconciled. The facility identified a census of 59 residents.</p>	F 755			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2020
NAME OF PROVIDER OR SUPPLIER GARDEN VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WEST NISHNA ROAD SHENANDOAH, IA 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	
F 755	<p>Continued From page 4</p> <p>Findings include:</p> <p>During an observation on 3/12/20 at 6:00 a.m. off going nurse, Staff A and on-coming nurse Staff B conducted a shift change narcotic count on the B wing. Staff A reviewed the controlled medication utilization record (CMUR) while Staff B checked the count in the bubble packs. Staff A read out the count on the CMUR while Staff B verified the count as correct on the bubble packs. Neither Staff A or Staff B crossed checked one another to verify the count. Neither Staff A or Staff B was observed signing the Shift Change for Narcotics form per required protocol. Staff B then entered the medication room, unlocked the cabinet and checked the tag number on the emergency kit. Staff B recorded the tag number and signed the Emergency Narcotic Container Count sheet. Staff A remained at the nurses station, never entering the medication room, never verified the emergency kit tag number and never signed the Emergency Narcotic Container Count sheet per required protocol. Once finished Staff A handed the B wing medication cart keys over to Staff B. Following observation of A wing shift change narcotic count, this surveyor returned to B wing to obtain the Shift Change for Narcotics form. Staff A had initialed the form noting it had been done prior to the shift change count at 6:00 a.m. and Staff B had not signed it per protocol. When shown to Staff B, Staff B stated she hadn't signed it yet and quickly placed her signature on the form.</p> <p>During an observation on 3/12/20 at 6:10 a.m. off going nurse, Staff A and on-coming nurse Staff C conducted a shift change narcotic count on the A wing. Staff A</p>	F 755			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2020
NAME OF PROVIDER OR SUPPLIER GARDEN VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WEST NISHNA ROAD SHENANDOAH, IA 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	
F 755	<p>Continued From page 5</p> <p>reviewed the controlled medication utilization record (CMUR) while Staff C checked the count in the bubble packs. Staff A read out the count on the CMUR while Staff C verified the count as correct on the bubble packs. Neither Staff A or Staff C crossed checked one another to verify the count. Staff A then handed the A wing medication cart keys over to Staff C. Neither Staff A or Staff C was observed signing the Shift Change for Narcotics form per required protocol. It was also noted that neither Staff A or Staff C entered the medication room to access the refrigerator which contained two bottles of a controlled medication. When reviewing the Shift Change for Narcotics form for A wing, Staff A's initials were recorded and there was no signature of Staff C. When asked when Staff A had initialed the form, Staff A stated at around 3:00 a.m. that morning.</p> <p>In an interview on 3/11/20 at 10:57 a.m. Staff G, licensed practical nurse, stated on 1/23/20 she was working B wing from 6:00 a.m. to 6:00 p.m. Staff D came in at 2:00 p.m. and shortly after that they completed a shift change narcotic count which included counting the contents in a bottle of Lorazepam (Ativan) belonging to Resident #5. All narcotics were accounted for and Staff G handed her keys over to Staff D. At 4:00 p.m. the nurse on A wing had to leave due to an emergency and Staff D had to take over on A wing. Staff G claims she and Staff D again counted the B wing narcotics, including the bottle of Lorazepam and that all narcotics were accounted for. Staff G received the B wing medication cart keys from Staff D. Staff G stated at 6:00 p.m. she again counted the narcotics on B wing with Staff D and all narcotics were accounted. Staff G stated she gave the B wing medication cart keys to Staff D</p>	F 755			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2020
NAME OF PROVIDER OR SUPPLIER GARDEN VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WEST NISHNA ROAD SHENANDOAH, IA 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	
F 755	Continued From page 6 and left. In an interview on 3/10/20 at 5:10 p.m. Staff D, licensed practical nurse, stated on the evening of 1/23/20 she was working 2:00 p.m. to 10:00 p.m. and assigned B wing. Upon arriving she completed a shift change narcotic count with Staff G. All narcotics were accounted for and she received the medication cart keys from Staff G. At 4:00 p.m. the A wing nurse had to leave due to an emergency and Staff D took over the A wing medication cart. Staff D stated she completed a narcotic count with the A wing nurse, all narcotics were accounted for and she received the medication cart keys from the A wing nurse. In addition, Staff G took back over the B wing medication cart. Staff D stated she and Staff G completed a narcotic count, the count was correct and she passed the B wing medication cart keys back to Staff G. Staff D stated at 6:00 p.m. Staff G's shift was completed. Staff E, who was scheduled to be in at 6:00 p.m. had not arrived to work yet, so Staff G and Staff D completed a narcotic count. Staff D claims the count was correct and she received the B wing medication cart keys from Staff G. At 6:45 p.m. Staff E arrived and Staff D claims she completed a narcotic count with Staff E, the narcotic count was correct and she passed the B wing medication cart keys to Staff E. Staff D stated at 10:00 p.m. she completed a narcotic count on the A wing and gave the A wing medication cart keys to Staff E. Staff D insists the contents of the bottle of Lorazepam (Ativan) belonging to Resident #5 were counted each time the B wing count was completed. Staff D stated shift change narcotic counts are to be completed at each shift change and anytime	F 755			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2020
NAME OF PROVIDER OR SUPPLIER GARDEN VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WEST NISHNA ROAD SHENANDOAH, IA 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	
F 755	<p>Continued From page 7</p> <p>medication cart keys are exchanged with one another. Both nurses are to then initial the Shift Change narcotic count form indicating the count was completed and correct.</p> <p>According to the January Shift Change for Narcotics form, neither, Staff D or Staff G initialed the form indicating a narcotic count was completed multiple times between 2:00 p.m. and 6:00 p.m. when Staff G left. Staff D also failed to initial a narcotic count on B wing completed between her and Staff E at 6:45 p.m.</p> <p>In a follow up interview on 9/21/20 at 3:40 p.m., Staff D again asked about completing narcotic counts on the evening of 1/23/20, noting the narcotic count sheet did not have any pintails by Staff D or Staff G indicating that they had completed the narcotic counts when exchanging the B cart keys. Staff D stated she didn't recall, but noted if she didn't initial the narcotic count sheet, she may have not completed a narcotic count. Staff D also didn't initial the narcotic count sheet at 6:45 p.m. when a count was supposed to be done with the on-coming nurse, Staff E. Staff D again admitted she may have not completed a count with Staff E before handing her the B wing keys. Staff D reminded that sometime on 1/23/20 and into the overnight of 1/24/20 a bottle of Ativan containing 27 doses was removed and discovered missing during a shift change narcotic count on the morning of 1/24/20. Staff D stated she was aware. Staff D asked if she could recall whether she or Staff G emptied the bottle contents and counted the pills on 1/23/20. Staff D indicated she couldn't recall and couldn't recall whether the bottle of Ativan was in the medication cart on 1/23/20.</p>	F 755			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2020
NAME OF PROVIDER OR SUPPLIER GARDEN VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WEST NISHNA ROAD SHENANDOAH, IA 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	
F 755	<p>Continued From page 8</p> <p>In an interview on 3/23/20 at 11:24 a.m. Staff E, registered nurse, stated upon arriving to work on 1/23/20 at 6:45 p.m. the 2:00 p.m. to 10:00 p.m. nurse Staff D was the only nurse present. Staff D tossed her the B wing keys. Staff E asked if they were going to count narcotics and Staff D stated in a hateful tone, I don't have time. Staff E stated several residents were wanting their medications, so she started passing medications. Staff E stated sometime around midnight she counted the narcotics by herself. Staff E stated all medications were accounted for, but she had failed to see the last page of a controlled medication utilization record (CMUR), which was related to a bottle of Ativan belonging to Resident #1. That morning (1/24/20) at around 6:00 a.m., she and Staff F conducted the narcotic count and discovered the bottle of Ativan (27 doses) was missing from the narcotic box. Staff E stated she had been very concerned with the facilities lack of professionalism when handling controlled medications. It was common for shift change narcotic counts to be ignored. During her short time there, Staff E stated she pointed out several discrepancies with missing narcotics to the Director of Nursing, including missing liquid Lorazepam and morphine. Staff E stated there was a second locked drawer in the A wing medication cart that held several discharged resident's controlled medications that were never counted or properly destroyed. Staff E stated the narcotic emergency kit was often not kept locked up as it should have been.</p> <p>In an interview on 3/11/20 at 8:45 a.m. the Director of Nursing (DON) stated on the morning of 1/24/20 she was alerted that a bottle of a controlled medication was discovered missing during the shift change narcotic count that</p>	F 755			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2020
NAME OF PROVIDER OR SUPPLIER GARDEN VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WEST NISHNA ROAD SHENANDOAH, IA 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	
F 755	<p>Continued From page 9</p> <p>morning. The DON stated Staff D, the 2:00 p.m. to 10:00 p.m. nurse on 1/23/20, indicated she did not conduct a shift change narcotic count with the overnight nurse, Staff E, when she arrived to work at 6:45 p.m. In a statement Staff E confirmed that a count was not conducted and Staff D handed Staff E the B wing keys. The bottle was discovered missing the following morning when Staff E was counting with the on-coming nurse, Staff F. The DON stated facility protocol requires nurses to conduct a shift change narcotic count prior to medication keys being passed to the on-coming nurse or anytime medication cart keys are passed from one nurse to another. Both nurses are expected to initial or sign the shift change narcotic count sheet indicating the count was completed and verified as correct. If a count is incorrect the nurse is to immediately notify the DON or Administrator so that an investigation can be initiated. The DON indicated nurses are also responsible for verifying the narcotic E-kit tag numbers at each shift change to ensure the E-kit and tag have not been tampered with or accessed by someone unauthorized. Both nurses are to verify the tag number and initial/sign the Emergency Narcotic Container Count form. If there is a change in tag number without explanation, no tag or discrepancy the nurse is to contact the DON or Administrator immediately so that an investigation can be initiated. The DON stated ANY controlled medication discrepancies are to be reported to the DON or Administrator immediately.</p> <p>Review of the current Emergency Narcotic Container Count form (E-kit) indicates an initial date of 3/5/20 at 6:00 a.m. verifying a tag number with two staff signatures. However the next entry by Staff A is on 3/7/20 at 3:30 a.m. with no other</p>	F 755			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2020
NAME OF PROVIDER OR SUPPLIER GARDEN VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WEST NISHNA ROAD SHENANDOAH, IA 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	
F 755	<p>Continued From page 10</p> <p>signature, followed by the next entry 4 days later on 3/11/20 at 6:00 a.m. which now has a different tag number, but is verified by two nurses, then a 3/11/20 entry at 10:00 p.m. and a 3/12/20 entry at 6:00 a.m. both with only one nurse signature. Despite the theft of thirty doses of hydrocodone from the E-kit discovered on 1/25/20, the facility has not yet corrected the process necessary to ensure controlled medications are kept safe from diversion.</p> <p>Review of the current Shift Change for Narcotics form for March 2020 B wing notes no recorded count completed by Staff D and on-coming overnight nurse 3/3 at 10:00 p.m. or on the morning of 3/4 at 6:00 a.m. No recorded count on 3/6 at 6:00 p.m., 3/7 at 6:00 p.m., 3/7 at 10:00 p.m., 3/8 at 6:00 a.m., 3/8 at 6:00 p.m., 3/9 at 6:00 a.m. or 3/9 6:00 p.m.</p> <p>Review of the Shift Change for Narcotics form for January 2020 B wing notes only 6 instances out of at least 62 opportunities in which two nurses initialed that the narcotic count was completed. 24 instances in which one nurse initialed the count as completed without a second nurse witness.</p> <p>According to Controlled Medication Utilization Records (CMUR) for Resident #5's Lorazepam 0.5 milligrams on 12/7/19 at 9:00 p.m. a dose was removed leaving 17 doses remaining in the bubble pack. On 12/8/19 at 12:00 p.m. through 12/9/19 at 8:00 p.m. 5 additional doses were removed leaving what should have been a count of 12 and instead the count was 11. The following morning on 12/10/19 at 6:30 a.m. two nurses including Staff A indicated there were now only 10 doses. Staff A indicated the "count</p>	F 755			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2020
NAME OF PROVIDER OR SUPPLIER GARDEN VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WEST NISHNA ROAD SHENANDOAH, IA 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	
F 755	Continued From page 11	F 755			
F 761 SS=E	<p>corrected" without explanation as to where two doses of a controlled medication went.</p> <p>Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)</p> <p>§483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure only authorized personnel has access to medication cart and room keys. The facility identified a census of 59 residents.</p> <p>Findings include:</p>	F 761			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2020
NAME OF PROVIDER OR SUPPLIER GARDEN VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WEST NISHNA ROAD SHENANDOAH, IA 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	
F 761	Continued From page 12 In an interview on 3/11/20 at 3:50 p.m. Staff B, licensed practical nurse, stated there is one set of medication cart keys for A wing which will open the medication cart and narcotic lock box as well as the A medication room, locked refrigerator and locked refrigerator narcotic box. There is one set of medication cart keys for B wing which will open the B wing medication cart, the narcotic lock box as well as the B medication room and locked cabinet in which the narcotic E-kit is located. Staff B stated there is also a charge nurse set of keys kept in an unlocked drawer at the A wing nurses station. These keys will open both the A and B wing medication carts and medication rooms, but will not unlock the narcotic boxes or access any cabinets or containers holding controlled medications. During an observation on 3/11/20 at 3:50 p.m. Staff B removed the charge nurse keys from an unlocked drawer at the A wing nurses station, then demonstrated that the keys would open the A wing medication cart, but not the narcotic box and opened the A wing medication room. Staff B did not believe the keys would open the refrigerator locks or access the locked narcotic storage box in the refrigerator, but when tried, the keys did open the narcotic box in the refrigerator containing two bottles of controlled medications. Staff B then accompanied surveyor to B wing medication cart and the keys opened the cart, but not the narcotic box. The keys also opened the B wing medication room, but would not unlock the cabinet holding the narcotic E-kit.	F 761			