STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165019	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chautauqua Guest Home #2	602 Eleventh Street Charles City, IA 50616

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review the facility failed to provide or offer as needed (PRN) pain medication in a timely manner, non-medication pain relief, and/or notify the resident's physician of new onset and increased pain for 1 of 3 residents reviewed for pain after a fall (Resident #14). Despite Resident #14 reporting increased amounts of pain to her leg, the facility failed to provide her with additional medication or request the physician review her medication orders. The facility learned Resident #14's pain occurred due to a fracture of the femoral neck (hip fracture). The facility reported a census of 38 residents. Findings include:Resident #14's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. Resident #14 required substantial/maximal assistance (helper does more than half the effort) with transferring and walking up to 10 feet. In addition, the MDS listed Resident #14 as dependent (helper does all of the effort or, the assistance of 2 or more helpers is required for the resident to complete the activity) with rolling left to right in bed. The MDS also documented diagnoses of hemiplegia (paralysis or weakness that only affects half of the body), diabetes mellitus, anxiety, depression, non-Alzheimer's dementia, and encounter for palliative care (a type of care between nursing home care and hospice level of care). The Fall Progress Note dated 9/13/25 at 9:40 AM, documented the staff heard Resident #14's chair alarm sounding and upon entering her room, the staff found her lying on the floor on her right side screaming my leg and back hurts, while touching her left thigh. The nurse assessed her range of motion (ROM) within normal limits and took her vital signs. The assessment didn't identify any injuries to her left leg or back. The nurse gave Resident #14, as needed (PRN) acetaminophen.The Fall Follow Up Progress Note dated 9/13/25 at 3:10 PM, documented Resident #14 refused to walk and she stated my leg is broken. The nurse assessed passive ROM to Resident #14's left leg. The assessment reflected ROM within normal limits, with her skin intact with no swelling and no bruising noted.The Fall Follow-Up Progress Note dated 9/14/25 at 5:50 AM, documented Resident #14 screamed on and off throughout the night. She complained of pain to her left leg and back. During routine cares was observed holding her left leg and refuses to give pain level and continues to say, It hurts me. Documentation also revealed Resident #14 left leg has been a chronic issue for a while now and will notify her Physician if she can go over for x-rays for her left leg.The Fall Follow Up Progress Note dated 9/14/25 at 1:11 PM, documented the staff obtained Resident #14 vital signs and she had no pain to her right extremities and had full ROM. The staff reported Resident #14 described her left leg as tender. The staff gave her PRN acetaminophen. The staff observed Resident #14 lifting up her legs and bending both knees while in her recliner chair. The staff didn't note any injuries.Resident #14's September 2025 Medication Administration Record (MAR) listed the following orders:8/27/25: Acetaminophen oral tablet 500 milligrams (mg). Give 2-tablets by mouth one time a day in the evening related to pain in leg, unspecified.7/30/24: Tramadol oral tablet 50 mg. Give 50 mg by mouth two times a day for leg pain.5/31/23: Acetaminophen oral tablet 325 mg. Give 2-tablets by mouth every 6 hours as needed for pain and/or fever PRN. Resident #14 received the medication at the following times:9/13/25 at 10:10 am - 4 pain level (0 equals '=' no pain, 10 = the worst pain ever)9/14/25 at 11:46 am - 2 pain levelThe (continued on next page)

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

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

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Chautauqua Guest Home #2	602 Eleventh Street Charles City, IA 50616

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	MAR reflected Resident #14 only received the PRN acetaminophen once before her fall on 9/13/25.The Physician Contact Progress Note dated 9/15/25 at 9:00 AM, documented Resident #14's Advanced Register Nurse Practitioner (ARNP) came to the facility that morning. The staff updated them on Resident #14's pain from her fall lessened but they would contact her if they didn't see improvement.The Family Contact Progress Note dated 9/15/25 at 11:24 AM, documented Resident #14's Daughter visited with her on 9/14/25. Resident #14 didn't wish to go out of the building and/or have an x-ray at that time.The Progress Note dated 9/15/25 at 6:10 PM, documented Resident #14 had a lot of pain during supper despite receiving her scheduled pain medications Tramadol and Tylenol 30-minutes before getting her up for supper. In addition, she refused to eat and begged the staff to lay her in bed, and refused to have a bath. She displayed facial grimacing (an involuntary facial movement that involves twisting or contorting the face, often in a way that appears painful or disgusted). The nurse took her vital signs and discovered an elevated blood pressure of 142/88 (typical 120/80). The staff assisted Resident #14 to lay down early to bed and re-positioned her for comfort with the head of the bed elevated.The Progress Note dated 9/16/25 at 2:35 AM, documented the staff heard Resident #14's floor alarm sounding as a pillow fell on the floor and set it off. The nurse obtained vital signs and noted her blood pressure elevated at 142/87. The nurse assessed Resident #14's lungs and heard crackles (abnormal breath sounds that sound like popping, crackling, or bubbling) in her bottom right lung. Resident #14 complained of pain to her left hip and left foot. The nurse observed her left foot internally rotated with 1+ pitting edema (indicates a mild degree of swelling) and her left hip with non-pitting edema (a type of swelling that didn't leave a dent when pressure is applied to the affected area). The nurse didn't observe bruising or redness to her left hip or thigh. The nurse noted her left elbow had a faint bruise and abrasion (a superficial wound caused by the skin rubbing or scraping against a rough surface, leading to the wearing away of the outer skin layers). The staff checked her blood sugar and the machine read 570 (normal for non-diabetic 70-110 and normal for diabetic 2 hours after a meal less than 180) as her blood sugar ran high on 9/15/25 and she received extra insulin then. The staff conducted a COVID test and received a negative result.The Progress Note dated 9/16/25 at 5:54 AM, documented Resident #14 had the following events on 9/16/25:a. 3:35 AM: Blood sugar reevaluated twice (x2) with both readings of HI (above 600). Resident #14 reported she wanted to have her hip looked at the hospital.b. 3:40 AM: The nurse updated Resident #14's ARNP. The ARNP gave an order to send to the local emergency room (ER).c. 3:42 AM: Resident #14 family notified she would be evaluated in the ER.d. 3:45 AM: The nurse notified the ambulance services.e. 4:10 AM: The nurse gave report to the ambulance services when they arrived about Resident #14.f. 4:15 AM: Resident #14 left the facility.The ER Physician Documentation Report dated 9/16/25 documented at 4:32 AM, reflected Resident #14 went to the ER and received 6 milligrams (mg) of Morphine (pain medication) by an Intramuscular Injection (IM). Her vital signs reflected an oxygen saturation (O2) of 84% on room air (normal is above 90% on room air). The staff applied oxygen at 3 Liters (L) and her O2 went up to 96%. She had a blood sugar level of 721. The hospital admitted her inpatient with diagnoses of pleural effusion (condition where excess fluid accumulates in the space between the lungs and the chest wall), left hip fracture, acute kidney failure, and congestive heart failure (CHF).The current Care Plan Focus related to pain control dated 9/17/25 documented Resident #14 had the following interventions dated 5/31/23:a. Anticipate Resident #14's need for pain relief and respond immediately to any complaints of pain.b. Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition.c. Monitor and document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations (seeing or hearing something not really there), dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician.d. Monitor/record/report to Nurse any s/sx of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); (continued on next page)

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Chautauqua Guest Home #2	602 Eleventh Street Charles City, IA 50616

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing).e. Monitor/record/report to Nurse Resident #14's complaints of pain or requests for pain treatment.f. Monitor, record, and report to the nurse a loss of appetite, refusal to eat, and/or weight loss.g. Notify physician if interventions are unsuccessful or if current complaint is a significant change from Resident #14's past experience of pain.h. Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM, withdrawal, or resistance to care.i. Report to the nurse any change in usual activity attendance patterns or refusal to attend activities related to signs, symptoms, complaints of pain, or discomfort.During an interview on 9/18/25 at 8:58 AM Staff G, Licensed Practical Nurse (LPN), reported she worked with Resident #14 after she fell on 9/13/25 and every night shift leading up to her going to the hospital on 9/16/25. She kept saying she had pain in her left leg and the Nurses had the impression her family didn't want her sent out. She explained Resident #14 never really told anyone if something was wrong, but you could see it in her face.During an interview on 9/18/25 at 11:03 AM with Staff E, Register Nurse (RN), revealed she worked on 9/13/25 when Resident #14 fell. Staff E said Resident #14's chair alarm went off and when she entered the room, she found her screaming on the floor. Resident #14 laid on her right side touching her left leg, she told the staff her leg and back hurt, but she denied hitting her head. Staff E reported her assessment showed everything normal. When the staff put her in the recliner, she had facial grimacing, so Staff E gave her an as needed (PRN) acetaminophen. On 9/14/25, Staff E worked with Resident #14 from 2:00 PM to 6:00 PM, they started using the full-body mechanical lift as she still had pain. Staff E reported the staff talked about having her physician see her and get an x-ray on 9/15/25. On 9/15/25 they continued to use the full-body mechanical lift. Resident #14 was quiet, but she still had left leg weakness and refused to take a bath.During an interview on 9/18/25 at 10:57 AM Staff D, Certified Nurse Aide (CNA), explained she worked with Resident #14 on the night of 9/13/25 into 9/14/25 after she fell and had a lot of pain. Staff D reported she told the nurse who worked that night, and she told her Resident #14 normally had a lot of pain.During an interview on 9/18/25 at 11:49 AM the Director of Nursing (DON) stated she didn't see Resident #14 from 9/13/25 to 9/16/25. She did speak with Resident #14's doctor and daughter regarding her pain on 9/15/25. They told her they planned to have Resident #14 remain at the facility unless she requested to go to the ER.During an interview on 9/18/25 at 12:00 PM Staff F, RN, said she arrived to work on 9/15/25 at 8:00 PM. She reported being the nurse for Resident #14 and the nurse leaving reported Resident #14 had high blood sugars, so Resident #14 received extra insulin. The nurse told Staff F, Resident #14 complained her hips hurt and she didn't eat supper. She stated Resident #14 slept and she checked everything on her. Around 2:30 AM when Resident #14's floor alarm went off, Staff F decided to check her vital signs. Resident #14 had a blood sugar of 570. Resident #14 only complained of pain when the staff moved her leg.In an e-mail correspondence on 9/18/25 at 12:28 PM the Administrator indicated the facility's follow-up request to the physician for pain control determined Staff E cared for Resident #14 on the evening shift of 9/15/25, she charted Resident #14 had pain and facial grimacing. She reported she didn't contact the provider because after they assisted Resident #14 to bed and repositioned her for comfort, she was comfortable and slept until the end of her shift (10:00 PM). In addition, Staff F sent Resident #14 to the ER. Staff F reported she didn't contact the provider at the beginning of her shift because she slept comfortably until about 2:30 AM. At that time her alarm went off because a pillow fell and triggered the alarm. Staff F explained she noted congestion and began an assessment for respiratory status. Her full assessment triggered her to contact the provider and Resident #14 agreed to go to the ER for evaluation.During an interview on 9/18/25 at 1:02 PM the Administrator explained if a resident complained of pain, typically the nurse would try PRN pain medicine and alternative interventions such as massage, a change in environment, and change in position. If none of the interventions worked, then the facility should notify the doctor.The undated Incident Reports policy instructed the following:a. When an incident occurred, the staff would notify the charge nurse, (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	complete an appropriate assessment of the resident and document their findings. The nurse would then notify the attending physician and family. Notification can be in person, by telephone, through fax, and/or envelope delivery. The Charge Nurse would initiate the incident report and complete it as described on the form. When the nurse completed the form, they must turn it in to the nurse manager.b. At any time, professional nurses may analyze and initiate nursing interventions that could prevent a recurrence of the incident. The nurse manager will formally complete this analysis and document any necessary actions prior to turning the completed form into administration. This includes the provision of first aid and documenting actions completed.The undated Pain Protocol Policy directed the facility to ensure any residents with pain receive proactive care to alleviate or minimize pain through the collaborative efforts of the interdisciplinary health care team including the attending physician. The policy listed the following:a. Pain indicators i. Verbalization of pain ii. Increase in agitation iii. Thrashing type behaviors/restlessness iv. Combativeness v. Change in level of consciousness/lethargyb. Non-medicinal methods of relieving pain i. Application of hot/cold ii. Massage therapy iii. Relaxation exercises, guided breathing iv. Social services counseling v. Isolation/stimulation vi. Light/Dark vii. Oxygen therapy viii. Reposition, body supports, immobilizations ix. Physical Therapy interventions

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, Certified Dietary Manager (CDM) interview, facility policy review, and review of the 2022 United States (US) Food and Drug Administration (FDA) Food Code, the facility failed to prevent soiled gloves coming into contact with food during food preparation, failed to serve milk below 40-degrees Fahrenheit, failed to ensure kitchen fans and shelves are free of dust, failed to cover the garbage, and failed to date stored food when opened and free of fuzzy growth. The facility reported a census of 38 residents. Findings include:During an initial kitchen tour on 9/15/25 at 9:15 AM observed the following:a. The large garbage can, located by the eye wash station sink, and the large garbage can, located by the dishwasher, both uncovered and overflowing with garbage. b. A box fan measuring approximately 20 inches tall with thick, gray dust covering the front grille, and facing 2 storage racks. The fan blew air directly towards the bottom 3 shelves of the 2 storage racks containing clean coffee cups, coffee mugs, and glasses turned upside down on trays. c. In the kitchen's food storage room had i. A 24-count bag of Hawaiian buns with 12 of the buns covered with a gray fuzzy substance. ii. An open and undated 20 count bag of flour taco shells, with 6 flour taco shells remaining, a 12-count bag of hamburger buns with 7 remaining in the bag, and a bag of cinnamon bread with 3 slices of bread remaining. d. 2 refrigerators didn't have an internal thermometer located inside (Victory refrigerator and Continental freezer). During the kitchen tour conducted 9/15/25 at 9:51 AM observed the following: a. The freezer with the thermometer displayed in the upper right thermometer insecurely attached with piece of duct tape. The location of the thermometer made it difficult to view.b. The Victory refrigerator didn't have a thermometer.c. The Continental freezer didn't have a thermometer. d. A dusty fan blew air in the kitchen towards 2 racks of clean cups. In addition, the kitchen had 3 racks of cups in direct line of the fan. The bottom 2 racks contained coffee mugs and cups, turned upside down on trays.e. The following remained in the kitchen i. An undated and opened bag of 12 buns, with 7 buns remaining. ii. A 20 ct. flour tortilla shell bag with 6 shells left. iii. An unopened package of Hawaiian buns: covered with mold across half the buns with a sell date 9/2/25.f. The microwave appeared visibly dirty with food on the turning plate and rust along the back inside of the microwave.g. An undated and open half bag of raisin bread, an undated and open half bag of cinnamon bread, and 3 slices of bread left in a bag not dated. h. The steam table had grease buildup underneath and around the griddle top stove.i. The stove top had a brown and black discoloration over half.j. The garbage can near the eye wash station overflowed without a cover.k. The drawers near the sink appeared dirty.During a follow-up kitchen observation on 9/16/25 at 10:47 AM revealed the following observations: a. The large garbage can located by the eye wash station sink and a large garbage can positioned by the dishwasher both remained uncovered. b. The facility removed the box fan from the kitchen. c. The dish rack inside the kitchen with the coffee pot had a thick layer of gray dust covering the surface of the lowest shelf that stored bowls, plates, and smaller dessert bowls. During the noon meal service on 9/16/25 at 10:49 AM observed Staff C, Dietary Aide, prepare multiple servings of white milk, chocolate milk, and juice into glasses and Styrofoam cups, then placed them on a tray. Staff C then placed the tray with the drinks on the preparation table by the coffee pot. During an observation in the kitchen on 9/16/25 at 11:01 AM the stove continued to have a thick buildup of a dark brown residue to the left side of the griddle, extending approximately 6 inches to the mid griddle and approximately 12 inches on the back of the griddle. During the noon meal service on 9/16/25 at 11:06 AM observed Staff B, Dietary Cook, apply (don) gloves, touch the outside of a bread bag with gloved hands, reach into the bread bag, pull out a slice of bread, place the slice of bread in the blender, and pureed the bread mixture.During the noon meal service on 9/16/25 at 11:39 AM observed Staff B check the temperature of a Styrofoam cup containing white milk. The thermometer revealed a temperature of 58.6 degrees Fahrenheit while Staff C distributed the milk for multiple room trays. During an interview on 9/16/25 at 1:20 PM Staff (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A, Dietary Aide, stated he wouldn't touch food or the plates, he would only grab the edge of the plate with his thumb. In addition, he stated he didn't usually handle the food. Staff A said he checked the refrigerator temperatures both on the inside and outside of the freezer. During an interview on 9/16/25 at 1:23 PM Staff C reported they expected her to wash her hands both before and after removing gloves. She knew the garbage cans should have lids on them but said, we just don't use them. Staff C reported when she opened up the food items, she needed to date items after she opened them. Staff C noted she checked the inside thermometer and the outside thermometer. During an interview on 9/16/25 at 1:25 PM Staff B reported, we have lids. We just don't use them. Staff B knew items need to be initialed and dated after opening. In addition, she wore gloves when she needed to butter bread. They expected her to wash hands before and after wearing gloves. During an interview on 9/16/25 at 1:42 PM the CDM reported the followinga. Maintenance assisted with helping to stock food and didn't put the dates on food. b. They expected the staff to date food items when opened. c. Leftovers should only be stored up to 3 days. d. All staff are to wash hands before and after using single use gloves. e. Gloves that touched other surfaces or items shouldn't touch food. They should change their gloves after they touch anything. f. They should cover all garbage.g. Staff should use tongs to get the bread out of the bread bag. h. Staff should take out the garbage after each meal. i. Staff should handle plates by the bottom of the plate, then slide it into their hand so that they didn't touch the inside of the plates. j. Staff shouldn't serve milk if the temperature is over 40 degrees. During a follow-up of the kitchen on 9/17/25 at 11:20 AM observed the following:a. Staff had the garbage cans covered with no overflow. b. The kitchen had a clean steam table shelf.c. The kitchen had a clean area under the coffee prep table. d. The staff sealed the cracked tile above the kitchen sink with caulk. e. The staff put thermometers inside the refrigerator and the freezer. f. The CDM educated the dietary staff. g. The staff cleaned the grease on top of the griddle/stove. During an Interview on 9/17/25 at 11:20 AM the CDM explained he would have the dietary staff scrub the griddle/stove more tonight with a stone.The Policy related to storing leftovers after meal services included the following: a. Label and date all containers.b. You may keep food for up to 3 days, then must throw away if not used.c. Everything open needed labeled and dated.d. All food items shall be prepared in such a manner as to meet the nutritional needs and preferences of the patient.e. All foods shall be prepared in a sanitary method with handwashing at appropriate intervals. The 2022 US FDA Food Code under 2-301.14 directed the staff when to wash (hands) clean their hands and exposed portions of their arms immediately before engaging in food preparation, afterhandling soiled equipment or utensils, during food preparation, as often as necessary to remove soil andcontamination and to prevent cross contamination when changing tasks, before donning gloves toinitiate a task that involves working with food, and after engaging in other activities that contaminatethe hands.The Food code at 3-301.11 Preventing Contamination from Hands directs food employees may notcontact exposed, ready to eat food with their bare hands, and should use suitable utensils such as deli meat.