STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165118	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madrid Home for the Aged	613 West North Street Madrid, IA 50156

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 40905 Based on clinical record review and staff interview, the facility failed to refer a resident to the appropriate state-designated authority for a Level II Preadmission Screening and Resident Review (PASARR) evaluation and determination who was identified with a newly evident mental disorder for one of one resident reviewed (Resident #17). The facility reported a census of 52 residents. Findings include: The Minimum Data Set assessment for Resident #17, dated 4/6/24, included diagnoses of schizophrenia and depression and revealed the resident received antipsychotic and antidepressant medications daily. The resident's PASARR Level I Screen form dated 2/24/21, documented no mental health diagnoses. The resident's medical diagnosis sheet revealed diagnosis of schizoaffective disorder, bipolar type dated 3/1/23 with diagnosis during stay at facility. During the interview on 6/4/24 at 2:45 PM, the Director of Nursing confirmed resident's new diagnosis of schizoaffective disorder and expectation for status change to be submitted with new diagnosis and new medication started.

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48886 Based on observations, clinical record review, staff interviews and policy review, the facility failed to develop and implement a comprehensive person-centered care plan for 4 of 16 residents reviewed (Residents #4, #17, #31 and #39) for care plans. The facility reported a census of 52 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #31, dated 3/1/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. The MDS further documented the resident had diagnoses to include non-traumatic brain dysfunction, atrial fibrillation and non-Alzheimer's dementia. The Electronic Health Record (EHR) review for Resident #31 revealed a progress note dated 4/17/24, titled Behavior Note. The note text documented after dinner, Resident #31 wheeling self back from dining room to his hallway and attempted to leave the facility from the locked front door, triggering the elopement alarm. Resident became combative with staff when they assisted him with getting back into the building safely. Resident stating that he was just going to leave. The EHR review revealed a progress note dated 4/20/24, titled Behavior Note. The note text documented Resident #31 sitting in front of the receptionist desk refusing breakfast and refusing to move or go back to his room. Resident stating, I'm getting out of here now. Resident not actually attempting to leave the facility. Several staff attempted to redirect him with no success. The EHR review revealed a progress note dated 4/30/24, titled Behavior Note. The note text documented Resident #31 attempted to go out one of the doors by the playground, staff able to get to him before he went out. He was confused when asked where he was going. He was upset about not being able to go out the doors but then was redirected. The Care Plan for Resident #31, with an initiation date of 2/28/24, lacked a focus area, goal and interventions/tasks to address elopement concerns and behaviors. During an interview on 6/5/24 at 8:13 AM, the Director of Nursing (DON) stated the Care Plan should have been updated in April after the elopement attempts for Resident #31. The DON acknowledged the Care Plan was not updated and stated an expectation of this to take place. The DON acknowledged the resident had 3 attempts to leave the building in April of 2024 and made statements about wanting to leave. 2. The MDS assessment for Resident #4, dated 5/9/24, documented a BIMS score of 10, indicating moderate cognitive impairment. The MDS further documented diagnoses to include non-traumatic brain dysfunction, anemia, Alzheimer's disease, non-Alzheimer's dementia, anxiety, depression and bi-polar disorder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EHR for Resident #4 revealed a progress note dated 5/7/24 titled Behavior. The progress note documented the resident attempted to exit through the Tiger Tots door (side door going outside) unattended. The resident stated she wanted to get some fresh air. Review of of the EHR for Resident #4 revealed an elopement evaluation completed on 5/1/24 with an elopement risk score of 2, indicating at risk for elopement. The Care Plan for Resident #4, with an initiation date of 1/31/24, lacked a focus area, goal and interventions/tasks to address elopement concerns and behaviors. During an interview on 6/06/24 at 8:08 AM, the DON stated she would expect the Care Plan to address elopement concern for Resident #4. The DON acknowledged elopement is not addressed in the Care Plan and Resident #4 has a risk identified for elopement. 3. The MDS assessment for Resident #17, dated 4/6/24, documented a BIMS score of 14, indicating intact cognition. The MDS further documented diagnoses to include medically complex conditions, cancer, heart failure, diabetes mellitus, depression and schizophrenia. Review of the EHR for Resident #17 revealed a diagnoses of schizoaffective disorder, bipolar type, initiated on 3/1/23. Review of a Psych Progress Note, dated 4/11/23, for Resident #17 documented under the assessment section the diagnosis of schizoaffective disorder, bipolar type (modified 1/31/23), formed hallucinations of insects, irritability and anger and other specified depressive episodes. The Plan section documents resident had displayed multiple behaviors which have included cursing, screaming, threatening, accusing staff, making disruptive sounds, expressing episodes of anger/frustration, appearing to be agitated and seeming anxious or restless. The Care Plan for Resident #17, with a revision date of 10/18/23, lacked a focus area, goal and interventions/tasks area related to the diagnosis of schizoaffective disorder and related behaviors. During an interview on 6/06/24 at 10:55 AM, the DON stated an expectation the Care Plan would address Schizoaffective disorder and behaviors and interventions specifically for Resident #17. Resident #17 received the diagnosis in March of 2023 and started Risperdal (antipsychotic medication) in March of 2023. The DON acknowledged the Care Plan lacked documentation and interventions related to the Schizoaffective disorder and behaviors. Review of the facility policy titled comprehensive person-centered care planning, with a revision date of 10/23, documents the facility will update the resident ' s comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities and the comprehensive care plan will be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Review of facility policy titled elopement prevention, with a revision date of 11/22, under the procedure section, documents elopement interventions are addressed in resident's plan of care. 40905 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. An MDS assessment for Resident #39 dated 4/9/24, included diagnoses of hemiplegia (paralysis), affecting right dominant side and personal history of traumatic brain injury (TBI). The MDS identified the resident had a functional impairment of range of motion to an upper and lower extremity. On 6/03/24 at 11:21 AM, observed Resident #39 in a wheelchair with right hand contracted, with wrist turned inward and fingers curled into palm of hand (no brace/splint) and with brace on right ankle. Observation on 6/4/24 at 12:24 PM, Resident #39 in the dining room with staff assisting to dine and no brace on right wrist. The Rehab Communication Form, dated 8/10/23, for Resident #39 documented recommendation/instruction to place wrist brace on right wrist during the day, remove overnight. Interview on 6/5/24 at 1:24 PM, Staff A Certified Nurse Aide (CNA) stated she was unaware of a right wrist brace for Resident #39. Interview on 6/5/24 at 1:35 PM, Staff B, CNA and Staff C, CNA stated Resident #39 wears a right ankle brace but no wrist brace. Resident #39's Care Plan with focus initiated 4/5/24 documented an activities of daily living self-care performance deficit related to TBI and having right side paresis with intervention to place wrist brace on right wrist during the day, remove overnight with date initiated 8/10/23. During an interview on 6/6/24 at 9:23 AM, the Assistant Director of Nursing stated expectation to follow therapy recommendations.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056 Based on clinical record review, observations, staff interviews and medical procedure guides, the facility failed to provide professional standards by not obtaining an order to have an indwelling catheter by a physician for 2 of 2 residents reviewed (Resident #10 and #26). The facility reported a census of 52 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #26 documented diagnoses of traumatic spinal cord dysfunction, neurogenic bladder, quadriplegia and seizure disorder. The MDS showed the Brief Interview for Mental Status (BIMS) was not completed as Resident #26 is coded as a persistent vegetative state. The MDS has Resident #26 coded as having an indwelling catheter. The Treatment Administration Record (TAR) dated June 2024 lacked an order for the indwelling catheter and when it should have been changed next. The TAR dated May 2024 lacked an order for the indwelling catheter and when it should have been changed next. The TAR dated April 2024 lacked an order for the indwelling catheter and when it should have been changed next. The TAR dated March 2024 lacked an order for the indwelling catheter and when it should have been changed next. The TAR dated February 2024 lacked an order for the indwelling catheter and when it should have been changed next. Review of Progress Notes dated 9/16/23 revealed Resident #26 had been readmitted to the facility with the indwelling catheter. Progress Notes stated Foley catheter in place patent and draining (placed on 9/9/23). The facility catheter insertion procedure guide dated 6/13/2006 revealed that part of the procedure is to check the physician order for type and size of catheter and related diagnosis. Interview on 06/05/24 at 10:04 AM with the DON revealed Resident #26 went to the hospital in April 2023 and all the orders regarding the catheter were discontinued, the order had always been to change the catheter as needed (prn). We received the order to change it today to 18 F, so we are going to change it today. I would have expected it to be transcribed correctly upon readmission. 40905 2. An MDS assessment for Resident #10 dated 5/16/24, included diagnoses of spastic quadriplegic cerebral palsy (brain damage condition that causes paralysis of both arms and both legs, with muscle stiffness). The MDS identified the resident had an indwelling urinary catheter. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 6/4/24 at 10:03 AM, of Resident #10 in bed with a catheter in place and the catheter bag in a dignity bag attached to the bed. Resident #10's electronic record of Physician Order Summary Report dated 6/4/24 at 2:38 PM, lacked an order for an indwelling catheter.