

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Fort Dodge Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 728 14th Avenue North Fort Dodge, IA 50501	

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)
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, staff, family, and Advanced Registered Nurse Practitioner (ARNP) interviews, the facility failed to assess a resident's lung sounds, before and after administering a nebulizer treatment (a medication that turns liquid medication into a mist, which is inhaled to treat respiratory conditions. It helps relax breathing muscles and makes it easier to breathe). In addition, the facility failed to intervene when the resident had shortness of breath (SOB) on exertion (walking, bathing, and transferring), sitting, at rest, and when lying flat in bed on 4/16/25, 4/17/25, 4/18/25, 4/19/25, and 4/21/25 for 1 of 3 residents reviewed (Resident #1). Without the assessment, the staff failed to notice the change in Resident #1's lungs, delaying the transfer to the hospital. On 4/22/25, the hospital admitted Resident #1 and tested positive for parainfluenza (lung infection) and passed away on 5/5/25. The facility identified a census of 63 residents.</p> <p>Findings include:</p> <p>Resident #1's Minimum Data Set (MDS) assessment dated [DATE], The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 8 which indicated moderate impaired cognitive decisions, is able to be understood and understand and no behavior or mood issues. The resident required dependent assistance for activity of daily living (ADL) and oxygen used in last 7 days. The MDS included diagnoses of heart failure, arthritis, non-Alzheimer's dementia, anxiety, depression, chronic obstructive pulmonary disease (long-term lung disease), and chronic respiratory failure with hypoxia (lung disease with low oxygen levels in the blood).</p> <p>The Care Plan Focus dated 2/24/24, indicated Resident #1 received diuretic therapy due to chronic obstructive pulmonary disease (COPD) with (acute) exacerbation (increased difficulty with breathing). The Interventions directed the following:</p> <p>a. 2/24/24: Administer medication as ordered.</p> <p>b. 2/24/24: May cause dizziness, postural hypotension, fatigue, and an increased risk for falls. Observe for possible side effects every shift.</p> <p>c. 2/24/24: Report pertinent lab results to the Medical Doctor</p> <p>The Care Plan Focus dated 4/12/25 reflected Resident #1 had oxygen therapy related to COPD. The Interventions instructed to provide oxygen per Medical Doctor orders.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The Medication Administration Note dated 4/17/25 at 9:08 AM indicated Resident #1 received AR formoterol Tartrate Nebulization Solution (a long acting medication that is used to relax the airway muscles, making breathing easier) 15 micrograms (MCG)/2 milliliters (ML). Inhale orally by a nebulizer 2 ML two times a day for COPD with acute exacerbation.</p> <p>The Medication Administration Note dated 4/21/25 at 11:10 PM identified Resident #1 received Albuterol Sulfate inhalation nebulization solution (Albuterol) (2.5 MG/3 ML) 0.083% (medication to help open the airway). Inhale 1 vial orally via nebulizer every 4 hours as needed (PRN) for SOB. Resident #1 reported I can't breathe honey.</p> <p>The Condition Follow-up Note dated 4/21/25 at 11:15 PM from start of: 4/21/25, reflected the staff monitored Resident #1 due to reporting she couldn't breathe. The nurse documented the vital signs as:</p> <ul style="list-style-type: none"> a. Blood Pressure (BP) 129/86 (average 120/80) position: sitting, right arm b. Temperature (T) 97.0 Fahrenheit (average 98.6), route: forehead (non-contact) c. Pulse (P) 120 beats per minute (expected 60-100), type: regular d. Respirations (R) 24.0 breaths per minutes (expected 12-20) e. Current Conditions: identified Resident #1 had audible wheezes with a low pulse oxygen level (measurement used to determine amount of air in the body). Confirmed oxygen set up. The nurse started an as needed (PRN) albuterol nebulizer treatment, repositioned her to 45-degree angle in bed, and increased her oxygen to 4 liters per nasal cannula (L/NC) and her pulse oximeter (ox) ratings (level of oxygen in the blood) increased to 90 %. When the nurse listened to her lungs, they heard congestion with wheezing throughout (a whistling sound as the person breathes). Resident #1 looked diaphoretic (very sweaty) with a blood sugar of 247 (expected 70-150). She rested during her albuterol nebulizer (neb) treatment and her pulse oximeter increased to 95% with supplemental oxygen at 4 L/NC. <p>The Condition Follow up Note dated 4/21/25 at 11:33 PM, from start of: 4/21/25, reflected the nurse monitored Resident #1 due to a report she couldn't breathe with pulse ox reading of 80% with oxygen at 2 L/NC. Her pulse ox read 97% after an increase to 4 L/NC. The nurse described her lung sounds continued to sound diminished, coarse, congested, and wheezes throughout. The nurse documented her vital signs as:</p> <ul style="list-style-type: none"> a. BP 117/81 Position: Lying right arm b. T 97.4 Forehead (non-contact) c. P 107 Pulse Type: Regular d. R 24.0 <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The Condition Follow up Note dated 4/21/25 at 11:55 PM, from start of: 4/21/25 indicated the nurse spoke with Resident #1's Power of Attorney, who reported she didn't like her going to emergency room (ER) at night but it sounded like she needed to go. Resident #1's daughter explained she might need her Lasix (medication used to remove excess fluid from the body) dose increased. The nurse heard an audible expiratory wheeze (whistle-like sound as someone breathes out and can be heard without a stethoscope). The nurse documented Resident #1 had zero improvement in her lung sounds. The nurse documented the vital signs as:</p> <ul style="list-style-type: none"> a. BP 117/81 Position: Lying right arm b. T 97.6 Route: Forehead (non-contact) c. P 107 Pulse Type: Regular d. R 25 <p>The section labeled Current Conditions identified the nurse waited for a return call from the on-call physician.</p> <p>The Condition Follow up Note dated 4/22/25 at 12:04 AM, from start of: 4/21/25, reflected the nurse monitored Resident #1 for SOB and abnormal lung sounds. The nurse increased Resident #1's supplemental oxygen to 4 L/NC and provided a PRN albuterol neb treatment. The nurse documented Resident #1's vital signs as:</p> <ul style="list-style-type: none"> a. BP 117/81 Position: Lying right arm b. T 97.6 Forehead (non-contact) c. P 107 Pulse Type: Regular d. R 25.0 <p>The section labeled Current Conditions identified the nurse received orders to send Resident #1 to the ER via ambulance for evaluation and treat due to her altered pulmonary (respiratory or lung) symptoms.</p> <p>The Medication Administration Note dated 4/22/25 at 12:10 AM indicated the nurse gave Resident #1 an Albuterol (2.5 MG/3 ML) 0.083% neb treatment due to SOB. The nurse labeled the treatment as effective.</p> <p>The Nursing Note dated 5/5/25 at 11:54 AM identified the hospital called and reported Resident #1 passed away. Resident #1's daughter called and instructed no one could take anything out of Resident #1's room. The nurse sent all medications back to the pharmacy and destroyed the narcotics with 2 nurses.</p> <p>Resident #1's April 2025 Treatment Administration Record (TAR) included an order dated 3/28/24 for staff to monitor for signs and/or symptoms of SOB every shift as exhibited (shown) by the following code:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>a. 0 = NONE</p> <p>b. 1 = SOB on exertion (e.g. walking, bathing, and transferring)</p> <p>c. 2 = SOB when sitting at rest</p> <p>d. 3 = SOB when lying flat</p> <p>- The documentation indicated Resident #1 didn't have signs and/or symptoms of SOB on any shift on 4/2/25, 4/3/25, 4/4/25, 4/5/25, 4/6/25, 4/9/25, 4/10/25, 4/11/25, 4/12/25, 4/13/25, 4/14/25, and 4/15/25.</p> <p>- Resident #1 did have SOB on exertion and while lying down on:</p> <p>i. Day shift: 4/7/25, 4/8/25, 4/16/25, 4/17/25, 4/19/25, and 4/21/25</p> <p>ii. Night shift: 4/16/25 (also while at rest) and 4/18/25.</p> <p>Resident #1's clinical record lacked documentation of her lung sounds before or after the twice daily nebulizer treatment.</p> <p>The Emergency Department (ED) Note dated 4/22/25 at 12:57 AM, documented Resident #1's chief complaint as Shortness of breath. When Resident #1 presented to the ED, she needed increased oxygen due to the difficulty breathing. Resident #1 reported having worsening problems with breathing and having a cough for over the past several weeks. Overnight the nurse found her to with low oxygen saturation despite receiving her usual 2 liters of oxygen through the nasal cannula (L/NC), diaphoretic (sweating excessively), and notably dyspneic (short of breath). She arrived using 4 L/NC with her oxygen saturation in the low to mid 90% (expected over 90%). The hospital diagnosed her with parainfluenza, acute on chronic respiratory failure with low blood oxygen levels (increased trouble with long-term lung issues), COPD exacerbation, shortness of breath, and generalized edema (swelling).</p> <p>Interview on 5/20/25 at 4:00 PM, Resident #1's family reported they expressed concerns to the facility a week before that Resident #1 complained more about SOB and having difficulty with breathing. Resident #1's family didn't think the facility took her concerns serious. If the facility took the concerns serious, they said she might be alive.</p> <p>Interview on 5/22/25 at 8:55 AM, Staff A, ARNP, verified they expected the facility staff to complete lung sounds before and after a nebulizer treatment. In addition, if Resident #1 had more shortness of breath on exertion, rest, or just lying flat they expected the facility to notify them, so they could give orders or send to her to the closest ED.</p> <p>Interview on 5/22/25 at 11:30 AM, Staff B, Registered Nurse (RN), explained they expected the nurses to complete lung sounds prior to and after giving a nebulizer. Resident #1's clinical record lacked documentation of the staff assessing her lung sounds per professional standards of nursing.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 5/22/25 at 2:00 PM, the facility Director of Nursing (DON), confirmed Resident #1's clinical record lacked documentation of the staff's assessment of her lung sounds before or after administering her nebulizer treatment. The DON reported they expected the nurse to complete lung sounds and as it is a standard of practice to complete lung sounds.</p> <p>The Policy and Procedure for Change of Condition and Reporting dated July 2024, directed to communicate all changes in a resident's condition with the physician. The section related to Acute Medical Change instructed to communicate any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior with a request for a prompt physician visit and/or acute care evaluations. The licensed nurse in charge has the responsibility to notify the physician.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, resident, and staff interviews the facility failed to ensure they had medications available at the facility to administer as ordered by the physician for 1 of 3 residents reviewed (Resident #2). The facility reported a census of 63 residents.</p> <p>Findings include</p> <p>Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. Resident #2 required partial/moderate assistance with their activities of daily living (ADLs). The included diagnoses of hypertension (high blood pressure), diabetes mellitus, depression, and oral cavity (mouth) with obvious or likely cavity or broken natural teeth.</p> <p>The Care Plan Focus initiated 4/3/25 and resolved on 4/30/25 indicated Resident #2 received an antifungal medication due to thrush (a fungus infection of the mouth and throat). The Interventions instructed:</p> <p>a. 4/9/25: Administer antipyretic (medication used to decrease body temperature) as per medical doctor (MD) orders.</p> <p>b. 4/9/25: Give antifungal medication as ordered.</p> <p>c. 4/9/25: Monitor temperature and pulse.</p> <p>d. 4/9/25: Monitor, document, and report to MD signs/symptoms of delirium (sudden change in mental abilities): Changes in behavior, altered mental status, wide variation in cognitive function throughout the day, communication decline, disorientation, periods of lethargy, restlessness and agitation, altered sleep cycle.</p> <p>The Care Plan Focus initiated 2/28/25 reflected Resident #2 had oral/dental health problems related to broken, missing, and cavities in teeth. The Intervention directed to monitor, document, and report to MD as needed (PRN) for signs/symptoms of oral/dental problems that need attention such as: pain (gums, toothache, palate roof of mouth), abscess (blister-like area possibly with drainage of fluid), debris (food or other substances) in mouth, lips cracked, lips bleeding, teeth missing, loose teeth, broken teeth, eroded (worn away) teeth, decayed teeth, tongue (black, coated, inflamed swollen, white, smooth), ulcers (sores) in mouth, lesions (abnormal area).</p> <p>Review of the Post-Acute Discharge Report dated 5/1/25, instructed staff to use Nystatin suspension (antifungal medication used to treat thrush), take 1 milliliter (ML) (100,000 units total) by mouth 4 times daily. Use on each side of the mouth until 2-3 days after symptoms have resolved.</p> <p>Interview on 5/20/25 at 3:30 PM, Resident #2 confirmed they didn't receive the mouthwash 4 times a day.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Progress Notes reflected Resident #2 didn't receive Nystatin as ordered due to the facility not having it available on these dates and times:</p> <ul style="list-style-type: none"> a. 5/1/25 at 5:26 PM b. 5/16/25 at 7:23 PM - Nurse notified c. 5/17/25 at 12:18 PM d. 5/18/25 at 7:52 AM e. 5/18/25 at 12:02 PM f. 5/18/25 at 3:54 PM - Nurse notified g. 5/18/25 at 8:37 PM - Nurse notified h. 5/19/25 at 3:55 PM - Nurse notified i. 5/19/25 at 8:40 PM - Nurse notified j. 5/20/25 at 9:06 AM k. 5/20/25 at 12:54 PM l. 5/20/25 at 4:26 PM m. 5/20/25 at 8:54 PM n. 5/21/25 at 9:08 AM o. 5/21/25 at 12:36 PM <p>Interview on 5/22/25 at 9:01 AM, Advanced Registered Nurse Practitioner (ARNP), confirmed if the facility failed to have the medication on hand, they expected them contact the pharmacy or contact the primary care provider to notify them Resident #2 didn't have the medication available. The ARNP stated during the assessment that day with Resident #2, they had white spots in their mouth, on their cheeks, and on their tongue, due to the facility staff not giving Resident #2 their medication.</p> <p>Interview on 5/22/25 at 3:00 PM, the Director of Nursing verified they expected the nursing staff to administer the physician's orders as written, make sure they have an adequate supply, and notify the pharmacy if running low or out of medications. In addition, they need to contact the physician to receive direction on missed medications.</p> <p>The Pharmacy Services policy and procedure dated January 2022, instructed to employ (use) or obtain the services of a licensed pharmacist to provide consultation on all aspects of pharmacy services in the facility. In addition, the policy directed to assure the staff request, receive, and administer medications in a timely manner as ordered by the physician.</p>