STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165156	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Dodge Health and Rehabilitation	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interview, Emergency Medical Services (EMS) interview, and review of the facilities Resident Rights, the facility staff failed to treat 1 of 3 residents with dignity and respect during a medical crisis (Resident #2). The facility identified a census of 64 resident. Findings include: Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 6, indicating severely impaired cognitive skills. Resident #2 required substantial to maximum assistance with toileting and hygiene. The MDS listed Resident #2 as non-ambulatory. The MDS listed Resident #2 as always incontinent of urine and frequently incontinent of bowels. The MDS included diagnoses of non-Alzheimer's dementia, other signs and symptoms with cognitive functions and awareness, age-related physical debility, sciatica (pain from pressure on a nerve in the back that goes down a leg), weakness, type ii diabetes mellitus (dm), and end stage renal disease (ESRD or end stage kidney disease). The Care Plan identified the following Focuses and Interventions as dated: a. 1/11/18: Resident #2 had a risk for impaired cognitive status related to short-term memory loss. i. 9/1/22: Explain exactly what you want her to do, her provision of care, listen to her concerns for care, and provide her emotional support.b. 6/8/22: Potential for psychosocial well-being problem related to (r/t) illness/disease process. ii. 11/1/22: Give Resident #2 short and accurate answers to questions when asked. Provide written material when possible about her health.The local Fire EMS Report dated 7/17/25 at 4:10 PM included the following information: a. Called for a non-emergent response to the listed location for a lady with a leg injury at 2:56 PM and arrived at 3:04 PMb. Resident #2 presented with moderate confusion which staff described as her normal. She appeared disoriented to person, place, time and event, due to a history of chronic dementia. c. While EMS began their assessment, Staff D, Certified Nurse Aide (CNA), told the Resident #2, don't worry, they will just cut your legs off. A very confused Resident #2 responded, I'm going to die multiple times throughout the rest of the assessment.d. Staff D's statements made Resident #2 very scared and nervous for the rest of the call. Staff D advised Resident #2 a total of 3 times that the medic crew planned to transport her to the hospital to cut her legs cut off. e. During preparation of movement of Resident #2 she again became agitated and stated I'm going to die, oh please help me. Staff D responded with don't worry, we can't let you die because we don't have anyone to fill your room yet.During an interview 8/7/25 at 2:32 PM an EMS provider indicated he witnessed the most fucked up situation as very upsetting to him. He further described the following: a. Resident #2 fell earlier that day but he wanted to be honest, her injuries (broken legs) didn't appear obvious at the time of the fall, due to Resident #2's size and dementia. The EMS provider indicated when the EMS crew arrived Resident #2 presented as anxious as Staff D told her she didn't have broken legs but the hospital staff planned to cut them off once she arrived at the hospital. Resident #2 voiced being scared, in pain, and said oh my God, I am going to die. Staff D told Resident #2 she couldn't die yet because they didn't anyone to replace her. The EMS provider verbalized concern with the verbal exchange as no staff member or any care giver should address a resident in that manor especially one with dementia. When they assisted Resident #2 to the ambulance, the crew settled her down. The EMS provider offered Resident #2 didn't made it through surgery at the hospital and passed away. During an interview on 8/7/25 at 2:48 PM Staff D denied made the statements documented above. She added if she said them, which she failed to remember, she would have said them in a joking manner. During an interview on 8/19/25 at 3:42 PM Staff D described Resident #2 as a known jokester. Staff D reported she still couldn't recall making the above statements but if she did say something like that, she would have said joking. She added maybe she said those words because she had a stroke last March and she might not remember. The Resident Rights policy reviewed June 2023 directed each resident had the right to been treated with consideration, respect and full recognition of his or her dignity and individuality.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, photos, staff interview, and facility policy review the facility failed to maintain resident rooms and care equipment in a clean, sanitary and homelike environment. The reported a census of 64 residents. Findings include:1. On 8/14/25 at 1:38 PM observed dried, brown, long, running stains that ran down the wall beside Resident #4's bed.On 8/15/25 at 1:30 PM witnessed Resident #4's wall continued to have the stains. On 8/27/25 at 11:00 AM witnessed the stains remained on Resident #4's wall. Photos taken during an observation on 8/15/25 at 11:10 AM revealed the following: a. Buildup of dust, dirt, and debris on a stand-up lift device positioned along the wall on the 100 hallway. b. Buildup of a brown/rust substance along a scale device attached to the anterior portion of a total lift device also positioned along the wall on the 100 hallway. Photos taken during an observation on 8/15/25 at 11:30 PM revealed the following: a. A bedside fall mat positioned beside Resident #4's bed contained a torn plastic covering which exposed the inner foam cushion (not sanitizable). b. The plastic covering of the fall mat contained a large amount of white stains and discoloration. c. The floor had a buildup of dust, dirt and debris throughout Resident #4's room. 2. Photos taken during an observation on 8/15/25 at 11:33 AM revealed a torn pillow/positioning device which exposed the inner foam (not sanitizable) on a bed in room [ROOM NUMBER]. An observation on 8/15/25 at 11:35 AM revealed a heating element that ran along the wall in a hallway by a resident's wheelchair scale in poor repair with the inner heating elements exposed and jagged edges. An interview on 8/20/25 at 10:06 AM Staff A, Certified Nursing Assistant (CNA), described the resident rooms as unclean and could use a deep clean. According to an interview on 8/20/25 at 12:54 PM Staff C, Registered Nurse (RN), described resident rooms as absolutely uncleaned as they contain dust, dirt and debris and the residents deserved more.

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. (continued on next page)

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and facility policy review the facility failed to complete an accurate Minimum Data Set Assessment (MDS) for 1 of 3 residents with multiple skin issues (Resident #4). The facility identified a census of 64 residents. Findings include: Resident #4's MDS assessment dated [DATE], indicated he had a short- and long-term memory deficit and severely impaired cognition. The MDS listed Resident #4 as dependent on staff with activities of daily living (ADL's). The MDS reflected Resident #4 didn't walk. The MDS included diagnoses of type II diabetes mellitus, Alzheimer's disease, non-Alzheimer's dementia and malnutrition. The MDS indicated Resident #4 didn't have a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. The MDS identified he had a risk for pressure ulcers/injuries. The MDS reflected he had diabetic foot ulcer(s). He had pressure reducing devices in the bed and chair, but didn't have a turning/repositioning program.Resident #4's MDS assessment dated [DATE], lacked documentation of his skin issues. The form indicated Resident #4 didn't have a risk for pressure ulcers. He had pressure reducing devices in the bed and chair, but didn't have a turning/repositioning program.The review of the facility's timeline listed the following areas with skin breakdown: a. 5/28/25 i. Left great toe diabetic ulcer scabbed area ii. Left foot third digit diabetic ulcer scabbed area iii. Outer aspect of the left foot diabetic ulcer iv. Left pinky toe diabetic ulcer b. 6/3/25 i. Left outer side of the foot with a small abrasion ii. Left outer ankle pressure area iii. Left great toe iv. Coccyx v. Scratches on bilateral legs c. 6/10/25 - The assessment reflected his toes appeared to heal. The assessment form lacked other assessments completed. d. 6/12/25 i. Left great toe diabetic ulcer pink abraded dry area ii. Left foot third digit diabetic ulcer scabbing. iii. Outer aspect of the left foot diabetic ulcer iv. Upper buttocks moisture associated skin damage (MASD) v. The coccyx had an intact blister. The assessment form lacked other assessments completed. e. 6/17/25 i. Left great toe pink abraded dry area, ii. Left foot third digit had a scabbed area iii. The outer aspect of the left foot had an abraded area. iv. The upper buttocks had a diabetic ulcer with granulation tissue. v. The coccyx had a diabetic ulcer with granulation tissue. The assessment form lacked other assessments completed. f. 6/19/25 i. Right upper buttock had an intact blister ii. Coccyx had an unopened dry area. The assessment form lacked other assessments completed. g. 6/24/25 i. Left great toe healed ii. Left foot third digit scabbed area iii. Outer aspect of the left foot abraded area iv. Left pinky toe healed. The assessment form lacked other assessments completed. During an interview on 8/27/25 at 11:55 AM the Corporate Clinical Market Leader indicated the facility failed to provide assessments of Resident #4's left pinky toe prior to the above documented entry of area healed. h. 6/25/25 - i. Left foot third digit scabbed area ii. Outer aspect of the left foot scabbed area iii. Right of the coccyx contained an unstageable area with slough. The assessment form lacked other assessments completed. i. 7/2/25 i. Left great toe, outer aspect of the left foot and left foot third digit - healed. ii. Right coccyx approximately 50 % slough covered. j. 7/17/25 - Resident #4's right buttock area and the outer aspect of the left foot - healed. k. 7/24/25 - Resident #4's right buttock area and the outer aspect of the left foot - healed. l. 8/6/25 - i. Coccyx area healed ii. Onset of a left knee area unstageable with slough and eschar. The assessment form lacked other assessments completed. m. 8/12/25 - i. Left abdominal blister ii. Left knee no assessment iii. The top of the right buttock. The assessment form lacked other assessments completed. n. 8/13/25 i. Left knee area unstageable ii. Left abdomen intact blister o. 8/15/25 - Right shin abrasion scabbed. The assessment form lacked other assessments completed. p. 8/16/25 i. Stage II right buttock ii. A flat pink area located above the stage II ulcer. iii. A bandage on the right shin. The assessment form lacked other assessments completed. q. 8/20/25 - i. Left knee area measured 0.1 cm ii. Stage II ulcer to the right buttock.During an interview on 8/27/25 at 11:10 AM Staff C, Registered Nurse (RN), indicated the description of scabbing came from a previous employee so they didn't know the meaning.The Accuracy of Assessment (MDS 3.0) policy reviewed August 2018 instructed the facility to ensure all assessments accurately reflected the resident's status.

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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. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record review, staff interview, family interview and facility policy review the facility failed to follow Physician orders for 1 of 3 residents reviewed (Resident #1). The facility identified a census of 64 residents. Findings include:A Progress Record form dated 7/10/25 indicated Resident #1 received a physician's order for a wound vacuum (vac) at 125 mmHg (millimeters of mercury which measured the pressure of the device), to start when available. The order directed to run continuously and changed every Monday, Wednesday and Friday.The Order Details form dated 7/15/25 at 5:52 PM directed to change the wound vac every 30 minutes on Monday, Wednesday and Friday starting 7/16/25.According to a Medication Admin Audit Report form printed 8/26/25 at 1:58 PM identified Resident #1's schedule to change wound vac on 7/16/25 as 6:00 AM, 6:30 AM, and 7:00 AM. The record indicated the nurse did the wound dressing at 5:09 AM, 10:59 AM, and 11:00 AM.The eMAR - Medication Administration Note dated 7/16/25 at 4:52 AM indicated Resident #1 got his wound vac changed twice the day before. He required and received an overlay of a clear, adherent dressing to have maintained the unit's function.During an interview on 8/8/25 at 12:57 PM the Director of Nursing (DON) confirmed Staff E, Registered Nurse (RN), entered the Physician Order incorrectly.During an interview on 8/8/25 at 2 PM Staff H, RN, confirmed she caught the order to change Resident #1's wound vac every 30 minutes. She brought it to the DON's attention because she never observed that kind of order in her nursing career. Staff H confirmed she corrected the order. During an interview on 8/8/25 at 12:09 PM Staff F, Certified Nurse Aide (CNA), confirmed Resident #1 always had his wound vac unplugged while he sat up in his chair. During an interview on 8/8/25 at 12:20 PM Staff G, CNA, confirmed Resident #1 had his wound vac unplugged while up for meals.During an interview on 8/8/25 at 2:34 PM Staff I, CNA, confirmed she found the wound vac shut off or unplugged. She added she knew because it beeped when non-functional.Resident #1's August 2025 Treatment Administration Record (TAR) included the following physician orders:a. 8/1/25: Wound vac continuously at 125 /hour (hr.) placed on the medial wound only (location where toe removed) change every Monday, Wednesday and Friday. The TAR lacked documentation on 8/4/25, indicating Resident #1 didn't receive the treatment.During an interview on 8/19/25 at 5:45 PM Staff B, Registered Nurse (RN), indicated she knew of Resident #1's wound vac device. She reported she worked once with Staff C, RN, who planned to change the device but left the shift without changing the wound vac. They didn't have supplies available for dressing changes. The DON, went out of town when Resident #1 received his wound vac order. She didn't know where the wound vac came from. She had no education on wound vacs. When it arrived, the DON told her to place the wound vac but she didn't know the process. Usually the wound nurse first placed the wound vac and then she could do it after she observed the process. She told the DON she didn't feel comfortable doing the wound vac without education. The DON became upset, but did arrange an education after the fact. Apparently, they cancelled it because she was busy in the back and she went up front, she saw nurses present. They said no one told them they canceled the meeting and/or they didn't know they canceled it. Staff B reported she knew Resident #1's wound vac did not get changed on August 4th and knew he went out the next or the following day.During an interview on 8/20/25 at 12:54 PM Staff C, RN, confirmed she couldn't change Resident #1's wound vac on 8/4/25 because she trained another nurse, had three (3) admissions, and no management support due to them being out of the facility.A Podiatrist Progress Note form dated 7/25/25 indicated Resident #1 arrived at his appointment with no wound vac machine, but still had the wound vac dressing in place. The Physician reinforced if the wound vac didn't run, the staff needed to remove the dressing and apply a Betadine dressing immediately.A Podiatrist Progress Note form dated 8/1/25 indicated Resident #1 arrived again at his appointment for a second week in a row with a nonfunctional wound vac machine. Resident #1's wound vac had a dead battery due to the staff's failure to plug in the device at night. Upon removal of the dressing, the wound had malodor (bad smell) drainage. The Physician note indicated he called the facility and discussed the unacceptable care provided to Resident #1.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, resident interview, staff interview, Physician interview, Nurse Practitioner (NP) interview, and facility policy review, the facility failed to complete thorough assessments and interventions when 3 of 3 residents (Residents #1, #4 and #5) sustained skin breakdown. In addition, the facility failed to properly assess one (1) resident following a fall (Resident #2). Resident #1 had a previous history of an amputation on his left foot. Following his surgery, the facility failed to follow physician orders, complete thorough skin assessments, and failed to follow treatments. Per the Podiatrist, Resident #1 had an additional amputation due to the lack of care and treatment he received. This resulted in an immediate jeopardy situation.On 8/14/25 at 5:20 p.m. the Iowa Department of Inspections and Appeals staff contacted the facility staff to notify them the Department staff determined an Immediate Jeopardy situation existed at the facility. The facility staff removed the immediacy on 8/14/25 and decreased the scope to G, after the facility staff completed the following:The Director of Nursing (DON) and the nursing staff identified all residents with wounds.The DON met with Wound Nurse and updated her on the residents with wounds. Assessed all residents with wounds which included measurements, documentation, and notified the primary care physicians. All staff re-educated on proper assessments and utilization of the wound vac. The facility identified a census of 64 residents.Findings include:The Complex Wound Management policy and procedure reviewed July 2022 instructed the facility to provide documentation that enabled the medical staff to evaluate the status of wounds. A complex wound be identified as an arterial ulcer, diabetic neuropathic ulcer, pressure ulcer and/or venous insufficiency ulcers. The Procedure directed the following: a. Complete a weekly skin assessment on all residents and document it in the resident's medical record. b. Measure each wound in centimeters (cm) weekly. Measurements, size and depth, drainage, odor, color and a short statement on the progress (or lack of) on the Skin Pressure Weekly or Skin Ulcer Non-Pressure Weekly forms. c. Use the treatments ordered by the medical provider. If the wound didn't have improvement, the facility must call the medical provider for an evaluation. d. Consider a significant change based on the information in regards to the presence of pressure ulcer(s). The staff must complete a Minimum Data Set (MDS) and Care Plan as soon as identified.According to an email dated 8/28/25 at 10:39 AM the Corporate Clinical Market Leader confirmed the facility's wound policy directed the staff to measure all wounds, even jagged edged wounds as they aren't exempt to the policy.Resident #1's MDS assessment form dated 5/5/25 identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognitive skills. The MDS reflected Resident #1 didn't exhibit rejection of care. He required substantial/maximum assistance with most activities of daily living (ADL's). He didn't walk. The MDS included diagnoses of atherosclerotic native arteries of the left leg with ulceration of the calf, coronary artery disease (CAD), peripheral vascular disease (PVD), diabetes mellitus (DM) with diabetic neuropathy and malnutrition. The assessment indicated Resident #1 had a risk for pressure ulcers but didn't have pressure ulcers at the time of the assessment. However, he had surgical wounds and moisture associated skin damage (MASD). The assessment indicated Resident #1 didn't have a turning and repositioning program.The Care Plan included the following Focuses and Interventions as dated: a. 4/11/25: Potential for pressure injury or impairment to skin integrity related to (r/t) diabetes mellitus (DM). The Interventions instructed the following: i. 5/13/25: Float heels when rested as he allowed. ii. 4/11/25: Left foot heel protector boot when he rested and as he allowed iii. 4/11/25: Provide preventative maintenance to his coccyx as directed and as needed (PRN). iv. Weekly and PRN skin assessments.b. 5/13/25: Actual impairment to the skin integrity r/t a surgical wound to the left foot mid amputation. The Interventions directed the following: i. 5/13/25: Administration of treatment to the left stump as ordered. ii. 5/13/25: Monitor/document location, size and treatment of the skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration and etc. to the Physician. iii. 5/13/25: Weekly skin assessments.c. 7/14/25: Infection of the left surgical site. The Intervention instructed to complete daily dressings by applying betadine-soaked gauze with a non-compressed gauze roll to the left foot surgical site until they could apply the wound vac. Resident #1 had an order that directed no weight bearing and protective boots on at all times.d. 5/15/25: ADL self-care performance deficit r/t limited mobility and impaired balance. The Intervention listed Resident #1 as dependent on staff with toileting hygiene, dressing, and rolling from left to right in the bed.e. 7/10/25: Unstageable pressure ulcer to his left outer ankle. The Interventions reflected the following: i. 7/10/25: Administer treatments as ordered and monitor for