STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165179	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwalk Nursing and Rehabilitation Center	921 Sunset Drive Norwalk, IA 50211

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. 46873 Based on observations, clinical record review, facility policy review and staff interviews the facility failed to provide a dependent resident a dignified eating experience during a noon meal service for 1 of 3 residents reviewed (Resident #3). The facility reported a census of 42 residents. Findings include: The Minimum Data Set (MDS) of Resident #3, dated 11/27/24, identified a Brief Interview of Mental Status (BIMS) score of 2 which indicated severe cognitive impairment. The MDS coded the resident as dependent for eating. The Care Plan revised 11/13/24, included a Focus area to address [Name redacted] has a self-care deficit as evidenced by requires assistance with ADLs (activities of daily living), impaired balance during transitions requires assistance and/or walking. Interventions included, in part; Eating: 1 (one) assist. The Care Plan revised on 11/27/24, included a Focus area to address [Name redacted] has potential nutritional problem r/t (related to) obesity, need for mechanically altered diet, CVA (cerebrovascular accident, or stroke); advanced age. Interventions included, in part; Dependent assist at all meals also encourage intake of additional fluids. A continuous observations of the noon meal on 12/3/24 starting at 11:36 am revealed the following: a. At 11:36 am, Resident #3 assisted to dining room. Her wheelchair placed at a dining table with other residents present. b. At 12:11 pm, staff started to service food and beverages. c. At 12:21 pm, the residents sitting at the table with Resident #3 began to get their meals, and receive assistance to eat and drink. d. At 12:27 pm, Staff A, Certified Nurse Aide/Housekeeping Supervisor brought food to Resident #3 and began to assist her to eat. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. At 12:32 pm, Staff A, CNA offered Resident #3 a drink and then began conversing with another staff member at the table. Without looking at Resident #3, he gave the resident a small sip of her milk. f. At 12:35 pm, Staff B, CNA entered the dining room and Staff A asked him to take over assisting Resident #3. Staff B sat with Resident #3. g. At 12:37 pm, Staff B left the table and assisted Staff C, CNA to reposition another resident in the dining room. h. At 12:38 pm, Staff B returned to the table to sit with Resident #3. i. At 12:41 pm, Staff B left the dining area. j. At 12:42 pm, Staff G, Licensed Practical Nurse (LPN) came to the table with medications for Resident #3. After administering the medications, she encouraged the resident to take some drinks. k. At 12:43 pm, Staff B returned and sat at the table and assisted another resident. l. At 12:44 pm, Staff C, CNA while sitting at table next to Resident #3, cued her to take a drink of milk. Staff D, CNA then sat at the table next to Resident #3. m. At 12:47 pm, Staff B and Staff D left the table. One staff member remained present at the table but was not assisting Resident #3. n. At 12:48 pm, Staff E, Activities Director and CNA arrived to the table and assisted Resident #3 to eat. She then moved to another resident at the table and also assisted that resident. Staff E stayed with Resident #3, alternating helping her as well as another resident until 12:56 pm. o. At 12:57 pm, Staff F, CNA sat with Resident #3 and encouraged fluids. p. At 1:00 pm, Staff F left, while Resident #3 remained at the table. q. At 1:02 pm, Staff Staff C stood at Resident #3's table, assisting another resident. She verbalized to Resident #3 to drink her fluids. r. At 1:03 pm, Staff E returned and assisted Resident #3. s. At 1:05 pm, Staff E left the table. t. At 1:07 pm, Staff F returned and sat with Resident #3 again. u. At 1:09 pm, Reident #3 continued to chew food while the dietary staff started clearing tables. The remainder of the food on Resident #3 plate was removed from the table and dumped into a refuse barrel. v. At 1:11 pm, observation ended with no food or drink remained on the table. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Norwalk Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 921 Sunset Drive Norwalk, IA 50211	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/3/24 at 1:44 pm, the Assistant Director of Nursing stated Resident #3 will sometimes get agitated and at times does better to have a switch in staff members. She stated that it was excessive to switch that many times and usually is two people per meal. During an interview on 12/3/24 at 1:46 pm, the Director of Nursing stated Resident #3 sometimes pushes her food away and prefers to feed herself rather than have staff feed her. He stated staff needs to just get her going to eat and give her a chance to feed herself. He stated sometimes a different face being there will spur her to eat. He stated she has had multiple hospitalization s but has maintained her weight. During an interview on 12/5/24 at 8:02 am, Staff F, CNA stated the normal routine for Resident #3 is for staff to assist her with food and drinks and to always have a staff member at the table. She stated she is currently on light duty and she helps wherever she is able. She stated Resident #3 will push her food away when she is done eating. She stated she asked Resident #3 if she was done on 12/3/24 and Resident #3 stated yes. During an interview on 12/5/24 at 10:46 am, Staff G, LPN stated usually a couple of staff members assist Resident #3 with each meal. She said they have tried to have a single person assist, but it usually does not happen. She stated that was not a normal day and a lot was happening that day. She stated it was a lot to have State Surveyors in the building. She was unable to give any other details but just said it was a lot that day. During an interview on 12/5/24 at 10:51 am, Staff B, CNA stated staff just kind of does that when asked why people came and went so much during lunch service. He stated staff likes to take turns answering call lights or helping residents toilet and alternate between who is sitting with residents and who is on the floor doing other things. During an interview on 12/5/24 at 11:05 am, Staff A, CNA and Housekeeping Supervisor stated if he sees a resident is sitting and needs fed, he will jump in and help. He stated he did not know why so many people came and went on 12/3/24. He stated she often doesn't like to directly be fed but will take cues to eat. During an interview on 12/5/24 at 11:08 am, Staff E, Activities Director/CNA stated there is supposed to be a staff member sitting with Resident #3 at all times during her meal. She stated she normally does not assist to feed residents but she saw other people get up and leave so she came when there was nobody else there with her. The facility policy Dignity, Revision Date February 2021 documented the following: 1. Residents are treated with dignity and respect at all times. 2. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident's facility stay. 3. Individual needs and preferences of the resident are identified through the assessment process.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 Based on clinical record review, facility policy review and staff interviews the facility failed to ensure accurate code status for 1 of 16 resident reviewed for advanced directives (Resident #28). The facility reported a census of 42 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #28 medical diagnoses included Parkinson's disease, peripheral vascular disease and respiratory disease. The Brief Interview for Mental Status exam scored 15 out of 15 which indicated intact cognition. The MDS reflected resident elected hospice care. The Clinical Resident Profile in the electronic health record for Resident #28 indicated Code Status: (Advance Directives) FULL CODE. Special Instructions: [Name redacted] Hospice. The Care Plan initiated [DATE] revealed a focus area for code status, Do not Resuscitate (DNR), code status will be honored. Interventions included, signed Do Not Resuscitate (DNR) orders, maintain copy of IPOST in chart. The Iowa Physician Orders for Scope of Treatment (IPOST) document signed by the resident on [DATE] directed DNR/Do Not Attempt Resuscitation. The provider signed the form on [DATE]. The IPOST found in a code status binder located at the nurses station. During an interview on [DATE] at 5:00 pm, the Director of Nursing (DON) stated Resident #28 wanted CPR. The DON reported there was a recent change from DNR to CPR. The DON reported the updated form signed by Resident #28 was not updated in the code status book and the new form should of been in the code book. The Administrator, also present during the interview, agreed the electronic record should be the same as the IPOST form. During an interview on [DATE] at 9:30 am, Staff G, Licensed Practical Nurse (LPN) stated she would check for code status in wherever was handy at the time, either the electronic record or the code book kept at the nurses desk. Staff G stated she knew from staff updates, Resident #28 changed to a full code and was still approved to be under hospice. On [DATE] at 9:49 am, Staff H, Registered Nurse stated she would look at the electronic record for code status or the code status binder for the IPOST paper copy. The facility policy, revised [DATE], Policy Interpretation and Implementation section directed, in part: (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatments and to formulate an advance directive if he or she chooses to do so. 19. Changes or revocations of a directive must be submitted in writing to the Administrator. The Administrator may require new documents if changes are extensive. The Care Plan Team will be informed of such changes and/or revocations so that appropriate changes can be made in the resident assessment MDS and care plan.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 47582 Based on personnel file reviews, staff interviews and facility policy review, the facility failed to assure all employees had a child abuse background check completed prior to working in the facility as a Certified Nursing Assistant (CNA) for 1 of 5 current employees sampled. The facility reported a census of 42 residents. Findings include: A review of the personnel file for Staff I, CNA revealed a hire date of 2/28/24. The file failed to contain an abuse registry check prior to hire date. Review of the background check titled Singe Contact License & Background Check (SING), completed on 2/27/24 at 11:02 AM, revealed Child Abuse results required initiating record check evaluation by contacting the Department of Human Services (DHS). During an interview on 12/05/24 at 11:04 am, the Administrator confirmed there was no documentation in the Staff I, CNA personnel file with the results of DHS child abuse evaluation record check. She stated the facility had removed Staff I, CNA from the schedule until they complete the required abuse evaluation through the DHS. The Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy updated 7.8.2024 documented The facility shall screen all potential employees for a history of abuse, neglect, exploitation, misappropriation of property, or mistreatment of Residents. It further described the facility will not engage or employ those applicants found on abuse registry and will maintain documentation with such results.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 Based on clinical record review, facility policy review and staff interview the facility failed to update the care plan to reflect a residents change in their choice of advance directives for 1 of 16 residents reviewed for advanced directives (Resident #28). The facility reported a census of 42 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #28 medical diagnoses, included Parkinson's disease, peripheral vascular disease and respiratory disease. The Brief Interview for Mental Status (BIMS) exam scored 15 out of 15 which indicated intact cognition. The MDS reflected resident elected hospice care. On [DATE] a review of the Clinical Resident Profile in the electronic health record for Resident #28 revealed Code Status: (Advance Directives) FULL CODE. Special Instructions: [Name redacted] Hospice. The Care Plan revealed a focus initiated [DATE] for Resident #28 documented Do not Resuscitate (DNR), code status will be honored, included signed Do Not Resuscitate (DNR) orders, maintain copy of IPOST (The Iowa Physician Orders for Scope of Treatment) in chart. During an interview on [DATE] at 5:00 PM Interview with the Director of Nursing (DON) relayed there was a recent change with Resident #28 code status choice, had signed an updated form wanted CPR. On [DATE] at 10:30 AM the Director of Nursing (DON) and the Administrator acknowledged Resident #28 care plan should have been updated to reflect resident wanted CPR. The facility policy, revised [DATE], titled Care Plans, Comprehensive Person-Centered, Policy Interpretation and Implementation directed, in part: 13. Assessments of residents are ongoing and care plans are revised as information about the resident and the residents' condition changes.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based on observations, clinical record review, facility policy review and staff interview the facility failed to utilize infection control techniques during incontinence cares for a resident with a history of multiple urinary tract infections in an attempt to minimize the potential for reoccurrence of an infection for 1 of 2 residents reviewed (Resident #3). The facility reported a census of 42 residents. Findings include: The Minimum Data Set (MDS) of Resident #3 dated 11/27/24, identified a Brief Interview of Mental Status (BIMS) score of 2 which indicated severe cognitive impairment. The MDS coded the resident as dependent for toileting hygiene. The MDS reflected the resident always continent with urine and bowel. The Care Plan, initiated date of 10/26/24, revised on 11/25/25 included a Focus area to address [Name redacted[has BLE (bilateral lower extremities, or legs) and UTI (urinary tract infection) and is at risk for increased temperature dehydration, pain/discomfort. The Care Plan, initiated date of 1/5/24, revised on 10/10/02/24 included a Focus area to address [Name redacted] has the potential for infection related to a history of UTI. A review of a General Progress Note dated 11/24/24, revealed Resident #3 returned from the emergency room with an order for Keflex Oral Capsule 500 mg 1 capsule by mouth four times a day for Cellulite /UTI for 10 days. A review of an Admission Assessment note dated 11/1/24, revealed Resident #3 returned to the facility after a hospitalization . The note documented currently on antibiotic therapy due to an active infection . Levofloxacin (an antibiotic) for UT (urinary tract). A review of a ED (Emergency Department) to Hosp-Admission (discharged) note revealed patient admitted on [DATE] with septic shock (a life-threatening condition that occurs when a severe infection causes dangerously low blood pressure) found to be from urinary source and started on cefepime (antibiotic). A review of a General Progress Note dated 10/27/24, revealed an order for Bactrim DS (an antibiotic) Oral Tablet 800-160 MG (milligrams). Give 1 tablet by mouth two times a day for UTI for 5 days. A review of an Order Note dated 9/13/24, revealed an order for Amoxicillin-Pot Clavulanate (an antibiotic combination) Oral Tablet 875-125 MG. Give 1 tablet by mouth two times a day for UTI for 7 days. A review of a General Progress Note dated 8/29/24, revealed an order for Cephalexin (antibiotic) Oral Tablet 500 mg. Give 500 mg by mouth two times a day for UTI until 9/4/24. During an observation on 12/3/24 started at 11:16 am the following revealed: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff C and Staff D, Certified Nurse Aides (CNA) took Resident #3 into her room for cares. The Director of Nursing (DON) was present in the room for the observation. After transferring the resident from her wheelchair onto her bed, Staff C, CNA washed her hands and donned gloves. Staff D, CNA remained next to the bed. Staff C reminded Staff D she needed to also wash her hands. Staff D washed her hands and donned gloves. She then opened the closed bathroom door to gather supplies for cares from the bathroom and also from the sink area outside the bathroom. Staff D returned to the resident's bedside, and both Staff C and Staff D assisted to turn the resident to her left side, then side to side to lower her pants. Staff D opened the resident's incontinence brief. Without changing gloves or washing hands, Staff D then performed peri care on Resident #3. The resident was incontinent of bowel and bladder. Staff D performed peri cares as Staff C provided supplies. After completing cares on Resident #3's front side, Staff D removed her gloves, performed hand hygiene and placed new gloves on her hands. Both staff then turned the resident to her side. Staff D gathered the dirty brief and placed the brief in the garbage and then began to cleanse the resident's buttocks. Staff C then placed a clean incontinence brief under the resident. Both staff removed their gloves, performed hand hygiene and placed new gloves. Staff then repositioned resident side to side to replace her clothing and secure the brief. Staff D removed her gloves and took the soiled trash out of the trash can and placed a clean bag in the can and placed the trash bag on the floor near the door. After using hand sanitizer, staff transferred the resident back to her wheelchair. During an interview on 12/3/24 at 1:39 pm, the DON stated staff did not wash their hands as frequently as they should have during the observation earlier in the day. He stated after hands were washed and gloves were placed, staff should not have then went into the bathroom for supplies or an additional hand hygiene and gloving should have been done prior to performing peri cares. The facility policy, revised February 2018, titled Purpose statement declared The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition.