STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165198	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iowa City Rehab & Health Care	3661 Rochester Avenue Iowa City, IA 52245

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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. 35434 Based on observation, policy review, and staff interviews, the facility failed to provide a homelike environment for residents when staff used a nicotine vape pen in the common areas of the facility. The facility reported a census of 46 residents. Findings include: Observations during the survey week of 5/5/25 to 5/8/25 revealed an outdoor smoking area located off the dining room. During an interview on 5/7/25 at 12:24 PM, Staff E, Certified Nursing Assistant (CNA) stated she caught Staff H, Activities staff vaping in her office. She stated her office was off the dining room and her door was open. She stated there were residents in the dining room at the time. During an interview on 5/7/25 at 12:49 AM Staff F, Certified Medication Assistant(CMA) stated Staff H inside her office and also during bingo while she sat right next to residents. She stated Staff C, Office Staff also vaped in her office. During an interview on 5/8/25 at 11:32 AM, the Director of Nursing (DON) stated she observed Staff H vape in her office and directed her to stop doing this. She stated the Administrator addressed this with the whole staff. During an interview on 5/8/25 at 12:15 PM, the Administrator stated she never heard of a staff member vaping inside the building. During an interview on 5/8/25 at 1:41 PM, Staff G, Housekeeping stated she witnessed Staff H smoking in her office. The facility policy, titled Tobacco Policy, dated 9/21/23, Purpose statement declared To establish policies, in accordance with applicable Federal, State and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also consider non-smoking resident rights. The Employee section of the policy directed,in part: a. Employees are only permitted to use tobacco products in facility designated areas. (continued on next page)

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	b. Employees are not permitted to carry cigarettes, electronic cigarettes, vapes, smoking items, lighters, matches, etc. in patient care areas.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 45775 Based on observation, clinical record review, and staff interview, the facility failed to assess and care plan for a resident to self-administer medications (Resident #42) for 1 of 6 residents reviewed for medications. The facility reported a census of 46 residents. Findings included: The Minimum Data Set (MDS) assessment tool for Resident #42, dated 4/25/25, list of diagnoses included: heart failure, diabetes, and shortness of breath. The Brief Interview for Mental Status (BIMS) score 14 out of 15 indicated intact cognition. Review of the Care Plan, Date Initiated: 11/1/24 included a Focus area to Address {Name redacted} is on diuretic therapy (medications used to treat fluid retention) r/t (related to) hypertension. Review of the May 2025 Medication Administration Record (MAR) revealed a 1/21/25 order for bumetanide (a diuretic) 1 milligrams(mg) twice daily at am and lunch. During an observation on 5/5/25 at 12:07 PM, Resident #42 laid in bed and had a pill in a medication cup in front of him on his bedside table. The resident stated it was a pill to make him urinate. He stated staff usually made him take the medication before they left the room. During an interview on 5/5/25 at 12:25 PM Staff A, Licensed Practical Nurse (LPN) stated she would check on the resident's pill at bedside. She entered the resident's room and when she came out, she stated the resident took the pill. Resident #42's clinical record lacked documentation the resident was safe to self-administer medications. The facility policy Administering Medications, revised 04/2019, included a Policy Statement which declared Medications are administered in a safe and timely manner, and as prescribed. The Policy Interpretation and Implementation section #27. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team determined, has determined that they have the decision-making capacity to do so safely.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 33874 Based on clinical record review and staff interview, the facility failed to provide a notice of Medicare Non-Coverage upon discharge from skilled nursing services to 1 of 3 residents reviewed (Resident #45). The facility reported a census of 46 residents. Findings include: The Minimum Data Set (MDS) Discharge Assessment for Resident #45, dated 5/1/25, identified the resident had a planned discharge from Part A, Medicare services, and discharged to the resident's home. The MDS revealed a Brief Interview for Mental Status (BIMS) of 15 out of 15 which indicated intact cognition. The MDS indicated Resident #45 capable of independently understanding written instructions. During an interview on 5/6/25 at 10:45 AM, the Administrator reported an inability to find a Notice of Medicare Non-Coverage (NOMNC) for Resident #45. The Administrator reported Staff B, Social Worker (SW), took over the responsibility of completing the Advance Beneficiary Notice (ABN) and NOMNC with residents from the business office staff recently; approximately 2 weeks after the social worker started on 3/7/25. The Administrator reported Staff B, SW, missed completing NOMNC form. The Administrator explained the resident would not have received the information on appeal rights due to not receiving the beneficiary notice of non-coverage. The Administrator reported that they had already identified a concern with Staff B's lack of training on completing beneficiary notification forms, and Staff B was scheduled to attend training on this topic next week. On 5/6/25 at 2:08 PM, the Administrator sent an email to verify the facility did not have a policy to address beneficiary notification of non-coverage. The Administrator reported the facility followed federal regulations. During an interview on 05/06/25 02:45 PM Staff B, SW, confirmed she became responsible for beneficiary notices of non-coverage a couple weeks after she started at the facility. Staff B confirmed that she did not complete the beneficiary notification for non-coverage form for Resident #45. Staff B reported she received some training for completing the beneficiary notice form from the Business Office Manager and a facility consultant. Staff B explained that she was still learning and has been referred for more training. Staff B stated that until she gets the needed training the Business Office Manager would provide her assistance to complete the beneficiary notifications.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 48888 Based on clinical record review, facility policy review, resident and staff interviews, the facility failed to assess the resident and notify the physician after 1 of 3 residents' (Resident #9) self-reported seizure activity. The facility reported a census of 46 residents. Findings include: The Minimum Data Set (MDS) Assessment, dated 2/06/25, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated intact cognition. The MDS list of diagnoses included: seizure disorder, multiple sclerosis, cerebrovascular accident (CVA or stroke), schizophrenia, and depression. The MDS identified Resident #9 took anticonvulsant (anti-seizure) medications. Review of the Care Plan, Date Initiated: 7/24/14, Revision on: 2/11/25 revealed a Focus area to address [Name redacted] has a seizure disorder r/t (related to) Epilepsy. Interventions directed, in part: a. POST SEIZURE TREATMENT: Turn on side with head back, hyper-extended to prevent aspiration, Keep airway open, After seizure take vital signs and neuro check, Monitor for aphasia, headache, altered LOC (level of consciousness), paralysis, weakness, pupillary changes. Revision on: 2/11/25 b. SEIZURE DOCUMENTATION: location of seizure activity, type of seizure activity (jerks, convulsive movements, trembling), duration, level of consciousness, any incontinence, sleeping or dazed post-ictal state, after seizure activity. Revision on: 2/11/25 c. SEIZURE PRECAUTIONS: Do not leave resident alone during a seizure. Protect from injury. If resident is out of bed, help to the floor to prevent injury, Remove or loosen tight clothing. Don't attempt to restrain resident during a seizure as this could make the convulsions more severe, Protect from onlookers, draw curtain, etc. Revision on: 2/11/25 During an interview on 5/05/25 at 10:50 AM, Resident #9 stated she is having trouble with multiple seizures per day, reported sometimes has had up to 7 seizures in a day. Resident #9 revealed when seizure activity occurred she would tell Certified Nursing Assistant (CNA) staff or Nursing staff who would notify the physician. Review of Progress Notes from 2/3/25 to 5/4/25 revealed a Health Status Note entered on 2/03/25 at 12:08 PM, Resident reports she had a 2 minute seizure this AM. Unwitnessed Resident is not post dictal [post ictal, meaning seizure that occur immediately after a previous seizure has ended]. Will continue to monitor. No further documentation of seizure activity found in the clinical record for this time frame. Review of the Order Summary, revealed an order to Call [Clinic name redacted, provider name redacted] Neuro if increase in seizures noted, every morning and at bedtime. Date of order: 1/23/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/06/25 at 2:30 PM, Resident #9 revealed she had seizure activity on 5/05/25 and notified Staff P, Registered Nurse (RN). Resident #9 stated Staff P would call and let the doctor know. During an interview on 5/07/25 at 12:33 PM, Staff E, Certified Nursing Assistant (CNA), reported that Resident #9 has had seizures, unsure what type of seizures but believed she saw Resident #9 spaced out in dining room a few weeks ago. Staff E reported Resident #9 will call staff to report when she's had a seizure. During an interview on 5/07/25 at 12:50 PM, Staff F, Certified Medication Aide (CMA), stated that Resident #9 will report having multiple seizures every day and has witnessed her clenching hands tightly but unsure what type of seizures Resident #9 had. Staff F stated she would report to the charge nurse whenever Resident #9 claimed to have seizure activity. During an interview on 5/07/25 at 1:11 PM, Staff A, Licensed Practical Nurse (LPN), stated Resident #9 was a big attention seeker and will report having seizure activity when a person walks by her room. Staff A, stated ed she would check on Resident #9 when seizure was reported and inform the resident that if she just had a seizure, she would not be able to remember it or report it. Staff A identified signs and symptoms of Resident #9 post seizure to be groggy or delirious with slurred speech. When queried about documentation of Resident #9's seizure activity, Staff A revealed this would likely be documented under behavioral charting for Resident #9. During an interview on 5/07/25 at 1:31 PM, Staff J, CNA, stated Resident #9 would say she's had 4 to 5 seizures per day, but Staff J believed this to be behavioral. Staff J stated she had not seen Resident #9's seizure activity and was unsure what type of seizures she had. Staff J stated she would notify the nurse if Resident #9 reported seizures and stated she assumed that the nurse would check on her. During an interview on 5/08/25 at 10:17 AM, Staff P, Registered Nurse (RN) identified that Resident #9 had seizure disorder and goes to a Neurology. Staff P stated that nursing staff are supposed to call Neurology for increased seizures and denied ever calling the Neurology Provider regarding resident reported seizures. During an interview on 5/08/25 at 4:17 PM, Director of Nursing (DON), identified that Resident #9 had seizure disorder and was taking seizure medications. DON revealed she's not seen Resident #9 having seizure activity and was unsure what type of seizures she had. DON revealed that she called Neurology Provider on 5/08/25 for missed appointment that was scheduled 4/17/25, to be rescheduled for 5/09/25 due to facility being unaware that Resident #9 had or missed the 4/17/25 Neurology appointment. The facility policy titled, Change in a Resident's Condition or Status, revised 2/2021, included a Policy Statement which declared Our facility promptly notify the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The Policy Interpretation and Implementation section, directed staff, in part: 1. The nurse will notify the residents attending physician or physician on call when there has been a(an): (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. specific instructions to notify the physician of changes in the resident's condition. 5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 35434 Based on observation, clinical record review, policy review, and staff interview, the facility failed to ensure a resident positioned in a safe manner when eating for 1 of 2 residents reviewed for positioning (Resident #25). The facility reported a census of 46 residents. Findings included: 1. The MDS assessment tool for Resident #25, dated 2/21/25, list of diagnoses included: hemiplegia (one-sided paralysis), cerebral infarction (stoke), and difficulty walking. The BIMS score of 10 out of 15 which indicated moderately impaired cognition. Review of the Care Plan, Date Initiated: 3/1/22 revealed a Focus area to address [Name redacted] has potential for altered nutritional status AEB PMHx of CI (as evidenced by past medical history of cerebral infarction), hemiplegia, anemia, hx of mild protein-calorie malnutrition dysphagia (difficulty swallowing). During an observation on 5/5/25 at 11:57 AM, Resident #25 laid in bed with a tray of food on a bedside table on the side of the bed. The head of the bed was less than 15 degrees. When interviewed, Resident #25 stated she could eat in that position but had some difficulty. During an observation on 5/6/25 at 11:36 AM, Resident #25 laid in bed and ate from a tray of food on a bedside table at the side of the bed. The head of the bed was elevated less than 15 degrees. During an observation on 5/7/25 at 9:44 AM, Resident #25 laid in bed and ate from a bowl of oatmeal located on a bedside table at the side of the bed. The head of the bed was elevated less than 15 degrees. When queried as to whether she would allow staff to elevate the head of her bed during meals, she stated this might be a good idea. During an interview on 5/7/25 at 10:06 AM, the Director of Nursing (DON) stated residents should be upright during meals. She stated Resident #25 was set in her ways and would not always allow the bed to be elevated. During an interview on 5/7/25 at 10:56 AM, Staff D, Certified Nursing Assistant (CNA) stated the resident ate in her room and they positioned her upright so she would not choke. They placed the table right in front of her. During an interview on 5/7/25 at 12:24 PM, Staff E, CNA stated they straightened her up in the bed to eat. She stated if staff suggested it, she would sit up. Staff E stated she would not want her to eat flat. During an interview on 5/7/25 at 12:49 PM Staff F, Certified Nursing Assistant (CMA) stated staff raised her head up when they delivered her food. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/25 at 11:32 AM, the DON stated staff should watch residents consume their medications. When asked what interventions staff could carry out if Resident #25 refused to have the head of the bed up while eating, she stated they should monitor or assist her. After a request for a facility policy on positioning residents while eating, on 5/8/25 at 1:19 PM, the Administrator stated the facility did not have such a policy.

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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. 35434 Based on observations, clinical record review, facility policy review, resident and staff interviews, the facility failed to develop and implement interventions to attempt to restore or improve bladder function for 1 of 1 residents reviewed for urinary incontinence (Resident #42); and the facility failed to ensure a urinary catheter collection bag and tubing secured in a manner that prevented contact with the floor in a an attempt to prevent the potential for a urinary tract infection for 1 of 2 residents (Resident #8) reviewed with catheters. The facility reported a census of 46 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 4/25/25, diagnoses list for Resident #42 included; heart failure, diabetes, and shortness of breath. The MDS stated the resident was always incontinent of urine and frequently incontinent of bowel. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 14 out of 15, which indicated intact cognition. The MDS stated the facility did not carry out a trial of a toileting program. Review of the Care Plan, Date Initiated: 11/1/24 included a Focus area to Address {Name redacted} is on diuretic therapy (medications used to treat fluid retention) r/t (related to) hypertension. Review of a Health Status Note, entered on 1/16/25 at 4:22 PM documented Resident c/o (complained of) lower abdominal pain. Pale yellow urine present in foley bag. 4 cc (cubic centimeter, a unit of volume, 1 cc is equal to 1 milliliter). Foley removed. Resident began urinating immediately. Stated his pain was lessening. This nurse spoke to him about why he has a catheter. He says it's either that or piss on himself. I reminded him that we have incontinent products if he is unable to use a urinal. He asked how that works. I told him that the brief would catch the urine and the staff would clean him up and change his brief on a routine basis. I re-educated him on the increased risk of infection with having a Foley. He agreed to try to go without the catheter to see how it goes and if it will help with his pain. Review of the Care Plan, Date Initiated: 1/27/25 included a Focus area to address [Name redacted] has a self-care deficit as evidenced by requiring assistance with ADL's (activities of daily living), impaired balance during transitions requiring assistance and/or walking, incontinence. Interventions included, in part: a. TOILETING: Ax1 (assist of one). Please assist with checking and changing brief and provide peri-care with every incontinent episode and as necessary as [name redacted] allows. Date Initiated: 1/27/25. During an interview on 5/8/25 at 9:18 AM, Resident #42 stated he did not recall the facility carrying out a bladder training program or other interventions to assist him in regaining urinary continence. The resident stated he could control his urination somewhat. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Bladder Incontinence Data Collection/Evaluation, effective date 7/22/24, revealed the resident had incontinence which began in the hospital. The assessment identified the resident could communicate the urge to void and could follow direction consistently. The assessment indicated the Interdisciplinary review determined the resident incontinence is likely: Reversible. The assessment further indicated the Resident is able to participate in the program. Review of the clinical record revealed the lack of a bladder training program or other interventions carried out to assist the resident to improve his bladder incontinence. During an interview on 5/8/25 at 11:32 AM, the Director of Nursing (DON) stated if a resident was incontinent, the facility should carry out a toileting plan and consult Occupational Therapy (OT). Review of the facility policy titled, Urinary Continence and Incontinence-Assessment and Management, revised 09/2010, the Policy Statement declared in part: 3. The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible. The Policy Interpretation and Implementation section directed, in part: 18. As indicated, and if the individual remains incontinent despite treating transient causes of incontinence, the staff will initiate a toileting plan. a. As appropriate, based on assessing the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to manage incontinence. 2. The MDS for Resident #8, dated 2/21/25, revealed a BIMS score of 13 out of 15 which indicated intact cognition. The MDS list of diagnoses included: neurogenic bladder (loss of bladder control due to nerve damage), obstructive uropathy (urine flow blocked), and cerebrovascular accident (CVA or stroke). The MDS identified Resident #8 required the use of an indwelling urinary catheter. Review of the Care Plan, Dated Initiated: 2/20/25, revealed a Focus area to address [Name redacted] has has a suprapubic (catheter placed through abdomen into bladder to drain urine) catheter due to dx (diagnosis) of neuromuscular dysfunction of bladder/obstructive and reflux uropathy of bladder. Interventions, initiated on 2/20/25, included, in part: a. Catheter change as ordered b. Provide catheter care as per facility policy. During an observation on 5/05/25 at 10:48 AM, Resident #8 sat in his wheelchair in his room, catheter tubing and bag hung underneath the wheelchair. Light yellow urine observed within the tubing, catheter tubing rested on the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/06/25 at 11:01 AM, Resident #8 self-propelled wheelchair in the hallway outside of his room, catheter drainage bag and tubing dragged on the floor underneath his wheelchair. Staff I, Certified Nursing Assistant (CNA) approached Resident #8 and rehung drainage bag underneath wheelchair, tubing continued to drag on the floor and Resident #8's foot stepped on the tubing. Staff I then asked Staff A, Licensed Practical Nurse, for advice and Staff A rehung tubing underneath Resident #8's wheelchair. During an observation on 5/07/25 at 9:32 AM, Resident #8 sat in his room, in his wheelchair. Catheter tubing rested on the floor of the bedroom. During an interview on 5/07/25 at 12:50 PM, Staff F, Certified Medication Aide (CMA), reported that she has seen Resident #8's catheter tubing dragging on the floor, date unknown, and hooked it back up underneath his wheelchair. Staff F identified the concern for catheter tubing dragging on the floor would be someone could potentially step on the tubing and pull on catheter. During an interview on 5/07/25 at 1:31 PM, Staff J, Certified Nursing Assistant (CNA), stated that Resident #8's suprapubic catheter comes off easily and explained that catheter tubing should remain off the floor because the ground is not clean. During an interview on 5/08/25 at 3:17 PM, the DON stated it is her expectation that Resident #8's catheter drainage bag and tubing remain off the floor and explained that catheter would get dirty and could cause infection. The facility policy, titled Urinary Catheter Care, revised 9/2014, revealed under the heading for Infection Control: 1. Use standard precautions when handling or manipulating the drainage system. 2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag. b. Be sure the catheter tubing and drainage bag are kept off the floor.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 35434 Based on observation, clinical record review, policy review, and staff interview, the facility failed to ensure residents were free from significant medication errors by not priming an insulin pen prior to the administration of the medication for 1 of 1 resident (Resident #22) reviewed for insulin. The facility reported a census of 46 residents. Findings: The Minimum Data Set (MDS) assessment tool, date 4/9/25, listed diagnoses for Resident #22 which included diabetes, depression, and lack of coordination. The MDS indicated Resident #22 received insulin injections 7 of the 7 days during the review period. During an observation on 5/7/25 at 11:34 AM, Staff A Licensed Practical Nurse (LPN) obtained a blood sugar on Resident #22 which measured 209 mg/dl. Staff A then dialed up four units on the resident's Humalog KwikPen and stated she was ready to inject the medication. Staff A stated she did not prime the pen because on this type of pen, it was only required to prime during the first use. Staff A proceeded to inject the resident with four units of insulin from the pen. Review of the May 2025 Medication Administration Record (MAR), revealed an order date of 1/20/25 for HumaLOG (a type of insulin) KwikPen 100 units/milliliter (ml) Solution pen-injector. Inject as per sliding scale (blood sugar result determines the units of insulin be administered) .if 181 - 240 = 4 unit. Review of the Humalog KwikPen U-100 Instructions for Use, retrieved from https://uspl.lilly.com/humalog/humalog.html#ppi0 on 5/8/25 at 10:06 AM, directed the pen be primed before each injection with 2 units. During an interview on 5/8/25 at 11:32 AM, the Director of Nursing (DON) stated staff should prime insulin pens prior to injections. Review of the facility policy, titled Administering Medications, revised 04/2019, revealed a Policy Statement which declared Medications are administered in a safe and timely manner, and as prescribed. On 5/8/25 at 1:48 PM, via email, the Administrator communicated the facility did not have a specific policy related to insulin pens.