STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165204	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Lane Manor	819 Country Lane Road Keosauqua, IA 52565

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on staff interview, clinical record review, and facility policy review, the facility failed to attempt to designate resident representation for 1 of 1 residents (Resident #23) with a moderate cognitive impairment and intellectual disability, to ensure medical and financial decisions were made with informed consent. The facility reported a census of 51 residents. Findings include: Review of the Minimum Data Set (MDS) assessment, dated 6/24/25, revealed Resident #23 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated moderate cognitive impairment. The list of diagnoses included mild intellectual disabilities, mood disorder, psychotic disorder, anxiety disorder, and depression. The MDS indicated Resident #23 had limited ability in making concrete requests and responded adequately only to simple, direct communication. Review of Resident #23's admission Record (also referred to as a Resident Face Sheet), revealed an admission date of 9/26/24 to the facility, and listed Resident #23 (self) as the only contact. Review of the Care Plan, revealed a Focus area, dated 4/09/25, to address Resident #23 impaired cognitive function or impaired thought processes related to mild intellectual disabilities with interventions to administer medications as ordered and to engage resident in simple, structured activities that avoid overly demanding tasks.The Care Plan also included a Focus area, dated 2/19/25, related to the Pre-admission Screening and Resident Review (PASRR) identification of rehabilitation services that must be implemented to address resident rehabilitation with an intervention listed, in part:a. Nursing Facility to assist in determining if there is an appropriate family member, friend, or support person who is well qualified to serve as Power of Attorney (POA), conservator, or guardian. If none available, a referral may be made to the Office of Substitute Decision Maker, Iowa Department on Aging.b. Nursing Facility staff will facilitate the identification and designation of a power of attorney for healthcare and/or finances.Review of a Provider Visit note, dated 3/01/25, revealed Advanced Care Planning (ACP) was attempted with Resident #23, but patient's cognitive status prohibited and/or Medical Power of Attorney (MPOA) could not be named. On 8/07/25 at 1:45 PM, Staff B, Registered Nurse (RN), reported that Resident #23 will call out or shut eyes when she hurts or doesn't feel good and stated that Resident #23 often is, in her own world. On 8/11/25 at 9:17 AM, Director of Social Services, denied having made attempts for designation of conservator, guardian, or POA for Resident #23.On 8/11/25 at 11:15 AM, Staff C, Certified Nursing Assistant (CNA), reported that Resident #23 was often disoriented to time of day. On 8/11/25 at 11:26 AM, Staff D, CNA, reported that Resident #23 was often disoriented to location and would think she's somewhere else. On 8/11/25 at 1:07 PM, Staff E, RN, stated that Resident #23 was pleasantly confused and unable at times to engage in conversation. Staff E explained that Resident #23 would be able to make decisions about what to drink, eat, or wear, but was unable to make medical or financial decisions related to health care. On 8/11/25 at 2:16 PM, Director of Nursing (DON), stated that Resident #23 was pleasantly confused and explained that resident was able to make simple decisions but would be best if she had someone to assist in medical or financial decision making. On 8/12/25 at 9:30 AM Facility Administrator denied having record of additional information related to facility attempts for resident representation. The facility policy, titled Advanced Directives, dated 9/2022, defined health care decision-making capacity as referring to possessing the ability (as defined by State law) to make decisions regarding health care and related treatment choice. The Section C, Decision-Making Capacity directed, in part:Upon admission, the interdisciplinary team assesses the residents decision-making capacity and identify the primary decision-maker if the resident is determined not to have decision-making capacity. The interdisciplinary team conducts ongoing review of the residents decision-making capacity and invokes the resident representative, or health care agent, if the resident is determined not to have decision-making capacity. Changes are documented in the Care Plan and Medical Record.

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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. Based on observation, clinical record review, facility policy review and staff interview, the facility failed to complete a self-medication assessment for 1 of 1 residents (Resident #9) who self-administered insulin. The facility reported a census of 51 residents. Findings include: Review of the Minimum Data Set (MDS) assessment, dated 7/31/25, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. The list of diagnoses included type 2 diabetes mellitus, paraplegia, and spina bifida. The MDS indicated Resident #9 received insulin injections on a daily basis. During an observation on 8/06/25 at 11:40 AM, Staff B, Registered Nurse (RN), prepared Resident #9's Novolog Flexpen by attaching needle and dialing pen to 30 units of insulin, as ordered. Resident #9 cleaned own right lower abdominal area with an alcohol wipe, Staff B handed the the prepared insulin pen to Resident #9, and Resident #9 injected self in right lower abdomen with insulin, then held pen in place as she counted to 10, as Staff B watched. Following Resident #9 self administration of insulin, Staff B removed and discarded the needle into a sharps container. Review of the Care Plan, date initiated 4/17/25, revealed a Focus area to address diagnosis of type 2 diabetes mellitus. Interventions included, in part: a. Administer diabetes medications as ordered and observe, document for side effects and effectiveness. b. Resident #9 utilizes insulin. c. Observe, document, and report signs or symptoms of low blood sugar or high blood sugar.The Care Plan lacked identification of Resident #9 request to self administer medication (insulin). Review of Resident #9's Order Summary, dated 8/06/25, revealed an active order for Novolog Injection Flexpen, with instructions to inject 30 units subcutaneously three times daily before meals. Review of Resident #9's electronic health records revealed a lack of a self medication assessment for safety and competency to determine if resident able to self administer any medications. During an interview on 8/07/25 at 1:45 PM, Staff B, RN reported being unable to locate any completed assessments on Resident #9 prior to observation of insulin self administered on 8/06/25.During an interview on 8/11/25 at 2:16 PM, the Director of Nursing (DON), stated she would expect a resident assessment to be completed prior to self administration of any medications to ensure safety. The DON reported that an assessment had not been completed on Resident #9 to self-administer medication prior to 8/06/25.On 8/12/25 at 9:30 AM, the Administrator, reported that an assessment of self-administration competency had been missed on Resident #9 and explained that the typical process is to complete an assessment prior to a resident self-administering any medication, to ensure resident safety with administration. Review of the facility policy, titled Self-Administration of Medications, dated 2/2021, revealed that Residents have the right to self-administer medications if the interdisciplinary team (IDT) has determined that it is clinically appropriate and safe for the resident to do so. The Section A. Policy Interpretation and Implementation directed, in part:3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re-assessed periodically based on changes in the resident's medical and/or decision-making status.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record review, facility policy review, resident and staff interviews, the facility failed to allow 1 of 1 residents (Resident #28) reviewed for smoking, to choose to continue smoking after the facility changed their smoking policy to be a smoke free campus. The facility reported 51 residents. Findings include: Review of the Minimum Data Set (MDS) assessment, dated 5/27/25, revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated intact cognition. The list of diagnoses included anxiety disorder and depression. The MDS indicated Resident #28 independent for all transfers and activities of daily living. The MDS identified an admission date of 11/25/2024. Review of the Care Plan, date initiated 1/09/25, revealed a Focus area to address Resident #28 liked to smoke related to a history of smoking. Interventions included, in part:a. Ensure Resident #28 is aware of facility smoking policy. b. Show Resident #28 where smoking is allowed and how to access. Review of a facility provided document titled, Memo to Resident Representative, dated 5/19/25, Subject: 30 Day Notice of a Change to Residents Smoking Policy revealed in part: We are writing to inform you of an important upcoming change to our facilities smoking policy. Effective June 23, 2025 Country Lane Manor will become a smoke-free campus for all residents. This means that smoking will no longer be permitted anywhere on the premises, indoors, or outdoors by resident of the facility.Review of the clinical record revealed an Interdisciplinary Note, entered on 5/29/25 at 11:22 AM, which documented Resident #28 had history of depression and anxiety and noted that behaviors increase with inability to smoke tobacco. During an interview on 8/05/25 at 12:39 PM, Resident #28 stated she used to be able to go outside and smoke at the facility, but is now using nicotine patches, which she said helped with smoking cravings. Resident #28 reported that she planned to continue smoking when she was able to return home.Review of Resident #28's electronic health records (EHR) revealed the lack of a completed smoking assessment to determine the residents safety and compliance with the facilities smoking policy upon admission. The EHR also lacked the resident and/or resident representative written or verbal understanding and agreement to the 6/23/25 change in the facility Resident Smoking Policy. Review of the EHR revealed a Behavior Note, entered on 6/25/25 at 8:30 AM, Resident has been in her room and not come out since the facility went to no smoking on 6/23/25. Resident has been compliant to wearing her nicotine patch daily. CNA (Certified Nursing Assistant) reported this morning to Nurse resident was asking what the temperature was outside today. Review of a Nursing Note, entered on 6/25/25 at 10:40 AM, revealed Resident attempted to go outside to smoke. Nurse attempted to redirect resident. Resident became combative and placed both of her hands with long fingernails on each side of nurses face and scratched down the sides of the nurses face and attempted place her hands around nurses neck. Nurse removed residents hands, resident went to the back door to try to get out. Door code had been changed. Resident unable to get out. Nurse went and got Administrator. Administrator was able to talk to resident and ger to go back to her room. Review of a Nursing Note, entered on 6/26/25 at 4:22 PM, revealed Resident told staff she will be going outside to smoke this evening. ADON (Assistant Director of Nursing) and BOM (Business Office Manager) were notified, they spoke with resident. Resident became highly agitated and angry at ADON. ADON and BOM left the room. Resident was reminded of the no smoking policy. During an interview on 8/07/25 at 1:45 PM, Staff B, Registered Nurse (RN), reported that Resident #28 had been very upset about the facility smoking policy change and became very self-isolating, refusing to leave her room. Staff B stated that Resident #28 would love to continue smoking. During an interview, on 8/11/25 at 1:07 PM, Staff E, RN, reported that Resident #28 used to go outside and smoke but had isolated self in room since policy change. During an interview on 8/12/25 at 9:30 AM, the Administrator identified Resident #28 as the only current resident who resided and was able to smoke on facility premises before policy change on 6/23/25. The Administrator revealed that the smoking policy change included a Memo sent to residents and resident representative issuing a 30-day notice of non-smoking. Administrator stated that she spoke directly with Resident #28 who initially had been upset, believed she was being punished. When asked if Resident #28 was able to be grandfathered in to the new non-smoking policy, the Administrator denied allowing any residents to continue smoking on facility premises when new policy went in to affect. Review if the facility provided policy titled, Smoking Policy and Procedure, dated effective 1/31/24, revealed the purpose of the policy to establish and clarify the policy and process for residents who desire to smoke. The Section A, Policy and Procedure directed, in part: Bullet Point #8. An assessment will be completed to determine which residents are safe and unsafe smokers and what restrictions, if any. These will be placed on the resident's

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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F 0580 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 observation, clinical record review, facility policy review, and staff interview, the facility failed to notify the physician of low blood pressure results, and of persistent coughing despite a change in diet order and the administration of an as needed cough syrup for 2 of 2 residents (Resident #17 and #46) reviewed for physician notification. The facility reported a census of 51 residents.Findings include: 1.Review of the Minimum Data Set (MDS) assessment, dated 7/29/25, revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated intact cognition. The list of diagnoses included orthostatic hypotension, quadriplegia (limited ability with movement or sensation of upper and lower extremities, and benign paroxysmal vertigo of unspecified ear (dizziness caused by an inner ear condition). Review of the Care Plan, date initiated 1/06/2022, revealed Resident #17 had a self-care deficit and was at risk for falls due, in part, to hypotension (low blood pressure). The Care Plan lacked identification of signs or symptoms of hypotension to monitor for or interventions related to diagnosis of orthostatic hypotension. Review of Resident #17's electronic health records (EHR) recorded the following blood pressure readings:a. 69/41 recorded on 1/10/25 at 9:22 AMb. 73/52 recorded on 2/08/25 at 3:50 PMc. 70/54 recorded on 2/24/25 at 9:18 AMd. 70/53 recorded on 3/19/25 at 9:17 AMe. 62/60 recorded on 4/14/25 at 8:42 AMf. 66/52 recorded on 5/13/25 at 9:23 AMg. 70/49 recorded on 6/07/25 at 3:30 PMh. 72/48 recorded on 6/22/25 at 3:46 PMi. 65/45 recorded on 6/27/25 at 9:03 AMj. 72/60 recorded on 7/09/25 at 3:33 PMk. 70/68 recorded on 7/29/25 at 9:01 AMl. 78/50 recorded on 8/03/25 at 3:03 PMReview of the Medication Administration Record (MAR), revealed an order for Midodrine 10 milligrams (mg), with instructions to give one tablet by mouth twice a day related to hypotension and instructed not to give this medication at bedtime. The MAR recorded Resident #17's blood pressure twice per day with administration of Midodrine and lacked parameters on when to notify physician of blood pressure results. Review of the EHR lacked documentation of physician notification related to blood pressure outside of normal limits. Normal limits may depend on the individual or physician orders, top number or systolic blood pressures normally read between 90 millimeters of mercury (mmHg) and 120mmHg and the bottom number or diastolic blood pressure normally read between 60-80 mmHg. During an interview on 8/07/25 at 1:45 PM, Staff B, Registered Nurse (RN) stated blood pressures with top number below 90, should typically be reported to the physician. Staff B explained that Certified Medication Assistants (CMA) staff would check resident blood pressure during medication administration and report abnormal results to the nurse. Staff B stated Resident #17 had low blood pressure a couple of times and stated if Resident #17 had systolic blood pressure less than 90mmHg, the medication should be held and provider notified. Staff B denied knowledge of Resident #17 having blood pressure results requiring physician notification and stated documentation of provider notification would be found in EHR Nursing (general) Notes. During an interview, on 8/11/25 at 12:55 PM, Staff G, CMA, revealed that Resident #17 required blood pressure check before giving morning medications and denied having parameters in which to report blood pressure readings. Staff G stated she would report to nurse if Resident #17's blood pressure results had a top number below 90mmHg and/or bottom number below 60mmHg. Staff G denied having to report any low blood pressure readings on Resident #17 to the nurse. During an interview on 8/11/25 at 2:16 PM, Director of Nursing (DON), stated she would expect that nursing staff report low blood pressure results to physician, even for residents with chronic low blood pressure. The DON explained that a request for blood pressure parameters had been sent to physician and would be implemented when facility received orders.2. The MDS assessment, dated 7/29/25, revealed Resident #46 had a BIMS score of 12 out of 15, which indicated moderate cognitive impairment. The list of diagnoses included cerebrovascular accident (CVA, also known as stroke) and aphasia (difficulty speaking). The MDS indicated Resident #46 had no difficulty swallowing, had no oral or dental concerns and required a mechanically altered diet. Review of the Care Plan, date revised 7/30/25, lacked identification of chronic cough, symptoms of a respiratory condition, or interventions related to Resident #46 cough. Review of the clinical record revealed a General Note, entered on 1/23/25 at 3:14 PM, which documented that Resident #46 had admitted to the facility on [DATE] with rehabilitation orders, plan to receive Physical Therapy, Occupational Therapy, and an evaluation with Speech Therapy. Review of a Speech Therapy (ST) Evaluation, dated on 1/23/25, revealed Resident #46 had referral for ST due to decline in overall functional abilities following hospitalization with diagnosis of influenza A, was referred for evaluation of swallowing function and cognitive communication abilities. The ST

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, clinical record review and staff interviews the facility failed to include the use of an indwelling catheter prior to admission on the care plan for 1 of 1 residents (Resident #49) reviewed for care plans. The facility reported a census of 51 residents.Findings include: Review of the admission Minimum Data Set (MDS) assessment, dated 7/01/25, revealed the list of diagnoses for Resident #49 included benign prostatic hyperplasia (BPH or enlarged prostate), urinary tract infection (UTI) within the last 30 days, and overflow incontinence. The MDS indicated Resident #49 required an indwelling urinary catheter and was always incontinent of bowel. The MDS indicated an admission date of 6/26/25. Review of an admission Order Sheet, signed by physician on 6/27/25, revealed that Resident #49 had an indwelling catheter which was to be changed every 30 days for diagnoses of BPH and overflow incontinence. During an observation, on 8/04/25 at 12:44 PM, Resident #49 sat in wheelchair, with an urinary catheter tubing and drainage bag stored underneath wheelchair, urine visible within the tubing appeared light yellow and cloudy.Review of the Care Plan, date initiated: 6/26/25, revised 7/16/25 revealed a Focus area to address [name redacted] incontinent of bowel and bladder. The Interventions did not include the use of a indwelling urinary catheter or directions for care of the device. During an interview, on 8/07/25 at 1:45 PM, Staff B, Registered Nurse (RN), reported that Resident #49 had indwelling urinary catheter since admission to facility and indications for catheter included diagnosis of BPH.Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, revealed a Policy Statement which declared A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The Policy Interpretation and Implementation section directed, in part: 7. The comprehensive, person-centered Care Plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; e. reflects currently recognized standards of practice for problem areas and conditions.

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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** Based on observation, clinical record review, facility policy review and staff interview, the facility failed to clarify orders for indwelling catheter care and follow up on an order for a urinalysis in a timely manner for 1 of 2 residents (Resident #49) reviewed for urinary catheters. The facility reported a census of 51 residents.Findings include:Review of the Minimum Data Set (MDS) assessment, dated 7/01/25, revealed Resident #49 had a Brief Interview for Mental Status score of 12 out of 15, which indicated moderate cognitive impairment. The list of diagnoses included benign prostatic hyperplasia (BPH or enlarged prostate), urinary tract infection (UTI) within the last 30 days, and overflow incontinence. The MDS indicated Resident #49 required an indwelling urinary catheter and was always incontinent of bowel. Review of the Baseline Care Plan, dated for admission on [DATE], revealed Resident #49 required indwelling urinary catheter. Review of the Care Plan, date initiated 6/26/25, revised 7/15/25 lacked identification of Resident #49 required use of an indwelling urinary catheter or interventions to instruct care of the urinary catheter. Review of an admission Order Sheet, signed by physician on 6/27/25, revealed orders for an indwelling catheter to be changed every 30 days for a diagnosis of BPH. The order did not specify the size or type of indwelling catheter for Resident #49. Review of the Treatment Administration Records (TAR) for the months of June 2025 and July 2025 revealed a lack of an order to specify the size, type, or frequency to change Resident #49's indwelling urinary catheter. The August 2025 TAR included an order, started on 8/08/25 at 10:00 AM for 16 French foley catheter with 10cc balloon and drainage bag to gravity, and instructions to change catheter as needed for leakage, dislodgement or occlusion, one time a day every 30 days, and instructions to check for catheter placement and patency. An additional order, started on 8/06/25 at 6:15 PM, directed for catheter cares to be completed every shift. During an observation, on 8/04/25 at 12:44 PM, Resident #49 sat in wheelchair, urinary catheter tubing and drainage bag stored underneath wheelchair, urine visible within the tubing appeared light yellow and cloudy. Review of Resident #49s EHR revealed the following Nursing Notes: a. On 8/06/25 entered at 5:13 AM, Resident’s urine is cloudy and foul smelling. Fax sent to [provider name redacted] for an order to obtain UA (sample of urine for a urinalysis – a lab test to determine if someone has a urinary tract infection). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 8/7/25 entered at 3:19 PM, Nurse contacted [provider name redacted] to report resident c/o (complained of) discomfort in lower abdomen, his tiredness, and cloudy urine. Order obtained for Urine C&S (culture and sensitivity – and order to test for specific antibiotic effectiveness if a infection is present) x1. Nurse contacted resident’s wife and notified her of UA and that his cath will be changed on 8/8/25. c. On 8/8/25 entered at 1:42 PM, Rc’d (received) call per [name of nurse and physician from provider office redacted] new order for change monthly et recheck UA after new foley catheter placement, rec’d call from res spouse as res c/o via text to her of side discomfort. [Wife name redacted] update do new order rec’d via [physician name redacted]. d. On 8/8/25 entered at 2:17 PM, removed prev cath et (and) 10 cc fluid from balloon (a [NAME] of saline used to maintain the indwelling catheter placement) et res c/o discomfort et mucousy discharge et foul odorous drainage noted form penis upon d/c foley with balloon deflated but intact, reinserted 16 fr (catheter size) per sterile technique, with dark scant amt of urine with copious amounts of sediment noted, foley drainage et straw colored urine noted with scant amount sediment noted, et clean catch UA obtained presently et will send to lab. e. On 8/08/25 entered at 2:52 PM, res UA obtained et reports discomfort in right flank is relieved et no further c/o voiced, lab sheet et results pending post-delivery to Lab. f. On 8/11/25 entered at 12:58 PM, received verbal order from [physician name redacted] resident will begin Levaquin (antibiotic) 750 milligrams (mg) QD (daily) x 7 days. During an interview, on 8/07/25 at 1:45 PM, Staff B, Registered Nurse (RN) stated a urinary catheter would typically be changed every 30 days and as needed, unless a resident's Urologist had ordered a different change frequency. Staff B reported that Resident #49 should have orders for urinary catheter and orders would be found on the TAR. Staff B stated urinary catheter orders should include size of catheter, indication for use, and frequency of change. On 8/07/25 at 2:34 PM, when queried about collection of a urinalysis on Resident #49, Staff B stated that the fax request for urinalysis related to cloudy urine, noted by a previous nurse, had been sent to the wrong provider, and a urinalysis had not yet been collected. Staff B reported that Resident #49's last documented indwelling urinary catheter change, had been at the hospital on 6/25/25, prior to his admission [DATE]). During an interview, on 8/07/25 at 3:04 PM, the Director of Nursing (DON) stated Resident #49 last documented catheter change had been on 6/25/25, prior to admission and was unsure if Resident #49 had any follow up appointments scheduled with Urology. The DON stated that the facility's policy was to change indwelling urinary catheters every 90 days and as needed. When queried if a written or verbal order had been obtained from the physician on size of catheter or change frequency every 90 days, the DON stated a physician order had not yet been obtained. (continued on next page)

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	165204	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Lane Manor	819 Country Lane Road Keosauqua, IA 52565

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 8/11/25 at 1:07 PM, Staff E, RN, confirmed performing change of Resident #49's catheter on 8/08/25 and stated the urine appeared very cloudy with chunks of sediment that resembled snot noted in his urine. Staff E reported that Resident #49 had complained of flank (lower back/side) pain which improved following catheter change and claimed to have received a call from physician instructing nurse to change his catheter and collect a urinalysis. Staff E explained that indwelling urinary catheters typically should be changed monthly unless otherwise ordered. During an interview on 8/12/25 at 9:30 AM, the Administrator, revealed expectation of orders for the size, frequency of change, and indication of use to be in place for a resident who admits to facility with an indwelling urinary catheter, as well as documentation by Certified Nursing Assistant (CNA) staff of urinary output. Facility Administrator stated resident's Care Plan should also reflect use of urinary catheter to direct care and how to manage catheter. Review of the facility policy, titled Catheter Care, Urinary, dated 8/2022, revealed a Purpose Statement which declared the purpose of the procedure is to prevent urinary catheter -associated complications, including urinary tract infections. The Complications section directed, in part: 1. Observe the resident for complications associated with urinary catheters. Report unusual findings to the physician or supervisor immediately: a. if the resident indicates that his or her bladder is full or that he or she needs to void (urinate); b. if urine has an unusual appearance (i.e., color, blood, etc.); c. in the event of bleeding, or if the catheter is accidently removed; d. if the resident complains of burning, tenderness, or pain in the urethral area; or e. if signs and symptoms of urinary tract infection or urinary retention occur.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, the facility failed to follows safe sanitation and food handling practices to prevent cross contamination and foodborne illness. The facility reported a census of 51 residents. Findings include:1. During the initial tour of the kitchen on 8/4/25 at 10:49 AM with the Dietary Manager (DM) included:a. Partially uncovered leftover chocolate cake on a cookie tray set in the dry goods storage areab. A gallon of 2% white milk with a date of 8/2/25 in the walk-in refrigerator. The Dietary Manager stated she thought the milk good for 3 days past the expiration date.c. An 18-quart container with shredded yellow cheese in the walk-in refrigerator. The container had a date of 7/6/25 written on a label. The Dietary Manager disposed of the container.d. The inside of a [brand name redacted] microwave had dried tan residue on the inside of the device. 2. During the observation of the noon meal process on 8/6/25 started at 11:00 AM, the following noted:a. The inside of the [brand name redacted] microwave continued to have dried tan residue on the inside of the device. b. During the puree and mechanical soft diet food preparation process, Staff J, Dietary [NAME] used different spatulas for each food item blended. After checking for the desired consistency, Staff J placed the spatula on the counter top, without a barrier. During an interview on 8/6/25 at 11:13 AM, Staff A, Dietary Cook, reported he is responsible for checking food in refrigerator for outdates. He stated he does not use milk after the expiration date. He also stated the [NAME] working is responsible for cleaning the inside of the microwave. During an interview on 8/7/25 at 9:13 AM, the DM stated milk should be discarded by the expiration date. She stated on 8/6/25 she threw away 10 gallons of milk because the staff did not rotate them properly. The DM stated the night [NAME] is responsible for checking item in the refrigerator for outdated food times nightly.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on staff interview, review of CMS-2567 reports, and facility policy review, the facility failed to ensure an effective QAPI (Quality Assurance Performance Improvement) process to prevent three deficiencies identified in the 2024 recertification from being cited again during the current recertification survey. The facility reported a census of 51 residents.Findings include: Review of the facility's CMS-2567 form the Recertification survey conducted from 9/09/24 to 9/16/24 revealed the following 3 (three) deficiencies cited:a. F690 (Bowel/Bladder, Incontinence, Catheter, UTI);b. F812 (Food Procurement, Store/Prepare/Serve-Sanitary);c. F865 (QAPI Program/Plan, Disclosure/Good Faith Attempt). During the most recert Recertification survey conducted 8/4/25 to 8/12/25 a total of 10 (ten) deficiencies cited, which included:a. F690 (Bowel/Bladder, Incontinence, Catheter, UTI);b. F812 (Food Procurement, Store/Prepare/Serve-Sanitary);c. F865 (QAPI Program/Plan, Disclosure/Good Faith Attempt). During an interview on 8/12/25 at 9:45 AM, the Administrator stated Quality Assurance Committee meets monthly and decides what to work on based on any grievances, information from resident council meetings, and from 5-star nursing home report data. When queried about repeat deficiencies noted from previous recertification survey to present, the Administrator agreed that facility continued to have repeat deficiency areas and planned to implement a focus on kitchen processes until audits show sustained improvements and continue to work on an established QAPI plan to reduce incidents related to bowel/bladder complications which included follow up on physician notifications and initiating interventions. Review of the facility policy titled, Quality Assurance and Performance Improvement (QAPI), revised 9/2022, revealed a Policy statement, which declared Our facility is committed to developing, implementing, and maintaining an effective, comprehensive, data-driven QAPI program that focuses on indicators on of outcomes of care and quality of life. The policy listed the organization's governing body and the facility administrator to have accountability for the QAPI program. The QAPI Feedback, Data Systems, and Monitoring section directed: A. Performance indicators will be developed for each aspect of care and services being monitored.B. A data collection and monitoring plan will be developed by following the CMS guide Measure/Indicator Collection and Monitoring Plan. C. Goals will be established by using the CMS Goal Setting Worksheet. D. Feedback will include communication of the information to those who need to know.E. The assigned QAPI team will identify gaps and opportunities for improvement and communicate them to the QAA Committee and the leadership team. F. Improvement activities will be assigned and high-risk, high frequency, and problem prone issues will be assigned to a Performance Improvement Project (PIP). G. The QAA Committee will work with the QAPI team to establish a frequency for monitoring the area of concern.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on attendance record review and interview, the facility failed to have the minimum required members in attendance at their Quality Assurance and Performance Improvement (QAPI) meetings. The facility reported a census of 51 residents. Findings include:Review of the facility's QAPI attendance sheets since the last recertification survey on 9/16/24, revealed that QAPI meetings were held on 10/18/24, 11/13/24, 1/15/25, 4/9/25, and 7/16/25. The attendance records revealed that the Medical Director was present only at the meeting on 4/9/25. On 8/12/25 at 8:50 a.m., the Administrator stated that the QAPI Policy does not address the members who need to be present quarterly. The Administrator added that she felt the Medical Director was at more than one meeting in the past year but cannot find anything to prove it.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility failed to follow infection prevention protocols for 2 of 3 residents (Resident #9 and Resident #14) reviewed with indwelling urinary devices. The facility reported a census of 51 residents.Findings include:1. Review of the Minimum Data Set (MDS) dated [DATE] identified Resident #9 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 out of 15. The list of diagnoses included diabetes mellitus, spina bifida and necrotizing fasciitis. The MDS identified Resident #9 dependent on staff assistance for toileting, showers, lower body dressing, putting on a taking off footwear. It also identified Resident #9 required partial/moderate staff assistance with upper body dressing, personal hygiene and transfers and had an ostomy (had both colostomy and urostomy). The MDS indicated Resident #9 admitted to the facility with a urostomy. Review of the Care Plan, dated 7/22/25, revealed a Focus area to address [name redacted] utilizes a urostomy and a colostomy. Review of the interventions revealed a lack of direction regarding the use of Enhanced Barrier Precautions during device care. During an observation on 8/5/25 at 1:23 PM, Staff F (Certified Nursing Assistant) donned an isolation gown, a face shield and gloves. She then emptied Resident #9's colostomy bag. Staff F removed the face shield and gown and disposed of the bag with the waste from the colostomy into the soiled utility room. Upon returning to the room, Staff F, donned gloves and without putting on an isolation gown, placed a barrier underneath a graduated cylinder and proceeded to empty the urostomy bag. During an interview on 8/11/25 at 10:44 AM, Staff C, CNA reported when emptying out a urinary drainage bag, she would need to don an isolation gown, gloves and face shield as the resident should be in Enhanced Barrier Precautions and place a barrier underneath the graduate when emptying the bag.During an interview on 8/11/25 at 2:16 PM, the Director of Nursing (DON) stated when emptying out a urinary drainage bag, she would expect to wear a gown, gloves, goggles or face shield and place a barrier underneath the graduate before emptying the bag.Review of the facility policy titled, Catheter Care, Urinary, revised August 2022, did not address the need to place residents with an indwelling urinary device in Enhanced Barrier Precautions2. Review of the MDS dated [DATE] identified Resident #14 as cognitively intact with a BIMS of 15. The list of diagnoses included diabetes mellitus, cerebrovascular accident (stroke) and hemiplegia (paralysis of one half of the body). The MDS also identified Resident #14 dependent on staff for toileting, showers, lower body dressing, putting on and taking off footwear and personal hygiene. The MDS indicated Resident #14 utilized an indwelling device Review of the Care Plan, dated 7/16/25, revealed a Focus area to address [name redacted] utilizes a nephrostomy tube. 7/16/25 suprapubic cath placed. Review of Physician Orders revealed an order, dated 7/27/25 to Cleanse Suprapubic catheter site with NSS (normal saline solution) and apply dry dressing, every day shift. During an observation on 8/5/25 at 2:05 PM, Staff B, Registered Nurse (RN) donned gloves and cleansed the suprapubic catheter insertion site. Without a change of gloves, Staff B proceeded to apply a new dry dressing on the site. During an interview on 8/11/25 at 1:07 PM, Staff E, RN reported when she cleanses the suprapubic catheter insertion site, she would need to change her gloves afterward and before she applies the new dressing.During an interview on 8/11/25 at 1:56 PM, Staff B, RN reported when she cleanses the suprapubic catheter insertion site, she would need to change her gloves afterward and before she applies the new dressing. She stated she may have forgotten to change her gloves when observed during site care on 8/5/25. During an interview on 8/11/25 at 2:16 PM, the DON stated after providing suprapubic catheter insertion site care, she would expect the nurse to remove her gloves, perform hand hygiene and put on new gloves before she applies the dressing.Review of the facility policy titled, Suprapubic Catheter Care, dated 2001 revealed a Purpose statement which declared The purpose of this procedure is to prevent skin irritation around the stoma site and to prevent infection of the residents urinary tract. The policy did not address the steps to apply a clean dry dressing.