STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on observation, record review, facility policy review, resident, staff, and physician interviews, the facility failed to thoroughly assess and follow through on interventions to maintain Resident #1's highest practical physical well being and function for 1 or 5 residents reviewed (Resident #1). Resident #1 experienced unnecessary pain, due to grossly decayed and non-restorable teeth. Resident #1 reported mouth pain in July 2024. She saw a dentist in August 2024. The dentist referred her to the University dental office at her appointment on 8/16/24. The facility failed to arrange an appointment. Resident #1 continued to have oral pain and saw the dentist again on 9/4/24. At this time, the dentist ordered to send Resident #1 to the University Hospital emergency room . On 9/8/24, Resident #1 experienced a change in mental status, difficulty breathing, and heart irregularities. Once she returned from the hospital, the facility still failed to transport Resident #1 to the University Hospital emergency room . The only pain relievers Resident #1 received was Tylenol, mouthwash, Orajel, and viscous lidocaine. Resident #1's mouth pain resulted in a change in condition that affected her eating and drinking. The facility reported a census of 72 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS listed them as independent with eating. The MDS included diagnoses of diabetes, seizure disorder, alcoholic cirrhosis (liver failure), and chronic obstructive pulmonary disease (COPD). Resident #1 rated their pain at a 5 out 10 (0 being no pain, 10 being the worst pain ever). They experienced their pain frequently in the previous 5 days. It affected their sleep and day-to-day activities occasionally. The MDS indicated Resident #1 received a mechanically altered diet. The oral/dental status was not marked, indicating Resident #1 had no mouth or facial pain. The MDS assessment dated [DATE] identified Resident #1 had a BIMS score of 15, indicating cognition intact. The MDS listed Resident #1 independent with eating and oral hygiene. The MDS indicated Resident #1 received a mechanically altered diet and had no mouth or facial pain. The MDS documented Resident #1 had moderate pain frequently that affected her sleep, therapy, and day-to-day activities frequently. The Care Plan Focuses: a. Initiated 9/29/23: related to activities of daily living (ADLs). The Interventions listed Resident #1 as having her own teeth and independent with oral hygiene and eating. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0697 Level of Harm - Actual harm Residents Affected - Few	b. Revised 1/19/24: indicated Resident #1 had chronic pain related to arthritis all over her body. She reported she learned to live with the pain because she got used to having pain. c. Initiated 10/24/24: Resident #1 had an appointment to have 3 teeth extracted due to pain. The Care Plan lacked information about dental care/services. Resident #1's Medication Administration Records (MAR) included an order to document her pain level every shift. The Order Note dated 7/19/24 at 2:24 PM, identified Resident #1 complained of mouth sores. The facility notified the Physician's Assistant (PA) who gave new orders for magic mouthwash twice a day (BID) for 7 days. The SPN - Focused Evaluation Note dated 7/31/24 at 8:50 AM, indicated Resident #1 continued to complain of mouth pain. The evaluation revealed no open sores in the oral cavity, any redness, or any white patches to back of throat. Resident #1's August 2024 MAR indicated she rated her pain between 0 to 6, with the most frequent ratings at 0 (47 times), 2 (12 times), and 5 (17 times). An Infection Control Surveillance of a Skin and Soft Tissue Infection dated 8/5/24 at 11:47 AM revealed Resident #1 had presence of raised white patches on an inflamed mucosa or plaques on oral mucosa noted in her chart on 8/5/24. The physician prescribed magic mouthwash on 8/5/24. The Order Note dated 8/5/24 at 4:24 PM, reflected the facility notified the PA that Resident #1 complained of mouth pain. The PA gave orders for magic mouthwash 5 milliliters (ml) BID for 7 days. The E Interact Change in Condition Evaluation dated 8/15/24 indicated Resident #1 had new or worsening pain. Resident #1 reported as she ate something, her left upper tooth filling may have fell out. Resident #1 had no redness, drainage, bleeding or any increased swelling to her left outer mouth. The recommendation included a referral to emergency dental appointment for evaluation and repair. The (paper) Physician Order Form noted by Staff A, Licensed Practical Nurse (LPN), on 8/15/24 included an order to refer Resident #1 to the dentist for a routine exam and evaluation of mouth and tooth pain. The SPN - Focused Evaluation dated 8/15/24 at 9:27 PM, indicated the facility monitored Resident #1 for mouth pain related to a left upper tooth filling. She reported pain 4 out of 10, adding her tongue and the left side of her mouth is sore. The evaluation determined no redness or swelling noted. Resident #1 aware of referral to dentist for pain related to filling. The Dental Office Visit Note on 8/16/24 indicated Resident #1 complained of pain to the upper left teeth. Resident thought the fillings fell out a couple of months ago. Area is painful with eating and sensitive to hot and cold. Exam findings revealed non-restorable carious (cavities) teeth #14 and #15. Recommendations for Resident #1 to follow up with oral surgeon at University hospital dentistry due to complexity of treatment and teeth extractions required. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0697 Level of Harm - Actual harm Residents Affected - Few	The Appointment/Visit Note dated 8/16/24 at 9:28 AM, identified the facility scheduled a dental appointment that day at 2:45 PM due to Resident #1's mouth pain and filling repair. The Appointment/Visit Note dated 8/16/24 at 5:47 PM, reflected Resident #1 left the facility for a dental appointment. She had images (x-rays) taken and received a referral to Iowa City for oral evaluation and teeth extractions. Facility to call back to schedule after 9/1/24. The SPN - Focused Evaluation dated 8/17/24 at 11:24 AM, indicated Resident #1 rated her pain at 7 on a 0 to 10 scale. The evaluation revealed Resident #1's tongue and left side of her mouth appeared red and swollen. Resident #1's September 2024 MAR identified she rated her pain between 0 to 6, with the most frequent pain rating at 0 (31 times), 4 (12 times), and 6 (9 times). The (paper) Physician's Order Form noted by Staff B, LPN, on 9/3/24, reflected a referral for Resident #1 to the dentist and begin Keflex 500 milligrams (mg) PO four times a day (QID) for 7 days. The Encounter Note dated 9/3/24 at 12:00 AM, the PA documented Resident #1 complained of a sore mouth. They noted small white lesions inside of her mouth. The lesions didn't appear raised and could be scrapped. Resident #1 used routine inhales for COPD. The PA educated the nursing staff about the importance of rinsing out her mouth after use. Referral made for Resident #1 to go to the dentist to further evaluate mouth pain but it hasn't been scheduled yet. The PA diagnosed Resident #1 with oral thrush and mouth pain. The PA suspected the oral thrush contributed to Resident #1's mouth discomfort. She gave an order to start nystatin (antifungal medicine) QID for 10 days and rinse mouth after using inhalers. Continue to monitor for new or worsening symptoms. The Nurses Note dated 9/4/24 at 4:20 PM, identified Resident #1 left the facility earlier in the shift to go to a dental appointment and returned at that time with instructions to send her to the University hospital emergency room (ER) to be evaluated by the ER oral surgeon. The Dental Office Visit Note on 9/4/24, reflected Resident #1 still complained of significant pain in the upper left (teeth) with a white coating on her tongue and cheeks. Resident #1 reported no one set up the appointment for her to have the teeth removed in Iowa City and she now had gum pain. The pain prevented her ability to eat. She received a diagnosis of grossly decayed, non restorable teeth #14, #15, and #29, and a potential candida (yeast) infection. Referral sent on 8/16/24 to hospital dentistry for extraction of teeth. Resident #1 didn't receive any contact from the hospital dentistry. The Dentist (local) called hospital dentistry and spoke with the charge nurse. The charge nurse recommended Resident #1 walk into the University hospital ER for evaluation. The oral surgeon on-call could evaluate Resident #1 if needed and do extractions there, or schedule her to come back for the extractions. Written instructions given on the discharge sheet for the nursing home today (9/4/24) on what needed to be done. The Infection Control Surveillance Skin & Soft Tissue Infection assessment dated [DATE] at 7:54 AM reflected Resident #1 started Bactrim DS (antibiotic) on 9/3/24 due to pus at wound, skin, or tissue site with warmth, redness, swelling and pain at the affected site. The Physician Order Form noted by Staff A on 9/5/24 revealed an order to begin nystatin suspension 5 ml PO QID for 10 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0697 Level of Harm - Actual harm Residents Affected - Few	The Report of Consultation on 9/4/24, Resident #1 referred to University hospital dentistry on 8/16/24. Resident #1 didn't hear back to schedule appointment. The Dentist called and spoke with the charge nurse in the hospital dentistry on 9/4/24. The charge nurse recommended sending Resident #1 for evaluation in the University hospital ER and if needed, she may be evaluated by the on call oral surgeon. The Dentist documented Resident #1 needed to go to the University hospital ER for evaluation of severe pain. The SPN - Focused Evaluation dated 9/5/24 at 8:20 PM, indicated Resident #1 started on oral nystatin suspension for thrush (yeast infection in the mouth). Resident complained of pain to mouth and still rated pain a 4 out of 10. Resident's tongue red but no white patches noted. The eInteract SBAR Summary for Providers dated 9/8/24 at 1:29 AM, identified Resident #1 transferred to hospital for high potassium. Resident #1 had abdominal pain and shortness of breath. A Hospital Note dated 9/8/24 at 1:30 AM revealed Resident #1 presented to the ER with hypotension (low blood pressure) and not very responsive. The facility called the Emergency Medical Services (EMS) due to Resident #1 having shortness of breath and diaphoretic (excessive sweating). Resident intubated and pacemaker started due to her being in complete heart block. Resident #1 diagnosed with chronic hypoxic (low blood oxygen levels) respiratory failure, hyperkalemia (high potassium in the blood) and cardiogenic shock (life-threatening condition due to the body not pumping enough blood to meet the body's needs). She had a white blood cell count of 15 (normal 5 10), potassium 7.8 (normal 3.5 5.2), glucose 392 (normal 70 100), and d dimer 1,059 (normal less than 0.5). The hospital admitted Resident #1 to the Coronary Care Unit. The Physician's Orders revealed the following: a. On 7/19/24, magic mouthwash 5 ml PO BID for 7 days for mouth sores. b. On 8/5/24, magic mouthwash 5 ml PO BID for 7 days for mouth pain. c. On 8/15/24 refer to dentist for exam and evaluation of mouth/teeth pain. d. On 9/3/24, refer to dentist. Bactrim DS (antibiotic) BID for 5 days for an abscess. e. On 9/5/25 nystatin suspension QID for 10 days. f. On 9/7/24, transfer to the ER (emergency room) for evaluation and treatment. The Nursing Dental Evaluations dated 4/14/24, 7/15/24, and 9/13/24 reflected Resident #1's upper and lower teeth in good condition, without loose teeth or decay present. The gums, tongue and cheeks were pink and the mouth had no sores present. The SPN - Admit/Readmit Note dated 9/13/24 at 12:33 PM identified Resident #1 readmitted to the facility. Staff L, LPN, documented Resident #1's upper and lower teeth in good condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0697 Level of Harm - Actual harm Residents Affected - Few	The Encounter Note dated 9/16/24 at 12:00 AM, reflected the PA evaluated Resident #1 following her recent hospitalization . She went to the hospital on 9/8/24 with shortness of breath. While there, they diagnosed her with acute pulmonary edema, hyperkalemia with potassium of 7.8, and noted to have complete heart block. They started her on transcutaneous pacing and transferred to another hospital for a cardiology evaluation. She was transitioned to transvenous pacing (external technique used in emergencies to treat severe low heart rate or heart blockages). They treated her hyperkalemia (high potassium) with medication. The listed her as in cardiogenic shock. She developed a fever and had blood cultures positive for Pseudomonas (infection). They started her on cefepime (antibiotic) and IV fluids. Her hospitalization was complicated by respiratory failure requiring intubation (a tube down the throat to help with breathing), anemia (low iron in the blood) requiring a blood transfusion, and hypertension (high blood pressure). Resident #1 eventually improved and the hospital discharged her back to the facility on [DATE] in stable condition. Resident #1's October 2024 MAR indicated her pain ratings increased from 4 to 9. 4 (10 times), 5 (15 times), 6 (4 times), 7 (4 times), 8 (3 times), and 9 (2 times). Resident #1's MAR reflected the following orders: a. Magic mouthwash 5 milliliters (ml) by mouth (PO) two times a day (BID) for mouth pain for 7 Days had a start date 7/19/24. b. Magic mouthwash 5 ml by mouth BID for mouth pain for 7 Days had a start date 8/5/24. c. Bactrim DS (antibiotic) one tablet PO BID for an abscess for 5 Days had a start date 9/3/24, and on hold 9/7/24 to 9/9/24. d. Lidocaine viscous (mouth throat) solution 15 ml PO every 4 hours as needed (PRN) for mouth pain had a start date 8/11/23 and on hold 9/7 9/13/24. - Resident #1 received the medication once on 8/16, 8/25, 8/30, 9/1, and 10/22/24. e. Tylenol 650 mg PO every 4 hours PRN for pain had a start date 9/13/24. - The [DATE]/1/24 to 10/24/24 revealed Tylenol administered on 8/28, 10/1, 10/15, 10/18, 10/21, and 10/22. f. Orajel 2X Toothache and Gum Gel to buccal (inside the mouth/cheek) every 4 hours PRN for mouth pain started on 9/16/24. - The MAR revealed no PRN Orajel documented 9/16/24 to 10/29/24. g. Orajel 2X Toothache & Gum gel every 2 hours PRN for tooth/mouth pain had a start date 10/16/24. The MAR documented - Resident #1 received the medication on 10/21 at 8:25 PM. h. Warm salt water rinse every 4 hours PRN for oral discomfort had a start date 9/16/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0697 Level of Harm - Actual harm Residents Affected - Few	- The MAR revealed no PRN warm salt water rinses documented 9/16/24 to 10/29/24. The Order Note dated 10/16/24 at 11:26 AM reflected Resident #1 had a new order for Orajel toothache and gum/mouth gel every 2 hours as needed (PRN) The Nurses Note labeled Late Entry documented on 10/18/24 at 3:22 PM, identified the facility made an appointment with a local dentist for 10/23/24. The Nurses Note dated 10/22/24 at 5:00 AM, identified Resident #1 complained of left sided tooth pain throughout the night. She requested Orajel twice, Tylenol once, and viscous lidocaine once. She had her cheek slightly swollen but didn't have drainage noted. She had an appointment scheduled to see the dentist on 10/23/24. The Orders - Administration Note dated 10/23/24 at 12:57 PM, indicated Resident #1 saw the local dentist related to increased tooth pain. Resident #1 received referral for extraction of 3 teeth immediately at the University hospital. A call placed to University (hospital) and the soonest they can schedule Resident #1 is 1/16/25 at 11 AM. They will call the facility if anything else becomes available sooner. The Report of Consultation on 10/23/24, resident has had pain since 8/16/24, and now had significant pain and difficulty eating. She was diagnosed with grossly decayed, and non restorable teeth and recommended Resident #1 be immediately referred to the University hospital dentistry for immediate extraction of teeth #14, #15, and #29. The dentist made a referral on 8/16/24 and 9/4/24. The Dental Office Visit Note on 10/23/24, Resident #1 still having pain to the upper left teeth and a sharp tooth cutting her tongue. She complained of having a hard time eating. Resident #1 referred to have teeth removed at the University hospital dentistry but the nursing home hadn't set up the appointment yet. Resident #1's teeth #14, #15, and #29 grossly decayed and non restorable and needed to be extracted. Oral surgery referral required for extractions due to the complexity of treatment. Teeth #14, #15 and #5 smoothed due to sharp edges cutting her tongue. Consultation report filled out and sent back to the nursing home stating Resident #1 needed transported to the University hospital dentistry immediately for extraction of teeth. The Orders - Administration Note dated 10/24/24 at 7:04 PM identified Resident #1 went to the Iowa City ER related to a broken tooth. The Orders - Administration Note dated 10/24/24 at 7:51 PM, reflected Resident #1 went to the Iowa City ER related to dental concerns. The Nurses Note dated 10/24/24 at 10:02 PM identified Resident #1 returned from the University hospital. They reported they didn't do anything and didn't get any new orders. An E Interact Change in Condition Evaluation dated 10/24/24 revealed Resident #1 broke a tooth and had uncontrolled pain since 10/24/24. Resident #1 saw a dentist on 10/23/24 and the dentist recommended a referral to the ER in Iowa City. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0697 Level of Harm - Actual harm Residents Affected - Few	An E Interact Change in Condition Evaluation dated 10/26/24 revealed Resident #1 had a blood glucose reading of 51 (low - expected 70-100). Blood sugar rechecked after Resident #1 consumed a glass of orange juice and ate supper, with a result of 165. On 10/24/24 at 4:05 PM, observed Resident #1 self propel her wheelchair from her room to the nurse's station and requested Tylenol for pain. Resident #1 opened her mouth and showed the CMA where it hurt. Resident #1 rated her pain at a 5. During an interview on 10/29/24 at 8:25 AM, Resident #1 reported she couldn't eat or drink because she had pain in her mouth and teeth. She had 2 upper left and 1 lower right back teeth that hurt. Resident #1 reported the pain got worse in the past 1 2 weeks since the tooth cracked and broke off. Resident #1 stated she saw a dentist but the dentist wanted her to go to Iowa City to see the dentist there but she needed a referral. She didn't know if she could wait a few months to have her teeth removed. She couldn't eat or drink, and it hurt a lot. Resident #1 reported she took Tylenol and used Orajel for the pain but it is not helping. Resident #1 reported having the pain there all of time, throbbing. Resident #1 reported she stay in the hospital in September 2024, because her heart stopped, they had to shock her heart back, and put a pacemaker in. During an interview on 10/29/24 at 10:15 AM, the Dentist reported he saw Resident #1 on 8/16/24 because she had pain in her left upper teeth and had a filling fall out of her tooth. He described her upper left teeth as decayed and sensitive to cold. He explained the teeth needed to be extracted. He referred her to the hospital dentistry but no one at the facility made her an appointment. He saw Resident #1 again on 9/4/24. Resident #1 told him she didn't have an appointment set up for her. Resident #1 had significant pain to her gums, upper left teeth, and lower right teeth. She reported she couldn't eat due to the pain. By that time, she had another tooth (#29) that needed extracted. She had a white coating with sores in her mouth. The upper molars were decayed. He couldn't retract the gum to look at her tooth due to her having too much pain. He spoke to the charge nurse in the University hospital ER and wrote an order on the yellow form to send her directly to the ER, but nobody took her to the ER. He saw her again on 10/23/24, Resident #1 had pain to her upper left teeth. He observed her teeth broken, sharp, and cutting her tongue. He smoothed off the area so it wasn't so sharp. She had significant pain in her left upper and right lower mouth. Resident #1 complained she had a hard time eating. He referred her to go to the University hospital but no one set up the appointment. He wrote on the yellow consult report (orders for the facility) Resident #1 was in pain and needed transported directly to the University hospital ER immediately for extraction of teeth. The facility needed to expedite her to go to the University hospital ER, and then the dentist/surgeon could possibly see her that day or the following day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/29/24 at 12:30 PM, Staff A, LPN, reported the provider wrote the summary of their visit and orders on the yellow consultation form. The yellow consultation form is given to the nurse when Resident #1 returned to the facility, and then they entered any orders into the computer. Staff A reported Resident #1 went to the dentist because she had thrush and had different things going on in her mouth. She was supposed to have teeth extractions done. She called Iowa City (dentistry) when she got a referral from the local dentist office. The dentist in Iowa City asked her to send information to them, and then they would call back to set things up. The surveyor advised Staff A of the progress note she wrote on 8/16/24 about resident out for a dental appointment and was referred to hospital dentist for oral evaluation and teeth extraction. The surveyor inquired as to which facility was to call back to schedule after 9/1, Staff A responded the nursing home staff was to call the hospital dental office back after 9/1/24. Staff A stated she knew it was written on a paper for the (nursing home) facility to call back after 9/1/24. She stated she didn't know for sure what happened. Staff A stated she would have to look at Resident #1's chart for documentation and dates. Staff A reported whenever a resident had a change in condition, she filled out a change in condition assessment and notified the provider. On 10/29/24 at 1:00 PM, Staff A confirmed she just charted whatever note was written on the form from the dentist office. The note written on the After Visit Summary showed Facility to call back to schedule after 9/1. She didn't know what happened. The facility was supposed to call back after 9/1 but she didn't know if it happened. She passed it on in report but didn't know if someone followed up. During an interview 10/29/24 at 11:55 PM, Staff B, LPN, reported Resident #1 went to a dentist in August 2024 and again in October 2024. After the 8/16/24 dental appointment, they didn't follow up like they should have when the dentist referred Resident #1 to see a provider in Iowa City. She called to let the dentist know Resident #1 went to theER on [DATE]. On 8/16/24 the facility staff called Iowa City but the staff dropped the ball. Someone was supposed to call them back but it didn't get done. Resident #1 had orders for Orajel, lidocaine swish, and nystatin mouth rinse for pain. Staff B said Resident #1 ate a lot of ice and she told her not to chew on ice because she didn't think that helped her teeth. During an interview 10/29/24 at 12:40 PM, the Director of Nursing (DON) reported Resident #1 saw the dentist on 8/16/24. The DON explained whenever someone made a referral to Iowa City, they had to wait 7 days to call for a referral. She didn't know for sure when they made the appointment to Iowa City dentist. When the surveyor advised no one made the appointment and asked her if she knew why, the DON responded she couldn't answer why no one followed up. Resident #1 went back to see the local dentist two weeks later (on 9/4/24). She went to the hospital ER for shortness of breath and abdominal pain. While there they found she had a heart blockage. During an interview 10/29/24 at 2:10 PM, the Director of Clinical Services (DCS) reported to the surveyor when she saw a dental concern listed on the letter the facility received from the State Department on 10/24/24, she began to do some follow up on things at the facility, and then began to provide staff education on 10/25/24. A systemic change was made in the past week for staff to write any pending appointments on the communication page (dashboard) in the computer. Staff education included to contact the physician if a resident had new swelling or edema to the face in addition to pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview 10/30/24 at 11:30 AM, Staff C, LPN, reported they placed the order in the appointment whenever the resident had an appointment when they processed the orders. Staff C reported she passed it on in report to set up Resident #1's appointment or transportation because she didn't usually make those calls at night. Staff C reported Resident #1 complained of a sore mouth. Staff C thought the soreness was related to dental stuff. She didn't know how long Resident #1 had the pain, but she gave her magic mouthwash and lidocaine to use for the pain. During an interview 10/30/24 at 2:45 PM, Staff D, certified medication aide (CMA), reported she told the nurse if she noticed a change in a resident's condition. During an interview 10/31/24 at 2:20 PM, Staff E, PA, reported she saw residents at the facility every Tuesday and Thursday. Staff E reported she assessed a resident's pain by getting a good history and then determined if the pain is new or chronic. She checked what medications Resident #1 took, and looked at her kidney function. Staff E stated she tried to offer different pain modalities besides medications. She offered scheduled or PRN pain medications but asked Resident #1 what they wanted to do. She tried to ask Resident #1 about pain when she saw her. Staff E reported Resident #1 had tooth pain recently and got canker sores in her mouth. The sores in her mouth went on a little bit longer than the tooth pain. She talked to her about doing Orajel, magic mouthwash, and a lidocaine solution. Staff E reported she provided education to Resident #1 to stay away from acidic foods. She also had Tylenol she could take for the pain. The goal for pain level management is hard to put a number on it because residents perceive pain differently. She expected staff to call her if Resident #1 had worsening pain, if there she had anything new going on, and for more urgent concerns. She saw Resident #1 when she had mouth pain, she made the initial referral to the dentist in August 2024. Staff E reported a resident experiencing tooth pain could get an infection, end up with a worsened condition if not cared for, and/or the resident could end up going to the ER. During an interview 10/31/24 at 3:05 PM, the DON reported she expected staff to call the provider for new orders if a resident had a change in condition, if a resident needed to go to the ER, or any complaints of chest pain. The DON reported they documented pain assessments under the evaluation tab in the computer, as well as on the MAR whenever staff gave a PRN pain medication. In addition, the system generated a progress note whenever someone documented an assessment. The DON explained Resident #1's pain level goal may be listed on the Care Plan but every resident's pain is different. A resident may rate pain at a 3 daily, which may be Resident #1's normal pain level but another resident's normal pain level could be a 5. The DON reported she doesn't do much with Resident #1 and preferred the surveyor talk to Staff F, ADON. The DON acknowledged Resident #1 went to the hospital for her heart. When she came back from the hospital, she saw Staff E on 9/3/24. Resident #1 went to the dentist again on 9/4/24. The facility sent her to the ER in Iowa City last week (October 2024), they didn't do anything, and they sent her back. They didn't get any paperwork from the ER visit and she is trying to get it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview 10/31/24 at 3:30 PM, Staff F, Assistant Director of Nursing (ADON) reported when staff called to set up an appointment at the University hospital, they often got a recording to wait 5 to 7 days and then call back for a referral. The recording also directed the caller to stay on the line to talk to someone if it had been after 7 days. Staff F reported Resident #1 complained about something every day. If the nurse inquired about what hurt or asked her if a certain area hurt such as her abdomen or another area, she always told the nurse yes. Staff F stated you don't know with her, it's something new every day. Resident #1 could tell the nurse whenever she had pain too. Resident #1 saw a number of specialists. She had a lot of complaints about having pain. She took Lyrica and used to take tramadol but when they switched providers, they discontinued the tramadol. She is not on Tylenol due to a history of cirrhosis. They just got a new order for ibuprofen. She also had Orajel (pain medicine applied to the gums), lidocaine, and magic mouthwash (a mouthwash with lidocaine to ease pain) for her mouth pain. Resident #1 had to ask for medication when she needed them. Staff F reported assessments and pain assessments documented in a focused evaluation on the computer under the evaluations tab. They reviewed the Care Plan quarterly and updated it with things such as pain. Staff F reported pain is different for different people so no set rate or goal for pain level, as pain is resident specific. A Change in a Resident's Condition or Status policy revised [DATE] revealed the facility promptly notify the resident, their attending physician, and the resident's representative of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident attending physician or the on call physician when they to transfer the resident to a hospital/treatment center. An Orders for Consultants policy revised September 2017 revealed residents will receive appropriate and timely consultations when needed. A Resident Examination and Assessment policy revised February 2014 revealed the physician notified of any abnormalities such as, but not limited to worsening pain as reported by the resident. A Pain Assessment and Management policy revised March 2020 revealed the procedure to help the staff identify pain in the resident, and to develop interventions consistent with the resident's goals and needs and that address the underlying causes of pain. Pain management is a multidisciplinary care process that includes recognizing the presence of pain, addressing the underlying causes of pain, developing and implementing approaches to pain management, monitoring the effectiveness of interventions, and modifying approaches as necessary. The policy also revealed to ask the resident if he/she is experiencing pain and be aware that the resident may avoid the term pain and use other descriptors such as throbbing, aching, hurting, or numbness/tingling. Prolonged, unrelieved pain despite Care Plan interventions reported to the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on observation, resident and staff interviews, and facility assessment review, the facility staff failed to consistently answer call lights within a reasonable amount of time, within 15 minutes, for 2 of 2 nursing units. The facility reported a census of 72 residents. Findings include: On 11/4/24 at 9:02 AM, observed 6 call lights on in the south (200) nursing unit. By 9:30 AM, 1 of the 6 initial call lights remained with an additional 3 call lights on. During a confidential resident interview starting on 10/29/24 at 9:50 AM, 5 of 5 interviewable residents reported prolonged responses to call lights and receiving the requested cares. Residents reported staff come to their room and turn off the call light without providing cares. The staff may or may not inform the resident why they couldn't provide the cares at that specific time. Several residents stated the staff told them additional help is needed but may not return for another 30 45 minutes if they returned at all. Residents reported a common practice of putting on the call light again after staff turn off the light and leave the room without providing cares as they know staff will not return otherwise. One resident reported being left on a bed pan for approximately one hour before staff returned. Residents reported prolonged call light times throughout the day and night but several voiced the overnights were worse than during the daytime. During an interview 11/4/24 at 2:05 PM, Staff I, Certified Nursing Assistant (CNA), reported they typically have a total of 3 CNAs for the facility during the overnight shift. One CNA for each unit and then a float CNA who may rotate between the 2 units every hour. Staff I reported on several occasions, the float hasn't been certified and couldn't provide direct resident care or assist with lifting and/or repositioning. Staff I acknowledged the resident's call lights may go unanswered for more than 15 minutes due to attending to other residents and some staff electing not to answer call lights. During an interview on 11/4/24 at 2:35 PM Staff J, CNA, reported several residents have complained about prolonged call light time, over 15 minutes. Staff J voiced some staff turned off resident call lights without providing cares, in part out of annoyance. Staff J stated the facility staffed 1 CNA for each nursing unit on the overnight shift with a float between the 2 units. If a staff called in, the float staff would be assigned to that person's unit. The float aide could be non certified and unable to provide direct resident cares. Staff J explained they have residents who prefer to get up for the day at 5:00 AM, some of which required the use of a mechanical lift, which needed 2 staff present to operate. When a non certified aide worked, they cannot assist with lifting assistance, and the residents have to wait until they have the appropriate staff available. During an interview on 11/4/24 at 4:40 PM, Staff K, Registered Nurse (RN), reported resident complaints about call light times, especially those who require 2 staff for assistance. During overnights, they staffed each nursing unit with 1 nurse and 2 aides. One of the aides may be non certified and unable to provide direct resident cares or assist with lifting. This made providing resident cares in a timely manner difficult, especially with the acuity of residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/5/24 at 11:15 AM, Staff G, RN, acknowledged the response to call lights took longer due to the time of day and having less staff. During overnights, typically they have 2 CNAs and 1 float CNA for the facility to cover the 2 nursing units. When the RN passed early morning medications, they are unable to assist with routine resident cares. Staff G reported providing timely resident cares and responding to call lights is hard given the number of residents who require 2 staff members for assistance. During an interview on 11/5/24 at 11:00 AM, the Director of Nursing (DON) reported the following staffing patterns for the facility: Day/Evening Shifts: 1 nurse on each unit with an occasional float nurse, 1 certified medication aide (CMA) on each unit, 2 3 CNAs on each unit or 2 CNAs on each unit, and 1 float CNA, with 2 bath aides during day shift (Monday Friday only). Overnight Shifts have 1 nurse on each unit, 1 CNA on each unit, with 1 float CNA. The facility utilized as needed (PRN) staff or volunteer staff to pick up the vacant shift if there was a call in. The DON acknowledged they typically scheduled the CNAs to work from 10PM to 6AM. Upon review of October's staff schedule, the DON acknowledged the schedule days with 1 of the 3 overnight CNAs scheduled till 5AM (19 days between October 1st thru 23rd). It is expected staff shouldn't leave if they didn't have enough staff remaining. The DON explained the 1 of the 3 evening CNA shifts recently adjusted to 11PM to 6AM. The evening shift remained from 2PM to 10PM. The change started October 24th. During an interview on 11/5/24 at 11:30 AM, the Administrator explained staffing levels based on resident acuity, resident census, and budget. Staffing increased with more skilled residents or high acutely ill residents. They had a staffing program they used to assist with staffing patterns as it accounts for acuity levels and budget. Daily staffing sheets laid out as if the facility had a full census. This number is 76 but will implement cost controlling measures to be closer to budget if the census does not support. This included staff leaving early or other schedule adjustments. The Facility assessment dated [DATE] revealed the assessment is utilized to serve as a resource to assist in decision making regarding key components of operation such as staffing allocations. They reviewed the Facility Assessment at each Quality Assurance and Performance Improvement (QAPI) meeting. If the resident population, contractual agreement, or large operation change, an immediate update is made to the Facility Assessment to reflect changes needed to operational structure including, but not limited to, staffing, and educational update. The Facility Assessment included the following: 1.Facility Overview a. Average daily census of 73.7 b. Short stay residents 10 15% of facility census c. Long stay residents 85 90% of facility census 2. Type of Residents Include: a .Muscle weakness: 65 residents b. Major depressive disorder: 33 residents (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Specialty diagnoses: Parkinson's and Alzheimer's d. Facility Assessment lacked specific information on the acuity of residents and the amount ADL (Activities of daily living) assistance required for residents 3. Services and Care Offered Include: a. ADLs b. Mobility and fall/fall with injury prevention c. Bowel/Bladder d. Skin integrity e. Mental health and behavior f. Medications g. Pain management h. Infection prevention and control i. Management of medical conditions j. Other special care needs (hospice/palliative/end of life care, ostomy care, tracheostomy care, bariatric care, intravenous care) 4. Daily Staffing Patterns: a. Staffing based on residents' acuity and staffing strengths b. Number of staff available to meet resident needs include: i. Licensed Nurse providing direct care 2 nurses 6AM to 6PM 2 nurses 6PM to 6AM ii. Nurse Aides/Restorative 9 CNAs on 1st shift 6 CNAs on 2nd shift 3 CNAs on 3rd shift (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	iii. Medication Aides (CMA) 2 CMAs on 1st shift 2 CMAs on 2nd shift

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50500 Based on record review, staff interview, and facility policy review, the facility failed to ensure accurate records for the administration of controlled substance medications for 1 of 6 residents (Resident #8) reviewed for medication administration. The facility reported a census of 72. Findings include: Resident #8's October 2024 Medication Administration Sheet (MAR) included orders for Morphine 0.25 milliliters (ml) 3 times a day related to chronic pain and Morphine 0.25 ml every 8 hours as needed (PRN) for pain. a. On 10/2/24: scheduled Morphine 0.25ml administered at 8:00 AM, 2:00 PM, and 8:10 PM. b. On 10/2/24: A PRN dose of Morphine 0.25ml administered at 11:56 PM for a pain rating of 8 on a scale from 1 to 10. The Order Administration Note dated 10/2/24 at 11:56 PM, Order Administration Note for Morphine 0.25 ml by mouth every 8 hours as needed for Pain. The Order Administration Note dated 10/3/24 at 3:02 AM listed Resident #8's PRN Morphine 0.25 ml as effective with a follow up pain scale of 4. Review of Resident #8's Liquid Controlled Narcotic log book on 10/2/24 revealed Morphine 0.25 ml signed out at 8:00 AM, 2:00 PM, and 8:10 PM. The Liquid Controlled Narcotic log book lacked documentation of PRN Morphine administered at 11:56 PM. The Liquid Controlled Narcotic log book is a separate log from the one used for patches or pill form narcotics. During an interview on 11/5/24 at 10:30 AM, the Director of Nursing (DON), acknowledged the lack of documentation in the controlled narcotic log book for the PRN Morphine 0.25 ml administration on 10/2/24 at 11:56 PM for Resident #8. The DON reported the staff who administered the medication was training on that particular night. During an interview 11/5/24 at 11:15 AM, Staff G, Registered Nurse, reported working at the facility for approximately 3 months. Staff G explained their orientation included documentation for narcotic administration, which consisted of charting in the computer and signing the narcotic book when given. Staff G unable to specifically recall the lack of documentation in the narcotic book/record on 10/2/24 but agreed it was feasible given how new she was to the position. Review of the undated policy Controlled Substances, the facility complies with all laws, regulations, and other requirements related to the handling, storage, disposal, and documentation of controlled medications. The policy outlined the following: 1. Upon receipt of a resident's-controlled substance, an individual resident's controlled-substance record is made for each resident who is receiving a controlled substance. The record contains: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Name of resident b. Name and strength of the medication c. Quantity received d. Number on hand e. Name of physician f. Prescription number g. Name of issuing pharmacy h. Date and time received 2. The nurse administering the medication is responsible for recording the following: a. Name of the resident receiving the medication b. Name, strength, and dose of the medication c. Time of administration d. Method of administration e. Quantity of the medication f. Signature of the nurse administering the medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on record review, resident, staff and physician interviews, and policy review, the facility failed to schedule routine and emergency dental service appointment for 2 of 3 residents reviewed for dental concerns (Resident #1 and #3). The facility reported a census of 72 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS listed them as independent with eating. The MDS included diagnoses of diabetes, seizure disorder, alcoholic cirrhosis (liver failure), and chronic obstructive pulmonary disease (COPD). Resident #1 rated their pain at a 5 out 10 (0 being no pain, 10 being the worst pain ever). The MDS indicated Resident #1 received a mechanically altered diet. The oral/dental status was not marked, indicating Resident #1 had no broken or loose teeth or mouth/facial pain. The Care Plan Focuses: a. Initiated 9/29/23: related to activities of daily living (ADLs). The Interventions listed Resident #1 as having her own teeth and independent with oral hygiene and eating. b. Revised 1/19/24: indicated Resident #1 had chronic pain related to arthritis all over her body. She reported she learned to live with the pain because she got used to having pain. c. Initiated 10/24/24: Resident #1 had an appointment to have 3 teeth extracted due to pain. The Care Plan lacked information about dental care/services. The Order Note dated 8/5/24 at 4:24 PM, reflected the facility notified the PA that Resident #1 complained of mouth pain. The (paper) Physician Order Form noted by Staff A, Licensed Practical Nurse (LPN), on 8/15/24 included an order to refer Resident #1 to the dentist for a routine exam and evaluation of mouth and tooth pain. The SPN - Focused Evaluation dated 8/15/24 at 9:27 PM indicated Resident #1 reported pain 4 out of 10 and reported her tongue and left side of her mouth as sore. The nurse didn't see redness or swelling to the left upper tooth area or tongue or swelling to the left side of her face noted. Resident aware of referral to dentist for pain. The SPN - Focused Evaluation dated 8/16/24 at 11:09 AM, reflected Resident #1 complained of a toothache to her left upper mouth. The evaluation found Resident #1's gums swollen with a reported pain of 4 out of 10. She had a dental appointment scheduled for 8/16/24. Resident doing salt water rinses as needed (PRN). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Dental Office Visit Note on 8/16/24 indicated Resident #1 complained of pain to the upper left teeth. Resident thought the fillings fell out a couple of months ago. Area is painful with eating and sensitive to hot and cold. Exam findings revealed non-restorable carious (cavities) teeth #14 and #15. Recommendations for Resident #1 to follow up with oral surgeon at University hospital dentistry due to complexity of treatment and teeth extractions required. A Referral to Hospital Dentistry form dated 8/16/24 included an order for Resident #1 to request a consultation and treatment to extract teeth #14 and #15. Another handwritten note on the backside of the form directed to wait 5 7 days to call for referral. The Order Note dated 9/3/24 at 4:15 PM reflected Resident #1 received new orders and a referral to the dentist. The Nurses Note dated 9/4/24 at 4:20 PM, indicated Resident #1 went to a dental appointment earlier in the shift and returned at that time with instructions to send her to the University hospital ER to be evaluated by the ER oral surgeon. The Report of Consultation on 9/4/24, Resident #1 referred to University hospital dentistry on 8/16/24. Resident #1 didn't hear back to schedule appointment. The Dentist called and spoke with the charge nurse in the hospital dentistry on 9/4/24. The charge nurse recommended sending Resident #1 for evaluation in the University hospital ER and if needed, she may be evaluated by the on call oral surgeon. The Dentist documented Resident #1 needed to go to the University hospital ER for evaluation of severe pain. The Nurses Note labeled Late Entry documented on 10/18/24 at 3:22 PM, identified the facility made an appointment with a local dentist for 10/23/24. The Orders - Administration Note dated 10/23/24 at 12:57 PM, indicated Resident #1 saw the local dentist related to increased tooth pain. Resident #1 received referral for extraction of 3 teeth immediately at the University hospital. A call placed to University (hospital) and the soonest they can schedule Resident #1 is 1/16/25 at 11 AM. They will call the facility if anything else becomes available sooner. The Report of Consultation on 10/23/24, Resident #1 had pain since 8/16/24, and now had significant pain and difficulty eating. She was diagnosed with grossly decayed, and non restorable teeth and recommended Resident #1 be immediately referred to the University hospital dentistry for immediate extraction of teeth #14, #15, and #29. The dentist made a referral on 8/16/24 and 9/4/24. The Orders - Administration Note dated 10/24/24 at 7:04 PM identified Resident #1 went to the Iowa City ER related to a broken tooth. The Orders - Administration Note dated 10/24/24 at 7:51 PM, reflected Resident #1 went to the Iowa City ER related to dental concerns. An EInteract Change in Condition Evaluation dated 10/24/24 revealed Resident #1 broke a tooth and had uncontrolled pain since 10/24/24. Resident #1 saw a dentist on 10/23/24 and the dentist recommended a referral to the ER in Iowa City. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/24 at 8:25 AM, Resident #1 reported she couldn't eat or drink because she had pain in her mouth and teeth. She had 2 upper left and 1 lower right back teeth that hurt. Resident #1 reported the pain got worse in the past 1 2 weeks since the tooth cracked and broke off. Resident #1 stated she saw a dentist but the dentist wanted her to go to Iowa City to see the dentist there but she needed a referral. During an interview on 10/29/24 at 10:15 AM, the Dentist reported he saw Resident #1 on 8/16/24 because she had pain in her left upper teeth and had a filling fall out of her tooth. He described her upper left teeth as decayed and sensitive to cold. He explained the teeth needed to be extracted. He referred her to the hospital dentistry but no one at the facility made her an appointment. He saw Resident #1 again on 9/4/24. Resident #1 told him she didn't have an appointment set up for her. Resident #1 had significant pain to her gums, upper left teeth, and lower right teeth. She reported she couldn't eat due to the pain. By that time, she had another tooth (#29) that needed extracted. She had a white coating with sores in her mouth. The upper molars were decayed. He couldn't retract the gum to look at her tooth due to her having too much pain. He spoke to the charge nurse in the University hospital ER and wrote an order on the yellow form to send her directly to the ER, but nobody took her to the ER. He saw her again on 10/23/24, Resident #1 had pain to her upper left teeth. He observed her teeth broken, sharp, and cutting her tongue. He smoothed off the area so it wasn't so sharp. She had significant pain in her left upper and right lower mouth. Resident #1 complained she had a hard time eating. He referred her to go to the University hospital but no one set up the appointment. He wrote on the yellow consult report (orders for the facility) Resident #1 was in pain and needed transported directly to the University hospital ER immediately for extraction of teeth. The facility needed to expedite her to go to the University hospital ER, and then the dentist/surgeon could possibly see her that day or the following day. During an interview 10/29/24 at 11:55 AM, Staff B, LPN, reported she helped set up appointments for the residents. Resident #1 went to a dentist in August 2024 and again in October 2024. After the 8/16/24 dental appointment, they didn't follow up like they should have when the dentist referred Resident #1 to see a provider in Iowa City. She called to let the dentist know Resident #1 went to theER on [DATE]. On 8/16/24, the facility staff called Iowa City but the staff dropped the ball. Someone was supposed to call them back but it didn't get done. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 10/29/24 at 12:30 PM, Staff A, LPN, reported the nurses set up appointments for the residents, along with the Assistant Director of Nursing (ADON) and the admission's coordinator. Whenever a resident needed an appointment, she first got an order for the appointment and checked to see where the resident went before (such as a specialist). She then called the office to set up the appointment and sent whatever information the doctor's office needed. Staff A stated the nurse should write on the report sheet and pass the information on in report if the doctor's office not open to make the appointment. The night shift got the paperwork ready for residents that had appointments for that day. The yellow consultation form is an appointment paper sent with the residents to the appointment. The provider wrote on the yellow consultation form a summary of their visit and any orders. The yellow consultation form is given to the nurse when the resident returned to the facility, and then they entered any orders into the computer. Staff A reported it's a challenge to get transportation and appointment set up with the number of residents at the facility and all of the appointments they went to. She correlated the facility's transportation and worked to coordinate transportation availability with the available appointment date/time to set up an appointment. Staff A stated they needed everyone to help out and it's all of the nurses' responsibility to help. Staff A reported Resident #1 went to the dentist because she had thrush and different things going on in her mouth. She was supposed to have teeth extractions done. Staff A reported she called Iowa City (dentistry) when she got a referral from the local dentist office. The dentist in Iowa City asked her to send information to them, and then they would call back to set things up. She had incidents when a resident had been a prior patient at the University and the University contacted the residents at their number instead of calling the facility back. The surveyor advised Staff A of the progress note she wrote on 8/16/24 regarding Resident #1 out for a dental appointment and received a referral to the hospital dentist for oral evaluation and teeth extraction. The surveyor inquired as to which facility to call back to schedule after 9/1/24. Staff A responded the nursing home staff was to call the hospital dental office back after 9/1/24. Staff A stated she knew it was written on a paper for the (nursing home) facility to call back after 9/1/24. She stated she didn't know for sure what happened, and added she would have to look at Resident #1's chart for documentation and dates. During an interview 10/29/24 at 12:40 PM, the Director of Nursing (DON) reported Resident #1 saw the dentist on 8/16/24. The DON explained whenever someone made a referral to Iowa City, they had to wait 7 days to call for a referral. She didn't know for sure when they made the appointment to Iowa City dentist. When the surveyor advised no one made the appointment and asked her if she knew why, the DON responded she couldn't answer why no one followed up. Resident #1 went back to see the local dentist two weeks later (on 9/4/24). She went to the hospital ER for shortness of breath and abdominal pain. While there they found she had a heart blockage and they placed a pacemaker. Resident #1 recently started complaining of mouth pain again and the staff called the local dentist again. Resident #1 saw the Dentist on 10/23/24, and went to Iowa City on 10/24/24. On 10/29/24 at 1:00 PM, Staff A confirmed she just charted whatever note was written on the form from the dentist office. The note written on the After Visit Summary showed Facility to call back to schedule after 9/1. She didn't know what happened, as the facility was supposed to call back after 9/1/24, she passed it on in report but didn't know if it got followed up on. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 10/29/24 at 2:10 PM, the Director of Clinical Services (DCS) reported when she saw a dental concern listed on the letter the facility received from the State Department on 10/24/24, she began to do some follow up on things at the facility. She also began to provide staff education on 10/25/24. The DCS reported the facility wrote appointments in the calendar book whenever a resident had a referral or an appointment. They made a systemic change in the past week for staff to write any pending appointments on the communication page (dashboard) in the computer. The DCS provided an in service form dated 10/25/24 to the surveyor. The education included the following: a. If an external provider made recommendations (dentist, podiatry, etc.), the recommendation needed followed. If unable to do so, the staff should follow up with the provider and notify them. b. If a clinic requested staff to call back to schedule an appointment, this will be added to the electronic communication board on the computer in addition to the scheduling book at the nurse's station. During an interview 10/31/24 at 3:05 PM, the DON reported she didn't know who wrote on the back of the Hospital Dentistry document from the dentist office to wait 5 7 days to call for a referral to the University Hospital dentist office. She just knows it wasn't done. The DON acknowledged Resident #1 went to the hospital for her heart, came back from the hospital, and saw Staff E, PA, on 9/3/24. Resident #1 went to the dentist again on 9/4/24. The facility sent her to the ER last week (October 2024). A Routine Dental Care policy revised April 2007 instructed each resident will receive routine dental care. The attending physician will be notified of a resident's need for dental treatment and order dental consultation as appropriate. 2. Resident #3's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS included diagnoses of progressive neurological condition (muscular dystrophy) and diabetes. The MDS indicated Resident #3 didn't have natural teeth (edentulous). The Care Plan Focus dated 11/3/23 related to activities of daily living (ADLs) include an Intervention of Resident #1 independent with oral hygiene with a full set of dentures. The Care Plan Focus revised 9/20/24 indicated Resident #3 had intermittent episodes of mild pain related to her muscular dystrophy. The Intervention directed the staff to administer her pain medications as ordered by the physician. The Care Plan lacked information about dental services or concerns. Resident #3's September 2024 and October 2024 Medication Administration Record (MAR) included the following orders dated 9/16/24: a. Orajel 2X Toothache and Gum Gel to buccal (inside the mouth/cheek) every 4 hours PRN for mouth pain. - The MAR revealed no PRN Orajel documented from 9/16/24 to 10/29/24. b. Warm salt water rinse every 4 hours PRN for oral discomfort had a start date 9/16/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The MAR revealed no PRN warm salt water rinses documented from 9/16/24 to 10/29/24. The Nursing Dental Evaluation 9/9/24 revealed Resident #3 edentulous. The Order Note dated 6/27/24 at 6:45 PM, reflected Resident #3 received new orders from the PA for a referral to the dentist for routine exam and new dentures. The Encounter Note dated 8/5/24 at 12:00 AM, identified Resident #3 complained of her lower dentures hurting her since they placed them one week ago. PA tried to reassure Resident #3 the pain typically recedes in time. However, Resident #3 requested a referral back to her dentist for refitting. Resident #3 referred back to the dentist for management of ill fitting dentures. The Nurses Note dated 8/5/24 at 2:20 PM, reflected the facility called the dental office and made an appointment made for 8/14/24 at 11 AM. The Nurses Note dated 9/24/24 at 9:41 AM, indicated Resident #3 didn't wear her lower denture related to pain. Resident #3 stated she thought a bone is rubbing on it, so she couldn't wear it. Resident #3 went to the dental clinic on 9/9/24 and thought they had it fixed but now it's bothering her again. The facility made an appointment with the Dentist on 10/9/24 at 10 AM. The Appointment Calendar book at the nurse's station reflected Resident #3 had a dental appointment on 10/9/24. Resident #3's clinical record lacked a dental appointment between 10/7/24 10/9/24. During an interview 10/31/24 at 12:30 PM, Resident #3 reported she had some sores in her mouth for at least 1 2 weeks. She thought her dentures rubbed and caused the sores in her mouth. She got Orajel when the staff brought it to her but she had to ask for the Orajel. She thought Staff H, Registered Nurse (RN), would make her an appointment with the dentist but she didn't know if she ever did. It was a week ago when someone told her they were going to see about getting her an appointment. She had sores in her mouth in the past, they get better but then the sores came back. She really thought the dentures caused the sores. During an interview 11/4/24 at 3:45 PM, Staff H, Registered Nurse (RN), reported Resident #3 saw the PA last week. She got dentures and saw the dentist on 9/9/24. On 9/16/24, she got Orajel. Resident #3 had to request Orajel when she wanted it. Staff H reported Resident #3's dentures bothered her again as the bottom dentures didn't fit right and rubbed. She had a dental appointment on 10/9/24. When the surveyor inquired about Staff H's follow up after Resident #3 reported sores in her mouth the previous week, Staff H denied knowing anything about it. At 4:15 PM, Staff H approached the surveyor and reported Resident #3 had a dental appointment set up for 11/8/24 to follow up. The Nurses Note dated 11/4/24 at 4:00 PM (note created 11/4/2024 at 4:02 PM), reflected Resident #3 had a dental appointment scheduled for 11/8/24 at 1:00 PM for dentures. Resident #3 notified. During an interview 11/5/24 at 1:00 PM, Staff M, LPN, reported Resident #3 requested Orajel on 11/4/24. When she asked Resident #3 what was going on, she told her she thought her denture rubbed and caused a sore in her mouth. Resident #3 went to the dentist a couple of times for new dentures. Staff M reported she called on 11/4/24 to make an appointment for the dentist to see her again.