| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165213 | A. Building<br>B. Wing | 09/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Good Samaritan Society - Forest City | 606 South Seventh Street<br>Forest City, IA 50436 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>46875<br><br>Based on clinical record review, staff interview and policy review the facility failed to develop a care plan to address risk factors and interventions for 3 out of 13 residents (Residents #87, #8, #30) reviewed for comprehensive care plans.The facility reported a census of 35 residents.<br><br>Findings include:<br><br>1. The Minimum Data Set (MDS) assessment for Resident #87 dated 3/14/24 identified a Brief Interview for Mental Status (BIMS) score of 12, which indicated intact cognition. The MDS included diagnoses of anemia, atrial fibrillation (irregular heart rhythm), hypertension (high blood pressure), deep venous thrombosis (blood clot in a deep vein), diabetes mellitus, and chronic kidney disease. The MDS documented Resident #87 received an anticoagulant medication during the assessment period (last 7 days).<br><br>Review of Medication Administration Records (MAR) for the months of March 2024 to June 2024 revealed Resident #87 received coumadin (anticoagulant medication) at various dosages for atrial fibrillation.<br><br>Review of Resident #87's Care Plan initiated on 3/8/24 revealed the anticoagulant medication, potential side effects and what to monitor for while taking the high risk medication was not addressed on the comprehensive care plan.<br><br>On 9/4/24 at 11:32 AM, the MDS Coordinator acknowledged and verified the coumadin was not addressed on Resident #87's Care Plan.<br><br>A facility policy titled Care Plan reviewed/revised 11/1/23 documented each resident to have an individualized, person centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident ' s optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. The plan of care will be modified to reflect the care currently required/provided for the resident.<br><br>49056<br><br>(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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. The MDS assessment for Resident #8 dated 8/5/24 identified a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. The MDS included diagnoses of atrial fibrillation, heart failure, hypertension (high blood pressure), anxiety and depression. The MDS documented Resident #8 received the diuretic medication during the assessment period (last 7 days).<br><br>Per the clinical Physician Order dated 3/19/24 directed staff to administer hydrochlorothiazide 12.5mg Capsule, give 1 capsule by mouth one time a day related to congestive heart failure.<br><br>Review of Resident #8's Care Plan with an initiated date of 3/15/23 revealed the diuretic medication, potential side effects and what to monitor for, while taking the high risk medication was not addressed on the comprehensive care plan.<br><br>3. The MDS assessment for Resident #30 dated 7/23/24 identified a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. The MDS included diagnoses of anxiety, depression, post traumatic stress disorder, and schizophrenia. The MDS documented Resident #30 received a antipsychotic medication during the assessment period (last 7 days).<br><br>Per the clinical Physician Order dated 3/29/24 directed staff to administer Abilify15mg, give 1 tablet by mouth daily, Quetiapine 25mg tablet, give 1.5 tablet by mouth two times daily, and Quetiapine 25mg, give 2 tablets by mouth daily.<br><br>Review of Resident #30's Care Plan with an initiated date of 1/29/24 revealed the antipsychotic medication, potential side effects and what to monitor for, while taking the high risk medication was not addressed on the comprehensive care plan. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>46875<br><br>Based on clinical record review, staff interviews, and policy review the facility failed to provide assessment and interventions necessary for the care and services, to maintain the residents' highest practical physical well- being for 1 of 13 residents reviewed (Resident #21). The facility failed to complete and document nursing assessments related to diuretic usage and increased edema (fluid retention). The facility reported a census of 35 residents.<br><br>Findings include:<br><br>The Minimum Data Set (MDS) assessment for Resident #21 dated 6/8/24 identified a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS included diagnoses of anemia, atrial fibrillation (irregular heart rhythm), heart failure (heart cannot pump blood well enough), hypertension (high blood pressure), and chronic kidney disease.<br><br>The Care Plan with revision date of 4/5/24 revealed Resident #21 had altered cardiovascular status related to atrial flutter, congestive heart failure (CHF), hypertension, anemia and history of tobacco use. The Care Plan directed staff to apply and remove bilateral ted hose. The Care Plan focus area and interventions dated 9/4/24 directed staff to monitor/document/report to health care provider as needed of any signs and symptoms of CHF: dependent edema of legs/feet, periorbital edema, shortness of breath upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles/wheezes upon auscultation of the lungs, orthopnea, weakness, fatigue, increase heart rate, lethargy and disorientation.<br><br>A Physician Order dated 11/26/23 directed staff to apply knee high ted hose on in the morning and remove at bedtime.<br><br>Review of Medication Administration Record (MAR) and Treatment Administration Record (TAR) for June through September 2024 lacked documentation Resident #21 ted hose were being applied and removed per the Physician order.<br><br>A Progress Note dated 8/8/24 revealed Resident #21 had a significant weight gain of 6.1% in the past 30 days.<br><br>A Progress Note dated 8/8/24 revealed a fax was sent to the Physician that documented Resident #21 had a significant weight gain, 3+ edema bilaterally and lung sounds were clear. The note revealed Resident #21 was not prescribed any diuretic (fluid pill) medications.<br><br>A Progress Note dated 8/13/24 documented the ARNP (Advanced Registered Nurse Practitioner) responded to please have Resident #21 seen and evaluated for concerns for heart failure. The noted documented a appointment to be made.<br><br>Review of the Progress Notes from 8/9/24 to 8/21/24 lacked documentation of nursing assessments and interventions related to fluid retention. The notes also lacked follow up documentation regarding the appointment for Resident #21 to be seen regarding the concerns for heart failure.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A Progress Note dated 8/21/24 revealed the Physician evaluated Resident #21 and new orders received for Lasix (diuretic medication) 20 mg (milligrams) every AM (morning) and to draw a BMP (Basic Metabolic Panel/lab work) in 2 weeks.<br><br>A Physician Progress Note dated 8/21/24 revealed the Physician was asked to see Resident #21 because of a lot of edema in her lower extremities. The note documented Resident #21 had swelling all the way up to the thigh area. The swelling started 1-2 weeks ago with it gradually getting worse. Resident #21 ankles had 2 to 3+ pitting edema in the lower extremities and 2+ edema up into the thighs. The note documented the plan was to add Lasix 20 mg 2 tablets in the morning and to repeat a BMP in 2 weeks. The facility to notify the Physician if there was no improvement.<br><br>Review of the Progress Notes from 8/22/24 to 8/25/24 lacked documentation of nursing assessments and interventions related to fluid retention and the diuretic usage that was started the morning of 8/22/24.<br><br>A Progress Note dated 8/26/24 documented Resident #21 was started on a new medication lasix on 8/21 with daily weight being completed at sporadic times and not at set time/same clothes. The note revealed Resident #21 had been slowly climbing with weight and fluid. The note documented Resident #21 had no shortness of breath and lung sounds diminished bilaterally. The note documented Resident #21 was educated regarding the importance of daily exercise but does not put forth the effort. Resident #21 was scheduled for a BMP lab draw on 9/5 and appointment with the Physician on 9/10/24. The clinical record lacked a daily weight on 8/26/24 per order.<br><br>A Physician Progress Note dated 8/28/24 documented nursing concerns of increased weight and fluid accumulation. No new orders documented on the Physician Progress Note regarding the weight or fluid accumulation.<br><br>Review of the Progress Notes from 8/29/24 and 8/30/24 lacked documentation of nursing assessments and interventions related to fluid retention.<br><br>A Wound Care Telemedicine Follow Up Evaluation dated 8/29/24 revealed Resident #21 had a full thickness venous wound to the right posterior thigh with duration greater than 3 days. The note documented the wound size (length x width x depth) was 5.0 x 17.0 x 0.1 cm (centimeters). The wound had moderate amounts of serous (clear fluid) drainage. The note revealed the treatment plan was to apply hydrocortisone cream 0.1 % twice a day until healed. Review of the Progress Notes on 8/29 and prior lacked documentation regarding the open area to the right posterior thigh. The notes lacked documentation Resident #29 was seen for a telemedicine visit on 8/29. Review of the August MAR revealed the Hydrocortisone cream was started on 8/31/24.<br><br>A Progress Note dated 8/31/24 at 3:11 PM documented Resident #21 had 4+ edema to both legs, weeping with open areas and a rash behind the right knee. The note documented a RN (Registered Nurse) wrapped legs in the morning, covered open areas with ABD (abdominal pad) and coban (self adherent wrap). The note reported at 2:30 PM Resident #21 had a bath, legs were redressed with ABD pad, ace wraps and an ABD pad under the right knee. The clinical record lacked documentation of a Physician Order for the legs to be wrapped with ace wraps.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A Progress Note dated 8/31/24 (Saturday) revealed a fax was sent to the Physician reporting Resident #21 had 4+ weeping edema to bilateral lower extremities, along with open areas present to the right leg and a rash on the back of the right knee. The note documented there were no present orders to treat and the staff implemented wrapping both legs with coban and/or ace wraps and using an ABD pad as a moisture barrier.<br><br>Review of the Progress Notes from 9/1/24 and 9/2/24 lacked documentation of any further nursing assessments related to the fluid retention, open areas to lower legs, lungs sounds or shortness of breath. The notes lacked any further communication to the Physician regarding the change in condition to the lower legs.<br><br>A Progress Note dated 9/3/24 documented the ARNP returned communication and directed to give Lasix 40 mg at 12 PM, check BMP now and in one week to monitor kidney function and electrolytes.<br><br>A Progress Note dated 9/3/24 at 1:52 PM documented the one time dose of lasix was given to Resident #21 per order. The noted documented Resident #21 denied shortness of breath and showed no signs or symptoms of difficulty breathing. Resident #21 legs were wrapped as weeping was present, especially in the right leg.<br><br>A Progress Note dated 9/3/24 at 3:03 PM documented Resident #21 legs wrapped with ace wraps and ABD pads on the sores. The sores on the right leg are growing in nature, and a rash was present and has an ABD pad on it.<br><br>On 9/4/24 at 1:00 PM, the DON (Director of Nursing) reported she would expect assessments to be completed when a new medication (lasix) was started.<br><br>On 9/4/24 at 1:30 PM, the DON acknowledged and verified she could not locate a weight for Resident #21 on 8/26/24. The DON reported the facility had been in contact with the Physician and would be receiving new orders.<br><br>A Progress Note dated for 9/4/24 at 2:10 PM documented a call was received from the Physician to discuss patient status and skin concerns. The Physician directed the following new orders:<br><br>1. Start spironolactone (diuretic) 25 mg daily<br><br>2. Increase Lasix to 40 mg twice daily<br><br>3. BMP in one week<br><br>4. Continue hydrocortisone cream for the rash<br><br>5. For the open area, use aquacel ag with silver or any equivalent calcium alginate with silver and cover with either a foam pad or ABD.<br><br>6. Continue to treat at the facility. If Resident #21 develops shortness of breath, heart rate is consistently greater than 120 beats per minute, or systolic blood pressure reading drops below 100, call back for further directives.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 7. Call back on 9/5/24 to follow up on how Resident #21 was tolerating the medication and if not improving, other options could be tried.<br><br>On 9/4/24 at 3:18 PM, the DON acknowledged R#21 did not wear ted hose to her lower legs and was waiting on a clarification order from the Physician.<br><br>On 9/4/24 at 3:49 PM, the DON acknowledged and verified she could not locate documentation for the ted hose for the past 60 days. She reported the Physician does not feel the ted hose are appropriate anymore and was going to discontinue the order. She stated Resident #21 wore the brown compression stockings and the stockings were stopped a couple of weeks ago due to the swelling and weeping in the legs. The DON stated she would expect when the wraps were started an order would have been obtained and the ted hose either put on hold or discontinued.<br><br>On 9/5/24 at 8:48 AM, the DON reported she expected physician orders to be followed and documentation completed if the resident refused and/or if nursing felt the order was contraindicated and to notify the Provider.<br><br>On 9/5/24 at 9:14 AM, the DON reported she expected the nurses to triage and use their judgment on whether a fax or phone call to the Provider was appropriate. She stated she expected nursing to continue to monitor the resident and document whether there were improvements or declines while waiting for the Physician to respond and if there were declines to follow up/notify the Provider. The DON acknowledge the documentation for Resident #21 was sparse and missing details regarding assessments and interventions. She stated she was working on educating the staff.<br><br>A facility policy titled Change in Condition reviewed/revised on 4/1/24 documented the purpose of the policy was the following:<br><br>*To improve communication between nurses and a provider when nursing was monitoring a change in condition.<br><br>*To enhance the nursing evaluation of and documentation of a resident who has a change in condition.<br><br>*To provide a standard format to collect pertinent clinical data prior to contacting the provider when there is a change in condition.<br><br>*To standardize shift to shift communication about a resident change in condition.<br><br>The policy documented nursing judgment should be used when determining the urgency of contacting the Provider and at what point to call the Provider. The policy directed that staff continue to monitor the resident and update the change of condition evaluation as appropriate.<br><br>A facility policy titled Physician/Practitioner orders reviewed/revised on 4/1/24 documented the purpose of the policy was to provide individualized care to each resident by obtaining and processing appropriate, accurate and timely Physician/Practitioner orders. |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>46875<br><br>Based on clinical record reviews, hospital record review, staff interviews and policy review, the facility failed to provide adequate nursing supervision to prevent accident and injuries for 1 of 3 residents reviewed (Resident #87). The facility failed to provide the appropriate level of assistance during a transfer which resulted in Resident #87 being lowered to the floor and hospitalized with a fracture requiring surgical intervention. The facility reported a census of 35 residents.<br><br>Citation considered past noncompliance as the facility completed the following interventions prior to the surveyor entering the facility on 9/3/24:<br><br>1. Staff A, CNA provided written disciplinary action for not following the plan of care transfer-4/22/24<br><br>2. Employee Huddles discussed the importance of following the kardex and assist levels with all transfers at all nursing huddles at 6 AM and 2 PM on 4/20, 4/21 and 4/22/24.<br><br>3. The DON and MDS Coordinator applied colored labels to each resident walker/wheelchair so the staff would know the proper assist level of each resident and made sure the colored labels match the kardex. Staff were provided education that they would have real time information on what the resident assist level was. The admission checklist was updated to place colored labels on the equipment and therapy was educated to change the labels immediately when the level of assist changed- 4/22/24<br><br>4. The DON met with therapy to discuss not having different assist levels at different times of the day, if there was a question, to defer to higher level of care.- 4/22/24<br><br>5. All nursing staff were provided face to face education with the Clinical Learning and Development Specialist regarding safe transfers. If staff did not attend one of the group meetings then they were provided 1:1 education.- 5/16/24 through 7/10/24<br><br>Findings include:<br><br>The Minimum Data Set (MDS) assessment for Resident #87 dated 3/14/24 identified a Brief Interview for Mental Status (BIMS) score of 12, which indicated intact cognition. The MDS identified Resident #87 required partial/moderate assistance with bed mobility, and was dependent on staff for transfers, and toileting. The MDS included diagnoses of anemia, atrial fibrillation (irregular heart rhythm), hypertension (high blood pressure), deep venous thrombosis (blood clot in a deep vein), diabetes mellitus, and chronic kidney disease.<br><br>The Care Plan dated 3/8/24 revealed Resident #87 had a ADL (Activity of Daily Living) self care performance deficit related to generalized muscle weakness, diabetes, hypertension, osteoarthritis, macular degeneration, edema and depression. The Care Plan directed the following:<br><br>-Resident #87 required extensive assistance x 2 staff to get to and from the commode, with completion of toileting hygiene and continence product management.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -Resident #87 required assist of one staff member for stand pivot transfers (transfers toward the right) only with use of gait belt and front wheeled walker during the day hours (6 AM to 6 PM), and assist of two staff members for stand pivot transfers during the night hours when more fatigued.<br><br>A Physical Therapy Discharge Summary dated 4/16/24 documented Resident #87 amounts of assistance with transfers and standing tolerance varied from day to day. The summary documented Resident #87 required an assist of one for transfers during the day (6 AM to 6 PM) and an assist of 2 at night.<br><br>A Fall Risk Evaluation dated 3/8/24 documented a fall risk score of 20 which indicated Resident #87 was at high risk for falls.<br><br>An Incident Report dated 4/19/24 at 8:45 PM documented Resident #87 had a sudden loss of strength to her left knee and caused a loss of balance. Staff member assisted Resident #87 to the floor. Resident #87 reported her left knee twisted. The report documented it was undetermined if Resident #87's knee twisted prior to being lowered to the floor or as she was lowered by staff. Resident reported she lost her balance when her knee gave out. Resident reported she wasn't standing that long this time.<br><br>A Progress Note dated 4/19/24 at 8:45 PM documented Resident #87 was transferring from the commode to her wheelchair. Staff was moving the commode and putting the wheelchair behind Resident #87, when she had a sudden loss of strength to her left knee/lower extremity which caused a loss of balance. Resident #87 was not able to regain balance or bear weight on her left lower extremity with staff assistance. Staff lowered Resident #87 to the floor. Staff reported Resident #87 left foot was hooked behind her right calf after being lowered to the floor. Resident #87 reported she had twisted her knee. A head to toe assessment was completed along with vital signs. The head to toe assessment and palpation revealed pain to both anterior and posterior left knee. Increased pain was noted to the left knee with slight movement. No immediate bruising or increased swelling noted. Call placed to on call Provider and new order received to transfer Resident #87 to the hospital for further evaluation. Resident #87's husband was notified of the fall and aware of the transfer to the hospital.<br><br>A Progress Note dated 4/20/24 documented Resident #87 was admitted to the hospital.<br><br>A Hospital Consultation Note dated 4/19/24 documented Resident #87 was admitted to the hospital for a management of left fibula periprosthetic fracture. The consultation note documented Resident #87 presented to the emergency room (ER) via Emergency Medical Services (EMS) after falling from the commode at the nursing home. Resident #87 was being assisted at the time and claimed her left knee gave out.<br><br>A Hospital Operative Report dated 4/22/24 revealed Resident #87 had an open reduction and internal fixation with a lateral plate due to the left distal femur periprosthetic fracture.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | An untitled facility form dated 4/22/24 documented Staff A, CNA (certified nursing assistant) transferred resident to the bedside commode with assistance of one. This level of assistance did not follow the resident's care plan of having assistance of two with transfers during the night time hours. The resident was lowered to the floor during the transfer resulting in a fracture. The summary and expectation portion of the form documented Staff A would follow resident care plans for all transfers and for all care. Staff A to ask for assistance when needed. The form documented Staff A was required to be in compliance with the policies. The form was signed by Staff A, the Director of Nursing (DON) and the Administrator on 4/22/24.<br><br>On 9/4/24 at 10:25 AM, the Administrator reported Staff A, CNA was given a written warning for not providing appropriate level of assistance per the care plan. The Administrator reported there were some inconsistencies in the care plan that had to be clarified with therapy. She stated there was education and training provided to all the nurses and CNAs on transfer techniques.<br><br>On 9/4/24 at 10:30 AM, Staff B, RN (Registered Nurse) reported she was called into Resident #87's room after she was lowered to the floor by Staff A. Staff B stated she completed vitals and a head to toe assessment. She reported Resident #87 had left knee pain. She stated she did some gently passive range of motion to the left knee and stopped when Resident #87 complained of pain. Staff B stated she sent Resident #87 to ER for an evaluation. She stated both Staff A and Resident #87 reported she did not hit her head during the fall. Staff B stated Resident #87 reported she went down easy. Staff B verified Staff A was not providing the appropriate level of assistance during the transfer. Staff B stated Resident #87 was supposed to have assistance from two staff members after 6 PM. Staff B stated she asked Staff A if she was in the room by herself and Staff A responded that she could not remember when Resident #87 was an assist of one vs. assist of two. She stated she did not believe Staff A. Staff B reported she had a conversation with Staff A, educating and reminding her on assistance levels. Staff B stated she told the Administrator and the DON and they also followed up with Staff A. Staff B reported the CNAs are to look at the care plan for assistance levels.<br><br>On 9/4/24 at 1:34 PM, Staff A, CNA reported Resident #87 call light was on and she went to answer the light. She stated Resident #87 wanted to use the commode. She stated she put the gait belt on Resident #87, stood her up, pulled the wheelchair out and put the commode in place. She said Resident #87 sat for a little bit and when she was done, she stood her up to complete peri cares, keeping the commode behind her. She stated Resident #87 sat back down and then stood up again to remove the commode. She stated before she could get the wheelchair in place, Resident #87 started going down so she let her down easily to the floor. Staff A stated she called for the nurse. Staff A reported it happened so fast. She reported she did not hear any pooping and there was no twisting. She stated Resident #87 complained of pain in her left leg and asked her to reposition it. Staff A stated she told Resident #87 she could not move her leg until the nurse evaluated her. She reported Resident #87's Care Plan directed an assist of one with transfers from 6 AM to 6 PM and an assist of 2 from 6PM to 6 AM. Staff A stated she was transferring Resident #87 by herself and was aware after 6 PM she required the assistance of two. She stated the level of assistance was on Resident #87's kardex. She verified and acknowledged she was given a written warning by the DON and Administrator regarding the incident and not following the care plan. She stated she was a rule follower and has had no incidents afterwards.<br><br>A facility policy titled Fall Prevention and Management reviewed/revised 7/29/24 documented the purpose of the policy was the following:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165213 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/05/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Forest City | | STREET ADDRESS, CITY, STATE, ZIP CODE 606 South Seventh Street Forest City, IA 50436 | |

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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | *To promote resident well being by developing and implementing a fall prevention and management program.<br><br>*To identify risk factors and implement intervention before a fall occurs.<br><br>*To give prompt treatment after a fall occurs.<br><br>*To provide guidance for documentation<br><br>A facility policy titled Care Plan reviewed/revised 11/1/23 documented the care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services. It will address the relationship of items or services required and facility responsibility for providing these services. |

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|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>50500<br><br>Based on observations, staff interview, and policy review the facility failed to obtain food temperatures with a resident's meal substitutions and ensure the kitchen ice machine wiped down on a regular basis to reduce the risk of bacteria growth and foodborne illness. The facility reported a census of 35 residents.<br><br>Findings include:<br><br>During the initial tour of the kitchen on 9/3/24 at 10:40 AM, the ice machine examined. Upon opening the lid, a line of pink/yellow residue found along the rim just above the ice collection bin.<br><br>Lunch service observed on 9/4/24 at 11:45 AM. A serving of tomato soup as well as an individual frozen portion of macaroni and cheese reheated in the microwave. When finished cooking, kitchen staff plated the items and sent out to the resident. Temperatures were not obtained for either item.<br><br>During an interview on 9/4/24 at 12:15 PM, the Certified Dietary Manager (CDM) made aware of the temperature oversight. The CDM acknowledged that temperatures should have been obtained on both food items to meet food safety standards.<br><br>During an interview on 9/5/24 at 8:40 AM, the CDM acknowledged the residue found during the initial kitchen tour. The CDM explained there is no scheduled spot checks or wiping down of the ice machine. Kitchen and maintenance staff will complete monthly deep cleaning which is tracked on a separate maintenance computer program. The CDM would expect staff to clean any visible dirt or residue immediately.<br><br>The policy Food Temperature Monitor-Food and Nutrition Services dated 12/21/23, outlines a minimal cook-to temperature of reheated or cooked foods in the microwave to 165 .<br><br>The policy Cleaning Schedule-Food and Nutrition Services dated 11/27/23 outlines staff to check kitchen equipment for cleanliness and that it's in good repair. Refrigerated units placed on a regular cleaning schedule to ensure removal of mold and mildew. |