STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165219	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurens Care Center	304 East Veterans Road Laurens, IA 50554

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review and staff interview, the facility failed to develop and implement a comprehensive care plan for 1 of 5 residents reviewed for psychotropic medications (Resident #21). The facility reported a census of 26 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #21 scored 9 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident had diagnoses including an unspecified nutritional deficiency. The resident received antidepressant medication. The Care Area Assessment (CAA) for psychotropic medication use documented the resident received antidepressant medication for a treatable medical condition. Adverse consequences of antidepressants exhibited by the resident were an increased risk for falls. The CAA documented psychotropic drug use would be addressed on the care plan to avoid complications, minimize risks, and symptom relief. The Clinical Physician's Orders in the Electronic Health Record showed the resident had an order for Mirtazapine (antidepressant) 7.5 mg at bedtime for failure to thrive dated 9/23/24. The resident's Care Plan lacked any identification of the antidepressant use. On 3/20/25 at 12:36 p.m. the Director of Nursing (DON) stated the Mirtazapine should be addressed on the care plan. At 1:43 p.m. the DON confirmed the Mirtazapine had been missed on the care plan. The DON responded to an email on 3/19/25 indicating the facility did not have a policy on care plans, but followed the Code of Federal Regulations on comprehensive person-centered care planning. The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on observation, record review, and staff interview, the facility failed to ensure a resident's care plan was reviewed and revised after each assessment for 2 of 11 residents reviewed (Resident #8 and #14). The facility reported a census of 26 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #8 had long and short term memory problems and severely impaired skills for daily decision making. The resident required substantial/maximal assistance with eating. The resident had diagnoses including Alzheimer's disease. The Care Plan revised 11/14/23 identified the resident had an Activity of Daily Living (ADL) self care performance deficit related to Alzheimer's. The interventions included the resident ate/drank independently. On 3/18/25 at 7:50 a.m. and 12:10 p.m. the resident was fed by staff. On 3/20/25 at 12:36 p.m. the DON confirmed the resident had declined with eating, and the care plan should be updated to reflect the resident's current status. The DON responded to an email on 3/19/25 indicating the facility did not have a policy on care plans, but followed the Code of Federal Regulations on comprehensive person-centered care planning. The regulations directed the care plan would be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. 49056 2. The MDS assessment dated [DATE] for Resident #14 documented diagnosis of non-Alzheimer's dementia, diabetes mellitus, and renal insufficiency. The MDS showed a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment. The MDS also revealed Resident #14 was independent with eating. Review of the Care Plan with an initiated date of 7/17/2023 showed Resident #14 was able to feed self independently. Review of the Visual/Bedside Kardex Report revealed Resident #14 was able to feed self independently. Review of the Electronic Health Record Response History from 2/19/25 to 3/19/25 revealed staff have documented Resident #14 needs limited assistance (residents highly involved in activity, staff provide guided maneuvering of limbs or other non weight bearing assistance) 27 out of 30 days.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on observation, record review, and staff interview, the facility failed to ensure a resident who needed Oxygen (O2) had documentation when they received oxygen for 1 of 2 residents reviewed (Resident #11). The facility reported a census of 26 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #11 scored 11 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident had diagnoses including pneumonia. The Clinical Physician's Orders showed the resident had the order for Oxygen, inhale 2-4 liters/minute as needed to keep sats above 90% dated 2/26/25. The Care Plan identified the resident had oxygen therapy related to Congestive Heart Failure (CHF) revised 3/5/25. The interventions included continuous O2 at 2 liters, may increase up to 4 as needed to keep sats >90% revised 1/22/25. The Treatment Administration Record (TAR) for March 2025 showed the only day documented for the use of O2 was on 3/4/25 at 9:03 a.m. but did not document how many liters. On 3/17/25 at 2:34 p.m. the resident had O2 at 2 liters on per nasal cannula. On 3/18/25 at 7:50 a.m. the resident sat at breakfast with O2 on at 2 liters per nasal cannula. On 3/18/25 at 1:20 p.m. the resident continued with the O2 at 2 liters per nasal. The TAR lacked documentation of the use of the O2. On 3/20/25 at 12:36 p.m. the Director of Nursing stated if the order was for as needed O2 it should be documented on the TAR if the resident received it, and how many liters it was set on. The DON responded to an email on 3/19/25, that the facility did not have a policy for as needed O2, they went by the physician's orders.