STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165222	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corydon Specialty Care	745 East South Street Corydon, IA 50060

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on Electronic Health Record (EHR) review, staff interview, and policy review, the facility failed to consistently complete physician's order for weekly weights for 1 of 1 residents reviewed for nutrition (Resident #13). The facility reported a census of 51. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 with a Brief Interview for Mental Status score of 15 indicating intact cognition. Diagnoses included atrial fibrillation/other dysrhythmias, heart failure, peripheral vascular disease, and Parkinson's disease. The MDS indicated use of a diuretic. The Care Plan revised on 11/8/24 documented a significant weight loss for Resident #13 with a goal to maintain weight or have a slow and gradual weight loss towards a healthier Body Mass Index for age. Interventions include obtaining weights per facility policy. The Care Plan further documented diuretic therapy related to congestive heart failure. Review of the EHR for Resident #13 showed a physician order for weekly weights times 4 weeks. The Physician Order Form signed by the Nurse Practitioner as well as the charge nurse and dated 11/11/24. The Weights and Vitals summary obtained on 12/12/24 show the following weights: 10/1/2024 270.6 Lbs 10/15/2024 261.3 Lbs 10/22/2024 260 Lbs 10/29/2024 257.3 Lbs 11/1/2024 256.8 Lbs 11/5/2024 256.8 Lbs 11/12/2024 254.0 Lbs (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/3/2024 254.2 Lbs 12/10/2024 250.7 Lbs The EHR revealed lack of documented weights for the weeks of 11/19/24 and 11/26/24. No documentation found related to staff attempts to obtain weights, resident refusing, or notifying the Primary Care Provider (PCP) of missing weights. During an interview on 12/11/24 at 10:40 AM, the Director of Nursing (DON) explained charge nurses will review PCP order sheets and enter orders in the EHR. The DON acknowledged the oversight of obtaining Resident #13's weights as ordered and the lack of documentation as to why. The DON voiced an expectation that physician orders to be implemented and followed as written. The policy Medication Orders, revised November 2014, established guidelines in receiving and recording medications order, which include treatments. This should include the specific treatment, frequency, and duration of treatment.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47582 Based on clinical record review, observations, policy review, and staff interviews the facility failed to protect residents from accidents and injuries to include failing to implement interventions to reduce risks for 1 of 3 residents (Resident #15) reviewed for falls. The facility reported a census of 51. Findings include: Review of the Minimum Data Set (MDS) assessment for Resident #15 dated 9/5/24 documented an admitted [DATE] and a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS documented diagnosis of Alzheimer's Disease, anxiety disorder and muscle weakness. The MDS revealed total dependence of 2 or more helpers to complete oral, upper and lower body dressing, putting on/taking off footwear and partial to moderate assistance with sit to stand and transfers. The MDS also revealed the resident had fallen since the prior assessment and had injuries. Review of Resident #15's Care Plan with an initiation date of 12/18/22 revealed Resident #15 was at risk for falls. On 10/3/23 updated to required assistance of 1 with transfers. Care plan documented updates to risk for falls interventions/task on followings dates: 7/19/24 Offer to assist me with positioning at the dinner table. 8/26/24 Encourage me to carry Reacher in my wheelchair to retrieve items off the floor when out of my room. 11/24/24 Therapy to assess for new wheelchair cushion to ensure proper positioning. 12/5/24 Care Plan updated to assist resident with moving foot pedals back while sitting at the Dining Room table. The Incident Report dated 11/1/24 at 2:55 pm documented the resident was on her bottom next to the door that separates the dining room and bird room. The Five Whys Worksheet for the fall documented a new intervention for aides to assist resident in adjusting her foot pedals. The Incident Report dated 11/24/24 at 6:55 pm documented the resident was found on the floor under the wheelchair crying and stating she leaned forward and fell out of the chair. She stated she leaned forward and fell . The Five Whys Worksheet for the fall 11/24/24 documented the intervention for therapy to assess for wheelchair cushion that encourages appropriate positioning. The Incident Report dated 12/5/24 at 5:10 pm documented the resident was found on the dining room floor crying and had a jagged laceration to her head. A puddle of blood under the resident's head. The resident unable to state what happened. The report documented the wheelchair food pedals were forward. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Electronic Healthcare Record (EHR) tab titled, Progress Notes, revealed the following falls and injuries: On 12/5/24 at 8:37 pm resident #15 was found by a staff member laying on the dining room (assist side) floor. Resident was crying. Resident had a jagged laceration to her head. A puddle of blood was on the floor underneath her head. Resident had shoes on both feet. Resident crying stating I'm sorry unable to describe what she was attempting to do. Resident assisted by EMS to wheelchair for treatment of laceration to head. Care Plan updated to assist resident with moving foot pedals back while sitting at DR table. On 11/24/24 at 9:20 pm resident found on the floor in the hallway under wheelchair. Crying stated leaned forward and fell out of chair. On 11/1/24 at 3:07 pm resident was found on the floor near the dining room and bird room. On 10/25/24 at 4:54 am resident complained of pain in her left forearm from a recent fall, area raised, pain upon palpitation. On 8/26/24 at 1:19 pm dietary staff observed resident attempting to reach for a muffin on the floor and fell to the floor, hitting her head on the table. On 7/20/24 at 12:43 pm resident fell to the floor in assisted dining side, wheelchair on the side, left pedal under her left hip. Resident told staff she was trying to pull left foot pedal back to scoot herself closer to the table. On 7/5/24 at 1:29 pm resident fell out of her wheelchair during a self-transfer. Injuries sustained to face: pink area to the forehead with blood noted by a staff member. During an observation on 12/10/24 at 10:45 am, Resident #15 noted to have an abrasion to her forehead. Observed the resident sitting in a wheelchair while she observed an activity. The wheelchair had 2 foot pedals locked in place while residents' feet rested on the floor. During the dining room (DR) observation on 12/10/24 from 12:00 pm to 1:00 pm, Resident #15 noted to self-propel in her wheelchair between dining room tables and after the meal service was completed, headed to her room, with the foot pedals locked in place, restricting her ability to extend her feet forward, causing her feet to tangle and bend under the wheelchair several times. Towards the end of this observation, a staff member approached the resident who by then partially slid towards the edge of the seat. The staff member placed Resident #15's feet onto the foot pedals and then assisted with the transfer. During the subsequent observation on 12/11/24 at 9:48 am, Resident #15 attended the activity in the common area, sitting in the wheelchair with the foot pedals locked in place, feet on the floor. During an interview on 12/11/24 at 9:57 am with Staff D, Certified Medication Aide (CMA), Staff D stated Resident #15 had frequent falls and slid out of her wheelchair often; recently therapy recommended a different seat cushion but it was not in place to her knowledge. Staff D, CMA further stated she would pull the resident up in the wheelchair if she saw her sliding out of it since the resident didn't have a strong core/torso. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 12/12/24 at 9:50 am with the Director of Rehabilitation, it was revealed that Resident #15 had been ordered a different cushion pad and there were some modifications made to her wheelchair. His knowledge of the Resident #15 included: staff assist with transferring since unable to lock the wheelchair on her own, history of sliding out of the wheelchair and poor safety awareness. Physical Therapy was attempted but unsuccessful due to Resident's physical limitations and only Occupational Therapy was in place. In an interview on 12/12/24 at 11:00 am with the Director of Nursing, she stated Resident #15 was able to reposition herself in the wheelchair and needed her foot pedals locked in place while she did it. After reviewing the Care Plan intervention dated 12/5/24 with the intervention to move foot pedals back while sitting at the DR table, she confirmed it was not followed by the facility staff. The facility provided policy titled Falls and Fall Risk, Managing revised March 2018, documented: Resident-Centered Approaches to Managing Falls and Fall Risk 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 2. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once). 3. Examples of initial approaches might include exercise and balance training, a rearrangement of room furniture, improving footwear, changing the lighting, etc. 4. In conjunction with the consultant pharmacist and nursing staff, the attending physician will identify and adjust medications that may be associated with an increased risk of falling, or indicate why those medications could not be tapered or stopped, even for a trial period. 5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. 6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. 7. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. 8. Position-change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. Monitoring Subsequent Falls and Fall Risk (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. 2. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved. 3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50500 Based on observations, staff interviews, and policy review, the facility failed to ensure proper food handling and hand hygiene practices during meal service. The facility reported a census of 51. Finding include: During a continuous observation during lunch service on 12/10/24 at 12:00 PM, the following was observed: 1. Staff A, Certified Nursing Assistant, cutting and buttering a resident's dinner roll with bare hands. 2. Staff B, Van Driver (who is also a Certified Nursing Assistant), cutting and buttering a resident's dinner roll with bare hands. Staff B observed feeding a resident one bite, walking over to another resident, interacting with them and then feeding one bite to that resident. No hand hygiene observed in-between the two residents. Throughout lunch service, Staff B also seen placing hands in pant pockets and rubbing a resident's arm with no hand hygiene observed after these actions. Staff B continued to assist residents eating. 3. Staff C, Cook, cutting and buttering a resident's dinner roll with bare hands. Gloves and a working automatic hand sanitizer dispenser identified in the dining room and readily available for staff use. During an interview on 12/10/24 at 12:15 PM, the Certified Dietary Manager acknowledged staff should not be touching ready-to-eat food with bare hands. During an interview on 12/11/24 at 9:45 AM, the facility Administrator acknowledged the use of bare hands during the previous day's lunch service via a written note from one of the offending staff members. The Administrator also acknowledged a lack of hand hygiene observed throughout lunch. The policy Food Preparation and Service, revised April 2019 revealed, bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single-use items and are discarded after each use. The policy Hand Hygiene Procedure, version 2.3 (H5MAPL0362), documented the use of an alcohol-based hand rub or alternative soap and water should be used in the following situations: a. Before and after coming on duty. b. Before and after direct contact with residents. c. After contact with objects. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Before and after assisting a resident with meals.