STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165235	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lenox Care Center	111 East Van Buren Lenox, IA 50851

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, resident interview, staff interview, and Medication Administration Records - Treatment Administration Records (MAR-TAR) review the facility failed follow physician ordered interventions for a resident with no bowel movement for 3 days and 5 days for 2 of 3 residents reviewed (Residents #2 and #3). The facility reported a census of 25 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #2 documented no Brief Interview for Mental Status (BIMS) indicating Resident #2 was rarely/never understood. The MDS also documented a diagnosis of constipation. The MDS further documented Resident #2 was always incontinent of bowel. Review of Resident #2's EHR titled, Bowel Elimination from 5/21/25 - 6/24/25 documented no bowel movement from 5/24/25 through 5/29/25. The previous bowel movement was recorded on 5/23/25 at 12:15 PM. The next bowel movement was recorded on 5/30/25 at 1:40 PM. No bowel movements were recorded from 6/18/25 - 6/19/25. The previous bowel movement was recorded on 6/17/25 at 9:20 AM. The next bowel movement was recorded 6/20/25 at 1:01 PM. No bowel movements were recorded from 6/21/25 - 6/22/25. The previous bowel movement was recorded on 6/20/25 at 9:59 PM. The next bowel movement was recorded 6/23/25 at 1:59 PM. Review of Resident #2's EHR titled, Orders documented current physician's orders for milk of magnesia suspension 1200 mg/15 mL give 30 mL by mouth as needed for constipation daily. Review of Resident #2's MAR-TAR for the month of May documented milk of magnesia was given as needed on 5/27/25 and 5/30/25. Review of Resident #2's MAR-TAR for the month of June lacked documentation that milk of magnesia was given as needed at all. Review of Resident #2's EHR titled, Care Plan documented interventions initiated 5/22/25 to document bowel movements every shift, follow facility protocol for administration of stool softeners / laxatives / enemas as indicated and observe for s/s of constipation (abdomen distention, nausea / vomiting, anorexia, decreased bowel sounds etc) and report to physician as indicated. Review of Resident #2's EHR titled, Progress Notes documented PRN milk of magnesia was given on 5/27/25 and was ineffective. Progress Notes also documented PRN milk of magnesia was given on 5/30/25 and was effective. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/24/25 at 4:38 PM Staff A, Assistant Director of Nursing (ADON) / Social Services stated she spoke to Staff B on 6/24/25 and she said on 5/27/25 Resident #2 had hypoactive bowel sounds. Staff A stated Staff B said the hospice Certified Nursing Assistant (CNA) reported on the 5/28/25 and 5/29/25 Resident #2 was smearing and that was in an email from the CNA to Staff B. Staff A stated Staff B told her that a nurse that worked at the facility gave milk of magnesia on 5/27/25. On 6/25/25 at 12:00 PM Staff B, Registered Nurse (RN) for hospice provider acknowledged Resident #2 was on her caseload. Staff B stated she had Resident #2 scheduled for 3 times a week for nursing visits. Staff B stated the hospice bowel protocol generally started on the 3rd day of no bowel movement. Staff B stated if milk of magnesia had been given and the results were ineffective on day 3 without a BM she would expect that the milk of magnesia would have been given every day after the 3rd day with no bowel movement. Staff B stated she had documented in her notes that milk of magnesia was given on 5/27/25. Staff B stated her hospice Certified Nursing Aide (CNA) reported Resident #2 was smearing BM during the bath on 5/28/25 and again on 5/29/25 but no bowel movement. Staff B stated there was a time where he was not eating much so it would be less of a concern than no bowel movement at all but still remained a concern. Staff B stated she would expect that an assessment would be expected and possibly the milk of magnesia PRN order given until notable BM depending on the assessment results. 2. The MDS dated [DATE] for Resident #3 documented a BIMS of 12 indicating moderate cognitive impairment. The MDS also documented diagnoses of malnutrition, depression, bipolar, and a history of falling. Review of Resident #3's EHR titled, Bowel Elimination from 5/16/25 - 6/23/25 documented no bowel movement from 5/23/25 through 5/25/25. Previous bowel movement recorded on 5/22/25 at 1:59 PM. Next bowel movement recorded on 5/26/25 at 1:08 PM. Review of Resident #3's EHR titled, Orders documented a current physician's order that started 12/16/24 of milk of magnesia 400 mg/5 mL to give 30 mL by mouth every 24 hours as needed for constipation, Miralax powder started 10/11/24 to give 17 grams by mouth every 24 hours as needed for complaints of constipation, bisacodyl rectal suppository 10 mg insert 1 suppository rectally every 24 hours as need for constipation and milk of magnesia to give 30 mL if no BM for 3 days, give bisacodyl suppository if no bowel movement for 4 days, contact PCC if no BM in 5 days as needed for bowel movement function bowel movement protocol for facility. Review of Resident #3's MAR-TAR for the month of May documentation that both orders for milk of magnesia, the order for Miralax and the order for bisacodyl were given on 5/11/25 and 5/26/25 only for the month of May. Review of Resident #3's EHR titled, Progress Notes documented both orders for milk of magnesia, the order for Miralax and the order for bisacodyl were refused. Progress Notes further lacked documentation of any assessment related to constipation. Review of Resident #3's EHR, Assessments, lacked documentation for abdominal assessment or change in condition. Review of Resident #3's EHR titled, Care Plan documented Resident #3 had potential for episodes of bowel obsessions. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/25 at 11:30 AM Staff C, Registered Nurse (RN) stated if a resident had gone 24 hours without a BM she would typically follow the bowel protocol that starts at 48 hours for milk of magnesia unless there was s/s of constipation. Staff C stated the protocol that starts at 48 hours was the order and that order superseded any 24 hours order unless the resident requested the medication or had s/s of constipation such as abdominal pain or distention. Staff C stated if an as needed medication was given for constipation and was ineffective she would follow the facility's bowel protocol. Staff C stated if the as needed medication for constipation was ineffective an abdominal assessment would be required. Staff C stated she would chart the results of the abdominal assessment in the Progress Notes. Staff C stated the bowel report was being completed every day shift. Staff C stated the report that she was using prior to the system switching over was accurate but now the bowel report that she utilized was not. Staff C stated the report showed people that had a bowel movement that day and also left residents off that had no bowel movement for 3 or 4 days. Staff C stated the facility found a different report to run that was accurate and that was started 6/24/25. On 6/24/25 at 11:15 AM the Director of Nursing (DON) stated the facility does have a protocol. The DON stated the night nurse was doing the resident bowel movement reports and then the nurses were told to run it on every shift by her. The DON stated the resident bowel movement report lets the nurse know which resident had been 3 or more days without a bowel movement. The DON stated the bowel protocol started on the third day of no bowel movement. The DON acknowledged Resident #3 had orders on the MAR-TAR for PRN constipation. The DON stated she would expect the milk of magnesia would have been given daily to Resident #2 if there was no BM in 24 hours and the order read that way. The DON acknowledged Resident #2 had 5 days without a bowel movement. The DON stated a change in condition assessment should have been completed or a Progress Note with bowel sounds or an abdominal assessment should have been completed. The DON stated a change in condition assessment would not be appropriate but a Progress Note with bowel sounds or an abdominal assessment in the Progress Notes because the as needed medication was utilized especially if the medication was ineffective. The DON stated the assessments should have been completed in the Progress Note when an as needed suppository or milk of magnesia related to constipation was given. On 6/24/25 at 4:23 PM the DON acknowledged the bowel report was not working appropriately. The DON stated there was a concern with the bowel report because the nursing staff had to select the exact right report or the report does not report anybody. The DON explained there were several options for bowel reports to be run. The DON acknowledged the facility noted the report was a problem on 6/24/25. On 6/25/25 at 1:00 PM the Administrator stated Resident #2 was in hospice and intake was very poor some days. The Administrator stated Resident #2 did not eat in the hospital prior to admission for a couple of weeks. The Administrator stated they did not have a bowel protocol policy. The Administrator stated the nurses are to follow the physician orders and that was the residents bowel protocol. The Administrator stated the facility did not have a policy for when an assessment should be completed. The Administrator stated the facility did not have a medication administration policy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, and staff interview the facility failed to provide appropriate infection prevention practices when providing care to a resident with a catheter, that was on Enhanced Barrier Precautions (EBP) for 1 of 3 residents reviewed (Resident #2). The facility reported a census of 25 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #2 documented no Brief Interview for Mental Status (BIMS) indicating Resident #2 was rarely/never understood. The MDS also documented utilization of an indwelling catheter. The MDS further documented Resident #2 was always incontinent of bowel. On 6/24/25 at 4:02 PM an observation of personal care and catheter care completed on Resident #2 with the Director of Nursing (DON) present revealed both Staff D, Certified Nursing Assistant (CNA) and Staff E, Certified Nursing Assistant (CNA) completed hand hygiene, applied gloves and donned gowns. Staff D applied lift cloth, full body mechanical lift utilized, Staff D utilized the controls of the mechanical lift, Staff E directed Resident #2 to the bed. The full body mechanical lift was removed from the bedside, Resident #2 assisted with turning to the right by Staff D, lift cloth rolled under, resident assisted to the left by Staff D, lift cloth removed by Staff D, Staff D did not change gloves or perform hand hygiene. Staff D obtained an alcohol wipe from sink area, Staff D cleansed Resident #2's meatus with the alcohol wipe, Staff D then utilized the alcohol wipe to cleanse down the catheter tubing from penis. Staff E removed gloves, completed hand hygiene, and applied gloves. Staff D walked towards the bathroom and opened the curtain, Staff D obtained the graduate and returned to the bedside, Staff D handed Staff E the graduate, Staff D opened an alcohol wipe, Staff E removed the catheter tip from catheter bag, Staff E did not cleanse the catheter tubing tip, Staff E emptied 100 cc of urine from catheter bag, Staff D handed Staff E the alcohol wipe, Staff E cleansed the tip of the catheter tubing, Staff D emptied the graduate into the toilet, Staff D placed a clear garbage bag around the graduate, Staff E removed their gown, removed gloves and completed hand hygiene, Staff D opened Resident #2's bedroom door, Staff D left Resident #2's room with the graduate in a bag with gloves and gown on, Staff D walked down the east hall towards the nurses station toward the utility on the north hall, walked into the residents common area past 4 residents seated near the television, Staff D walked down the north hall to the utility room, Staff D entered the utility room, Staff D removed gloves, and gown and completed hand hygiene. On 6/24/25 at 4:23 PM the DON stated she did have a concern with the personal care and catheter cares provided to Resident #2. The DON stated her expectation was hand hygiene would have been completed when gloves were changed, when moving between tasks, when moving from a dirty area of the body to clean area, after catheter cares, before and after emptying urine from the catheter bag. The DON stated her expectation was that gloves would have been removed and hand hygiene would have been completed before opening the curtain to the bathroom and before leaving the residents room. The DON stated her expectation was that the gown and gloves would have been removed and hand hygiene would have been completed before the staff exited Resident #2's room, before walking down the hall to the dirty utility room. The DON stated her expectation was alcohol would have been utilized to cleanse the catheter tip before opening to drain and after draining urine from the catheter bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy dated 3/25/24 titled, Enhanced Barrier Precautions documented EBP's are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use during high-contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied before performing high-contact resident care activities (as opposed to before entering the room). Personal protective equipment (PPE) was changed before caring for another resident. Examples of high-contact resident care activities requiring the use of a gown and gloves include transferring, providing hygiene, changing briefs or assisting with toileting and indwelling device care such as urinary catheters. Review of policy dated 6/19 titled, Handwashing / Hand Hygiene documented hand hygiene should be completed in situations such as before and after handling an invasive device (e.g. urinary catheters), before moving from a contaminated body site to a clean body site during resident care, after contact with a resident's intact skin, after contact with blood or bodily fluids, after handling contaminated equipment, after removing gloves and before and after entering isolation precaution settings.