STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165243	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chautauqua Guest Home #3	302 Ninth Street Charles City, IA 50616

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of staff training records, facility policies, observation and staff interviews, the facility failed to ensure residents are treated with dignity and respect for 1 of 1 resident (Resident #13) reviewed. The facility reported a census of 42 residents.Findings include:Resident #13's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 99, indicating the inability to conduct the resident interview. The MDS documented Resident #13 ate independently. The MDS included diagnoses of Alzheimer's disease, non-traumatic brain dysfunction (brain damage that occurs due to internal factors, rather than external trauma), and depression.The Medication Review Report dated and signed by the Advanced Registered Nurse Practitioner (ARNP) on 4/15/25, listed Resident #13's diet as a general diet, regular texture, regular consistency, small portions and mechanical soft consistency as needed. Observation on 7/2/25 12:16 PM revealed Resident #13 sat at the second table away from the nurses' station. Resident #13 had her back towards the wall with the nurses' station located to her right with 2 medication carts between the nurses' station and the dining area. Staff B, Certified Nursing Assistant (CNA), sat to the left of Resident 13. The table had 2 other residents there. Resident #13 ate by herself with a spoon in her right hand and lowered her right hand below table height when Staff A, CNA/Certified Medication Aide (CMA), approached the table and forcibly pulled the spoon out of Resident 13's right hand. Staff A pulled up on the handle of the spoon raising Resident 13's hand above the table. Resident #13 had her hand clenched tightly to the handle of the spoon before letting go of the spoon. Resident #13 didn't grimace, make any expression, or speak during this interaction. Staff A used the spoon to cut Resident #13's chocolate cake into pieces. Staff A scooped up a piece of cake up and handed the spoon back to Resident #13. Resident #13 continued to eat independently. Staff A made no comment to Resident #13 or to Staff B prior to pulling the spoon from her hand. Staff A returned to the medication cart located closest to the front entrance after returning the spoon to Resident #13. In an interview on 7/2/25 at12:19 PM, Staff A acknowledged they pulled the spoon away from Resident #13. Staff A verbalized she didn't explain to Resident #13 what she planned to do. Staff A admitted she shouldn't have pulled the spoon from her hand. Staff A commented if you cut her food and give her a bite, she will finish eating. Staff A reported Resident #13 didn't have other silverware provided as she had a known history of placing silverware up her sleeves. In an interview on 7/2/25 at 12:22 PM, Staff B witnessed Staff A pull the spoon from Resident #13's right hand. Staff B reported Staff A didn't verbalized anything prior to pulling the spoon away. Staff B reported it shouldn't have happened and revealed Resident #13 ate at her own pace. In an interview on 7/2/25 at 12:32 PM, the Administrator, Registered Nurse (RN)/ Bachelor of Science in Nursing (BSN), verbalized they allowed Resident #13 the time to eat independently. The Administrator described Resident #13 as a slow eater. The Administrator acknowledged staff members shouldn't pull the silverware away from a resident. Resident #13's July 2025 Documentation Survey Report related to eating listed on 7/2/25 at 12:27 PM Resident #13 completed the activity by themselves with no assistance from a helper. The Documentation Survey Report revealed staff documented Resident #13 ate 0-25% of the meal and drank 0-25% of fluids. Staff training records revealed the following:Staff A completed Dependent Adult Abuse Mandatory Reporter Training on 3/1/24.Staff B completed Dependent Adult Abuse Mandatory Reporter Training on 1/24/23.The facility's undated Resident' [NAME] of Rights stated the following:A. Residents Rights - The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.(1) A facility must treat each resident with respect and dignity and care for each resident in a manner in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.The undated Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy documented the following:All residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This includes prohibiting nursing facility staff from taking part in acts that result in person degradation, including taking or using photographs or recording in any manner that would demean or humiliate a resident, and prohibits using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep or distribute photographs and/or recordings on social media or through