STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Acres Care Center	309 Railroad Street Hull, IA 51239

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review and staff interview the facility failed to notify the Long Term Care (LTC) Ombudsman for 2 of 2 residents reviewed who transferred to the hospital (Resident #4 and #15). The facility reported a census of 27 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #4 documented diagnoses of heart failure, anemia and peripheral vascular disease. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Review of Resident #4's Progress Notes revealed the following information: On 2/5/24 at 11:06 p.m., Resident leaves facility via nonemergent transport. On 2/6/24 at 1:46 a.m., staff placed a phone call to the local hospital and the resident will be admitted to the local hospital. On 2/19/24 at 12:58 p.m., the local hospital called to give the facility report. Review of Resident #4's Census tab revealed the following: On 2/5/24- hospital paid leave. On 2/19/24- active. Review of MDS listing revealed the following: On 2/5/24- discharge return anticipated On 2/19/24- Entry Review of the facility document titled Notice of Transfer Form to Long Term Care Ombudsman dated February 2024 lacked Resident #4's name. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The MDS assessment dated [DATE] for Resident #15 documented diagnoses of atrial fibrillation, heart failure and Chronic Obstructive Pulmonary Disease (COPD). The MDS showed the BIMS score of 15, indicating no cognitive impairment. Review of Resident #15's Progress Notes revealed the following information: On 5/25/24 at 3:37 p.m., transported to emergency room . On 5/25/24 at 10:22 p.m., resident is admitted to the local hospital. On 6/3/24 at 12:15 p.m., resident returns from hospital stay. Review of Resident #15's Census tab revealed the following: On 5/25/24- hospital paid leave. On 6/3/24- active. Review of MDS listing revealed the following: On 5/25/24- discharge return anticipated On 6/3/24- Entry Review of the facility document titled Notice of Transfer Form to Long Term Care Ombudsman dated May 2024 lacked Resident #15's name. Interview on 12/10/24 at 12:54 p.m., with the Administrator revealed Resident #4 and Resident #15 were not submitted on the Ombudsman notification due to the report that was run did not include those resident's names. The 2 residents should have been on the notification. Interview on 12/11/24 at 12:24 p.m., with the Administrator revealed the facility does not have a policy on notification to the Ombudsman. The facility submits the report every month.

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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 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** 47673 Based on electronic health record review, policy review, resident interviews, family interviews, and staff interviews the facility failed to provide an opportunity for a comprehensive care plan to be reviewed and revised by an interdisciplinary team composed of each resident and resident representative to allow developing the care plan and making decisions about his or her care to 2 of 12 residents reviewed (Resident #14 and #19). The facility reported a census of 27 residents. Finding include: 1. The Minimum Data Set (MDS) dated [DATE] documented Resident #14 was rarely / never understood and a Brief Interview for Mental Status (BIMS) was not completed indicating severe cognitive impairment. On 12/09/24 02:36 PM Resident #14's brother / POA stated there were no care conferences and would like them. Resident #14's brother / POA stated he was not ever told by the facility that he could be a part of the care conference. Review of EHR revealed no documentation of completion of care conference with family or resident present. 2. The Minimum Data Set (MDS) dated [DATE] documented Resident #19 had a Brief Interview for Mental Status (BIMS) of 14 indicating no cognitive impairment. On 12/09/24 at 12:48 PM Resident #19 stated he was not invited to care conferences since he has been at the facility. On 12/11/24 at 10:45 AM Staff B, Registered Nurse (RN) / Infection infection preventionist (IP) stated she had been in the position since 12/2/24 and since then been in charge of care conferences. Staff B acknowledged the residents had been telling her that the care conferences had not been completed with them. Staff B stated the administration team had discussed that care conferences had been missed and would need to get back on track with them. Staff B acknowledged care plan conferences had not been completed with Resident #14 or Resident #19 or their families. On 12/11/24 at 2:08 PM the Administrator acknowledged the facility had identified that care plan conferences had not been completed per the regulation. The Administrator stated the facility had been catching up to get back into compliance with the care plan conferences. Review of policy titled Care Planning - Interdisciplinary Team revised 9/13 documented The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family.

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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** 44474 Based on record review, resident and staff interviews and facility policy review the facility failed to provide physician ordered medications and failed to notify the physician of missed medications for 1 of 1 residents reviewed (Resident #4). The facility reported a census of 27 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #4 documented diagnoses of heart failure, anemia and peripheral vascular disease. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Review of the facility provided document titled Order Summary Report signed by the physician 11/20/24 revealed the following orders: Coumadin tablet, Bupropion tablet, and Calcitriol capsule. Review of Resident #4's Progress Notes revealed the following: On 11/14/24 at 5:16 p.m., Coumadin tablet, medication not available, attempted to remove medication from med bank-med bank states med bank unable to connect to drawers unable to take out medication. On 11/15/24 at 4:27 p.m., Coumadin tablet, on order. On 11/16/24 at 4:41 p.m., Coumadin tablet, on order. On 11/20/24 at 6:58 a.m., Calcitriol capsule, on order. On 11/23/24 at 7:54 p.m., Bupropion tablet, not available, on order. On 11/23/24 at 4:00 p.m., Coumadin tablet, not administered, on order. On 11/24/24 at 7:39 a.m., Bupropion tablet, not available, on order from pharmacy. On 11/25/24 at 5:14 p.m., Coumadin tablet, not available, on order. Review of Resident #4's Electronic Health Records (EHR) failed to indicate physician notification for missed medications on 11/14/24, 11/15/24, 11/16/24, 11/20/24, 11/23/24, 11/24/24 and 11/25/24. Review of facility provided policy titled Adverse Consequences and Medication Errors Revised February 2023 revealed promptly notify the provider of any significant error or adverse consequence. Interview on 12/11/24 at 12:22 p.m., with the Director of Nursing (DON) revealed there are times where the medications do not come on time to the facility. If a medication is missed or not given it should be documented in the progress notes and the nurse should be notifying the physician and documenting that in the progress notes as well.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 44474 Based on interview, record review, and policy review, the facility failed to ensure call lights responded to in a timely manner for 2 out of 4 residents reviewed (Resident #4 and #23). The facility reported a census of 27 residents. Findings include: 1. Interview on 12/09/24 at 1:14 p.m., with Resident #4 revealed call lights can take awhile. Resident #4 revealed he has waited over 15 minutes several times. Review of facility provided document titled Alarm Event Report dated 12/4/24-12/11/24 revealed the following: On 12/4/24 the call light turned on at 8:12 a.m. and was on for 29 minutes. On 12/4/24 the call light turned on at 8:59 a.m. and was on for 28 minutes. On 12/4/24 the call light turned on at 12:19 p.m. and was on for 48 minutes. On 12/5/24 the call light turned on at 8:46 a.m. and was on for 16 minutes. On 12/6/24 the call light turned on at 12:15 p.m. and was on for 37 minutes. On 12/7/24 the call light turned on at 11:05 a.m. and was on for 20 minutes. On 12/8/24 the call light turned on at 12:02 p.m. and was on for 1 hour and 7 minutes. On 12/9/24 the call light turned on at 6:19 a.m. and was on for 51 minutes. On 12/9/24 the call light turned on at 8:28 a.m. and was on for 21 minutes. On 12/9/24 the call light turned on at 4:57 p.m. and was on for 35 minutes. On 12/9/24 the call light turned on at 6:22 p.m. and was on for 24 minutes. On 12/10/24 the call light turned on at 2:41 p.m. and was on for 17 minutes. On 12/11/24 the call light turned on at 8:09 a.m. and was on for 21 minutes. 2. Interview on 12/09/24 at 1:52 p.m., with Resident #23's family revealed the facility takes a while to answer his call light and there are times it has been over 15 min especially on the weekends. Review of facility provided document titled Alarm Event Report dated 12/4/24-12/11/24 revealed the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/7/24 the call light turned on at 6:43 a.m. and was on for 55 minutes. On 12/8/24 the call light turned on at 5:35 p.m. and was on for 26 minutes. Interview on 12/11/24 at 2:47 p.m., with the Administrator revealed all call lights should be answered in under 15 minutes.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on observation, document review and staff interview the facility failed to follow the menu and prepare food to meet the residents nutritional needs. The facility reported a census of 27 residents. Findings include: On 12/11/24 at 12:45 PM Staff D, [NAME] stated that she used one bag of diced chicken for the lunch meal. Staff D stated she followed the recipe for 36 servings of Chicken [NAME] Alfredo. Staff D acknowledged the menu required 9 lbs of chicken. Staff D acknowledged that she used 1 bag of diced chicken from the box that contained 2 bags of diced chicken. Staff D stated she did not know how many pounds of chicken were in the bag but she could look at the box to find out. On 12/11/24 at 1:00 PM an observation of the box of diced chicken used for lunch 12/11/24 revealed two 5lbs bags in each box. Review of a document titled, Chicken [NAME] Recipe #8723 documented the recipe required 9lbs of chicken for 36 servings. Review of document titled, Week 2 Wednesday documented Chicken [NAME] for noon meal. On 12/11/24 at 1:10 PM Staff D stated she used one bag of chicken for the recipe because she was told by the trainer when she started that one bag was the appropriate amount for the recipe. On 12/11/24 at 12:50 PM Staff C, Dietary Manager acknowledged two 5 lbs bags of diced chicken in each box. Staff C acknowledged one 5lbs bag was utilized for the recipe for 36 servings. Staff C stated 1.75 bags of diced chicken should have been used for the 36 serving recipe. Staff C acknowledged Staff D did not use the appropriate amount of chicken for the recipe. Review of undated policy titled, Portion Control documented foods will be served according to standard portion sizes to ensure adequate servings of food and to provide portions that are equal in size for those residents that do not require specialized dietary modifications. Standard portion sizes according to food groups include Meat Group 2-3 oz each at lunch & supper. On 12/12/24 at 9:28 AM the Administrator stated the facility's expectation was the recipe was followed. The Administrator stated if the recipe required 9 lbs of chicken that 9 lbs of chicken was used. The Administrator stated they did not have a policy related to following a recipe to provide the appropriate amount of each ingredient, but the facility followed professional standards and the regulations.

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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** 47673 Based on observation, record review, policy review, and staff interview the facility failed to provide appropriate infection prevention practices when providing care to a resident with a suprapubic catheter, that was on Enhanced Barrier Precautions (EBP) for 1 of 1 reviewed (Resident #21). The facility reported a census of 27 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] documented Resident #21 was rarely / never understood and a Brief Interview for Mental Status (BIMS) was not completed indicating severe cognitive impairment. On 12/11/24 at 9:11 AM an observation revealed Staff A, Certified Medication Assistant (CMA) knocked on Resident #21's door, entered the room, completed hand hygiene, applied gloves, applied mask, applied a gown, placed a barrier on the ground, sat a graduate on the barrier, emptied urine from the catheter bag, alcohol wipe utilized to clean the catheter tip, and catheter tip reapplied to bag, 450mL of urine removed from the catheter bag. Urine emptied from the graduate into the toilet. Staff A removed the gown, removed gloves, removed the mask, and completed hand hygiene. Staff A applied gloves, obtained a washcloth, obtained barrier, and placed the barrier on the counter, pulled Resident #21's pants and brief down, removed gloves, completed hand hygiene, applied gloves, cleansed suprapubic area with no rinse cleanser, cleansed catheter tubing down about 6 inches, suprapubic area dried, brief pulled up, pants pulled up, gloves removed, and hand hygiene completed. No gown worn during catheter care. On 12/11/24 at 9:32 AM Staff A, CMA stated all Personal Protective Equipment (PPE) had been available the entire time she had worked at the facility. Staff A stated PPE is kept right outside of the residents room in drawers. Staff A stated PPE must be worn gown, gloves, and mask when possible contact with residents with EBP. Staff A stated she knew to wear a gown because it was explained that recently there was a change that required a gown, mask and gloves should be worn when catheters are emptied. On 12/11/24 at 3:23 PM Staff B, Registered Nurse (RN)/Infection infection preventionist (IP) stated she was not sure if a gown was required during supra pubic catheter cares. Stated she would need to speak to the DON. On 12/12/24 at 8:20 AM the DON stated there were no signs for EBP but there are drawers in the room and EBP was discussed with new hires as well as agency employees as well. The DON stated she would expect that a gown and appropriate PPE would have been worn with catheter care. The DON stated the facility's expectation was a gown would be worn with all catheter cares. (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 Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs). 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). Examples of high-contact resident care activities requiring the use of a gown and gloves include indwelling device care or use (Central lines, Urinary catheters, feeding tubes, tracheotomy/ventilator etc.). Centers for Disease Control and Prevention website titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), visited 7/11/24 and updated 7/12/22 revealed recent changes included, additional rationale for the use of Enhanced Barrier Precautions (EBP) in nursing homes, including the high prevalence of multidrug-resistant organism (MDRO) colonization among residents in this setting. Expanded residents for whom EBP applies to include any resident with an indwelling medical device or wound (regardless of MDRO colonization or infection status). Expanded MDROs for which EBP applies. Clarified that, in the majority of situations, EBP are to be continued for the duration of a resident's admission. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status and Infection or colonization with an MDRO. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care.