STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165253	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Panora Specialty Care	805 East Main Panora, IA 50216

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 0689 Level of Harm - Minimal harm or potential for 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** 34817 Based on clinical record review, observation, staff interview and policy review the facility failed to ensure staff transferred a resident safely and utilized a gait belt for one of three residents reviewed for transfers (Resident #39). The facility reported a census of 40 residents. Findings include: The Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 had diagnoses of Parkinson's Disease, diabetes, and dementia. The MDS revealed the resident had a Brief Interview for Mental Status score of 10 which indicated moderately impaired cognition. The resident required partial to moderate assistance for transfers, The Care Plan initiated 12/26/24 revealed the resident had poor safety awareness related to cognition and had a risk for falls. The resident required assistance with activities of daily living (ADL's). The Care Plan directed staff to provide assistance of one for bed mobility and transfers. The Progress Notes revealed the following: a. On 1/8/25 at 4:00 AM revealed the resident found on the floor by CNA (certified nursing assistant). Resident was incontinent of stool and had an abrasion to the forehead and his knees. Resident running a 100.6 fever. Currently on antibiotic for pneumonia. Resident stated he did not know why he fell . b. On 1/13/25 at 5:42 PM, the resident is on skilled level of care following hospitalization for falls. Resident alert and oriented x 3 (person, place, time) with moments of confusion and forgetfulness. He is able to make needs known but had some difficulty communicating due to memory issues. Resident has poor safety awareness, and has had a recent and past history of falls. Resident needed reminders to not ambulate without assistance. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observations on 1/12/25 at 10:54 AM, Staff A, CNA moved Resident #39's feet over the edge of the bed, held the resident's hand, and pulled on the resident's right arm. The resident hollered out. Staff A asked the resident if it would be better for him to get up from the other side of the bed. The resident said it would probably be better. Staff A placed the wheelchair on the left side of bed. Staff A pulled the resident's right arm and pulled the resident up to a sitting position on the edge of the bed. Staff A then placed a front wheeled walker in front of the resident and assisted the resident to stand. Staff A pulled the resident's pants up. Staff A transferred the resident into the wheelchair then wheeled the resident backward in the wheelchair without foot pedals to the opposite side of the room. The resident had a pair of white socks on his feet (no gripper socks or shoes on) when Staff A transferred him from the bed to the wheelchair. Staff A left the room. The call light was left out of the resident's reach. During an interview on 1/15/25 at 9:45 AM, the Director of Nursing (DON) reported she expected a gait belt used for transfers for safety reasons. A gait belt used and encouraged even if it wasn't on the resident's care plan. The DON reported the call light should be placed within the resident's reach. The facility's Assisting a Resident policy revised 2/2018 revealed the following steps: 1. Assemble equipment and supplies as needed, including a gait belt. 2. Position the bed so that the resident can get out of bed easily. 3. Assist the resident to sit up on the edge of the bed as necessary. 4. Assist the resident in putting on slippers/shoes, 5. Place the gait belt around the resident for safety 6. Assist the resident to a standing position. 7. Assist the resident into the chair or bed. 8. Place the call light within easy reach of the resident. 9. Wash and dry hands.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 50500 Based on observation, resident and staff interviews, staff schedules, and facility assessment review, the facility staff failed to ensure sufficient nursing staff present during scheduled shifts and to ensure call lights were consistently answered within a reasonable amount of time, within 15 minutes, for 5 of 5 nursing halls. The facility reported a census of 40 residents. Findings include: 1. During a continuous observation on 1/14/25 starting at 8:50 AM and ending at 9:40 AM on the 100 and 300 nursing halls, a total of 6 call lights were observed. Breakfast was served in the dining room during this time. Call lights were primarily addressed by one Certified Nursing Assistant (CNA). Two CNA were helping residents during the meal. One was a CNA from the 400 hallway and the other was the Restorative Aide. By the end of the observation period, 1 call light remained unanswered which had been on since 9:20 AM. During confidential resident interviews starting on 1/12/25 at 11:00 AM, 6 of 11 interviewable residents reported prolonged responses to call lights and receiving the requested cares. Several residents stated there have been times when call light responses may be anywhere from 30-60 minutes throughout the day. Two residents reported wait times were so long that their buttock went to sleep or legs go numb due to sitting on the toilet too long. During a confidential interview on 1/14/25 at 12:15 PM, a resident acknowledged that they had pushed the call light earlier in the morning (at approximately 9:20 AM) with no response in 15 minutes. Upon further questioning, the resident indicated the call light was eventually cleared by 10:30 AM. However the resident indicated the wait time was too long and they had urinated in their incontinence brief prior to staff assistance. During an interview on 1/14/25 at 8:15 AM with Staff B, CNA, she reported 1 CNA is assigned to both the 100 and 300 halls, 1 CNA to both the 500 and 600 halls, and 1 CNA to the 400 hall. The CNA on the 400 hall is to assist on the 100 and 300 halls when needed. During an interview on 1/15/25 at 12:00 PM with the Director of Nursing (DON), the facility goal time is to respond to call lights in 15 minutes. The DON acknowledged that certain times of the day, such as meal times, are more challenging than others to ensure call lights are answered in a timely manner. The policy Answering the Call Light, version 1.2 (H5MAPR0016), states the purpose of the policy is to ensure timely responses to residents' requests and needs. 48886 2. Review of the Payroll Based Journal (PBJ) report revealed the facility triggered for excessively low weekend staffing and a one star staffing rating for the fiscal year quarter 4 for 2024, July 1 to September 30. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview 1/15/25 at 9:00 AM, the Administrator and DON advised their census averages between 37 and 41 residents. For this census, to be adequately staffed, they need 2 nursing staff on the 6 am to 6 pm shift, or 1 nurse and 1 Certified Medication Aide (CMA) and they need 3-4 CNA's. For the 2 pm to 10 pm shift they need 3 CNA's and from the 10 pm to 6 am shift they need 2 CNA's. They have 1 nurse from the 6 pm to 6 am shift. Review of the staffing schedule and daily posting for nursing staff for the time period of July 1 to September 30, 2024 revealed the facility only had two CNA's on the 2 pm to 10 pm shift for Saturday the 13th of July. On Sunday, the 4th of August, the facility only had two CNA's from 2 pm to 6 pm. On Sunday, the 18th of August, the facility only had two CNA's from 2 pm to 5:48 pm. On Saturday, the 24th of August, the facility only had two CNA's on the 2 pm to 10 pm shift. On Sunday, the 1st of September, the facility had 2 CNA's on the 2 pm to 10 pm shift. On Sunday, the 15th of September, the facility only had two CNA's on the 2 pm to 10 pm shift. On Sunday, the 29th of September, the facility only had two CNA's on the 2 pm to 10 pm shift. During an interview 1/15/25 at 12:42 PM, the DON acknowledged the low weekend staffing for CNA coverage for the weekends showing low staffing on their schedule and daily posting. On Sunday, the 1st of September, the DON stated she came in to the facility to help cover from 4 pm to 8:30 pm due to low staffing, this was not reported to PBJ. Review of the Facility Assessment report, dated 6/13/24, documented under the staffing plan nursing services and staffing are evaluated at the beginning of each shift and adjusted as needed to meet the care needs and acuity of the resident population.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on record review, observations, staff interview, and policy review, the facility failed to provide peri-care in a manner to prevent cross-contamination and infection for one of three residents observed for peri-care. The facility also failed to ensure staff changed gloves and sanitized hands in accordance with proper infection control techniques when contaminated to protect against cross contamination and potential infection for four of twelve residents observed in the sample. The staff failed to utilize a barrier when emptied one of two catheters observed for catheter care, and failed to remove personal protective equipment prior to exit from an enhanced barrier precautions room for one of five halls observed. The facility reported a census of 40 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had diagnoses of a pressure ulcer and osteomyelitis (a bone infection and inflammation) to the sacrum and coccyx, neurogenic bladder, and multidrug resistant organism (MDRO). The MDS revealed the resident had an indwelling catheter and ostomy. The MDS revealed the resident took an antibiotic. The Care Plan initiated 11/25/24 revealed the resident had pressure ulcers on his sacrum and coccyx and a MDRO. The resident had a suprapubic catheter and took an antibiotic related to a bacterial infection. The Care Plan directed staff to provide catheter care each shift and used Enhanced Barrier Precautions (EBP). During observations on 1/12/25 at 11:19 AM, Staff A, Certified Nursing Assistant (CNA) entered Resident #2's room, then left the room and donned a yellow gown, N95 mask and gloves. Staff A returned to the room and reported she was going to empty the resident's catheter. Staff A obtained a graduate container from the bathroom, unclamped the catheter, then drained the urine contents into graduate container, and clamped the catheter port. Staff A held the graduate full of urine with her gloved hands and took it to the bathroom. Staff A lifted the glasses on her face with her right gloved hand to check the amount of urine in the graduate, then placed her glasses back down over her eyes. Staff A emptied the graduate into the toilet, turned the faucet on, filled the graduate with water to rinse the container, then emptied the graduate into the toilet. Staff A placed the graduate on the back of the toilet. At 11:23 AM, Staff A continued to wear the same gloves, opened the top drawer and obtained an alcohol swab, then cleansed the end of the catheter port with the alcohol swab. Staff A placed the catheter port into the holder, removed one glove, then opened the door to the room and walked down the hall wearing a yellow gown and N95 mask. At 11:24 AM, Staff A removed the yellow gown and placed the gown in a lidded cart in the hallway, then removed the N95 mask, and threw the mask in a lidded cart in the hallway. Staff A proceeded to walk down the hall and did not sanitize her hands. During an interview 1/15/25 at 9:45 AM, the Director of Nursing (DON) reported she expected staff to use a barrier whenever a catheter is emptied. She also expected staff to change gloves and sanitize hands whenever they completed a dirty task and before they moved to a clean area. She expected staff remove the gown and mask before they left the resident's room whenever a resident on EBP's. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Enhanced Barrier Precautions policy dated 3/28/24 revealed EBP's designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. Personal protective equipment (PPE) removed prior to exiting the room or before provided care for another resident. An Emptying a Urinary Drainage Bag policy revised 10/2010 revealed the following procedural steps: 1. Assemble the equipment and supplies as needed, including PPE such as gowns, gloves, and mask. 2. Place the clean equipment on the bedside stand or overbed table. Arrange the supplies so they can be easily reached. 3. Wash and dry hands. 4. [NAME] gloves 5. Place a paper towel on the floor beneath the drainage bag and position the measuring container under the drainage bag. 6. Remove the drain tube from the holder. 7. Open the drainage bag and drain urine into the measuring container. 8. Close the drain. 9. Wipe the drain with an alcohol sponge or swab. 10. Replace the drain tube back into the catheter bag holder. 11. Measure and record the urinary output, if indicated. 12. Pour urine down the commode. 13. Rinse out the measuring container and return to its designated storage area. 14. Discard all disposable items into designated containers. 15. Remove gloves and discard in designated container. 16. Wash hands. A Handwashing/Hand Hygiene policy revised 8/2019 revealed hand hygiene is the primary means to prevent the spread of infections. Hands washed with soap and water or an alcohol-based hand rub used before and after direct contact with residents, before and after handling a catheter, before moving from a contaminated body site to a clean body site during resident care, before and after isolation precautions, and after gloves removed. Hand hygiene is the final step after PPE removed and disposed. Glove use does not replace hand washing/hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The Admission MDS assessment dated [DATE] revealed Resident #39 had diagnoses of Parkinson's Disease, diabetes, and dementia. The MDS revealed the resident had a Brief Interview for Mental Status score of 10 which indicated moderately impaired cognition. The resident had incontinence and required partial to moderate assistance for toileting. The Care Plan initiated 12/26/24 revealed the resident required assistance with activities of daily living (ADL's) and had urinary incontinence. The Care Plan directed staff to provide assistance of one for bed mobility, toileting and provide perineal cleansing as needed. During observations on 1/12/25 at 10:47 AM, Staff A, CNA, donned gloves, removed tabs on the resident's brief, then took disposable wipes and cleansed the resident buttocks from front to back. Staff A then applied barrier ointment to the buttock area. Staff A assisted the resident to roll onto his back then removed the brief over the front (groin). Staff A took disposable wipes and cleansed the resident's penis and scrotum, then applied barrier ointment to the area. Staff A rolled the resident onto his right side, rolled the soiled brief up under him, then applied a clean brief. Staff A did not change her gloves or sanitize her hands when she provided pericare. At 10:50 AM, Staff A applied gloves, rolled the resident onto his left side, tucked a clean pad under his bottom, then rolled the resident onto his right side, and removed the soiled pad. Staff A continued to wear the same gloves and proceeded to open and close dresser drawers, then opened the closet door and obtained a pair of pants. Staff A donned the clean pants on the resident then removed her gloves. At 10:54 AM, after Staff A completed cares with the resident, she left the room but did not wash her hands. During an interview on 1/15/25 at 9:45 AM, the DON reported she expected staff changed their gloves and sanitize their hands whenever they completed a dirty task and before they moved to a clean area. 3. The MDS assessment dated [DATE] revealed Resident #40 had diagnoses of anemia, diabetes, and hemiplegia (paralysis on one side of the body). The MDS documented the resident had a catheter. The Care Plan initiated 1/1/25 revealed the resident had a catheter. The Care Plan directed staff to use EBP's and provide catheter care each shift. During observation on 1/12/25 at 11:10 AM, observed Resident #40 lying in bed and had a catheter bag hung on the bedframe. The catheter bag had amber colored urine in it. At 2:05 PM, a CNA exited the resident's room wearing a yellow gown. The CNA walked down the hall to the soiled linen cart, removed the gown, and placed the gown in the lidded cart. During an interview 1/15/25 at 9:45 AM, the DON reported she expected the yellow gown be removed before staff left the resident's room whenever a resident is on EBP's. 50500 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a continuous meal time observation on 1/14/25 at 9:00 AM and ending at 9:40 AM, Staff A provided feeding assistance to a total of 3 residents. While assisting the first resident to eat, Staff A got up from the table to answer the front door alarm. No hand hygiene was observed when Staff A returned to the table and resumed assisting the resident. When the first resident was done eating, Staff A got up and sat in-between two other residents who needed feeding assistance. No hygiene observed during this transition. While assisting the residents, Staff A got up to obtain a glass of milk and proceeded to pour a small amount in the residents' cereal. Once completed, Staff A resumed feeding assistance, which included not only touching eating utensils but also glasses/mugs with no hygiene observed. During an interview on 1/15/25 at 12:30 PM the DON reported an expectation that staff will perform hand hygiene in-between feeding different residents. A Handwashing/Hand Hygiene revised 8/2019 revealed hand hygiene is the primary means to prevent the spread of infections. An alcohol-based hand rub used before and after direct contact with resident, after contact with objects in the immediate vicinity of the resident, before and after eating or handling food, or before and after assisting a resident with meals.