

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165256	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/27/2024
NAME OF PROVIDER OR SUPPLIER  Elmwood Care Centre		STREET ADDRESS, CITY, STATE, ZIP CODE  222 North 15th Street Onawa, IA 51040	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</b></p> <p>Based on staff interviews and clinical record review the facility failed to follow medication orders for 1 of 3 residents. Resident #1 had a medication order for treatment of low blood pressure (BP) and staff were directed to hold the medication when the systolic BP (top number) was higher than 130. In the month of June, staff administered the medication many times outside of the parameters. The facility reported a census of 35 residents.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 had a Brief Interview for Mental Status (BIMS) score of 11 (moderate cognitive deficits). The resident was totally dependent on staff for transfers and dressing and required hemodialysis services. Her diagnosis included anemia, hypertension, gastroesophageal reflux disease (GERD), end stage renal disease (ESRD) and diabetes mellitus.</p> <p>The Care Plan for Resident #1, dated 7/26/24, showed that the resident received hemodialysis related to ESRD. Staff were directed to communicate with the dialysis unit and to monitor for signs and symptoms of renal insufficiency such as change in heart and lung sounds, obtain vital signs and weight per protocol and report significant change in pulse, respirations and blood pressure immediately. Resident #1 was at risk for alteration in nutritional status related to diabetes with potential for abnormal blood sugar. Staff were to obtain blood sugar per physician order and monitor for hyperglycemia and hypoglycemia.</p> <p>The Clinical Physician's Order revealed an order dated 2/28/24 at 2:34 PM, for Midodrine 10 milligrams (mg) one tab three times a day. Hold if systolic BP was greater than 130.</p> <p>The Medication Administration Record for June 2024 showed that the medication was given on the following date and blood pressures:</p> <ul style="list-style-type: none"> <li>a. June 1; 135/95</li> <li>b. June 2; 148/75</li> <li>c. June 3; 138/74 and 132/70</li> <li>d. June 16; 135/74 and 140/68</li> </ul> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>e. June 18; 141/68</p> <p>f. June 20; 144/65</p> <p>g. June 24; 134/70</p> <p>h. June 25; 138/64</p> <p>On 7/27/24 at 2:45 PM, the Director of Nursing (DON) said they did not have a policy on following physician orders. Nurse Consultant said we follow the orders.</p> <p>On 7/27/24 at 4:00 PM, the DON said that she needed to do some education with the staff that documented that they gave the medication when the blood pressures had been outside the recommended parameters.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</b></p> <p>Based on staff interviews, clinical record review and hospital record review, the facility failed to provide complete and timely assessments and interventions for 1 of 3 residents reviewed. Resident #1 was readmitted to the facility after a long hospitalization . Staff failed to document current vital signs and failed to obtain a blood glucose level upon admission. The facility reported a census of 35 residents.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 had a Brief Interview for Mental Status (BIMS) score of 11 (moderate cognitive deficits). The resident was totally dependent on staff for transfers and dressing and required hemodialysis services. Her diagnosis included anemia, hypertension, gastroesophageal reflux disease (GERD), end stage renal disease (ESRD) and diabetes mellitus.</p> <p>The Care Plan for Resident #1, dated 7/26/24, showed that the resident received hemodialysis related to ESRD. Staff were directed to communicate with the dialysis unit and to monitor for signs and symptoms of renal insufficiency such as change in heart and lung sounds, obtain vital signs and weight per protocol and report significant change in pulse, respirations and blood pressure immediately. Resident #1 was at risk for alteration in nutritional status related to diabetes with potential for abnormal blood sugar. Staff were to obtain blood sugar per physician order and monitor for hyperglycemia and hypoglycemia.</p> <p>The Medication Administration Record (MAR) for the month of July 2024 showed an order dated 2/28/24 at 2:29 PM for Insulin Lispro Solution 100 units per milliliters to be injected as per sliding scale (units determined per glucose level).</p> <p>According to a Nursing Data Collection document for reentry, dated 7/16/24 at 2:59 PM Resident #1 was readmitted to the facility after a hospitalization . The vital signs entered upon admission were from 6/26/24 at 7:39 PM and the chart lacked a blood glucose check.</p> <p>On 7/27/24 at 12:34 PM, the Director of Nursing (DON) said that the admitting nurse had documented the vital signs (VS) on paper but failed to enter them into the electronic chart but the VS were stable. She did not find documentation of a blood glucose level upon admission. The DON said that the insulin had not been delivered from the pharmacy on 7/16, the resident was not having symptoms of hypo or hyperglycemia, and the nurse did not have an order for blood glucose checks, so not having checked the blood glucose upon admission was not a failure.</p> <p>On Page 15 from the Hospital Discharge Instructions dated 7/16/24 at 12:14 PM, showed that staff were to check blood glucose before meals and at bedtime unless otherwise directed by the physician. Staff were to notify the physician if the blood glucose was above 240 milligrams per deciliter (mg/dl) for 48 hours if it was above 400 mg/dl, and did not respond to attempts to correct it. If the blood glucose was less than 70 was symptomatic and did not respond to attempts to correct it.</p> <p>On 7/27/24 at 1:45 PM the DON said that they do not have a policy on admission assessments.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</b></p> <p>Based on staff interviews, clinical record review and policy review the facility failed to conduct pre-dialysis assessments for 2 of 2 residents (Resident #1, and #3) reviewed. The facility reported a census of 35 residents.</p> <p>Findings include:</p> <p>1. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 had a Brief Interview for Mental Status (BIMS) score of 11 (moderate cognitive deficits). The resident was totally dependent on staff for transfers and dressing and required hemodialysis services. Her diagnosis included anemia, hypertension, gastroesophageal reflux disease (GERD), end stage renal disease (ESRD) and diabetes mellitus.</p> <p>The Care Plan for Resident #1, dated 7/26/24, showed that the resident received hemodialysis related to ESRD. Staff were directed to communicate with the dialysis unit and to monitor for signs and symptoms of renal insufficiency such as change in heart and lung sounds, obtain vital signs and weight per protocol and report significant change in pulse, respirations and blood pressure immediately. Resident #1 was at risk for alteration in nutritional status related to diabetes with potential for abnormal blood sugar. Staff were to obtain blood sugar per physician order and monitor for hyperglycemia and hypoglycemia.</p> <p>A review of the Dialysis Communication documents for the month of June revealed that on 6/10, 6/12, 6/14 and 6/21/24 staff failed to include pre-dialysis assessments to include vital signs or weights.</p> <p>A Nursing Note dated 6/28/24 at 11:00 AM documented the dialysis unit called the nursing home that morning to inform them the resident was sent to the Emergency Department (ED) with a high pulse and low blood pressure. The chart lacked documentation of vital signs on 6/28/24 before the resident was sent to dialysis.</p> <p>2. According to the MDS assessment dated [DATE] Resident #3 had a BIMS score of 0 (severe cognitive deficits). The resident was totally dependent on staff for eating, dressing, showering and transfers. Diagnosis included dependence on renal dialysis, Parkinsons, seizure disorder and obstructive uropathy.</p> <p>The Care Plan for Resident #3, updated on 5/21/24 showed that the resident required hemodialysis related to renal failure. Staff were to obtain vital signs and weight per protocol and report significant changes in pulse, respirations and blood pressure immediately.</p> <p>A review of the Dialysis Communication documents for the month of July revealed that on 7/10, 7/15 7/17, 7/19 and 7/24/24, staff failed to include pre-dialysis assessments to include vital signs or weights for Resident #3.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/27/24 at 10:11 AM, the Director of Nursing (DON) said that the nursing staff at the facility did not do pre-dialysis assessments because the dialysis department completed those. The nursing home staff had been instructed to keep that part of the form blank for the dialysis nurses to fill out. When asked how the staff would know if the resident was well enough to tolerate going to dialysis before sending her, the DON again responded dialysis does their own assessment.</p> <p>According to the facility policy titled: Dialysis Communication dated 8/2015, the purpose of the policy was to communicate resident information between the nursing facility and dialysis center. Prior to the resident departure to the dialysis center, and upon return to the nursing facility, the nurse would record vital signs, blood sugar and any changes since the last dialysis appointment.</p>