STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165257	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Age Care Center	1915 South 18th Street Centerville, IA 52544

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on clinical record review, policy review, and staff interviews, the facility failed to ensure thorough documentation of an assessment of a resident's ability to self-administer insulin (an injectable medication used to lower blood sugar) for 1 of 1 residents reviewed for medication self-administration (Resident #35). The facility reported a census of 40 residents. The Minimum Data Set (MDS) assessment tool, dated 5/6/25, listed diagnoses for Resident #35 which included diabetes, hypertension, and Parkinson's disease (a disease that caused difficulty with mobility). The MDS stated the resident took insulin and listed his Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. On 7/31/25 at 12:34 p.m. , via phone, Staff H Licensed Practical Nurse (LPN) stated she drew up the resident's insulin and she handed it to him or the Certified Medical Assistant (CMA) sat it on his table. She stated the resident refused to have certain staff administer his insulin so they started doing this recently. On 7/31/25 at 12:43 p.m., the Director of Nursing (DON) stated Resident #35 administered his own insulin but she did not know if there was documentation of an assessment which determined that he could do this. She stated Staff K LPN sat with him and ensured he could do this and she would search for the documentation. A 6/4/25 untitled note, handwritten by Staff K LPN stated she had the resident self-administer his insulin and he did fine. The facility lacked additional details or assessments regarding the resident's self-administration of insulin including whether staff were required to observe him administer his insulin. The resident's Care Plan focus, the resident has diabetes mellitus and is insulin dependent, initiated 2/13/24 lacked documentation the resident was able to self-administer his insulin. The undated facility policy Self-Administration of Medications, stated if a resident requested to self-administer medications, the facility would assess the resident to determine if self-administration of medication was clinically appropriate.

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on clinical record review, policy review, and staff and resident interviews, the facility failed to make prompt efforts to resolve concerns for 1 of 1 resident reviewed for grievances (Resident #34). The facility reported a census of 34 residents. The Minimum Data Set (MDS) assessment tool, dated 5/6/25, listed diagnoses for Resident #35 which included diabetes, hypertension, and Parkinson's disease (a disease that caused difficulty with mobility). The MDS stated the resident received insulin (an injectable medication used to lower blood sugars) and listed his Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. The facility Resident Grievance Policy revised 3/31/23, stated the facility had a grievance system to resolve issues and respond to grievances as soon as possible. On 7/28/25 at 2:19 p.m., Resident #35 stated he had to sit in his own waste frequently and stated last Sunday (7/27/25), he had to sit in waste for 4-5 hours before anyone changed him. He stated this was humiliating. He stated 3 weeks ago on a Sunday the staff did not check his blood sugar or give him insulin. On 7/30/25 at 4:40 p.m., via phone, Staff F Certified Nursing Assistant (CNA) stated she worked with Resident #35 on 7/27/25 and he complained to her that staff sometimes left him in his brief soiled with fecal matter. On 7/31/25 at 10:47 a.m., Staff B Licensed Practical Nurse (LPN) stated Resident #35 told her that staff left him in his own excrement and she reported this to either the Director of Nursing(DON) or Staff I Social Services. On 7/31/25 at 11:22 a.m., Staff J CNA stated if a resident reported to her that staff did not change them, she would report this to the DON or the Assistant Director of Nursing(ADON). On 7/31/25 at 11:55 a.m., Staff G Certified Medication Assistant (CMA) stated the DON and Staff C Registered Nurse (RN) stood at their medication carts at lunch and talked about Resident #35's insulin. Staff G stated the DON stated she would write refused because the resident didn't like her. Staff G stated at supper time, the resident was very angry that he did not get his lunch insulin. Staff G stated she reported this to the night nurse (Staff H LPN) and the next day she reported it to the Assistant Director of Nursing (ADON). The facility lacked documentation of a grievance process carried out related to Resident #35's concerns. On 7/31/25 at 1:22 p.m., the Administrator stated she expected staff to report such complaints as residents not getting insulin or not being changed. She stated she was not aware of these issues and if staff reported this, they would carry out a grievance process.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record review, policy review, and staff interview, the facility failed to carry out interventions and ordered treatments to treat a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers (Resident #45). The facility reported a census of 45 residents.Findings include:The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers:Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister.Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar.Unstageable Ulcer: inability to see the wound bed.Other staging considerations include:Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface.The MDS assessment tool, dated 3/6/25, listed diagnoses for Resident #45 which included humerus (upper arm bone) fracture, history of falling, and diabetes. The MDS stated the resident was at risk for pressure ulcers but had no unhealed pressure ulcers. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 10 out of 15, indicating moderately impaired cognition. The facility policy Skin Care Program, revised 6/14/20, stated the facility would ensure residents with pressure ulcers received treatment and services consistent with the goal of promoting healing. A 3/14/25 Care Plan entry stated the resident had potential/actual impairment to skin integrity. A 3/24/25 entry stated the resident had a purple, boggy blister to the right and left heels. A 3/24/25 Health Status Note stated the resident had deep purple, circular areas on both heels. The right heel measured 2 centimeters (cm) x 1.2 cm (length x width) and the left heel measured 1.2 cm x 1.2 cm. A 3/25/25 Skin/Wound Note stated the provider assessed the resident's heels and agreed it was suspected deep tissue injury. The April and May 2025 Treatment Administration Records (TARS) listed the following orders:a. Skin prep to discolored areas to heels twice daily. The entries for the morning shifts on 4/2/25 and 4/8/25 were blank and lacked staff initials to indicate the completion of the treatment.b. Cleanse areas to the heels with saline and dry, apply skin prep to both peri wounds, apply a nickel thick layer of Santyl (an ointment used to treat wounds) to both wound beds and cover with border foam gauze every day and as needed. Entries on 4/18/25, 4/21/25, and 4/22/25 were blank and lacked staff initials to indicate the completion of the treatment.c. Cleanse areas to heels with saline and dry, apply skin prep to both peri wounds, apply a nickel thick layer of Santyl and cover with Tegaderm (a type of dressing) every day. The entries for 4/30/25 and 5/11/25 were blank and lacked staff initials to indicate the completion of the treatment.A 5/13/25 Health Status Note stated the facility received an order for Physical Therapy (PT) for positioning for heel wounds. The facility lacked documentation of this order carried out. On 7/31/25 at 10:28 a.m., Staff C Registered Nurse (RN) stated due to staffing it was difficult to complete everything. She stated there were a couple of times when she had to report to the next shift that she did not get a dressing change completed. She stated when she returned to work, she realized no one completed the dressing change. On 7/31/25 at 10:47 a.m., Staff B Licensed Practical Nurse (LPN) stated there were times when patches were not changed over the weekend and she determined that by the date on the patch. On 7/31/25 at 12:12 p.m., the Director of Nursing (DON) stated staff should carry out treatments as ordered. She stated staff should carry out PT orders in a timely manner.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on clinical record review, policy review, and resident and staff interviews, the facility failed to ensure 1 of 6 residents (Resident #35) reviewed for medications was free of a significant medication error due to the omission of insulin (an injectable medication used to lower blood sugar). The facility reported a census of 40 residents. The Minimum Data Set (MDS) assessment tool, dated 5/6/25, listed diagnoses for Resident #35 which included diabetes, hypertension, and Parkinson's disease (a disease that causes difficulty with mobility). The MDS stated the resident took insulin and listed his Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. A 12/5/24 Care Plan entry stated the resident had diabetes and was dependent on insulin. The undated facility policy Recording of Physician Orders directed staff to ensure physician orders were accurate and to avoid medication errors. On 7/28/25 at 2:19 p.m., Resident #34 stated 3 weeks ago on a Sunday the staff did not check his blood sugar or give him insulin. The May and July 2025 Medication Administration Records (MARs) directed staff to check the resident's blood sugar in the evening at 4:00 p.m. and listed an order for Novolog (a type of insulin) per sliding scale three times per day. The entries for insulin on the evening shifts of 5/4/25 and 7/6/25 were blank and lacked initials to indicate staff administered the insulin. The entry for the blood sugar check on 7/6/25 was blank and lacked staff initials to indicate the completion of the blood sugar check.The resident's Progress Notes lacked documentation the resident received or refused insulin on the evenings of 5/4/25 and 7/6/25On 7/31/25 at 11:55 a.m., Staff G Certified Medication Assistant (CMA) stated the Director of Nursing (DON) and Staff C Registered Nurse stood at their medication carts and talked about Resident #35's insulin. Staff G stated the DON stated she would write refused because the resident didn't like her. Staff G stated at supper time, the resident was very angry that he did not get his lunch insulin. Staff G stated she reported this to the night nurse (Staff H Licensed Practical Nurse (LPN) and the next day she reported it to the Assistant Director of Nursing (ADON). On 7/31/25 at 11:13 a.m., Staff D CMA stated Resident #35 complained to her that he did not get his insulin.On 7/31/25 at 12:12 p.m., the DON stated if a resident refused insulin, they should document why and notify the physician. She stated the only time she documented the resident refused was when he did refuse.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, Centers for Disease Control and Prevention (CDC) guidelines, resident and staff interview, the facility failed to offer the pneumococcal vaccine to 4 of 5 sampled residents reviewed for immunizations (Residents #4, #5, 26 and #27). The facility reported a census of 40 residents. On 7/31/2025 at 8:49AM, the Director of Nursing (DON) reported she had been in her role as the DON and Infection Preventionist (IP) since May 2023. The DON reported they should check the immunization status of residents upon admission and residents should be offered immunizations at that time. The DON reported she followed the Center for Disease Control and Prevention (CDC) guidelines for offering residents the pneumococcal vaccine. The DON reported being aware that there were residents eligible for the vaccine who had not been offered. The DON explained the facility's pharmacy representative just did an audit related to vaccines to determine which residents were in need of vaccines. The DON reported she had issues accessing her Iowa Immunization Registry Information (IRIS) account. The DON reported the hard chart and electronic clinical record contained current immunization status information for each resident; however, she maintained a separate file that might have more current information. Review of CDC guidelines, dated 10/2024, revealed the following recommendations:Administer Prevnar 20 (PVC20), Prevnar 21 (PVC21), or Vaxneuvance (PVC15) for all adults 50 years or older who have never received any pneumococcal conjugate vaccine, or whose previous vaccination history is unknown.If a person received just Prevnar (PVC13) at any age, administer PVC20 or PVC21 one year or greater after the administration of PVC13.If a person received PVC13 at any age and Pneumovax (PPSV23) vaccine at age [AGE] or older, administer PVC20 and PVC21 5 years or greater after the last dose of PPSV23. 1. Review of the clinical record for Resident #4 revealed the following:The Minimum Data Set (MDS) assessment, dated 6/5/25, identified an admission date of 3/1/24, the resident was over age [AGE], and had diagnoses that included diabetes, dementia and sleep apnea. The assessment identified a Brief Interview for Mental Status (BIMS) score of 2 out of 15 (indicated a severe cognitive impairment). On 7/30/25, review of the clinical record for Resident #4's immunization status revealed a lack of documentation on whether Resident #4 had ever been offered or received the Pneumovax (PPSV23) vaccine, or any of the pneumococcal conjugate vaccines, Prevnar 20 (PVC20), Prevnar 21 (PVC21), Vaxneuvance (PVC15) per CDC guidelines. 2. Review of the clinical record for Resident #5 revealed the following:The MDS assessment, dated 7/18/25, identified an admission date of 10/13/24, the resident was over age [AGE], and had a diagnosis of coronary artery disease. The assessment identified a BIMS score of 15 out of 15 (indicative of no cognitive impairment).On 7/30/25, review of the clinical record for Resident #5's immunization status revealed the resident had received Pneumovax (PPSV23), dated 3/14/2013, and an unidentified pneumococcal conjugate vaccine (PCV13, PCV15, PCV20, or PCV21), dated 10/21/2016. The clinical record lacked documentation facility staff had offered Resident #5 the PCV20 or PCV21 vaccine per CDC guidelines.On 7/30/2025 at 4:14 PM, Resident #5 reported that if the facility had offered, she would have taken the pneumococcal vaccine. She was unsure of the last time she received the pneumococcal vaccine and what type. 3. Review of the clinical record for Resident #26 revealed the following:The MDS assessment, dated 6/2/25, identified an admission date of 6/20/2019, the resident was over age [AGE], and had diagnoses of dementia and diabetes. The assessment identified a BIMS score of 3 out of 15 (indicative of a severe cognitive impairment).On 7/30/25, review of the clinical record for Resident #26's immunization status revealed the resident had received Prevnar 13, dated 9/5/2002, and PPVS23, dated 10/21/2002. The clinical record lacked documentation facility staff had offered Resident #5 the PCV20 or PCV21 vaccine per CDC guidelines. 4. Review of the clinical record for Resident #27 revealed the following:The MDS assessment, dated 6/21/25, identified an admission date of 3/17/22, the resident was over age [AGE], and had diagnoses of chronic obstructive pulmonary disease (COPD) and heart failure. The assessment identified a BIMS score of 12 out of 15 (indicative of a moderate cognitive impairment).On 7/30/25, review of the clinical record for Resident #27's immunization status revealed the resident had received Prevnar 13, dated 1/31/2017. The clinical record lacked documentation facility staff had offered Resident #5 the PCV20 or PCV21 vaccine per CDC guidelines. On 7/31/2025 at 10:20 AM, the DON confirmed that the identified residents in the sample (Residents #4, #5, #26 and #27) had not been offered or administered the pneumonia vaccine, and the residents were all past due. Review of the facility policy, titled Pneumococcal Vaccine Policy, dated 8/2017, revealed that all residents would be assessed for eligibility per

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, resident interviews and policy review, the facility failed to provide a proper functioning call system to ensure resident timely access to staff for 2 of 16 residents reviewed (Resident #3, Resident #22). The facility reported a census of 40. Findings include: 1) The Minimum Data Set (MDS) dated [DATE] for Resident #3 listed diagnoses to include traumatic brain injury, heart disease, renal insufficiency, neurogenic bladder, urinary tract infection, anxiety chronic pain, reduced mobility. The resident was coded to need substantial/maximus assistance with transferring from bed or chair, or to the toilet. The MDS section for Brief Interview of Mental Status (BIMS) scored 13 out of 15 indicated intact cognitive function. The Care Plan initiated 3/25/24 for Resident #3 documented impaired balance, assistance of two staff with stand lift, noted to put on call light to use bed side commode or to be changed. 2) The MDS dated [DATE] for Resident #22 listed diagnoses to include diabetes, depression, vision deficits and heart disease. Resident coded for using a walker and had a BIMS score of 10 indicating moderate cognitive impairment. The Care Plan dated 4/29/24 for Resident #22 documented the resident needs prompt response to all requests for assistance.On 7/28/25 at 2:45 PM Resident #3 relayed it can take a half hour to forty-five minutes at times to get staff assistance and believes the long wait time is related to the system not functioning correctly, relayed all other lights can be seen and or heard from the nurse's station call light board except for this room. On 7/28/25 at 2:47 PM Resident #22 relayed awareness Resident #3 could not transfer independently and was uncomfortable waiting a long time when needing to use the bathroom. Resident #22 relayed is able to walk with her walker and had gone looking for staff to assist Resident #22. Resident #22 relayed is aware that their room call light cannot be heard or seen at the nurse's station call light board. Resident #22 stated only if staff is walking by and see the overhead light on would they know assistance is needed and felt the malfunction contributed to long wait times. On 7/28/25 at 2:55 PM the Certified Nursing Aide (C.N.A.), Staff B relayed they thought the call light would show up on the nurse's station board. Agreed to test the system, the call light button was pushed and verified, no sound or light at the nurse's station call light board. On 7/28/25 at 2:58 PM the Licensed Practical Nurse (LPN) Staff B relayed they felt sometime the call light will be activated on the board, and is unpredictable. Staff B stated the entire call system is an old system and needs work.On 7/31/25 at 10:20 AM Registered Nurse (RN), Staff C relayed 100, 200 and 300 halls call systems do not have sound, hall four is only hall that had sound. On 7/31/25 at 10:25 AM CNA Staff D, relayed call light system is really old and heard had trouble getting parts, stated all call lights use to have sound, sound was turned off related to malfunctioning, not certain where the sound was coming from and or it was going off for no reason. Staff D stated 400 hall will sound at the nurse's station but the other halls will only light up. Relayed a room in 100 hall will not sound or light up at the nurse's station and staff are only aware if they view the light from the overhead door. Agreed if did not view the overhead light directly could cause a longer wait time for those residents. On 7/31/25 at 10:27 AM with CNA Staff E relayed the call light system is old and needed repaired often and had heard management was looking into another system. On 7/31/25 at 10:30 AM the Administrator acknowledged the call light in R#22, R#3 room does not function properly. Discussion of the call system included Administrator awareness the system is old and is repaired often for various issues. Relayed the system is costly and ongoing work is in process to get a replacement. The facility policy titled Call Light Policy, not dated documented aims to ensure prompt and effective communication between residents and staff to meet their needs and ensure their safety and well-being, each resident room shall be equipped with a functioning call light system, be inspected and maintained to ensure proper functionality.