

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165285	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/05/2024
NAME OF PROVIDER OR SUPPLIER  Corning Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE  1614 Northgate Drive Corning, IA 50841	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074</b></p> <p>Based on record view, family, staff, clinic staff and physician interview, the facility failed to ensure 1 of 3 residents went to their follow up appointments post hospitalization (Resident #1). The facility reported a census of 26 residents.</p> <p>Findings include:</p> <p>According to the admission Minimum Data Set (MDS) assessment tool with a reference date of 5/23/24, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 8. A BIMS score of 8 suggested mild cognitive impairment. The MDS documented the resident was admitted to the facility on [DATE]. The following diagnoses were listed for Resident #1: sepsis, anemia, atrial fibrillation, heart failure, septicemia, stroke, malnutrition, anxiety, and depression.</p> <p>The Care Plan focus area with an initiation date of 5/31/24 documented Resident #1 had a biliary drain.</p> <p>The After-Visit Summary dated 5/4/24 through 5/17/24 was faxed to the facility on [DATE], to the previous Director of Nursing (DON). The summary included the following scheduled appointment:</p> <p>a. May 24, 2024 at 10:20 AM video tele-medicine with a Physician's Assistant (PA) at a Nephrology Clinic.</p> <p>Review of Resident #1's Progress Notes revealed no documentation about her 5/24/24 appointment with the nephrologist.</p> <p>Clinical record review revealed Resident's record lacked documentation from her 5/24/24 appointment with the nephrologist.</p> <p>Review of the facility's appointment book for May 2024 revealed no appointments for Resident #1 had been documented for 5/24/24.</p> <p>On 7/2/24 at 2:07 PM the MDS Coordinator/Interim Director of Nursing (DON) stated the family had requested some labs to be completed on Resident #1 and discussed the missed appointment. This prompted the MDS Coordinator/Interim DON to go through Resident #1's After-Visit Summary. As she reviewed that summary, found the appointment with her nephrologist was missed. She called them to get that rescheduled.</p> <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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/3/24 at 2:54 PM a call was placed to the nephrologist clinic where Resident #1's 5/24/24 appointment was scheduled at. The clinic staff indicated they had documented on 5/24/24 the resident was a no show with no follow-up communication to indicate why it was missed. She indicated a month ago today, it looked like they wanted to know if another tele-health appointment was ok. The clinic indicated the resident would need to be seen in person and rescheduled the appointment for 7/11/24. When asked to speak with the PA that the resident was scheduled to see, she indicated she was out of the office. She added this would have been the first time the PA would have seen Resident #1 and was unsure how much information she could provide.</p> <p>On 7/5/24 at 11:27 AM the Regional Nurse Consultant acknowledged she was unable to find any documentation on the missed 5/24/24 appointment. She added she was not able to find the appointment in their schedule book either.</p> <p>On 7/5/24 at 1:17 PM the previous Director of Nursing (DON) stated Resident #1's first tele-health appointment was missed. She had the MDS Coordinator/Interim DON rescheduled that appointment for the resident. When asked what appointment was missed, she thought it may have been with the Nephrologist. When asked who had set up the initial appointment, the previous DON indicated she wanted to say it was on her discharge instructions but was not 100% on that. When asked why the appointment was missed she stated it may have been an IT type of issue.</p> <p>On 7/5/24 at 2:35 PM the Administrator spoke with the MDS Coordinator/Interim DON about the 5/24/24 appointment for Resident #1. They have a Registered Nurse (RN) that does all the scanning of documents for the facility. Believed at that time, the RN was on vacation. When the Administrator was asked if the nurse admitting the resident to the facility is responsible for review hospital documentation to reconcile medications, note any appointments, or anything pertinent to the hospitalization , he acknowledged they should be reviewing the discharge paperwork.</p> <p>The facility provided a document titled Admission Orders. The documented indicated the purpose was to provide essential care according to physician directives. Staff are to obtain information for orders from transfer forms received from resident and/or family, or any other accompanying information. Orders must be obtained at a minimum for food service, medical administration, routine care, additional specific needs, and rehabilitation directives.</p>		