

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 05/28/2025
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>49628</p> <p>Based on clinical record review, facility document review, staff interviews, and facility policy review the facility failed to provide dignity to 1 of 4 residents (Resident #1). The facility failed to provide dignity to the residents as demonstrated by a staff telling the resident to complete their own peri care when assistance was requested by the resident. The facility reported a census of 25 residents.</p> <p>Findings Include:</p> <p>The Minimum Data Set (MDS) for Resident #1, dated 1/15/25 in progress, identified a Brief Interview for Mental Status (BIMS) score of 15/15 indicating normal cognitive functioning. The resident had diagnoses of other fractures, seizure disorder or epilepsy, and Schizophrenia. The document identified the dependence for toileting hygiene and lower body dressing, and significant/maximal assistance for transfers and bed mobility. The document revealed frequent incontinence of bladder or always incontinent of bowel.</p> <p>Resident #1's Care Plan dated 3/24/25 revealed a focus area of Activities of Daily Living (ADL's) initiated on 1/10/25 with interventions including healing fractures of low back and pelvis with pain and needing time to adjust and instruct in safe manners to move when completing ADL's, partial assistance of 1 staff with gait belt and walker for toilet transfers, and dependence for toileting hygiene with date of 1/10/25.</p> <p>Resident #1's Electronic Medical Record (EMR) identified diagnoses of fracture of unspecified parts of lumbosacral spine and pelvis, subsequent encounter for fracture with routine healing.</p> <p>The EMR toileting hygiene document identified 39 entries of Resident #1 requiring dependent assistance from staff 10 entries for substantial/maximal assistance from staff, 2 entries for partial/moderate assistance, 2 entries for supervision, and 2 entries for independence.</p> <p>On 5/27/25 at 12:42 PM Staff B, Certified Nurse Assistant (CNA), stated she heard Staff G, CNA, walk into Resident #1's room and state you did this to yourself, so you can get yourself up and clean yourself up. Staff B stated Resident #1 told her Staff G had previously refused to provide care to him.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/27/25 at 12:55 PM Staff A, Licensed Practical Nurse (LPN), stated she heard Staff G make the comment to Resident #1 to clean himself up after an incontinence episode. Staff A stated she separated Staff G from Resident #1, and Resident #1 was crying after the statement by Staff G. Staff A stated Staff G had used inappropriate language in front of residents prior to the reported incident.</p> <p>On 5/27/25 at 1:07 PM Staff C, Certified Medication Aide (CMA), stated when working on 2/18/25 that Resident #1 requested she help him get up after Staff G made the statement, as he didn't want her (Staff G) helping any more. Staff C stated the resident was crying, and indicated he couldn't complete his own pericare all the time and sometimes had accidents.</p> <p>The facility provided document, interview with the identified resident, dated 2/19/25, revealed an interview with Resident #1 and Staff E, Director of Nursing (DON), and Staff F, Administrator. The document revealed Resident #1 identified Staff G told him you can clean your butt, you did it yourself. The resident stated Staff G makes him do it like every day.</p> <p>The facility provided document, Staff Statements, revealed Staff C's written statement that she had witnessed Staff G on many occasions tell Resident #1 that he is a grown ass man and needs to wipe his own ass. The statement also revealed Resident #1 requested Staff G no longer work with him due to the way she spoke to him. A written statement by Staff B revealed on 2/18/25 she heard Staff G tell Resident #1 to clean himself up after soiling himself. The statement further revealed Resident #1 acted upset and held his head down when Staff G made this comment to the resident. A statement written by Staff A revealed on 2/19/25 Staff G told her she (Staff G) told Resident #1 she was not going to clean his ass, if he was going home he needed to do it himself.</p> <p>On 5/28/25 at 10:17 AM Staff E and Staff F stated they expected facility staff to follow the residents' Care Plans, treat residents with respect, and follow the facility's Abuse Policy.</p> <p>The facility's document, Resident Rights, revised 12/16, revealed residents have the right to a dignified existence, and be treated with respect, kindness and dignity.</p> <p>The facility's document, Resident's [NAME] of Rights, revised 1/17, revealed the facility must treat each resident with respect and dignity and care for each resident in a manner that promotes maintenance or enhancement of the resident's quality of life, recognizing each resident's individuality. The document further revealed the facility must protect and promote the rights of the resident. The document disclosed each resident has the right to be treated with dignity and respect.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>49628</p> <p>Based on documents reviewed, staff interviews and policy review, the facility failed to report an alleged violation of verbal abuse in a timely manner. The facility failed to report observed verbal interactions between a staff member and Resident #1 within the required timeframe. The facility reported a census of 25.</p> <p>Findings include:</p> <p>The Intake Information to the State Agency for the Facility Reported Incident (FRI) revealed a submission date and time of 2/19/25 at 7:45 PM. The document revealed the date of the alleged abuse occurred on 2/19/25.</p> <p>On 5/27/25 at 12:42 PM Staff B, Certified Nurse Assistant (CNA), stated she heard Staff G, CNA, tell Resident #1 you did this to yourself, so you can get yourself up and clean yourself up. Staff G initially stated she notified the Director of Nursing (DON) within 24 hours of the incident, then stated she notified the DON immediately as the primary nurse was on a break.</p> <p>On 5/27/25 at 12:55 PM Staff A, Licensed Practical Nurse (LPN), stated she heard the comment made by Staff G to Resident #1, and separated the staff from the resident. Staff A stated she told Staff G she could not make those statements to a resident, and Staff G was not happy with Staff A. The staff stated the resident was crying.</p> <p>On 5/27/25 at 1:07 PM Staff C, CNA, stated she was working on the date of the verbal statement by Staff G, CNA, to Resident #1. The staff stated she provided care to Resident #1 following the statement by Staff G as the resident was crying and requested Staff G not help him anymore.</p> <p>The facility's self report document revealed the Director of Nursing was notified on 2/19/25 by Staff B of a comment made to Resident #1 by Staff G that he soiled himself and needed to clean himself up.</p> <p>The facility's document, Staff Statements, provided a written statement by Staff C stating Resident #1 requested the staff to assist him following Staff G's statement to him on the date of the reported incident and not wanting Staff G to work with him anymore. Staff C's statement further included witnessing on many occasions Staff G tell Resident #1 he was a grown ass man and needs to wipe his own ass. A written statement by Staff B revealed the staff witnessed Staff G make a comment to Resident #1 regarding soiling himself and needing to clean himself up on 2/18/25. Staff B's written statement further revealed witnessing Staff G making these types of statements prior to 2/18/25 and had assumed it had been reported by other staff. A statement written by Staff A revealed on 2/19/25 Staff G told her she (Staff G) told Resident #1 she was not going to clean his ass, if he was going home he needed to do it himself.</p> <p>The facility's Nursing Schedule 2/6/25-2/19/25 confirmed Staff G worked on 2/18/25 and not on 2/19/25. The document revealed Staff A, Staff B, and Staff G worked on 2/18/25 and 2/19/25.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with Staff E and Staff F, Administrator, on 5/28/25 at 10:17 AM the DON stated she was notified of Staff G's statement to Resident #1 on 2/19/25. Staff F acknowledged at the time of the notification she had left the building for the day. Staff E stated she was getting ready to leave when Staff B returned to the facility and provided the statement regarding the interaction between Staff G and Resident #1. Staff E confirmed Staff B had completed her shift for the day when she returned to the facility and reported the interaction. When questioned whether the verbal statement by Staff G to Resident #1 occurred on 2/18/25 or 2/19/25 as it was reported on the FRI to the State Agency, Staff E and Staff F acknowledged the interaction had occurred on 2/18/25 not 2/19/25. Staff E and Staff F admitted as staff had not reported the verbal incident from Staff G to Resident #1, Staff G continued to work with the resident until 2/19/25 when the administration was notified after Staff G's shift. Staff E and Staff F expected staff to report alleged violations of abuse within the required time frame.</p> <p>The facility's Abuse Policy and Procedures, Dependent Adult Abuse 11/19 Edition, revealed mental abuse is the use of verbal conduct which causes or has the potential to cause resident humiliation, shame or degradation. The document revealed verbal abuse included mocking or ridiculing the resident and could be construed as a type of mental abuse. The document disclosed neglect included failure by the facility or employees to provide services to residents that was necessary to avoid mental anguish. The document revealed all allegations of resident abuse, neglect, or mistreatment must be reported immediately to the Charge Nurse, who is responsible for immediately reporting the allegation(s) to the Administrator or designated representative. The document further provided that all allegations of abuse shall be reported to the SA no later than 2 hours after the allegation was made.</p>		