

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165295	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Montezuma Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 316 Meadow Lane Drive Montezuma, IA 50171	
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>35434</p> <p>Based on clinical record review, policy review, and resident and staff interviews, the facility failed to treat 2 of 9 residents reviewed for resident rights with dignity (Resident #5 and #11) by failing to assist residents with the bedpan and/or incontinent care and instructing them to urinate/defecate in their incontinent briefs. The facility reported a census of 31 residents.</p> <p>Findings include:</p> <p>1. The Admission Minimum Data Set(MDS) assessment tool, dated 4/24/24, listed diagnoses for Resident #5 which included tibia(a lower leg bone) fracture, weakness, and difficulty walking, and stated the resident required substantial/maximal assistance for toilet transfers and was dependent on staff for toileting hygiene. The MDS listed her Brief Interview for Mental Status(BIMS) score as 15 out of 15, which indicated intact cognition.</p> <p>Care Plan entries, dated 4/18/24, stated the resident required the assistance of 1 staff for toileting and personal hygiene.</p> <p>A 4/19/24 1:38 p.m., Nurses Note documented the resident admitted to the facility following a right ankle fracture and would complete therapy. The note stated the resident was incontinent of bladder but was aware of when she was incontinent and called promptly to request staff to change her.</p> <p>On 5/8/24 at 1:15 p.m., Resident #5 stated she had trouble with a night shift staff member who told her that she was not wet and she should defecate in her incontinent brief. She stated this happened several times and the staff member would reach into her brief and tell her she was not wet enough and to go in her brief. The resident stated she had had a suppository and really needed to use the bedpan but because the staff member would not provide this to her, she had to go in her brief. She stated this made her feel dirty.</p> <p>2. The MDS assessment tool, dated 4/17/24, listed diagnoses for Resident #6 which included heart failure, respiratory failure, and morbid obesity. The MDS listed the resident's BIMS score as 15 out of 15, which indicated intact cognition.</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 5/8/24 at 1:15 p.m. Resident #6, who is Resident #5's roommate was present during Resident #5's interview. Resident #6 stated the staff member who told Resident #5 to defecate in her pants was Staff A Certified Nursing Assistant (CNA). Resident #6 stated she heard her say that to Resident #6 2 times on 2 separate shifts. Resident #6 stated they reported it but she could not remember who it was they reported it to. Resident #6 stated this happened about 2 weeks ago and the next day someone came into talk to them about it and they had to sign a paper regarding the complaint. Resident #6 stated she was shocked when she heard Staff A state this to Resident #5 and stated this treatment was treating them like they were not human.</p> <p>3. The Annual MDS assessment tool, dated 2/5/24, listed diagnoses for Resident #3 which included arthritis, morbid obesity, and high blood pressure. The MDS listed her Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition.</p> <p>On 5/8/24 at 1:45 p.m., Resident #3 stated about a year ago she heard Staff A tell Resident #11 to urinate in her pants.</p> <p>4. The Quarterly MDS assessment tool, dated 5/11/23, listed diagnoses for Resident #11 which included heart failure, hip fracture, and weakness. The MDS stated the resident required extensive assistance of 1 staff for toilet use and personal hygiene and listed her BIMS score as 13 out of 15, which indicated intact cognition.</p> <p>Care Plan entries, dated 11/21/22, stated the resident required the assistance of 1 staff for toileting and personal hygiene related to limited mobility due to a hip fracture.</p> <p>On 5/8/24, the facility provided all reported grievances from 12/1/23 to 5/8/23 listed on the Resident/Family/Staff Grievance Concern Investigation Log. The form did not contain any concerns related to staff failing to change residents or provide a bed pan or directing them to urinate/defecate in their briefs.</p> <p>On 5/8/24 at 1:08 p.m. Staff B CNA stated Resident #5 reported to her that Staff A would not provide her the bed pan and instructed the resident to go in her brief. Staff B stated she reported this to Staff E, former Director of Nursing (DON).</p> <p>On 5/8/24 at 1:16 p.m. Staff C CNA stated Resident #5 reported to her that Staff A refused to provide her the bed pan and instructed her to urinate in her pants.</p> <p>On 5/8/24 at 3:23 p.m. via phone Staff D Registered Nurse (RN) stated that he administered a suppository to Resident #5 and asked her to call when she needed help. Staff D heard later from Resident #5's roommate, Resident #6 that Staff A came in and told Resident #5 to go in her brief. Staff D stated he reported the concern to the Assistant Director of Nursing (ADON). He stated Staff A should have provided the resident with a fracture pan (a smaller bed pan which was easier to move on and off of).</p> <p>On 5/8/24 at 4:08 p.m., the ADON stated she worked the night shift around 4/23/24 and on 4:00 a.m. rounds Residents #5 and #6 told her that Staff A told Resident #5 to just soil herself and she would change her rather than giving her a bed pan. The ADON stated she reported this to Staff E, former DON.</p> <p>(continued on next page)</p>		

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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 5/9/24 at 9:36 a.m. via phone, Staff E, former DON stated staff reported to her that Staff A did not round on residents who were sleeping and she educated Staff A about making sure resident's were not wet. Staff E stated she did not think anyone reported to her that Staff A instructed residents to urinate in their briefs. She stated if she did hear that she would investigate it and report it because that was wrong.</p> <p>On 5/9/24 at 12:01 p.m., the Administrator stated that she found out yesterday about a staff member who told a resident to go to the bathroom in her brief and she would change her. She stated they called Staff A and suspended her and were currently completing their investigation. She stated she did not hear about this until yesterday and stated she would want this investigated and reported right after it occurred.</p> <p>The facility policy Dignity, revised February 2021, stated staff would care for each resident in a manner that promoted and enhanced well-being, level of satisfaction with life and feelings of self-worth and self-esteem.</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>35434</p> <p>Based on clinical record review, policy review, and resident and staff interviews, the facility failed to report an allegation of abuse (a staff member allegedly failed to assist a resident with the bedpan and/or incontinent care and instructed her to urinate/defecate in her incontinent brief) for 1 of 1 residents reviewed for an allegation of abuse(Resident #5). The facility reported a census of 31 residents.</p> <p>Findings included:</p> <p>1. The Admission Minimum Data Set (MDS) assessment tool, dated 4/24/24, listed diagnoses for Resident #5 which included tibia (a lower leg bone) fracture, weakness, and difficulty walking, and stated the resident required substantial/maximal assistance for toilet transfers and was dependent on staff for toileting hygiene. The MDS listed her Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition.</p> <p>Care Plan entries, dated 4/18/24, stated the resident required the assistance of 1 staff for toileting and personal hygiene.</p> <p>A 4/19/24 Nurses Note stated the resident admitted to the facility following a right ankle fracture and would complete therapy. The note stated the resident was incontinent of bladder but was aware of when she was incontinent and called promptly to request staff to change her.</p> <p>On 5/8/24 at 1:15 p.m., Resident #5 stated she had trouble with a night shift staff member who told her that she was not wet and she should defecate in her incontinent brief. She stated this happened several times and the staff member would reach into her brief and tell her she was not wet enough and to go in her brief. The resident stated she had had a suppository and really needed to use the bedpan but because the staff member would not provide this to her, she had to go in her brief. She stated this made her feel dirty.</p> <p>2. The Annual MDS assessment tool, dated 4/17/24, listed diagnoses for Resident #6 which included heart failure, respiratory failure, and morbid obesity. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition.</p> <p>On 5/8/24 at 1:15 p.m. Resident #6, who is Resident #5's roommate was present during Resident #5's interview. Resident #6 stated the staff member who told Resident #5 to defecate in her pants was Staff A Certified Nursing Assistant (CNA). Resident #6 stated she heard her say that to Resident #6 2 times on 2 separate shifts. Resident #6 stated they reported it but she could not remember who it was they reported it to. Resident #6 stated this happened about 2 weeks ago and the next day someone came into talk to them about it and they had to sign a paper regarding the complaint. Resident #6 stated she was shocked when she heard Staff A state this to Resident #5 and stated this treatment was treating them like they were not human.</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>On 5/8/24, the facility provided all reported grievances from 12/1/23 to 5/8/23 listed on the Resident/Family/Staff Grievance Concern Investigation Log. The form did not contain any concerns related to staff failing to change residents or provide a bed pan or directing them to urinate/defecate in their briefs.</p> <p>On 5/8/24 at 1:08 p.m. Staff B CNA stated Resident #5 reported to her that Staff A would not provide her the bed pan and instructed the resident to go in her brief. Staff B stated she reported this to Staff E, former Director of Nursing (DON).</p> <p>On 5/8/24 at 1:16 p.m. Staff C CNA stated Resident #5 reported to her that Staff A refused to provide her the bed pan and instructed her to urinate in her pants.</p> <p>On 5/8/24 at 3:23 p.m. via phone Staff D Registered Nurse (RN) stated that he administered a suppository to Resident #5 and asked her to call when she needed help. Staff D heard later from Resident #5's roommate, Resident #6 that Staff A came in and told Resident #5 to go in her brief. Staff D stated he reported the concern to the Assistant Director of Nursing (ADON). He stated Staff A should have provided the resident with a fracture pan (a smaller bed pan which was easier to move on and off of).</p> <p>On 5/8/24 at 4:08 p.m., the ADON stated she worked the night shift around 4/23/24 and on 4:00 a.m. rounds Residents #5 and #6 told her that Staff A told Resident #5 to just soil herself and she would change her rather than giving her a bed pan. The ADON stated she reported this to Staff E, former DON.</p> <p>On 5/9/24 at 9:36 a.m. via phone, Staff E, former DON stated staff reported to her that Staff A did not round on residents who were sleeping and she educated Staff A about making sure resident's were not wet. Staff E stated she did not think anyone reported to her that Staff A instructed residents to urinate in their briefs. She stated if she did hear that she would investigate it and report it because that was wrong.</p> <p>On 5/9/24 at 12:01 p.m., the Administrator stated that she found out yesterday about a staff member who told a resident to go to the bathroom in her brief and she would change her. She stated they called Staff A and suspended her and were currently completing their investigation. She stated she did not hear about this until yesterday and stated she would want this investigated and reported right after it occurred.</p> <p>The facility provided the survey team with a policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program with revised date of April 2021. The policy documented the following under the heading Policy Interpretation and Implementation; The resident abuse, neglect and exploitation program consists of a facility-wide commitment and resource allocation to support the following objectives: (which included the following directives)</p> <p>-Develop and implement policies and protocols to prevent and identify:</p> <p>a. abuse or mistreatment of residents;</p> <p>b. neglect of residents; and/or</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>c. theft, exploitation or misappropriation of resident property.</p> <ul style="list-style-type: none"> -Protect residents from abuse, neglect, exploitation or misappropriation of property. -Establish and maintain a culture of compassion and caring for all residents -Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property -Provide staff orientation and training/orientation programs that include topics such as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior -Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. -Investigate and report any allegations within timeframes required by federal requirements. <p>The facility policy Dignity, revised February 2021, stated staff would care for each resident in a manner that promoted and enhanced well-being, level of satisfaction with life and feelings of self-worth and self-esteem.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>35434</p> <p>Based on clinical record review, policy review, and resident and staff interviews, the facility failed to investigate an allegation of abuse (a staff member allegedly failed to assist a resident with the bedpan and/or incontinent care and instructed her to urinate/defecate in her incontinent brief) and ensure protection from further abuse for 1 of 1 residents reviewed for an allegation of abuse(Resident #5). The facility reported a census of 31 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set(MDS) assessment tool, dated 4/24/24, listed diagnoses for Resident #5 which included tibia(a lower leg bone) fracture, weakness, and difficulty walking, and stated the resident required substantial/maximal assistance for toilet transfers and was dependent on staff for toileting hygiene. The MDS listed her Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition.</p> <p>Care Plan entries, dated 4/18/24, stated the resident required the assistance of 1 staff for toileting and personal hygiene.</p> <p>A 4/19/24 Nurses Note stated the resident admitted to the facility following a right ankle fracture and would complete therapy. The note stated the resident was incontinent of bladder but was aware of when she was incontinent and called promptly to request staff to change her.</p> <p>On 5/8/24 at 1:15 p.m., Resident #5 stated she had trouble with a night shift staff member who told her that she was not wet and she should defecate in her incontinent brief. She stated this happened several times and the staff member would reach into her brief and tell her she was not wet enough and to go in her brief. The resident stated she had had a suppository and really needed to use the bedpan but because the staff member would not provide this to her, she had to go in her brief. She stated this made her feel dirty.</p> <p>2. The MDS assessment tool, dated 4/17/24, listed diagnoses for Resident #6 which included heart failure, respiratory failure, and morbid obesity. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition.</p> <p>On 5/8/24 at 1:15 p.m. Resident #6, who is Resident #5's roommate was present during Resident #5's interview. Resident #6 stated the staff member who told Resident #5 to defecate in her pants was Staff A Certified Nursing Assistant(CNA). Resident #6 stated she heard her say that to Resident #6 2 times on 2 separate shifts. Resident #6 stated they reported it but she could not remember who it was they reported it to. Resident #6 stated this happened about 2 weeks ago and the next day someone came into talk to them about it and they had to sign a paper regarding the complaint. Resident #6 stated she was shocked when she heard Staff A state this to Resident #5 and stated this treatment was treating them like they were not human.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/8/24, the facility provided all reported grievances from 12/1/23 to 5/8/23 listed on the Resident/Family/Staff Grievance Concern Investigation Log. The form did not contain any concerns related to staff failing to change residents or provide a bed pan or directing them to urinate/defecate in their briefs.</p> <p>On 5/8/24 at 1:08 p.m. Staff B CNA stated Resident #5 reported to her that Staff A would not provide her the bed pan and instructed the resident to go in her brief. Staff B stated she reported this to Staff E, former Director of Nursing(DON).</p> <p>On 5/8/24 at 1:16 p.m. Staff C CNA stated Resident #5 reported to her that Staff A refused to provide her the bed pan and instructed her to urinate in her pants.</p> <p>On 5/8/24 at 3:23 p.m. via phone Staff D Registered Nurse(RN) stated that he administered a suppository to Resident #5 and asked her to call when she needed help. Staff D heard later from Resident #5's roommate, Resident #6 that Staff A came in and told Resident #5 to go in her brief. Staff D stated he reported the concern to the Assistant Director of Nursing(ADON). He stated Staff A should have provided the resident with a fracture pan(a smaller bed pan which was easier to move on and off of).</p> <p>On 5/8/24 at 4:08 p.m., the ADON stated she worked the night shift around 4/23/24 and on 4:00 a.m. rounds Residents #5 and #6 told her that Staff A told Resident #5 to just soil herself and she would change her rather than giving her a bed pan. The ADON stated she reported this to Staff E, former DON.</p> <p>On 5/9/24 at 9:36 a.m. via phone, Staff E, former DON stated staff reported to her that Staff A did not round on residents who were sleeping and she educated Staff A about making sure resident's were not wet. Staff E stated she did not think anyone reported to her that Staff A instructed residents to urinate in their briefs. She stated if she did hear that she would investigate it and report it because that was wrong.</p> <p>On 5/9/24 at 12:01 p.m., the Administrator stated that she found out yesterday about a staff member who told a resident to go to the bathroom in her brief and she would change her. She stated they called Staff A and suspended her and were currently completing their investigation. She stated she did not hear about this until yesterday and stated she would want this investigated and reported right after it occurred.</p> <p>The facility provided the survey team with a policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program with revised date of April 2021. The policy documented the following under the heading Policy Interpretation and Implementation; The resident abuse, neglect and exploitation program consists of a facility-wide commitment and resource allocation to support the following objectives: (which included the following)</p> <ul style="list-style-type: none"> -Protect residents from abuse, neglect, exploitation or misappropriation of property. -Establish and maintain a culture of compassion and caring for all residents -Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35434</p> <p>Based on observation, clinical record review, policy review, and staff interview, the facility failed to create interventions based on root cause analysis of falls in order to prevent future falls for 1 of 4 residents reviewed for falls(Resident #4). The facility reported a census of 31 residents.</p> <p>Findings include:</p> <p>The Admission Minimum Data Set(MDS) assessment tool, dated 2/9/24, listed diagnoses for Resident #4 which included pelvic fracture, non-Alzheimer's dementia, and heart failure, and stated the resident depended on staff for transfers and toilet transfers but did not walk due to a medical condition or safety concerns. The MDS documented the resident had a fracture related to a fall within the last 6 months and stated the resident's cognition was severely impaired. The MDS stated the resident was admitted to the facility on [DATE].</p> <p>An untitled Hospital Report, dated 2/4/24, documented the resident sustained a fracture of the left greater trochanter(the upper part of the thigh bone) and a fracture of the pubic ramus (a part of the pelvic bone) from a ground-level fall.</p> <p>A 3/4/24 10:35 p.m. untitled Fall Incident Report stated staff found the resident on the floor after he took a couple of steps. The resident sustained 3 small skin tears to the left elbow.</p> <p>A 3/5/24 Fall Risk Evaluation stated the resident was at high risk for falls.</p> <p>A 3/9/24 untitled Fall Incident Report stated staff found the resident on the floor after he got up to use the bathroom. There was blood on the floor and running down the right side of his head. The resident transferred to the hospital.</p> <p>A 3/10/24 3:41 a.m. Nurses Note stated the resident returned from the ER with 5 staples to a right scalp laceration(cut) and multiple skin tears, blood blisters, and bruises to the right and left upper extremities.</p> <p>A 3/17/24 10:30 p.m. untitled Fall Incident Report stated staff observed the resident slide forward out of his electric recliner and the resident stated he had to go to the bathroom.</p> <p>A 4/11/24 2:00 a.m. untitled Fall Incident Report stated staff found the resident on the floor near the window. The resident stated he rolled over and caught the wall. He sustained a laceration to the right leg.</p> <p>The resident's Care Plan lacked interventions related to the above falls and the clinical record lacked documentation of a facility analysis of the root causes of each fall and interventions implemented to prevent future falls.</p> <p>Observation on 5/8/24 at 8:03 a.m. two staff transferred the resident from his wheelchair to his recliner a gait belt was used with the transfer.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165295	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Montezuma Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 316 Meadow Lane Drive Montezuma, IA 50171	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy Assessing Falls and Their Causes, revised March 2018, stated the facility would identify possible or likely causes of the incident.</p> <p>The facility policy Falls and Fall Risk, Managing, revised March 2018, stated staff would identify interventions related to the resident's specific risks to try to prevent the resident from falling.</p> <p>On 5/9/24 at 9:48 a.m., the Director of Nursing (DON) reported for each resident fall, they tried to come up with a root cause analysis and an intervention that fit the cause. She stated with regard to Resident #4, his lack of Care Plan interventions was not what was expected.</p>