STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165295	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montezuma Specialty Care	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44512 Based on observation, interviews, resident and staff interviews, the facility failed to provide the diet as ordered for 1 of 2 residents reviewed for nutrition (Resident #28). The facility did not provide double the protein for Resident #28 as recommended by the Registered Dietitian (RD) and as per the physician order. The facility reported a census of 31 residents. Findings include: The Annual Minimum Data Set (MDS) dated [DATE] for Resident #28 revealed a diagnosis of hyponatremia, chronic obstructive pulmonary disease (COPD), pulmonary embolism (blood clot in lung), and osteoarthritis. The MDS identified Resident #28 was at risk for the development of pressure injuries, and was on a therapeutic diet. Resident #28 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated an intact cognition. The Care Plan for Resident #28 directed staff to provide and serve the diet as ordered for a Nutritional Interventions Program (NIP) with double protein two times a day (BID) with initiated date of 1/24/24. On 5/28/24 at 11:14 A.M. Resident #28 stated that she was to be receiving double the protein at lunch and supper as she had skin injuries to her buttocks. She reported she had been receiving a large amount of starches. Resident #28 reported that she had seen the dietitian one time, and since she is on the blood thinner, Resident #28 reported she had to watch the vitamin K level, They keep giving me broccoli and green leafy foods that I can't eat. The Clinical Physician Orders reveal a regular, small portion diet with extra protein source at lunch and supper with start date of 7/5/23. The Dietary Progress Note dated 1/24/24 at 9:50 A.M. for Resident #28 revealed: a. Small portion diet, level 7, regular texture, level 0 thin consistency. b. Extra protein source at lunch and supper per diet directions. c. By mouth (po) intakes with mostly 26-100% two meals daily (appears to refuse breakfast). d. Notify RD of nutritional concerns. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/28/24 at 12:15 P.M. Resident #28 had 1 small portion of fish, rice, peas, pineapple juice, tomato juice and chocolate milk. The lunch lacked evidence of a second portion of protein. A document titled [NAME] Specialty Care Lunch Week 1 Wednesday May 29, 2023 for Resident #28 revealed Level 7 Regular thin fluids, small protein, with Alert: Extra protein lunch & supper. During an observation on 5/29/24 at 12:05 P.M. Resident #28 had 1 single protein source, turkey served at lunch. During an interview on 5/29/24 at 1:13 P.M., Staff A, Certified Dietary Manager (CDM) stated for a double portion of protein, the cook serving would give an extra serving of meat. Staff A stated Resident #28 picked out what she wanted and had the extra protein diet order. Staff A stated that the dietary staff were aware, and double the protein meant that the resident receives extra meat. During an interview on 5/29/24 at 1:32 P.M., Staff B, Registered Dietitian (RD) described small portions for diabetics and it was for carbohydrate control, therefore the resident received a small serving of the desert. Staff B described the double the protein as double the protein portion source of the meal. Staff B stated she had reviewed Resident #28's diet order and the menu, and found the menu directed the dietary staff to provide double the protein. Staff B stated she will meet with the CDM.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46513 Based on observation, staff interview, resident interview and Facility Assessment the facility failed to ensure safe transport of resident in a wheelchair for 1 of 3 resident reviewed. (Resident #18). The facility reported a census of 31. Findings include: The Admission Minimum Data Set (MDS) for Resident #18 dated 4/10/24 revealed resident scored 13 on a Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS revealed diagnoses of arthritis, osteoporosis, cerebrovascular accident (CVA) referring to stroke and fracture of right humorous. The MDS documented the resident normally used a manual wheelchair for a mobility device, with dependence on staff to operate the wheelchair. The Care plan initiated 4/6/24 documented resident continued to work with therapy, recent fall with fractured humorous. Resident #18 to use a wheel chair for mobility, non-weight bearing to right upper extremity, sling to right upper extremity at all times and required assist of one related to recent fracture. Observation on 5/28/24 at 10:45 AM revealed Staff#C, Certified Nursing Assistant (CNA) pushed resident in a wheelchair down the hall, both feet of the resident on one-wheel chair pedal. Staff C voiced, wish we could find the other wheel chair pedal and directed resident to keep your feet up. On 05/28/24 at 11:07 AM The Assistant Director of Nursing (ADON) relayed expectation is to have both food pedals on the wheelchair when pushed, for safety. On 05/28/24 at 1:55 PM Resident #18 reported she had only one (1) wheel chair pedal since she arrived at the facility and it did upset her that they can't find the another one. On 5/29/24 at 5:00 PM the Administrator acknowledged a resident should have both wheel chair pedals on when being pushed by staff. The Facility Assessment identified resident with abnormalities of gait and mobility. The Facility Assessment documented resident footing assessed upon admission and ongoing, proper transfer equipment provided as needed included cane, walker and wheelchair.