STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165304	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montrose Health Center	400 South 7th Street Montrose, IA 52639

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on clinical record review and staff interview the facility failed to ensure Minimum Data Set (MDS) assessments were submitted per required regulatory timeframe's for one of one resident reviewed for Resident Assessment Instrument Task (Resident #33). The facility reported a census of 36 residents. Findings include: Review of the Resident Assessment Task indicated Resident #33 had an MDS record over 120 days old. Review of the resident's MDS history revealed not all assessments documented as accepted and/or submitted. Review of Resident #33's census revealed the resident initially admitted to the facility 5/8/24, and discharged on [DATE]. On 9/18/24 at 3:50 PM, the Nurse Consultant explained did not think got submitted, and was an oversight. The Nurse Consultant explained although assessment completed, did not change a question to yes (in system) which had auto-populated from a previous assessment, and now the assessment export ready and would be late to federal. Continued review of the resident's MDS assessments revealed the following Assessment Reference Date (ARD) and date submitted: a. Review of the resident's Quarterly MDS assessment (ARD 8/6/24) was submitted 9/18/24. b. Review of the resident's MDS assessment completed for death in facility (ARD 8/19/24) was accepted 9/18/24. On 9/19/24 at 4:04 PM, a Facility Policy pertaining to guidelines for submitting was requested via email from the facility's Administrator. On 9/19/24 at 4:07 PM, the Administrator responded via email the facility did not have a policy to address, and followed CMS (Centers for Medicare and Medicaid Services) guidelines.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on interview, record review, and policy review, the facility failed to ensure resident care plans were revised following a resident's hot liquid spill with burn, failed to address a diagnosis of diabetes mellitus, and to accurately reflect insulin use related to steroid-induced hyperglycemia for three of twelve residents reviewed for care plans (Resident #11, Resident #26, Resident #139). The facility reported a census of 36 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment for Resident #11 dated 5/28/24 revealed the resident scored 06 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment, the resident required set-up or cleanup assistance with eating. The Care Plan dated 2/9/22, revised 5/29/24, revealed the following: The resident with potential for altered nutritional status r/t (related to) PMH (past medical history) of bradycardia, hypothyroidism, weakness, HLD (hyperlipidemia), CKD (chronic kidney disease) stage 2, HTN (hypertension), depressive episodes, CAD (coronary artery disease), hx (history) of significant weight loss. Interventions per the above Care Plan did not specifically address hot liquids. The Care Plan dated 9/13/24 revealed, The resident is dependent on staff for meeting emotional, intellectual, physical, and social needs d/t Cognitive deficits, Physical Limitations. The Intervention dated 9/13/24 revealed, Provide the resident with materials for individual activities as desired. The resident likes the following independent activities: (solitaire cards, a cup of hot tea with a lid). The Health Status Note dated 7/9/2024 at 8:58 AM revealed, CNA (Certified Nursing Assistant) called this nurse to res (resident) room to report a reddened area to res (resident) right anterior thigh. Res believes she may have spilled some hot tea on herself at supper last noc (night). Area is light to medium pink, no open areas noted. No c/o (complaints of) pain voiced unless area is palpated, then res states it's a little tender. All necessary persons notified including provider. Verbal orders rec'd (received) to apply Medihoney et (and) cover with gauze et tape BID (twice a day) daily u/h (until healed). On 9/19/24 at 3:28 PM during an interview with the MDS Coordinator and Nurse Consultant, the MDS Coordinator explained an intervention was put in place and explained different interventions implemented for the resident. When queried if went into the care plan, the MDS Coordinator explained would have to look. On 9/19/24 at 4:11 PM when queried about care plan interventions if accident with injury, the Nurse Consultant responded should be, and explained would open risk management, do immediate intervention, and would have been done with [Resident #11] with spills. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the Minimum Data Set (MDS) assessment dated [DATE] for Resident #26 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Per this assessment, the resident had a diagnosis of diabetes mellitus. Review of Resident #11's Medical Diagnoses in the Electronic Health Record (EHR) included the following: Type 2 diabetes mellitus with other specified complication, noted to be assigned during the resident's stay versus on admission. Review of the Care Plan for Resident #26 did not address diabetes. The Physician Order dated 2/13/24 revealed, empagliflozin Tablet 10 MG (milligram) with instructions to give 1 tablet by mouth one time a day for DM2 (Diabetes Mellitus Type 2). On 9/19/24 at 3:28 PM, the MDS Coordinator explained if resident diabetic and on insulin got a care plan. On 9/19/24 at 4:19 PM when during an interview with the Director of Nursing (DON) and Nurse Consultant, queried if resident with diabetes not on insulin should be care planned. The Nurse Consultant acknowledged she would care plan it. On 9/19/24 at 4:04 PM, a Facility Policy pertaining to guidelines for care plan revision requested via email from the facility's Administrator. On 9/19/24 at 4:07 PM, the Administrator responded via email the facility did not have a policy to address, and followed CMS (Centers for Medicare and Medicaid Services) guidelines. 48888 3. The Minimum Data Set (MDS), dated [DATE], revealed Resident #139 received insulin injections on 7 out of 7 days reference period. The MDS listed diagnoses included: disorder of bone, unspecified, cerebral infarction without residual effects (stroke with no ongoing effects). The MDS did not list diabetes mellitus as a diagnosis for Resident #139. The Care Plan, initiated 9/16/24, revealed Resident #139 had insulin-dependent diabetes mellitus with the goal that Resident #139 would have no complications related to diabetes through the review date. The Medication Administration Record (MAR), dated September 2024, revealed an order for Insulin Lispro Injection Solution 100 units per milliliter (mL) following sliding scale parameters for diabetes mellitus. A Hospital Discharge Note, dated 9/04/24, revealed Resident #139 had diagnosis of steroid-induced hyperglycemia (high blood sugar) and utilized sliding scale Insulin Lispro. On 9/19/24 at 4:10 PM, the Nurse Consultant for the facility, stated that Resident #139 did not have diagnosis of diabetes mellitus and that the Care Plan had been incorrect. The Nurse Consultant stated she would expect the Care Plan list the use of insulin related to diagnosis of steroid-induced hyperglycemia with interventions appropriate for the diagnosis. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/07/24 at 4:07 PM, Facility Administrator revealed the facility had no written policies or procedures related to Care Plan revisions.

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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** 45338 Based on clinical record review, interview, and facility policy review the facility failed to ensure digoxin administered per Physician Order adhering to established parameters for one of six residents reviewed for medications (Resident #26). The facility reported a census of 36 residents. Findings include: Review of the Minimum Data Set (MDS) assessment dated [DATE] for Resident #26 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. The Physician Order dated 2/13/24 revealed, Digoxin Tablet 125 MCG (microgram) with instructions to give 1 tablet by mouth one time a day for heart failure hold if pulse below 60. Review of Medication Administration Records (MARs) revealed the following dates and documented pulse rate when the resident received the medication outside of parameters: a. On 7/8/24 for 6:00 AM scheduled dose: pulse of 59, and medication documented as administered. b. On 8/14/24 at 6:00 AM scheduled dose: pulse of 55 and medication documented as administered. On 9/19/24 at 2:43 PM during an interview with Staff B, Registered Nurse (RN) explained standard would be if a pulse less than 60 hold it [digoxin]. When it was explained about parameter present with the order, Staff B responded if in there would go by that. On 9/19/24 at 4:20 PM, the Director of Nursing (DON) acknowledged should hold the medication and call the provider. Review of the Facility Policy titled Medication Administration effective 2/17, revised 8/24, revealed the following: Policy: Medications shall be administered per physician order.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45338 Based on observation, interview, and record review the facility failed to ensure a resident with severely impaired cognition remained free from a burn from hot liquids when the resident sustained a second degree burn (involving the first two layers of skin) to the thigh from a hot beverage believed to have occurred on 7/8/24, and had a second hot liquid spill from a beverage on 9/17/24 resulting in redness to the skin for one of four residents reviewed for accidents (Resident #11). This deficient practice resulted in tenderness of burn area and documented voiced discomfort during treatment. The facility reported a census of 36 residents. Findings include: Review of the Minimum Data Set (MDS) assessment for Resident #11 dated 5/28/24 revealed the resident scored 06 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment, the resident required set-up or cleanup assistance with eating. The Care Plan dated 2/9/22, revised 5/29/24, revealed the following: The resident with potential for altered nutritional status r/t (related to) PMH (past medical history) of bradycardia, hypothyroidism, weakness, HLD (hyperlipidemia), CKD (chronic kidney disease) stage 2, HTN (hypertension), depressive episodes, CAD (coronary artery disease), hx (history) of significant weight loss. Interventions per the above Care Plan did not specifically address hot liquids. The Care Plan dated 9/13/24 revealed, The resident is dependent on staff for meeting emotional, intellectual, physical, and social needs d/t Cognitive deficits, Physical Limitations. The Intervention dated 9/13/24 revealed, Provide the resident with materials for individual activities as desired. The resident likes the following independent activities: (solitaire cards, a cup of hot tea with a lid). The Health Status Note dated 7/9/2024 at 8:58 AM revealed, CNA (Certified Nursing Assistant) called this nurse to res (resident) room to report a reddened area to res (resident) right anterior thigh. Res believes she may have spilled some hot tea on herself at supper last noc (night). Area is light to medium pink, no open areas noted. No c/o (complaints of) pain voiced unless area is palpated, then res states it's a little tender. All necessary persons notified including provider. Verbal orders rec'd (received) to apply Medihoney et (and) cover with gauze et tape BID (twice a day) daily u/h (until healed). Review of the Incident Report dated 7/9/24 for Resident #11 revealed, resident will not have any styrofoam cups in room and kitchen will dilute hot tea with ice or <sic> tape water. Review of the Progress Note dated 7/9/24 at 11:07 PM revealed, Resident continues to be provided cups with lids, resident removes lids at times. Education provided about need for lids on cups and resident voices understanding. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Progress Note dated 7/10/24 at 4:26 PM revealed, Resident continues to be provided cups with lids; however, resident removes lids at times. Education provided about need for lids on cups and use for safety. Resident with short term memory only and needs reminded frequently. The Encounter Note dated 7/12/24 at 12:00 AM revealed the following per Chief Complaint / Nature of Presenting Problem: Burn. History Of Present Illness: Patient being evaluated today for a wound that has developed after she spilled her hot coffee on herself. Patient was drinking her coffee does not know how she spilled it but it hit her right thigh, she did develop a blister like wound. This occurred on Tuesday 7/9. We have been applying Medihoney to the area. Patient denies any discomfort. There is minimal redness and the blister is almost completely gone. No other reports of illness including fever, cough or other ill symptoms. Per the Encounter Note Resident #11 had second-degree, partial-thickness burn to the right anterior thigh. The Plan section documented, in part, Decreased coordination: Continue to monitor patient's coordination especially with sharp utensils, hot liquids and so forth. Educated patient about safety possibility of needing to cool hot liquids due to tolerance over time. The Health Status Note dated 7/22/24 at 4:34 PM revealed, Burned areas to right upper thigh observed. No intact blisters, pink, blanchable borders. Medihoney treatment continues. Voices discomfort to area during tx (treatment) but resolves with rest. Observation conducted on 9/16/24 of Resident #11 in the dining room revealed the following: a. 12:01 PM: Resident #11 took the tea bag out of cup, stirred, and Resident #11 had the cup in their hands with the cup lid on the table. b. 12:02 PM: Cup on the table without a lid on it. c. 12:04 PM: Cup on the table without a lid on it. d. 12:19 PM: Resident #11 present in wheelchair at the table, and fluid in the cup without the lid on it. Observation conducted on 9/17/24 at 11:28 AM revealed the following: a. 11:28 AM: Resident #11 was delivered a drink cup with a lid and a glass of a beverage as well. The resident observed in her wheelchair at a table in the dining room. b. 11:35 AM: Resident #11 observed with puddle of liquid underneath the resident and resident's cup (cup that previously observed with lid) on the floor. Director of Nursing (DON) alerted by State Agency. Staff then heard to say resident spilled. Staff were asked about contents of the beverage and was identified by Staff A Dietary Staff as hot tea. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Health Status Note dated 9/17/24 at 12:00 PM revealed, DON (Director of Nursing) was walking towards the dining room when resident was observed to have spilled her hot tea onto the floor table and on her pants. Resident was then removed from the main dining hall by DON. DON and MDS nurse assessed resident in her room. Resident is noted to have a reddened area to her lateral posterior thigh. No blisters noted. Area is intact. Resident denied pain and discomfort to the area. Provider notified at this time. The Health Status Note dated 9/17/24 at 12:01 PM revealed, reddened area is to right lateral posterior thigh. Review of the Incident Report dated 9/17/24 revealed the following description: I'm not sure what happened, I was drinking my tea. Review of a Note per the Incident Report revealed, Redden area to right lateral posterior thigh measuring 0.4 cm (centimeter) x 15cm. Review of the Other Info section revealed, Resident was observed attempting to remove lid from hot tea. Observation on 9/19/24 at approximately 8:00 AM revealed Resident #11 in the dining room with a cup with a lid on it. The cup had a tea bag inside with the string part of the tea bag on the outside of the cup. On 9/19/24 at 8:22 AM during an interview with the Dietary Manager (DM), the DM queried about what kind of drinks Resident #11 liked, and responded hot tea and water. When queried about the cup with the lid, the DM explained the resident normally had a regular cup and she was spilling and didn't want her to get burnt. Per the DM, dietary staff put in two pack of sugar substitute. Per the DM, Resident #11 couldn't get the lid off to spill it. The DM explained the resident left the tea bag in cup per her preference. When queried if there were issues with spilling since the resident got the cup with the lid, the DM responded nope. Per the DM, if the resident was in the dining room the tea was sent hot. The DM explained the flap was placed over the cup handle. When queried if the DM heard of the resident getting burned in the last couple of months, the DM responded not to my knowledge. When queried about interventions for this resident, the DM responded just the lidded mugs, and if the resident went to her room a few ice cubes added so not as hot. The DM explained the hot water came from the coffee machine from the spout. When queried if she took the temperature of it, the DM responded she had but it had been awhile. A hot water temperature was requested from the DM. On 9/19/24 at approximately 8:30 AM, the DM reported hot water temperature was 168 degrees. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 9/19/24 at 2:44 PM Staff B, Registered Nurse (RN) explained the resident had treatments where had to monitor the right thigh for redness/blistering. When queried what the wound looked like, Staff B responded it blistered up and was kind of like white discoloration kind of thing that eventually faded. When queried if he was told how it had happened, Staff B responded the resident had hot tea at the table and it spilled. Staff B explained he knew they implemented that Resident #11 was to have the cups with the lids now instead of open cup and that she needed to drink liquids in the dining room. Staff B further explained if the resident went back to her room, then cold liquids only for safety. Per Staff B, he thought it was a regular coffee cup with hot tea in it for July incident. When queried if the facility did hot liquid assessments, Staff B responded he was not for sure. Staff B further explained many of the assessments were done by the Care Manager. When queried if the resident was known to spill liquids prior to July, Staff B responded he was not sure, and he hadn't heard of a lot of spills before hand. Per Staff B, that was the that was the first time Staff B had heard of. When queried if he had ever seen Resident #11 with the lid off her cup, Staff B responded he hadn't seen it but did know the resident was physically able to remove the lid. When queried about the incident which occurred 9/17/24 (when Staff B not present at the facility), Staff B explained he was made aware and it was on the resident's chart to monitor for any types of changes/skin issues, and on the TAR (Treatment Administration Record) to check off. Staff B explained he did not see any redness or anything on 9/19/24. On 9/19/24 at 3:16 PM during an interview with Staff C, Certified Nursing Assistant (CNA) and the Director of Nursing (DON), Staff C explained Resident #11 had a lidded cup that is stuck on the top and has a straw that comes out to keep the resident safe, and that is what she drank out of. Staff C further explained with cool liquids used a regular cup, and if hot used a lidded cup. When queried if she had ever seen the resident take the lid off, Staff C responded yes indeed and explained tried to tell the resident not appropriate and tried to explain instructions. Per Staff C, sometimes could not get through to the resident. The DON explained the resident loved her hot tea and was something wanted the resident to keep. The DON explained following the recent incident, the resident was ordered a elderly spill proof twist cup so the resident could not take the top off. When queried about the tea bag, Staff C explained the resident usually left the tea bag in when she liked to drink. Staff C explained when the kitchen staff made the tea they took the tea bag out of it. On 9/19/24 at 3:28 PM during an interview with the MDS Coordinator and Nurse Consultant, the MDS Coordinator explained she was present for the resident's spill (second spill which occurred week of survey) and explained the resident had a small reddish s shaped area on the side of the leg. The MDS Coordinator explained she was the one that assessed and measured. The MDS Coordinator was unable to recall whether she had been at the facility in July when the resident had spilled. The MDS Coordinator further explained an intervention had been put in place to not allow hot tea in resident's room, and to encourage resident to sit out here and socially and have a lid on it. Per the MDS Coordinator, kitchen put ice cubes in it. When queried if that went into the resident's care plan, the MDS Coordinator responded they would have to look. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The MDS Coordinator explained the resident used to drink with a different cup, and the cup was changed completed with lid put on it. Per the MDS Coordinator, the original cup was styrofoam, and the resident always used to have a styrofoam cup. When queried if she had ever seen the resident take the lid off, the MDS Coordinator responded no, and the MS Coordinator further explained she would say a little harder to get off hence the intervention for the resident. Per the MDS Coordinator she had never seen the resident with the lid off, and explained it was not the easiest to take off. On 9/19/24 at 3:47 PM during an interview with the Administrator, the Administrator explained the resident very much enjoyed hot tea, had one incident a couple months ago where spilled hot tea, resident was in her room, and addressed not being in her room, being in the main dining room. Per the Administrator, resident also not to have it hot, hot, and would have a couple of pieces of ice. The Administrator further explained the resident spilled a couple days ago and facility decided to get the spill proof cup. The Administrator acknowledged needing to do something to protect the resident. On 9/19/24 at 4:24 PM during an interview with the Director of Nursing (DON), the DON explained the facility was trying to find something for resident to have hot tea and be safe also. When queried if hot liquid assessments done, the DON responded not that she was aware of. On 9/19/24 at 4:04 PM, a Facility Policy pertaining to accidents and hazards requested via email from the facility's Administrator. On 9/19/24 at 4:07 PM, the Administrator responded via email the facility did not have a policy to address, and followed CMS (Centers for Medicare and Medicaid Services) guidelines.