STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165326	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bloomfield Care Center	800 North Davis Street Bloomfield, IA 52537

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on clinical record review, policy review, and staff interviews, the facility failed to develop and implement a discharge plan which focused on the resident's goal to return home, in the event alternative therapy services could not be obtained for 1 of 3 residents (Resident #1) reviewed for discharge planning. The facility reported a census of 34 residents. Findings include: Review of the Minimum Data Set (MDS) assessment tool, dated 3/26/25, for Resident #1 revealed a list of diagnoses which included heart failure, diabetes (a disease which caused abnormal blood sugars), and unsteadiness on his feet. The MDS indicated the resident required partial to moderate assistance with rolling from right to left, standing, transferring, and eating; substantial to maximal assistance with showering; and dependent for toileting hygiene. The MDS Brief Interview for Mental Status score of 15 out of 15, indicated intact cognition. The MDS documented Resident #1 had an ostomy (a surgically created opening, called a stoma, on the body's surface, allowing waste to exit the body when the normal elimination process was disrupted) and received insulin (a medication used to lower blood sugars) injections. During an interview on 6/17/25 at 9:13 a.m., Resident #1's wife stated during her husband's stay they were very dissatisfied with therapy services. She stated on 4/29/25, her spouse was provided a NOMNC (Notice of Medicare Non-Coverage, written notice that Medicare providers must give beneficiaries when their Medicare covered services are ending) indicating his skilled care would no longer be available after 5/6/25. She stated her husband [Resident #1] signed the NOMNC, but she was never made aware of any appeal process. During a follow up interview on 6/18/25 at 10:35 a.m., Resident #1 wife stated she was called the day her husband got notice of skilled care ending on 5/6/25, and at some point, she declined home health services. She stated referrals were made to different facilities for further therapy. She explained she knew Medicare would not provide skilled care. Resident #1's wife stated at discharge her husband was in a wheelchair, and two aides brought him out to the car and assisted him into the vehicle. She stated the facility did not provide a wheelchair. She further explained after discharge from the facility she took her husband to a hospital. She stated he did not qualify for a hospital admission. She stated on 5/8/25 after an overnight hospital stay she picked him up and took him to a hotel as she was unable to get Resident #1 into her home due to the narrow entryway and 4 steps. Review of the Care Plan, dated 3/21/25, revealed a Focus areas to address: (continued on next page)

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Risk of falls. b. Assistance with ADL's (activities of daily living which include tasks such as transferring, showering, eating, personal hygiene, etc.). c. Risk of nutritional status related to diabetes. d. Risk of alteration in skin integrity related to diabetes. e. PASRR (Preadmission Screening and Resident Review - an assessment used to evaluate for a serious mental illness, intellectual disability, resident offered the most appropriate setting, and needed services provided for setting). f. Psychotropic medication used related to neuropathy (pain caused by peripheral nerve damage). g. Advanced Directives. h. Resident states he never has pain. The Care Plan lacked a Focus area to address discharge goals and planning related to the resident/family members request for referrals for alternative therapy services or for his return home in the event such services could not be obtained. Review of the electronic health record (EHR) revealed a Communication - with Resident note, dated 4/29/25 at 3:58 p.m. Note Text: This nurse, and [name redacted] SW (Social Worker) spoke with the resident about NOMNC with the last day of therapy indicated as 5/6/25. Resident agreeable, sings NOMNC, and verbalizes plan is to return home 5/7/25. This nurse and [name redacted] SW ask if resident would like to us to notify wife and he is agreeable to us calling his wife. Review of a Communication -with Family/Related Party note, dated 4/30/25 at 8:31 a.m. Note Text: Spouse called at this time to inform SW that she would like information to be sent to [name of three facilities redacted] for therapy services after resident's therapy services ends here on 6\5/6/25. Resident will not be staying after services end and will discharge the morning of 5/7/25. Review of the 5/5/25 Nurse Practitioner (NP) Discharge Summary revealed a History of Present Illness section, which documented, in part . His insurance has denied continuation of skilled therapy at the facility and he prefers to transfer to another facility to continue physical therapy. He plans to discharge on Wednesday [5/7/25]. He continues to have difficulty standing and is unable to ambulate, which was necessary for him to return home where he lived with his wife. An Order Note dated 5/5/25, listed the following orders: discharge to a skilled facility on 5/7/25, PT (physical therapy) and occupational (OT) to evaluate and treat at the new facility, continue current medications and treatments. Review of a Communication with Family Related Party note, dated 5/6/25, revealed the resident's representative stated if other facilities did not accept the resident, she would take him home. Review of the EHR revealed a Instructions for Discharge document, dated 5/2/26 revealed: (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Therapy section which indicated, in part: 4. If other, please specify: Recommend 24 hour care including either home health or hospice care for follow up after SNF (Skilled Nursing Facility) d/c (discharge). Electronically signed by [name redacted] Occupational Therapist on 5/6/25. A Communication with Physician note, dated 5/7/25, listed an order to discharge to home. Review of the EHR revealed a lack of documentation to indicate assessments completed and discharge planning occurred for Resident #1 to address: a. Specific needs related to: transfer ability, safety/supervision needs, and equipment needed for safe transition to home. b. The caregiver's capacity and ability to care for the resident such as how she would assist him with transfers and if she had a support system. c. The living situation including any potential challenges or difficulties such as accommodation needed to get into the home, stairs within the home, location of bathroom, etc. d. A discussion with the resident regarding the implications and/or risks of being discharged to a location that was not equipped to meet his needs and if he felt safe returning home. During an interview on 6/18/25 at 11:46 a.m., Staff B, Registered Nurse (RN) stated the resident required quite a bit of care including transfer assistance, ostomy care, showering, and oral care. She stated his assistance needs remained pretty much the same during his stay. During an interview on 6/18/25 at 12:41 p.m., Staff A, Physical Therapy Assistant (PTA) stated the facility sometimes conducted a home assessment if the resident lived close but not always. Staff A stated the facility talked to the resident's wife about his post-discharge care and she said that she would be able to stop by the house throughout the day on days she worked. Staff A stated she did not feel that the resident should be alone. On 6/18/25 at 12:06 p.m., when queried about discharge planning for Resident #1, the MDS Coordinator stated the resident's wife requested referrals to other facilities after his discharge from this facility, however those facilities did not accept him. The MDS Coordinator stated that the resident's spouse stated if other facilities did not accept him, she would take him home. During a phone interview on 6/19/25 at 1:44 p.m., the Administrator stated the only policy the facility had related to discharge was the bed hold policy. She stated the resident's wife was insistent on taking the resident home. She stated if the Nurse Practitioner thought the resident was unsafe, he would have discharged against medical advice (AMA). She stated she didn't know if therapy carried out an assessment regarding the wife's ability to care for the resident at home or if they carried out a home assessment. The Administrator stated she felt the resident's spouse was capable of transferring him and the spouse never made any comments to them that she could not handle it. The Administrator stated she didn't see any additional paperwork other than the Discharge Instructions when asked about a discharge notice. The Administrator stated they felt that since the spouse was a nurse she could take care of him. (continued on next page)

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Bed Hold and Return Policy, revised 10/2023, revealed a Purpose statement which declared To ensure that residents are made aware of facilities bed hold and return policy before and upon transfer or when taking a therapeutic leave from the facility.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review, policy review, and staff interview, the facility failed to provide the resident or resident's representative 30 day written notice before discharge, with instruction on how to appeal for 1 of 3 residents (Resident #1) reviewed for discharges. The facility reported a census of 34 residents. Findings include: Review of the Minimum Data Set (MDS) assessment tool, dated 3/26/25, for Resident #1 revealed a list of diagnoses which included heart failure, diabetes (a disease which caused abnormal blood sugars), and unsteadiness on his feet. The MDS indicated the resident required partial to moderate assistance with rolling from right to left, standing, transferring, and eating; substantial to maximal assistance with showering; and dependent for toileting hygiene. The MDS Brief Interview for Mental Status score of 15 out of 15, indicated intact cognition. The MDS documented Resident #1 had an ostomy (a surgically created opening, called a stoma, on the body's surface, allowing waste to exit the body when the normal elimination process was disrupted) and received insulin (a medication used to lower blood sugars) injections. Review of the electronic health record (EHR) revealed: a. A 4/29/25 Communication with Resident Note documented the resident received notice of his last day of therapy and stated his plan was to return home. b. A 5/5/25 Order Note listed the following orders: discharge to a skilled facility on 5/7/25, physical therapy(PT) and occupational therapy(OT) to evaluate and treat at the new facility, continue current medications and treatments. c. A 5/7/25 Communication with Physician note listed an order to discharge to home. On 6/19/25, the State Agency requested the Notice of Discharge given to the Resident #1. On 6/19/25 at 1:34 p.m., via email, the Administrator provided Resident #1's Instructions for Discharge in response to the request for a Notice of Discharge. Review of an Instruction of Discharge document in the EHR, dated 5/2/25 at 10:12 a.m., revealed: (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I. Social Services section: Responsible party: Name and phone number of wife/emergency contact listed. Physician in the Community: Name of primary physician in community listed, and name and phone number of primary physician in facility listed. Discharge Location: 1. Home checked. 1a. If other: Discharging home first and potential admit to another SNF. Pharmacy: Name and town of pharmacy listed. Home Health/Hospice Services:blank/no information (clinical record documented refusal of service), Medical equipment Arrangements: blank/no information listed. Psychosocial: 1. Cognitive Status: a.Alert to person, b. Alert to place and c. Alert to time checked, 2. Psychosocial needs: a. Able to communicate needs checked. 3. Mood and Behavior Patterns: No mood or behavior patterns applicable upon discharge. Comments: 0. Code Status: Full Code. 1. Resident is discharging to home before 10am May 7th, 2025. SW has sent our referrals [facility names redacted] for this resident to continue therapy services. Electronically signed on 5/6/25 by SW. II. Nursing Section: A. Summary: 1. During stay: a. Wound care, c. Medication management, e. Disease management checked. 2 - 9. Most recent weight, blood pressure, temperature, pulse, respiration, blood glucose, O2 sats (blood oxygen saturation), and pain level indicated. 10. Current Diet: Regular. 11. Oral/Eating: Set up/cueing assistance with meals indicated, B. Basic Care Needs: 1. Basic Care Needs: d. Continent, f. Requires assistance with ADL's (activities of daily living) checked. C. Medications: 1. Discharge Nurse to print Order Summary Report and reconcile with discharge orders .checked. D. Skin/Treatment: 1. Skin and treatment orders and education reviewed with patient and/or responsible party and provided within Order Summary Report checked. E. Reconciled Medication List: 1. Yes - current reconciled medication list provided to the subsequent provider. 2. Indicate route of transmission of the current reconciled medication list to subsequent provider: d. Paper-based (e.g. fax, copies, printouts) checked. 3. Provision of Current Reconciled Medication List to Resident at discharge: 1. Yes, Current reconciled medication list provided to the patient, family, and/or caregiver. 4. Indicate the route(s) of transmission .: Paper-based (e.g. fax, copies, printouts) checked. F. Nursing Instructions: Discharge Nursing: 1a. Medications have been reconciled . checked. d. Provide copy of care plan . checked. 2a. Discharge instructions and summary of care reviewed and education provided to resident and/or representative checked. b. Copy of Discharge Instructions and summary of care offered/provided to resident and/or responsible party checked. Document signed on 5/7/25 by Responsible Party Signature (resident signature), and facility MDS Coordinator and SW and summary of care offered/provided to resident and/or responsible party. Document signed on 5/7/25 by Responsible Party Signature (resident signature), and facility MDS Coordinator and SW. III. Therapy section: Therapy during my stay: 1. a.PT (physical therapy), b. OT (occupational therapy) checked. 2. Therapy discharge instruction reviewed with patient and/or responsible part checked. 3. Select all that apply: a. Therapy after discharge. c. Safety tips checked. 4. If other, please specify: Recommend 24 hour care including either home health or hospice care for follow up after SNF(Skilled Nursing Facility) d/c (discharge). Electronically signed by [name redacted] Occupational Therapist on 5/6/25. The Instructions for Discharge document did not give a 30 day notice or include information on how to appeal the discharge. The resident's clinical record lacked documentation of a discharge notice given to the resident or the resident's representative which included the following information: a. The reason for discharge (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. The effective date of discharge c. An explanation of the right to appeal the discharge to the State d. The name, address (mail and email), and telephone number of the State entity which received such appeal hearing requests e. Information on how to obtain an appeal form During a phone interview on 6/19/25 at 1:44 p.m., the Administrator stated the only policy the facility had related to discharges was the bed hold policy. She stated the resident's wife was provided discharge instructions but she didn't see another form provided other than this. She stated the resident's spouse informed them he would discharge the morning of 5/7/25. Review of the facility policy Bed Hold and Return Policy, revised 10/2023, revealed a Purpose statement which declared To ensure that residents are made aware of facilities bed hold and return policy before and upon transfer or when taking a therapeutic leave from the facility.