

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Cherokee Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 North Roosevelt Cherokee, IA 51012	

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 0572</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents a notice of rights, rules, services and charges.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858</p> <p>Based on clinical record review, admission agreement, resident bill of rights, facility document manager process, resident council meeting minutes, staff and family interview the facility failed to provide the resident/resident representative in writing the resident rights, rules and regulations and responsibility during the stay in the facility or upon admit for 1 of 3 residents reviewed. (Resident #4). The facility identified a census of 46 residents.</p> <p>Findings include:</p> <p>The Clinical Census report dated [DATE] at 5:18 p.m., documented Resident #4 admitted on [DATE].</p> <p>The Progress Notes dated [DATE] at 12:18 p.m., documented with Physician Note Text: Resident admits to facility</p> <p>this morning 11:30 a.m., via family vehicle with daughter. Resident is weak when transferring. No complaints. No current illness suspected. Please review orders and advise.</p> <p>On [DATE], the Resident/Power of Attorney (POA) signed and dated the Admission Care Plan which indicated acknowledgement of the said form.</p> <p>The POA e-signed the Cardiopulmonary Resuscitation (CPR) and Do Not Resuscitation (DNR) order Declaration Form on [DATE] at 12:01 p.m.</p> <p>Review of the Admission Agreement form page 13 date [DATE] in Point Click Care (PCC), revealed the Durable Power of Attorney (DPOA) for Health Care Decision marked the form with an X followed by a facility Representative to have signed the form on [DATE] with no time.</p> <p>Interview on [DATE] at 12:30 p.m., with the Social Service Director, no one in the facility knew who signed the form with an X and he/she failed to confirm or deny the X as her/his mark although he/she had been present on admit.</p> <p>Review of the printed Admission Agreement form on page 13, revealed the DPOA checked the box that represented No for DPOA and the box that represented a Yes for the resident representative e-signed by the POA on [DATE] at 11:46 a.m.</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 0572</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an Arbitration Procedure form revealed the POA e-signed the form [DATE] at 11:46 a.m. and the facility representative on [DATE] at 11:16 a.m.</p> <p>An Explanation of Medicare Benefits form revealed the Resident/Guardian/Legal Representative e-signed the form on [DATE] at 11:47 a.m.</p> <p>Interview on [DATE] at 2:38 p.m., POA, stated that the admission paperwork was not completed with them on [DATE], when Resident #4 was admitted to the facility. The POA asked for a copy of the admission paperwork during a careplan conference and noticed that the e-signature was on [DATE]. The POA confirmed and verified that they were not in the facility on [DATE].</p> <p>Interview on [DATE] at 12:30 p.m , the Social Service Director, confirmed as well as the DPOA/POA had been present with the review of the admission forms and clicked on the e-signature on the form however there was no explanations as to why the date on the computer failed to automatically time stamp per normal routine with any e-signature on a computer system. The Social Service Director confirmed and verified that the facility failed to give a written admission paperwork to the POA or the Resident on [DATE].</p> <p>Interview on [DATE] at 1:30 p.m., the Regional Director of Human Resources, confirmed and verified that the facility has changed their admission process and revised the Process: Document Manger on [DATE].</p> <p>The Resident Council Meeting Minutes dated [DATE] at 10:30 a.m., revealed, a Resident and /or resident request to review the admission packet with all the information in it including an activity calendar for the month.</p> <p>The Resident [NAME] of Rights dated ,d+[DATE], stated that the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>*The right to be fully informed in language that her or she can understand of his or her total health status including but not limited to his or her medical condition.</p> <p>*The resident has the right to receive notices orally (meaning spoken) and in writing in a format and a language he or she understands.</p> <p>*Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights.</p> <p>The Process: Document Manager revised on [DATE] and [DATE], documented the purpose is to provide direction for entry of documentation into the PCC. For guidance on clinical documentation expectations please refer to appropriate facility procedures.</p> <p>(continued on next page)</p>		

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<p>F 0572</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Document Manager in PCC allows staff, resident and/or resident responsible parties to sign documents electronically. Signatures can be obtained in person or remotely. When a user is signing in person they will use the facility chromebook (is a lap-top or tablet that runs on Google's operating system). When a user is signing remotely they do need to provide a mobile phone number and email and then will be able to sign on their own personal device. Documents can still be printed and signed on paper if requested.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858</p> <p>Based on clinical record review, facility investigation, resident bill of rights, facility policy/procedures, and staff interviews the facility failed to provide a supportive and safe environment for Resident #3. On 8/26/24, the facility staff learned of a Certified Nurse Aide (CNA) being accused of backing Resident #3 into a wall and bitching at them. After learning of this allegation of abuse, the facility staff told the CNA not to help Resident #3, but allowed them to work with other residents. The facility identified a census of 46 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE], documented Resident #3 with a Brief Interview for Mental Status (BIMS) score of 15 for which indicated no impaired decision making abilities, no physical or verbal behavior symptoms directed towards others, was able to be understood and ability to understand others and had adequate vision. The MDS also documented the resident as required partial/moderate assistance with showering/bathing and independent with other activities of daily living and diagnosis for which included anemia, coronary artery disease, hypertension, anxiety, depression and chronic pain.</p> <p>The Plan of Care with an initiated date 12/18/22, documented Resident #3 has a behavior problem, for which has negative outcome from my behaviors. Interventions include:</p> <ul style="list-style-type: none"> *Anticipate and meet my needs. *Approach me and speak to me in a calm manner. *Divert my attention. Remove me from situations as needed and take me to an alternate location as needed. *Intervene as necessary to protect the rights and safety of others. *Social Services to evaluate and visit with me. *I ambulate independently without the use of an assistive device, but do use a walker at request as needed. <p>A Grievance/Concern Investigation Form dated 8/26/24, documented Resident #3 reported to the facility, Can't remember when, but Staff A, CNA backed me up against the dining room wall, bitching at me about cleaning up my room and have stuff under bed. I will call my attorney if this keeps happening. Follow-up from facility, Staff A, CNA had removed numerous boxes of gloves from under Resident #3's bed and resident was upset. Staff A, never backed up resident against a wall.</p> <p>A Police Department Call for Service Record dated 8/29/24 at 9:32 a.m., recorded a Resident advised Nurses Aide pushed him up against the wall. Resident would like to speak with an officer. At 10:08 a.m., Officer unable to confirm at this time, will speak with other residents.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A written comment on the Investigation Note dated 9/4/24, documented, Staff A, stay totally away from Resident #3, no cares, not in his room, no smoking outside together, Stay away!</p> <p>The Progress Notes dated 9/4/24 at 9:16 a.m., documented Behavior Note Text: Resident called this nurse over to him at the dining room table. Asked resident how things were going. Resident stated that his elbow was hurting. When asked what happened. Resident stated that it was stemming from the incident he previously reported. This</p> <p>nurse then asked the resident I thought it was your head that was hurt. He replied yeah it was but now my elbow hurts. This nurse asked resident if Range of Motion (ROM) was intact and everything was fully functional. Resident</p> <p>responded yes. Resident informed and educated on the use of pain medications as needed.</p> <p>The Progress Notes dated 9/4/24 at 2:10 p.m., documented Administration Note Text: Monitor target behaviors and side effects every shift every day and evening shift. CNA witnessed resident saying he was going to get staff in trouble again. I also saw him walk up the hall and try to look around the corner for that same staff member.</p> <p>The Progress Notes dated 9/4/24 at 4:29 p.m., documented Note Text: Director of Nursing (DON) and Administrator visited with this resident regarding a recent incident in which himself and staff member were in a</p> <p>disagreement. Resident states staff member is still his friend and eventually will come around and speak with her again as they used to. States he does not have any issues with her currently. DON and Administrator offered other living solution in an assisted living in another town. States he does like the idea but will think about it for a while and let us know if decides this would be a good idea. Resident states he has a headache. Educated on medications he can use</p> <p>and encouraged fluid intake to prevent dehydration which can cause headaches. No further concerns from administration or resident. Will follow as needed</p> <p>A Police Department Call for Service Report dated 9/27/24 at 2:48 p.m., Resident wants to speak to an officer about him being assaulted at the facility. At 3:00 p.m., Resident has already spoken with the officer about the assault, it has been unfounded.</p> <p>A written comment on the investigation noted dated 10/24/24, still upset with Staff A on 9/4/24 incident.</p> <p>Review of the Employee Punch Report with a run dated 1/30/25 at 11:55 a.m., revealed Staff A worked on 8/26/24 from 6:28 a.m., to 8:40 a.m., then from 9:04 a.m., to 10:36 a.m., and 11:00 a.m., to 2:51 p.m.</p> <p>Interview on 1/28/25 at 8:45 a.m., Resident #3 was not able to recall the exact date and time with Staff A, treating him rough and threw him up against a wall, did state the facility Administrator was told about the incident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 1/28/25 at 11:30 a.m., the facility Administrator did an internal investigation and felt that Staff A, was not capable of backing Resident #3 up against a wall in the dining room as alleged by Resident #3 and allowed Staff A to continue to work in the facility with the directive to not work with Resident #3.</p> <p>Interview on 1/28/25 at 1:00 p.m., Staff A, CNA, explained that on 8/26/24, she was cleaning under Resident #3's bed while he was outside smoking, sometime around lunch, and found a box of gloves and Kleenex. Resident #3's roommate told Resident #3 that Staff A had taken some things from underneath his bed and then accused me of backing him up against the dining room wall and yelling at him for all the stuff that was found. The facility asked me to go to my car until they determined for me to come back into work. I came back into work and finished my shift, I am not sure of the time I punched out or in.</p> <p>The Dependent Adult Abuse Policy dated 11/19, documented the policy is that all residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident medical symptoms. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.</p> <p>It shall be the policy of this facility to implement written procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.</p> <p>The Resident [NAME] of Rights dated 1/2017, stated that the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>*A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each residents individuality. The facility must protect and promote the rights of the resident.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858</p> <p>Based on clinical record review, resident bill of rights, facility investigation, staff interview and review of policy and procedures, the facility failed to ensure all alleged violations involving mistreatment, neglect, or abuse of a resident and/or residents (Resident #3) were reported to the Department of Inspection and Appeals and Licensing (DIAL) within 2 hour and the facility also failed to report potential abuse for missing Fentanyl (a topical opioid pain medication) patches were reported to the DIAL within 24 hours. (Resident #3 and Resident #1). The facility reported a census of 46 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) assessment dated [DATE], documented Resident #3 with a Brief Interview for Mental Status (BIMS) score of 15 for which indicated no impaired decision making abilities, no physical or verbal behavior symptoms directed towards others, was able to be understood and ability to understand others and had adequate vision. The MDS also documented the resident as required partial/moderate assistance with showering/bathing and independent with other activities of daily living and diagnosis included anemia, coronary artery disease, hypertension, anxiety, depression and chronic pain.</p> <p>The Plan of Care with an initiated date 12/18/22, documented Resident #3 has a behavior problem, for which has negative outcome from my behaviors. Interventions include:</p> <p>*Anticipate and meet my needs.</p> <p>*Approach me and speak to me in a calm manner.</p> <p>*Divert my attention. Remove me from situations as needed and take me to an alternate location as needed.</p> <p>*Intervene as necessary to protect the rights and safety of others.</p> <p>*Social Services to evaluate and visit with me.</p> <p>*I ambulate independently without the use of an assistive device, but do use a walker at request as needed.</p> <p>A Grievance/Concern Investigation Form dated 8/26/24, documented Resident #3 reported to the facility, Can't remember when, but Staff A, CNA backed me up against the dining room wall, bitching at me about cleaning up my room and have stuff under bed. I will call my attorney if this keeps happening. Follow-up from facility, Staff A, CNA had removed numerous boxes of gloves from under Resident #3's bed and resident was upset. Staff A never backed up resident against a wall.</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>A Police Department Call for Service Record dated 8/29/24 at 9:32 a.m., recorded a Resident advised Nurses Aide pushed him up against the wall. Resident would like to speak with an officer. At 10:08 a.m., Officer unable to confirm at this time, will speak with other residents.</p> <p>A written comment on the investigation note dated 9/4/24, documented, Staff A, stay totally away from Resident #3, no cares, not in his room, no smoking outside together, Stay away!</p> <p>The Progress Notes dated 9/4/24 at 9:16 a.m., documented Behavior Note Text: Resident called this nurse over to him at the dining room table. Asked resident how things were going. Resident stated that his elbow was hurting. When asked what happened. Resident stated that it was stemming from the incident he previously reported. This</p> <p>nurse then asked the resident I thought it was your head that was hurt. He replied yeah it was but now my elbow hurts. This nurse asked resident if Range of Motion (ROM) was intact and everything was fully functional. Resident</p> <p>responded yes. Resident informed and educated on the use of pain medications as needed.</p> <p>The Progress Notes dated 9/4/24 at 2:10 p.m., documented Administration Note Text: Monitor target behaviors and side effects every shift every day and evening shift. CNA witnessed resident saying he was going to get staff in trouble again. I also saw him walk up the hall and try to look around the corner for that same staff member.</p> <p>The Progress Notes dated 9/4/24 at 4:29 p.m., documented Note Text: Director of Nursing (DON) and Administrator visited with this resident regarding a recent incident in which himself and staff member were in a</p> <p>disagreement. Resident states staff member is still his friend and eventually will come around and speak with her again as they used to. States he does not have any issues with her currently. DON and Administrator offered other living solution in an assisted living in another town. States he does like the idea but will think about it for a while and let us know if decides this would be a good idea. Resident states he has a headache. Educated on medications he can use</p> <p>and encouraged fluid intake to prevent dehydration which can cause headaches. No further concerns from administration or resident. Will follow as needed</p> <p>A Police Department Call for Service Report dated 9/27/24 at 2:48 p.m., Resident wants to speak to an officer about him being assaulted at the facility. At 3:00 p.m., Resident has already spoken with the officer about the assault, it has been unfounded.</p> <p>A written comment on the Investigation Note dated 10/24/24, still upset with Staff A on 9/4/24 incident.</p> <p>Interview on 1/28/25 at 8:45 a.m., Resident #3 was not able to recall the exact date and time with Staff A, treating him rough and threw him up against a wall, did state the facility Administrator was told about the incident.</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>Interview on 1/28/25 at 11:30 a.m., the facility Administrator did an internal investigation and felt that Staff A, was not capable of backing Resident #3 up against a wall in the dining room as alleged by Resident #3 and allowed Staff A to continue to work in the facility with the directive to not work with Resident #3.</p> <p>Interview on 1/28/25 at 1:00 p.m., Staff A, CNA, explained that on 8/26/24, she was cleaning under Resident #3's bed while he was outside smoking, sometime around lunch, and found a box of gloves and Kleenex. Resident #3's roommate told Resident #3 that Staff A had taken some things from underneath his bed and then accused me of backing him up against the dining room wall and yelling at him for all the stuff that was found. The facility asked me to go to my car until they determined for me to come back into work. I came back into work and finished my shift, I am not sure of the time I punched out or in.</p> <p>Interview on 1/29/25 at 11:30 a.m., the facility Administrator confirmed and verified that the facility failed to notify DIAL of the incident between Resident #3 and Staff A within the 2 hour time frame.</p> <p>2. The MDS assessment dated [DATE], documented Resident #3 with a BIMS score of 15 for which indicated no impaired decision making abilities, was able to be understood and ability to understand others and had adequate vision. The MDS also documented the resident as required partial/moderate assistance with showering/bathing and independent with other activities of daily living and diagnosis included anemia, coronary artery disease, hypertension, anxiety, depression and chronic pain. The MDS documented the resident had pain frequently over the last 5 days and described the pain as moderate and receiving an opioid medication daily in the last 7 days.</p> <p>The Plan of Care with an initiated date 8/16/23, identified a focus area of I am on pain medication therapy (Fentanyl) related to disease process (Chronic pain). Interventions include:</p> <p>*Fentanyl exposes patients and other users to the risks of opioid addiction, abuse, and misuse, which can lead to overdose and death. Assess each patient's risk prior to prescribing fentanyl, and monitor all patients regularly for the development of these behaviors or conditions.</p> <p>*Accidental exposure of even one dose of fentanyl, especially by children, can result in a fatal overdose of fentanyl. Deaths due to an overdose of fentanyl have occurred when children and adults were accidentally exposed to fentanyl transdermal patch. Strict adherence to the recommended handling and disposal instructions is of the utmost importance to prevent accidental exposure.</p> <p>The Progress Notes dated 12/15/24 at 8:03 a.m., documented Administration Note Text: Fentanyl Patch 72 Hour</p> <p>50 micrograms/hour Apply 1 patch transdermally one time a day every 3 day (s) for pain and remove per schedule. No patch found to remove.</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>The Progress Notes dated 12/15/24 at 8:05 a.m., documented Administration Note Late Entry: Note Text: Entered resident's room to administer scheduled medications and a fentanyl patch as scheduled. Upon assessing the resident no patch from previous administration was found in the location listed. This nurse then proceeded to check the resident's entire back by lifting up his shirt and still no patch was found. This nurse asked the resident to remove his shirt to assess his entire upper half for the previous patch. After complete assessment of resident, no patch was found on him. Resident's bed and floor also checked and no patch was found. Resident was asked if he knew what had happened to the patch and if it had fallen off at some time and resident stated that he had no idea what had happened to it.</p> <p>Interview on 1/28/25 at 3:00 p.m., the facility Director of Nursing, stated that no investigation was completed on the missing Fentanyl patch and that it is the expectation of the nurses to make sure that the patch is on every shift and if not able to find the patch then to start an investigation immediately.</p> <p>Interview on 1/29/25 at 12:00 p.m , the facility Director of Nursing, confirmed and verified that the facility failed to do an investigation into the missing fentanyl patch and failed to notify DIAL of the missing patch.</p> <p>3. The MDS assessment dated [DATE], documented Resident #1 with a BIMS score of 9 for which indicated moderate impaired decision making abilities, was able to be understood and ability to understand others and has adequate vision. The MDS also documented the resident as required substantial/maximum assistance with showering/bathing and independent with other activities of daily living and diagnosis included coronary artery disease, renal failure, Non-Alzheimer Dementia, anxiety, depression and chronic pain. The MDS documented the resident denied pain.</p> <p>The Physician Order dated 8/27/24 at 2:00 p.m., instructed staff to place a Fentanyl Patch 72 Hour 25 micrograms/hour and change every 3 days.</p> <p>The Plan of Care with an revision dated 8/6/24, had a focus area of I take opioid pain medication. Interventions include:</p> <p>*To ensure that the benefits of opioid analgesics outweigh the risks of addiction, abuse, and misuse. Under the requirements of the drug companies with approved opioid analgesic products-compliant education programs available to health care providers.</p> <p>*Health care providers are strongly encouraged to complete a compliant education program and counsel patients and/or their caregivers, with every prescription, on safe use, serious risks, storage, and disposal of these products,</p> <p>emphasize to patients and their caregivers the importance of reading the Medication Guide every time it is provided by their pharmacist, and consider other tools to improve patient, household, and community safety.</p> <p>The Progress Note dated 8/30/24 at 1:48 p.m., documented Administration Note Text: Fentanyl Patch 72 Hour</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Cherokee Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 North Roosevelt Cherokee, IA 51012	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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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>25 micrograms/hour Apply 1 patch transdermally one time a day every 3 day (s) for pain and remove per schedule</p> <p>patch not found.</p> <p>Interview on 1/29/25 at 12:00 p.m., the facility DON, stated that the facility failed to report the missing Fentanyl to DIAL as per policy/procedure.</p> <p>The Dependent Adult Abuse Policy dated 11/19, documented the policy is that all residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and physical or chemical restraint not required to treat the resident medical symptoms. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.</p> <p>It shall be the policy of this facility to implement written procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.</p> <p>Timely Abuse Reporting dated 11/19, documented all allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the Charge Nurse. The Charge Nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative. All allegations of resident abuse shall be reported to DIAL no later 2 hours after the allegation is made.</p> <p>The Resident [NAME] of Rights dated 1/2017, stated that the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>*A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each residents individuality. The facility must protect and promote the rights of the resident.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858</p> <p>Based on clinical record review, resident bill of rights, facility policy/process, and staff interviews, the facility staff failed to investigate Resident #3 and Resident #1 missing Fentanyl (a topical opioid pain medications) patches. The facility reported a census of 46 residents.</p> <p>Findings included:</p> <p>1. The Minimum Data Set (MDS) assessment dated [DATE], documented Resident #3 with a Brief Interview for Mental Status (BIMS) score of 15 for which indicated no impaired decision making abilities, was able to be understood and ability to understand others and has adequate vision. The MDS also documented the resident as required partial/moderate assistance with showering/bathing and independent with other activities of daily living and diagnosis included anemia, coronary artery disease, hypertension, anxiety, depression and chronic pain. The MDS documented the resident had pain frequently over the last 5 days and described the pain as moderate and receiving an opioid medication daily in the last 7 days.</p> <p>The Plan of Care with an initiated dated 8/16/23, identified a focus area of I am on pain medication therapy (Fentanyl) related to disease process (Chronic pain). Interventions include:</p> <p>*Fentanyl exposes patients and other users to the risks of opioid addiction, abuse, and misuse, which can lead to overdose and death. Assess each patient's risk prior to prescribing fentanyl, and monitor all patients regularly for the development of these behaviors or conditions.</p> <p>*Accidental exposure of even one dose of fentanyl, especially by children, can result in a fatal overdose of fentanyl. Deaths due to an overdose of fentanyl have occurred when children and adults were accidentally exposed to fentanyl transdermal patch. Strict adherence to the recommended handling and disposal instructions is of the utmost importance to prevent accidental exposure.</p> <p>The Progress Notes dated 12/15/24 at 8:03 a.m., documented Administration Note Text: Fentanyl Patch 72 Hour</p> <p>50 micrograms/hour Apply 1 patch transdermally one time a day every 3 day(s) for pain and remove per schedule. No patch found to remove.</p> <p>The Progress Notes dated 12/15/24 at 8:05 a.m., documented Administration Note Late Entry: Note Text: Entered resident's room to administer scheduled medications and a fentanyl patch as scheduled. Upon assessing the resident no patch from previous administration was found in the location listed. This nurse then proceeded to check the resident's entire back by lifting up his shirt and still no patch was found. This nurse asked the resident to remove his shirt to assess his entire upper half for the previous patch. After complete assessment of resident, no patch was found on him. Resident's bed and floor also checked and no patch was found. Resident was asked if he knew what had happened to the patch and if it had fallen off at some time and resident stated that he had no idea what had happened to it.</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>During interview on 1/28/25 at 3:00 p.m., the facility Director of Nursing, stated that no investigation was completed on the missing Fentanyl patch and that it is the expectation of the nurses to make sure that the patch is on every shift and if not able to find the patch then to start an investigation immediately.</p> <p>During interview on 1/29/25 at 12:00 p.m., the facility Director of Nursing, confirmed and verified that the facility failed to do an investigation into the missing fentanyl patch and failed to notify DIAL of the missing patch.</p> <p>2. The MDS assessment dated [DATE], documented Resident #1 with a BIMS score of 9 for which indicated moderate impaired decision making abilities, was able to be understood and ability to understand others and has adequate vision. The MDS also documented the resident as required substantial/maximum assistance with showering/bathing and independent with other activities of daily living and diagnosis included coronary artery disease, renal failure, Non-Alzheimer Dementia, anxiety, depression and chronic pain. The MDS documented the resident denied pain.</p> <p>The Physician Order dated 8/27/24 at 2:00 p.m., instructed staff to place a Fentanyl Patch 72 Hour 25 micrograms/hour and change every 3 days.</p> <p>The Plan of Care with a revision dated 8/6/24, had a focus area of I take opioid pain medication. Interventions include:</p> <p>*To ensure that the benefits of opioid analgesics outweigh the risks of addiction, abuse, and misuse. Under the requirements of the drug companies with approved opioid analgesic products-compliant education programs available to health care providers.</p> <p>*Health care providers are strongly encouraged to complete a compliant education program and counsel patients and/or their caregivers, with every prescription, on safe use, serious risks, storage, and disposal of these products,</p> <p>emphasize to patients and their caregivers the importance of reading the Medication Guide every time it is provided by their pharmacist, and consider other tools to improve patient, household, and community safety.</p> <p>The Progress Note dated 8/30/24 at 1:48 p.m., documented Administration Note Text: Fentanyl Patch 72 Hour</p> <p>25 micrograms/hour Apply 1 patch transdermally one time a day every 3 day(s) for pain and remove per schedule</p> <p>patch not found.</p> <p>Interview on 1/29/25 at 12:00 p.m., the facility Director of Nursing confirmed and verified that the facility failed to do an investigation into the missing Fentanyl patch.</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>The Dependent Adult Abuse Policy dated 11/19, documented the policy is that all residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and nay physical or chemical restraint not required to treat the resident medical symptoms. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.</p> <p>It shall be the policy of this facility to implement written procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.</p> <p>The Resident [NAME] of Rights dated 1/2017, stated that the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>*A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each residents individuality. The facility must protect and promote the rights of the resident.</p>		

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<p>F 0689</p> <p>Level of Harm - 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** 25858</p> <p>Based on clinical record review, staff interview, facility photographs, and facility education, the facility failed to secure a hot cup of coffee, monitor a resident known to drink hot coffee all hours of the day and night, test coffee temperatures, follow physicians orders for which resulted in a 2nd degree burn to the groin region that progressively worsened and caused substantial pain for 1 of 3 resident reviewed. (Resident #1) The facility identified the census of 46 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE], documented Resident #1 with diagnoses Coronary Artery Disease, Renal Failure, Non-Alzheimer Dementia, anxiety, depression, malnutrition and abnormalities of gait and mobility. The Brief Interview for Mental Status (BIMS) showed the resident scored a 9 which indicated moderate impaired decision making abilities, was able to be understood and has the ability to understand others and has adequate vision. The MDS documented the resident frequently incontinent of urine and a wheelchair was used for mobility. The MDS documented the resident denied pain, no skin issues and received Hospice services.</p> <p>The Plan of Care with focus areas of I have been provided with a diet order for regular diet, (initiated 12/12/22), I am/have a potential to be verbally aggressive (towards residents and staff) related to dementia, and poor impulse control (initiated: 8/12/24) I have a burn of the (inner thighs) related to coffee spill (initiated 9/7/24). Interventions include:</p> <p>*Resident to use sippy cups to prevent skin injuries. (Initiated 9/7/24)</p> <p>*I am noted to be noncompliant with transfer assistance. Redirect as able. (Initiated 8/30/24)</p> <p>*Place me in area where frequent observation is possible. (Initiated 8/30/24)</p> <p>*Adjust my treatment plan if no healing within 2-4 weeks. (Initiated 9/12/24)</p> <p>*Avoid scratching and keep hands and body parts from excessive moisture.(Initiated 9/7/24)</p> <p>*Cover my arms to prevent me from scratching. (Initiated 9/12/24)</p> <p>*Give anti-pruritic (itching cream) medication as ordered by physician. Monitor and document side effects and effectiveness. (Initiated 9/12/24)</p> <p>*I have a tendency to pick at my bandages and pull them off. Please kindly remind me to not do this as it may cause an infection/worsen the wounded area.(Initiated 9/11/24)</p> <p>*I need a full skin evaluation weekly with bath/shower. (Initiated 9/12/24)</p> <p>*Monitor me for signs and symptoms of infection or spreading. (Initiated 9/12/24)</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*Monitor skin rashes for increased spread or signs of infection. (Initiated: 9/7/24)</p> <p>*Provide my progress report to me/my family on healing status. (Initiated: 9/7/24)</p> <p>The Progress Notes documented on these dates and times the following:</p> <p>*9/7/24 at 6:41 a.m., Incident, Accident, Unusual Occurrence Note Late Entry Text: Resident found to have burn marks on his inner thighs (spilled coffee on his lap), Night shift gave coffee per his request. Resident known to be terminally restless. Accidentally spilled in his lap. Placed calomoseptine on burns and called on call hospice and primary care provider. Also gave as needed morphine for pain.</p> <p>*9/7/24 at 6:46 a.m., Morphine Sulfate (medicine to treat moderate to severe pain)(Concentrate) Solution 20 milligram (MG)/milliliter (ML) Give 0.5 ml by mouth every 1 hours as needed for severe bilateral thigh pain.</p> <p>*9/7/24 at 12:29 p.m., Resident sleeping after being up all night and receiving as needed pain medication.</p> <p>*9/7/24 at 5:37 p.m., Give 0.5 ml of morphine by mouth every 1 hours as needed for severe pain, burns on thighs hurt</p> <p>*9/7/24 at 5:42 p.m., Hospice Nurse visit completed. Continuity of Care (COC) with Facility Staff Nurse (FSN), Staff E, Licensed Practical Nurse (LPN)</p> <p>*9/7/24 at 6:07 p.m., Hospice Verbal Order Obtained: To burns to bilateral thighs apply Silvadene cream and cover with Mepilex (absorbent foam dressing designed for low to medium exudates (fluid that leaks out of blood vessels into surrounding tissues) change every day and as needed (PRN). May use Triad (used to treat light to moderate levels of wound leakage) cream until Silvadene (a cream used to treat wound infections in patients with second and third degree burns) until obtained from pharmacy. Prescribed by physician. Facility Nurse Notified.</p> <p>*9/9/24 at 6:50 a.m. Morphine Sulfate Solution, Gave 0.5 ml by mouth every 1 hours as needed for severe pain legs and back pain.</p> <p>*9/10/24 at 6:42 a.m., Morphine Sulfate Solution, Gave 0.5 ml by mouth every 1 hours as needed for severe pain, leg burns.</p> <p>*9/10/24 at 3:28 p.m., Morphine Sulfate Solution, Gave 0.5 ml by mouth every 1 hours as needed for severe pain, burn pain.</p> <p>*9/10/2024 at 6:46 p.m., Morphine Sulfate Solution, Gave 0.5 ml by mouth every 1 hours as needed for severe pain, pain from burns.</p> <p>*9/12/24 at 8:22 p.m., Morphine Sulfate Solution, Gave 0.5 ml by mouth every 1 hours as needed for severe pain, leg pain.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*9/13/24 at 4:37 p.m., Morphine Sulfate Solution, Gave 0.5 ml by mouth every 1 hours as needed for severe pain, Requested for pain in hand and legs.</p> <p>*9/14/2024 at 9:15 p.m., Morphine Sulfate Solution, Gave 0.5 ml by mouth every 1 hours as needed for severe pain, Resident requested PRN morphine due to the burns on his legs really bothering him.</p> <p>*9/15/2024 at 7:34 a.m., Morphine Sulfate Solution, Gave 0.5 ml by mouth every 1 hours as needed for severe pain, wounds.</p> <p>*9/15/2024 at 8:35 a.m., Morphine Sulfate Solution, Gave 0.5 ml by mouth every 1 hours for pain.</p> <p>*9/15/2024 at 9:53 a.m., Hospice Note Text: Can we change residents morphine order to be able to have 0.5 ml to 1 ml PRN? It's currently just 0.5 ml.</p> <p>*9/16/2024 at 11:30 a.m., Hospice Note Text: Received verbal order signed by Hospice Nurse to start Morphine 0.5 ml to 1.0 ml PRN every 1 hour and discontinue previous 0.5 ml order.</p> <p>*9/16/2024 at 2:41 p.m., Physician Note Text: Received signed verbal orders for treatment to bilateral inner thighs.</p> <p>*9/17/2024 at 7:48 a.m., Morphine Sulfate Solution, Gave 0.5 ml by mouth every 1 hours as needed for severe pain, Resident requested for pain.</p> <p>*9/17/2024 at 5:28 p.m., Morphine Sulfate Solution, Gave 1 ml by mouth every 1 hours as needed for Pain - Severe, dressing change was done.</p> <p>*9/18/2024 at 2:49 a.m., Morphine Sulfate Solution, Gave 1 ml by mouth every 1 hours as needed for Pain - Severe.</p> <p>*9/19/2024 at 4:50 p.m., Morphine Sulfate Solution, Gave 0.5 ml by mouth every 1 hours as needed for severe pain, was given for pain in legs.</p> <p>*9/20/2024 at 3:20 a.m. Morphine Sulfate Solution, Gave 1 ml by mouth every 1 hours as needed for Pain - Severe, Resident yelling out ouch, help me. Noted resident removing bandages to bilateral thighs. Administered medication and changed dressing at this time.</p> <p>*9/20/2024 at 8:39 a.m., Morphine Sulfate Solution, Gave 1 ml by mouth every 1 hours as needed for Pain - Severe, for pain in resident's legs.</p> <p>*9/20/2024 at 1:18 p.m., Morphine Sulfate Solution, Gave 1 ml by mouth every 1 hours as needed severe leg pain.</p> <p>*9/20/2024 at 1:33 p.m., Monitor target behaviors and side effects every shift every day and evening shift restless, pulling apart brief and trying to take bandages off.</p> <p>*9/20/2024 at 7:05 p.m., Morphine Sulfate Solution, Gave 1 ml by mouth every 1 hours as needed for pain.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*9/21/2024 at 2:49 p.m., Morphine Sulfate Solution, Gave 1 ml by mouth every 1 hours as needed for Pain - Severe, resident restless, in pain</p> <p>*9/22/2024 at 6:16 a.m., Morphine Sulfate Solution, Gave 1 ml by mouth every 1 hours as needed for Pain-Severe, Resident repeatedly yelling out 'help', admits to pain to legs.</p> <p>*9/22/2024 at 10:17 a.m., Morphine Sulfate Solution, Gave 1 ml by mouth every 1 hours as needed for Pain-Severe, resident in increased pain during dressing change to burn to thighs.</p> <p>*9/22/2024 at 11:38 a.m., Morphine Sulfate Solution, Gave 1 ml by mouth every 1 hours as needed for Pain - Severe, PRN Administration was: Ineffective, Follow-up Pain Scale was: 8</p> <p>*9/22/2024 at 11:39 a.m., Morphine Sulfate Solution, Gave 1 ml by mouth every 1 hours as needed for Pain - Severe, Resident has pain due to burns on thighs.</p> <p>*9/22/2024 at 1:21 p.m., Monitor target behaviors and side effects every shift, every day and evening shift. Resident yelling out in pain frequently throughout this nurse's shift. PRN morphine utilized.</p> <p>*9/22/2024 at 4:01 p.m., Morphine Sulfate Solution, Gave 1 ml by mouth every 1 hours as needed for Pain - Severe, resident yelling out in pain during cares.</p> <p>*9/22/2024 at 7:45 p.m., Morphine Sulfate Solution, Gave 1 ml by mouth every 1 hours as needed for Pain - Severe, crying out during cares.</p> <p>*9/23/2024 at 7:53 a.m., Morphine Sulfate Solution, Gave 0.75 ml by mouth every 1 hours as needed for severe pain.</p> <p>*9/24/2024 at 9:05 a.m., Morphine Sulfate Solution, Gave 1 ml by mouth every 1 hours as needed for Pain - Severe</p> <p>*9/24/2024 at 2:04 p.m., Morphine Sulfate Solution, Gave 1 ml by mouth every 1 hours as needed for Pain - Severe</p> <p>*9/24/2024 at 7:59 p.m., Morphine Sulfate Solution, Gave 1 ml by mouth every 1 hours as needed for Pain - Severe</p> <p>*9/24/2024 at 8:06 p.m., resident is not swallowing water, did not feel it safe to administer morphine.</p> <p>*9/25/2024 at 10:09 a.m., Morphine Sulfate Solution, Gave 0.5 ml by mouth every 1 hours as needed for severe pain, Was given for pain in legs.</p> <p>*9/26/2024 at 9:37 a.m., Atropine Sulfate Ophthalmic Solution 1 %, Give 4 drop by mouth every 1 hours as needed for secretions.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*9/27/2024 at 9:02 a.m., Morphine Sulfate Solution, Give 1 ml by mouth every 1 hours as needed for Pain - Severe,</p> <p>labored breathing, unresponsive.</p> <p>*9/27/2024 at 9:46 a.m., Atropine Sulfate Ophthalmic Solution 1 %, Give 4 drop by mouth every 1 hours as needed for secretions, gurgly and secretions.</p> <p>*9/27/2024 at 2:33 p.m., Morphine Sulfate Solution, Give 1 ml by mouth every 1 hours as needed for Pain - Severe</p> <p>*9/27/2024 at 7:13 p.m., Morphine Sulfate Solution, Give 1 ml by mouth every 1 hours as needed for Pain - Severe</p> <p>*9/28/2024 at 11:48 p.m., On 9/28/2024, during morning rounds at 6:00 a.m., This nurse discovered Resident unresponsive, not breathing, with no pulse or respiration. The resident's skin was cold to touch, indicating death had occurred. This nurse announced resident death at 6:03 a.m.</p> <p>Review of the Hospice Skilled Nursing Visit Note dated 9/7/24 at 5:01 p.m., documented the following:</p> <p>*Left inner leg thigh/burn second degree (a burn that affects the epidermis (outer layer of skin) and dermis (the thick layer below the epidermis) with wound bed as slough, (the white/yellow material in the wound bed) length 11 cm by width 8 cm, cleanse with soap and water and apply silvadene, cover with mepilex (dressing).</p> <p>*Right inner leg thigh/burn second degree with wound bed as slough, length 10 cm by width 3 cm, cleanse with soap and water and apply silvadene and cover with mepilex.</p> <p>*Narrative notes: Received call from facility staff nurse, Staff E, LPN. Patient spilled hot coffee in his lap this am. Patient has blistered/open areas to bilateral upper, inner thighs. Patient denies pain unless touch area. New orders for Silvadene per Physician. Triad wound cream applied until Silvadene arrives from pharmacy. Patient tells this nurse Thank you that feels much better.</p> <p>Facility photos of the wound evaluation documented on 9/7/24 at 6:34 a.m., revealed:</p> <p>Left Medial thigh, First degree Burn, in-house acquired.</p> <p>*Dimensions= length 12.2 cm by width 4.7 cm</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Cherokee Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 North Roosevelt Cherokee, IA 51012	
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*Wound Bed (the underlying surface of a wound, consisting of various tissues that contribute to the healing process)= 100% granulation (the development of new tissue and blood vessels in a wound during the healing process), increased pain and warmth with pink or red wound bed</p> <p>*Pain= cognitively impaired-yes, sad/frightened/frown, and tense body language</p> <p>*Treatment= calmoseptine (moisture barrier that helps protect and heal skin irritations), morphine</p> <p>Facility Photos of the wound evaluation documented on 9/13/24 at 8:17 a.m., revealed:</p> <p>Left Medial Thigh, first degree burn, in house acquired</p> <p>*Dimensions=8.2 cm by 5.2 cm</p> <p>*Wound Bed= 20% epithelial (helps to protect or enclose organs), with 30 % granulation and 50% slough and bleeding with pink/red surface area.</p> <p>*Exudates (mass of cells and fluid that has seeped out of blood vessels) = moderate amount of serosanguineous (a fluid that contains both blood and serum) drainage</p> <p>*Pain=7 at dressing</p> <p>*Progress=deteriorating, new treatment.</p> <p>Facility Photos of the wound evaluation documented on 9/20/24 at 3:27 a.m., revealed:</p> <p>Left Medial thigh, first degree burn, in house acquired</p> <p>*Dimensions= 8.3 cm by 2.8 cm</p> <p>*Wound Bed= 10 % epithelial tissue, 30% granulation tissues, 20% slough, 40% eschar (dead tissue that eventually sloughs off healthy skin after an injury) and area is bleeding, islands of epithelium and pink/red surface area.</p> <p>*Exudate= light serosanguineous drainage</p> <p>*Peri Wound (the skin surrounding a wound) = 1.5 cm of attached erythema (superficial reddening of the skin) tissue and temperature is warm.</p> <p>*Progress=stable, no new treatment.</p> <p>Facility photos of the wound evaluation documented on 9/7/24 at 6:34 a.m., revealed:</p> <p>Right Medial thigh, first degree burn, in house acquired.</p> <p>*Dimensions=length 5.8 cm by 3.6 cm</p> <p>*Wound Bed=100% epithelial and pink/red wound bed</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*Pain=score of 8, with sad/frightened/frown facial expressions and cognitively impaired.</p> <p>Facility Photos of the wound evaluation documented on 9/13/24 at 8:17 a.m., revealed:</p> <p>Right Medial Thigh, first degree burn, in house acquired</p> <p>*Dimensions=1.4 cm by 6.8 cm</p> <p>*Wound Bed= 30% epithelial, and 70% granulation and pink/red surface area</p> <p>*Exudate= light, serosanguineous drainage</p> <p>*Peri-Wound= excoriated surrounding the tissue, 2.5 cm and warm</p> <p>*Pain= 7 at dressing change</p> <p>*Progress=deteriorating, new treatment</p> <p>Facility Photos of the wound evaluation documented on 9/20/24 at 3:27 a.m., revealed:</p> <p>Right Medial thigh, first degree burn, in house acquired</p> <p>*Dimensions= 1.7 cm by 3.0 cm</p> <p>*Wound Bed= 30% of epithelial tissue, 70% of granulation tissue and area is pink/red surface area</p> <p>*Exudate= light serosanguineous drainage</p> <p>*Peri Wound= 1.5 erythema with attached edges and temperature is warm</p> <p>*Progress=stable with no new orders</p> <p>Review of the Facility Skin and Wound Evaluation form dated 9/7/24 at 12:45 p.m., revealed a first degree burn of the left medial thigh, from a coffee spill, area measures 46.2 cm by 12.3 cm by 4.8 cm, with 100% of wound filled with granulation, increased pain, warmth, with no dressing applied, resident with wound pain by loud moaning or groaning and crying, pulling and pushing away, appears frightened.</p> <p>Review of the Facility Skin and Wound Evaluation form dated 9/20/24 at 4:09 a.m., revealed a first degree burn on the right medial thigh, from a coffee spill, with start date 9/7/24, area measures 2.6 centimeters (cm) by 1.8 cm by 3.1 cm., with 30 % of wound covered with granulation, with light amount of exudate, of serosanguineous type, resident with wound pain by loud moaning or groaning and crying, pulling and pushing away, appears frightened.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 1/29/24 at 2:45 p.m., The Senior Director of Nursing (DON), confirmed and verified that the Silvadene order was not on the September Medication Administration Record (MAR) or the September Treatment Administration Record (TAR) and it is the expectation of the nurses to follow the physician orders and note orders per the State and Federal Rules and Regulations and that the facility failed to follow the orders.</p> <p>Interview on 1/29/25 at 3:00 p.m., Staff B, Certified Nursing Assistant (CNA), stated that Resident #1 would like to always have a cup of coffee with him and that there was no directive to put a lid on the mug. Resident #1 would be impulsive and want to transfer themselves unexpectedly. The directive now is that any resident that wants coffee out of the dining room will have a tumbler with a lid.</p> <p>Interview on 1/29/25 at 4:00 p.m., Staff E, LPN, confirmed and verified that the order for the Silvadene was not noted on the September MAR or TAR, Staff E stated that they did not see the burn until later on 9/7/24, when the Hospice Nurse came to evaluate the burns and the burns were blistered and peeling. Staff E, stated that it was not uncommon for Resident #1 to always have a cup of coffee with them at all times and there was not a directive to have a lid on the mug and that the resident was impulsive with transferring and would unexpectedly stand up.</p> <p>Interview on 1/29/25 at 4:15 p.m., the DON stated that after this incident with the coffee spill and burn the facility had put in place that if a resident wants coffee out of the dining room they will have a small tumbler with a lid at all times. The DON failed to admit or deny that they had seen the burn on the morning of 9/7/24.</p> <p>Interview on 1/30/25 at 11:15 a.m., the facility Assistant Director of Nursing (ADON) confirmed and verified that the order for the Silvadene cream failed to get noted on the September MAR/TAR. The ADON stated that they took the pictures of the resident burn on 9/7/24 and that the DON gave the directive to put calmoseptine on them until the Hospice nurse comes to see them. The ADON stated that the resident had a cup of coffee with them at all times and that there was no directive to have a lid on the mug and that the resident would be impulsive with wanting to transfer by themselves and stand up unexpectedly.</p> <p>Interview on 1/30/25 at 8:15 a.m., the Dietary Manager stated the kitchen staff follow the Federal and State rules and regulations for temperature of the food and that the food and liquids are to be at 135 degrees Fahrenheit or above. The Dietary Manger stated that no records are kept of the food temperatures of the coffee and that staff will randomly take a coffee temperature, but is not written down anywhere.</p> <p>An In-Service Form dated 1/29/25 with no time, revealed, Educations Description: Nurse Education regarding</p> <ol style="list-style-type: none"> 1. Processing Hospice Orders and Noting them. 2. Time line for Completing assessments after risk management; Nursing focus Evaluation (incident/accident/unusual occurrence follow up charting). option B <ol style="list-style-type: none"> a. Time Line for Completing assessments after risk management: <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*This Hot Charting is related to an Incident/Accident/Unusual Occurrence (example=resident had a recent fall or an injury and a Risk Management has been completed and now you are following up every shift.</p> <p>*This charting is expected to be completed at least every shift for 24 hours or until stable.</p> <p>*If the injury is a burn, it will be expected that this chart will stay a Hot Chart and be completed every day until healed.</p> <p>3. Following orders for treatments;</p> <p>a. All skin that is identified as impaired due to an injury is to have</p> <p>*Risk management completed.</p> <p>*Skin evaluation completed with weekly/as needed follow up evaluations completed until healed.</p> <p>*Doctor notification completed.</p> <p>*An order for treatment will be put into place and initiated immediately. This treatment will continue until the area is healed or the treatment needs to be changed due to a change in condition.</p> <p>*The nurse will sign the treatment off when completed.</p> <p>*If wound show a decline in treatment after 1-2 weeks, physician is to be notified and a new treatment to be initiated.</p> <p>4. Follow documentation for burns.</p> <p>A Hospice Verbal Order Process with a revision dated 4/1/24, purpose is to provide direction for entry of documentation into Point Click Care (PCC). For guidance on clinical documentation expectations please refer to appropriate procedures.</p> <p>1. When a Hospice Nurse obtains a verbal order for a resident, they will notify the facility nurse and complete the Hospice Verbal Order Evaluation.</p> <p>a. The hospice nurse will document the date/time the order was obtained, verbal order details, prescribing physician and who at the facility was notified.</p> <p>b. The Hospice Nurse Verbal Order Evaluation will display on the Clinical Dashboard > Clinical Alerts and on the 24 hour Summary Report.</p> <p>2. The facility nurse will then enter the verbal order into PCC and obtain signature from physician.</p> <p>3. Facility nurse will fax the pharmacy if needed.</p> <p>4. The hospice nurse will enter the verbal order into their software and obtain signature.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	5. The hospice office will scan their signed verbal order into PCC< into the residents miscellaneous tab (there will be two signed orders).		

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p>25858</p> <p>Based on clinical record review, observation, resident and staff interview the facility failed to provide profession standards according to the plan of care to have the residents colostomy checked every 3 hours for 1 of 1 resident reviewed (Resident #2). The facility identified a census of 46 residents.</p> <p>Findings include:</p> <p>A Minimum Data Set (MDS) assessment form dated 11/18/24 documented Resident #2 had diagnosis of anemia, hypertension, diabetes mellitus, neurogenic bladder, paraplegia, depression and anxiety. The assessment documented the resident with a Brief Interview for Mental Status (BIMS) score of 15 for which indicated no impaired decision making abilities, is understood and has the ability to understand others. The assessment documented the resident as dependent with all activities of daily living and has an colostomy.</p> <p>The Plan of Care with an initiated dated 8/14/24, had a focus area of, I use colostomy. Interventions include:</p> <p>*Staff to check colostomy bag every 3 hours and empty as needed.</p> <p>The Point of Care Response History dated 1/27/25 at 4:47 p.m., revealed the task segment instructed staff to check colostomy bag every 3 hours, empty if needed. The following dates and times revealed the colostomy bag checked:</p> <p>1/20/25 at 3:02 a.m. and 10:30 a.m.</p> <p>1/21/25 at 00:57 a.m., and 5:00 a.m.</p> <p>1/22/25 at 00:26 a.m., and 5:18 a.m.</p> <p>1/24/25 at 12:00 p.m., and 9:19 p.m.</p> <p>1/25/25 at 2:40 a.m., and 8:12 a.m.</p> <p>1/26/25 at 2:06 a.m., and 6:00 a.m., 12:00 p.m., and 9:53 p.m.</p> <p>The Clinical Record lacked any documentation of the colostomy bag being checked every 3 hours per the Plan of Care.</p> <p>Interview on 1/27/25 at 3:30 p.m., Resident #2, stated that staff fail to check the colostomy bag every 3 hours as requested and sometimes the colostomy bag is really full of air and needs to be burped and it bothered him.</p> <p>(continued on next page)</p>		

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 1/28/25 at 12:15 p.m., Staff D, Certified Nursing Assistant (CNA) went into Resident #2's room to burp the colostomy. Staff D stated that the colostomy was full of air and burped the bag. Staff D confirmed and verified that the colostomy bag is to be checked every 3 hours but admitted that the bag does not get burped every 3 hours per the plan of care due to staffing.</p> <p>Interview on 1/30/25 at 11:15 a.m., the facility Director of Nursing stated that the facility has no policy/procedure on colostomy bags and that the facility follows the State and Federal guidelines for colostomy cares and that it is the expectation of the staff to check the colostomy every 3 hours per the task on the Point of Care segment.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858</p> <p>Based on resident and staff interviews, resident council minutes and the facility assessment, the facility staff failed to answer resident call lights in a timely manner (no longer than 15 minutes) for 2 of 3 residents (Resident #2, and #3). The facility identified a census of 46 residents.</p> <p>Findings include:</p> <p>1. A Minimum Data Set (MDS) assessment form dated 11/18/24 documented Resident #2 had diagnosis that included anemia, hypertension, diabetes mellitus, neurogenic bladder, paraplegia, depression and anxiety. The assessment documented the resident with a Brief Interview for Mental Status (BIMS) score of 15 for which indicated no impaired decision making abilities. The assessment documented the resident as dependent with all activities of daily living and was able to be understood and understands others.</p> <p>Interview on 1/27/25 at 3:30 p.m., Resident #2 stated that it will take the staff over a half hour and up to an hour to answer the call light.</p> <p>2. The MDS assessment form dated 7/4/24, documented Resident #3, had diagnosis of anemia, coronary heart disease, hypertension, anxiety, depression and chronic pain. The MDS revealed the resident with a BIMS score of 15 which indicated no cognitive impairment, able to make self understood and has the ability to understand others, and dependent with shower/bathing.</p> <p>Interview on 1/28/25 at 8:45 a.m., Resident #3 confirmed and verified that the call light is on for longer than 15 minutes, sometimes over 45 minutes.</p> <p>Interview on 1/29/25 at 3:00 p.m., Staff B, Certified Nursing Assistant (CNA) confirmed and verified that it will take longer than 15 minutes to answer a call light and that the facility needs more staff.</p> <p>Interview on 1/29/25 at 4:30 p.m., Staff C, CNA, confirmed and verified that it will take over 15 minutes to answer a call light especially if two staff are in a resident room using a mechanical lift.</p> <p>Interview on 1/30/25 at 11:55 a.m., the facility Director of Nursing confirmed and verified that the facility needs more staffing and that it could take over 15 minutes to answer a call light and that the expectation of the staff are to follow the guidelines of answering the call lights within the 15 minutes.</p> <p>The Resident Council Meeting Minutes dated 9/27/24, documented that residents feel call lights are not being answered timely.</p> <p>The Facility assessment dated [DATE], instructed that the Daily Staffing Pattern to be per day:</p> <p>Nurse Aides=4-7 on 1st shift</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4-5 on 2nd shift</p> <p>2 on 3rd shift</p> <p>Restorative aide included in the above staffing.</p> <p>The Two Week Work Schedule dated 1/23/25-2/5/25, revealed:</p> <p>1/27/25=2 CNA for the 2:00 p.m.-10:00 p.m. shift with 1 CNA scheduled from 6:00 p.m.-6:00 a.m.</p> <p>1/28/25=3 CNA for the 2:00 p.m.-10:00 p.m. shift with 1 CNA scheduled from 6:00 p.m.-6:00 a.m.</p> <p>1/29/25=2 CNA for the 2:00 p.m.-10:00 p.m. shift with 2 CNA scheduled from 6:00 p.m.-6:00 a.m.</p> <p>1/30/25=2 CNA for the 2:00 p.m.-10:00 p.m., shift with 2 CNA scheduled from 6:00 p.m.-6:00 a.m.</p>