

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/15/2026
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, resident interview, staff interview, and policy review the facility failed to provide a homelike environment by not replacing pillow cases on residents' beds for 1 of 5 residents (Resident #7) reviewed. The facility reported a census of 46 residents. Findings include: Review of Resident #7's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated Resident #7 had one or more unhealed pressure ulcers. The MDS further indicated Resident #7 had diagnoses of diabetes mellitus, paraplegia (the inability to voluntarily move the lower parts of the body), and acute osteomyelitis (an infection in a bone) to the right foot and ankle. During interview on 7/12/26 at 11:58 AM Resident #7 revealed the staff leave blood on his pillows from under his legs when the dressings are changed. Observation at this time revealed several pillows, and bedding with dried reddish brown substance on them. Interview on 7/13/26 at 9:03 AM with Staff B Laundry Aide revealed bed linens are changed every time residents have a bath or shower. Staff B further revealed that she also goes throughout the day as she is cleaning, and will change things if they are needed. Staff B stated there are extra pillow cases and linens in the linen closet for staff if something needs changed. Observation on 7/13/26 at 9:08 AM revealed Resident #7's pillow cases had a dried reddish brown fluid on the same pillow cases from the day before laying on Resident #7's bed and had not been changed. Interview on 7/13/26 at 9:13 AM with Staff A Licensed Practical Nurse confirmed pillows in Resident #7's room was soiled and should have been changed. Staff A further revealed that when she sees soiled bedding she will change it. Staff A stated the sheets and the pillow cases should have been changed. Interview on 7/13/26 at 9:34 AM with the Director of Nursing (DON) revealed she would expect bedding to be changed if there is drainage or if they are soiled. Review of a facility provided policy titled, Homelike Environment with a revised date of February 2021 indicated the facility staff and management maximizes the characteristics of the facility that reflect a personalized, homelike setting which includes a clean, sanitary, and orderly environment.		

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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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** Based on clinical record review and staff interviews, the facility failed to provide care and services according to accepted standards of clinical practice for 2 of 12 residents reviewed (Residents #1, #53). The facility reported a census of 46 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #1 dated 5/4/26 identified a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS included diagnoses of hypertension (high blood pressure) and orthostatic hypotension. The MDS documented Resident #1 did not receive diuretic medication during the last 7 days. The Care Plan with a target date 9/20/26 revealed Resident #1 was on diuretic therapy and directed staff to monitor for side effects and effectiveness. The June and July 2026 Medication Administration Record (MAR) and Treatment Administration Record (TAR) directed the following physician orders: A. Furosemide (diuretic medication) 20 milligrams (mg) one tablet every 24 hours as needed for weight gain greater than 3 pounds in a day. B. Daily weight- notify the physician if weight gain of 2-3 pounds (lbs) overnight or 5-6 pounds in 5 days. Review of the June 2026 TAR revealed the following weights: 6/9- weight not documented 6/10- 318.96/11- 324.1 (5.2 lb weight gain) 6/18- 312.56/19- 318.4 (5.9 lb weight gain) 6/20- 322.5 (4.1 lb weight gain in one day, 10 lb weight gain in 2 days) 6/21- weight not documented 6/24- 323.7. Review of the July 2026 TAR revealed the following weights: 7/4- 316.37/5- weight not obtained 7/6- weight not obtained 7/7- 322.3 (6 lb weight gain in 3 days) 7/8- 323.5 (additional 1.2 lbs weight gain, 7.2 lbs in 4 days). Review of the June and July 2026 MAR revealed Furosemide was not given. The clinical record lacked documentation that the Physician was notified of the weight gain. On 7/13/26 at 3:22 PM, the Director of Nursing (DON) said she expected the staff to follow physician orders and give the Furosemide medication as directed. She said if the Furosemide was not documented on the MAR then it was not given. On 7/13/26 at 3:34 PM, the Administrator reported the facility did not have a policy on following Dr orders. She said the facility followed the standard of practice. 2. The MDS assessment for Resident #53 dated 4/27/26 identified a BIMS score of 08, which indicated moderately impaired cognition. The MDS included diagnoses of pneumonia, chronic lung disease, respiratory failure and pulmonary fibrosis (progressive lung disease where deep tissue in the lung becomes scarred and stiff). The Clinical Census revealed Resident #53 was admitted to the facility on [DATE]. The Care Plan with a target date 5/10/26 revealed Resident #53 had altered respiratory status/difficulty breathing related to pulmonary fibrosis. The Care Plan directed staff to administer medication/puffers as ordered, monitor effectiveness and side effects. The Hospital Discharge Orders dated 4/24/26 directed staff to administer the following medications: A. Budesonide 0.5 mg/2 ml, 0.5 mg nebulizer treatment two times per day for pulmonary fibrosis. B. Breztri aerosol inhaler 160-9-4.8 MCG/ACT 2 puffs in the morning and afternoon for pulmonary fibrosis. Review of the April MAR and May MAR revealed the Budesonide nebulizer treatment was not administered 4/24/26 through 5/1/26 and the Breztri inhaler was discontinued on 4/27/26. Review of the Hospital Discharge Orders on 4/24/26 revealed the Pharmacy requested clarification on whether the Provider would like Resident #53 to use the Budesonide nebulizer solution as the Breztri inhaler contained Budesonide. On 4/27/26 (3 days after admission) the Provider gave direction to discontinue the Breztri inhaler but did not provide direction on the Budesonide nebulizer treatments. Review of the April and May MAR revealed Resident #53 did not receive any Budesonide medication from 4/28 through 5/1/26 (4 days). The Clinical Record lacked documentation the facility had requested any clarification orders for the Breztri inhaler and the Budesonide nebulizer treatments on admission or on 4/27/26 when the inhaler was (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discontinued. The Progress Note dated 4/30/26 documented the Nurse Practitioner (NP) saw Resident #53 on rounds due to staff reporting low oxygen levels and coarse lung sounds. The Progress Note dated 5/1/26 documented the facility received signed orders from the NP with the diagnosis of rhonchi (abnormal lung sounds), hypoxia (low oxygen levels) and pulmonary fibrosis:1. Duonebs four times daily for 7 days.2. Budesonide nebulizer treatments twice a day and rinse mouth after use3. Levaquien (ATB) 750 mg every day for 7 [NAME] 7/14/26 at 1:44 PM, the Director of Nursing (DON) said she completed Resident #53's admission. She said the pharmacy would not send both the Breztri inhaler and the Budesonide nebulizer treatments. She said the pharmacy reported the Breztri inhaler was the better choice of the two medications. The DON reported the Budesonide nebulizer treatments were put on hold until the order was clarified. She said the NP discontinued the Breztri inhaler on 4/27/26 but did not say anything about the Budesonide nebulizer treatments. She said the NP ordered the Budesonide nebulizers on 5/1/26. On 7/14/26 at 3:35 PM, the NP she would have liked to have more communication from the pharmacy regarding the admission orders. She said she would have preferred a phone call instead of a fax so the orders could have been clarified in a timely manner. The NP verified the request for clarification orders on the hospital discharge orders was documented from the pharmacy.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interview, and policy review the facility failed to use universal infection control measures while completing wound care for 1 of 3 residents (Resident #7) reviewed. The facility reported a census of 46 residents. Findings include: Review of Resident #7's Minimum Data Set (MDS) dated [DATE] revealed a readmission to the facility on 8/28/24 from a short-term general hospital stay. The MDS indicated Resident #7 had one or more unhealed pressure ulcers. The MDS further indicated Resident #7 had diagnoses of diabetes mellitus, paraplegia (the inability to voluntarily move the lower parts of the body), and acute osteomyelitis (an infection in a bone) to the right foot and ankle. Review of Resident #7's Electronic Health Record page titled, Clinical Physician Orders revealed an order for a treatment to the left heel as well as a treatment to left calf with order dates of 6/27/26. Observation on 7/13/26 at 1:22 PM Staff A Licensed Practical Nurse completed hand hygiene and donned gown, gloves, and a gown. Staff A then placed a barrier under Resident #7's legs. Staff A removed the dressing to the left leg and foot while wearing the same gloves. Staff A then doffed the gloves and utilized hand sanitizer from under the gown being worn. Staff A donned new gloves. Staff A then completed the dressing to the left calf of Resident #7. Staff A doffed the gloves being worn and again utilized the hand sanitizer from under the gown being worn. Staff A donned new gloves and reached under the gown being worn to obtain scissors to remove the rest of the dressing from the left foot. Staff A completed the dressing to the left foot of Resident #7. Staff A again doffed the gloves being worn and again utilized the hand sanitizer from under the gown being worn. Staff A was observed multiple times touching the front of the gown being worn without gloves to obtain scissors and hand sanitizer from under the gown being worn while the treatment was being completed for Resident #7. Interview on 7/13/26 at 1:59 PM with Staff A revealed that she missed a couple opportunities for hand hygiene as well as glove changes during the completion of the treatment for Resident #7. Interview on 7/14/26 11:09 AM with the Director of Nursing (DON) revealed that she would expect hand hygiene to be completed at the appropriate times as well as changing gloves at the appropriate times. The DON further revealed she would like to see staff not obtaining items from under their gowns during treatments. Review of a facility provided policy titled, Handwashing/Hand Hygiene with a revision date of August 2019 indicated staff should complete hand hygiene: a. Before handling clean or soiled dressings. b. Before moving from a contaminated body site to a clean body site. c. After contact with blood or bodily fluids. d. After removing gloves.		