STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165349	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belle Plaine Specialty Care	1505 Sunset Drive Belle Plaine, IA 52208

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26529 Based on clinical record review, and staff, resident and resident responsible party interviews, the facility failed to assess a resident's decline in condition, and failed to complete and document assessments imperative for the resident's condition/care required over a 3 day period for 1 of 4 resident records reviewed (Resident #2). The facility reported a census of 43 residents. Findings include: The Minimum Data Set (MDS) Assessment tool dated 9/20/24 revealed Resident #2 scored 8 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment, that indicated moderate cognitive impairment with symptoms of delirium present, always able to make himself understood and understood others, had diagnoses that included diabetes, non-Alzheimer's dementia, and muscle weakness, weighed 122 pounds, without weight gain or loss in the 6 months that preceded the assessment and had no identified skin conditions. The Assessment revealed the resident required substantial staff support to reposition in bed, transfer to and from bed and chair, dressing, toileting, bathing, and personal hygiene, and required moderate staff assistance for eating. Weights recorded in the resident's record revealed: 8/13/24 123.0 pounds (#) 8/15/24 124.0 # 8/20/24 123.5 # 8/22/24 123.0 # 8/27/24 119.5 # 8/29/24 121.5 # 9/3/24 122.0 # 9/5/24 120.0 # 9/10/24 123.0 # (continued on next page)

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/12/24 121.5 # 9/17/24 121.5 # 9/19/24 122.5 # 9/26/24 120.5 # 10/1/24 120.0 # 10/15/24 109.5# A problem labeled I use hypoglycemic medications related to diabetes initiated 4/12/23 on the Nursing Care Plan, directed staff with interventions that included: a. Administer diabetic medications as ordered by physician, initiated 4/12/23, revised 10/15/24. b. Monitor blood glucose as ordered, initiated 4/12/23, revised on 10/15/24. c. Monitor for side effects (low blood sugar, headache, weakness, sweating and fainting) and effectiveness, initiated 4/12/24, revised on 10/15/24. Another problem labeled I have PRN (apply as needed) oxygen therapy related to Covid respiratory illness, initiated 10/15/24 on the Nursing Care Plan, with 1/22/25 goal date, the resident would not have signs and symptoms of poor oxygen absorption, directed staff: a. Administer oxygen as ordered, initiated 10/15/24. b. Ensure that oxygen supply is available at all times, initiated 10/15/24. c. Monitor for signs and symptoms of respiratory distress and report to physician as needed: respirations, pulse oximetry, increased heart rate, restlessness, diaphoresis, headaches, lethargy, confusion, hemoptysis (blood-tinged or bloody mucous produced with cough) cough, pleuritic pain (pain associated to the chest wall), accessory muscle usage (actions in attempts to draw more air into the chest during respirations, that include sitting upright with chest leaned forward, using muscles in the neck not normally used during respirations) and skin color, initiated 10/15/24. d. Oxygen settings: Oxygen via nasal cannula at 2 liters per minute PRN, humidified, initiated 10/15/24. The resident's recorded food intake, recorded by percentage at the breakfast, lunch and supper meals, and fluid intake, recorded in milliliters (ml) at each of the 3 daily meals revealed the following: Food Fluid 10/7/24 0-25% 120 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	0-25% 60 0-25% 240 420 total, or 14 ounces 10/8/24 0-25% 50 Refused 0-25% 240 290 total, or just under 10 ounces 10/9/24 0-25% 0-25% 20 0-25% 25 45 total, or 1 and 1/2 ounces 10/10/24 0-25% 120 Refused 120 0-25% 50 290 total, or just under 10 ounces 10/11/24 0-25% 60 0-25% 80 0-25% 120 240 total, or 8 ounces 10/12/24 Refused 0-25% 60 26 - 50% 120 180 total, or 6 ounces 10/13/24 0-25% 120 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	0-25% 120 76 - 100% 340 580 total, or just over 19 ounces 10/14/24 0-25% 50 Refused 100 0-25% 0 150 total, or 5 ounces 10/15/24 26 - 50% 110 0-25% 0 0-25% 60 170 total, or just under 6 ounces 10/16/24 0-25% 240 0-25% 120 0-25% 0 360 total, or 12 ounces Physician orders directed staff: 1. Administer Metformin (an oral anti-diabetic medication that helps reduce blood sugar) 500 milligrams (mg) oral 2 times daily, ordered 9/17/24. 2. Administer Mucinex 600 mg Extended Release (ER), 1 tablet oral every 12 hours as needed, ordered 10/8/24. This order was changed later on 10/8/24 to 2 ER tablets (1200 mg) administered oral twice daily for 14 days. 3. Administer Albuterol 2.5 mg in 3 milliliter (ml) solution via inhalation nebulizer every 6 hours as needed, ordered 10/8/24. This order was discontinued later on 10/8/24 and changed to administer DuoNeb, (Ipratropium-Albuterol 0.5-2.5 mg in 3 ml, inhaled via nebulizer 4 times daily for 14 days. 4. Prednisone (a steroid used to reduce swelling and treat infection) 40 mg administered oral daily for 5 days, ordered 10/8/24 to start 10/9/24. The facility's daily nursing schedules revealed the following nursing staff assigned: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/12/24 6:00 a.m. to 2:00 p.m. Director of Nursing (DON) 2:00 p.m. to 6:00 p.m. DON 6:00 p.m. to 6:00 a.m. on 10/13/24 Staff C, Licensed Practical Nurse (LPN) 10/13/24 6:00 a.m. to 2:00 p.m. DON 2:00 p.m. to 10:00 p.m. Staff D, LPN 10:00 p.m. to 6:00 a.m. on 10/14/24 Staff C, LPN 10/14/24 6:00 a.m. to 2:00 p.m. Staff A, LPN 2:00 p.m. to 10:00 p.m. Staff E, LPN 10:00 p.m. to 6:00 a.m. on 10/15/24 Staff B, RN 10/15/24 6:00 a.m. to 2:00 p.m. Staff A, LPN 2:00 p.m. to 10:00 p.m. Staff D, LPN 10:00 p.m. to 6:00 a.m. on 10/16/24 Staff B, RN 10/16/24 6:00 a.m. to 2:00 p.m. Staff A, LPN 2:00 p.m. go 10:00 p.m. DON Nursing Progress Note entries included the following: 10/2/2024 at 2:53 p.m., Staff A, Licensed Practical Nurse (LPN): Resident with cold symptoms including runny nose, cough, voice change, chest congestion. Covid test completed and positive. Notified provider, order for Molnupiravir (an anti-viral medication used to treat Covid) 800 milligrams (mg) administered oral twice daily for 5 days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/8/2024 at 2:15 a.m., Staff B, Registered Nurse (RN): Contacted provider, physician order for 2 view portable chest X-Ray for congested lung sounds, low oxygen saturation, and positive for Covid. Order to administer Mucinex (an expectorant that loosens and thins mucous/congestion) 600 mg oral every 12 hours as needed, apply Oxygen at 2 liters per nasal cannula as needed to keep oxygen saturation above 90%, and 1 vial Albuterol (a potent bronchodilator, used for emergency relief during airway constriction and asthma attacks) administered by nebulizer inhalation 4 times a day as needed. 10/8/2024 at 6:33 a.m., Staff B, RN: Changes in condition with congestion. Vital signs: T: 97.9, P: 67, R: 18, BP: 121/87, Oxygen saturation (O2 Sat): 85%, lung sounds congested. Applied Oxygen, notified Director of Nursing (DON) then on-call provider with orders received as noted. 10/8/2024 at 4:28 p.m., Staff A, LPN: Provider in facility and clarified Mucinex and nebulizer orders given by on call provider last evening. Orders changed to DuoNeb (mixture of Albuterol and Ipratropium, bronchodilator and a mucous expectorant) administered by inhalation 4 times daily for 14 days, and Mucinex increased to 1,200 mg administered oral twice daily for 14 days. 10/8/2024 4:50 p.m., Staff A, LPN: Resident continues on Oxygen and doesn't show any signs or symptoms of distress. He doesn't communicate well and just rests with his eyes closed. Chest X-ray completed earlier this shift, orders received, see previous documentation for details. Resident states he just feels tired. 10/9/2024 4:44 p.m., Staff B, RN: Resident is tolerating anti viral medication without noted or reported adverse reactions. Resident's appetite or fluid intake at baseline. Resident continues on Oxygen and doesn't show any signs or symptoms of distress. Vital signs within normal limits. Will continue to monitor per protocol. 10/10/2024 at 3:14 a.m., Staff C, LPN: Monitoring for positive COVID. O2 Sat level has come up to 93% on room air. Lungs clear bilaterally, diminished throughout. Denies shortness of breath, afebrile. Will continue to monitor. 10/11/2024 at 2:00 a.m., Staff C, LPN: Monitoring for positive COVID. O2 level has come up to 93% on room air. Lungs clear bilaterally, diminished throughout, some upper chest/throat congestion noted that clears with cough. Occasional dry cough reported. Denies shortness of breath, denies pain. Afebrile. Will continue to monitor per protocol. 10/11/2024 5:25 p.m., Staff A, LPN: Resident currently being monitored as he is Covid positive and currently in isolation. He is tolerating anti viral medication without noted or reported adverse reactions. Resident's appetite or fluid intake decreased today. Resident's O2 Sat's adequate on room air and doesn't show any signs or symptoms of distress. Resident did have a large loose stool this shift and was noted to have redness to his right medial heel that resolved when pressure was relieved. Heel boots applied and feet floated on a pillow as well. Vitals within normal limits. Will continue to monitor per protocol. 10/12/2024 at 11:45 p.m., recorded as a Late Entry, actually recorded on 10/13/24 at 7:47 a.m. by Staff C, LPN: Monitoring for positive COVID. Lungs congested bilaterally, diminished throughout. O2 Sat 86% on room air. No cough noted. Denies shortness of breath, denies pain. Afebrile. Will continue to monitor per protocol. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/12/2024 at 11:50 p.m., recorded as a Late Entry, actually recorded on 10/16/24 at 8:47 a.m. by the Director of Nursing (DON): Oxygen applied, O2 Sat 96% with Oxygen at 2 liters per minute per nasal cannula. Resident denies concerns, call light in reach upon exit. 10/13/2024 at 12:00 a.m., Staff C, LPN: Recheck O2 Sat 93% on Oxygen at 2 Liters per nasal cannula. There were no other entries recorded in the resident's medical record until this entry, recorded by the facility's Registered and Licensed Dietician (RDLD), who wrote: 10/16/2024 at 7:55 a.m. Resident with rapid significant weight loss. Nutrition focused physical exam (NFPE) performed with severe fat loss noted to orbital sockets and triceps. Severe muscle loss to temporalis, clavicle, shoulder and calf. Resident is not interested in any food or supplements. No appetite. Hospice level of care recommendable from dietary perspective. The next entry, recorded by the DON, stated: 10/16/2024 at 8:10 p.m., Resident not answering questions, hard to respond. Family visited an hour prior. Power of Attorney (POA) notified of current events and said they will be up to visit. Vital signs within normal limits, call light within reach, will continue to check frequently. 10/16/2024 at 8:32 p.m., the DON stated: Resident unresponsive, with [NAME] Stokes breathing noted (a breathing pattern that involves alternating periods of deep, rapid breathing with shallow breathing, and sometimes pauses in breathing or apnea, and usually associated with imminent death.) Order obtained from provider on call for transfer to hospital by ambulance. Resident remains full code, paramedics arrived and transferred resident to hospital. The last recorded vital signs recorded in the resident's record were: 10/8/24 at 7:12 a.m., T 97.9, B/P 121/87, P 67, by Staff B, RN. 10/12/24 at 11:45 p.m., R 20, by Staff C, LPN. 10/12/24 at 11:45 p.m. O2 Sat 86% on room air, 10/13/24 at 12:00 a.m. O2 Sat 93% on Oxygen at 2 liters via nasal cannula, by Staff C, LPN. There was no documentation of any physical assessment of the resident between 10/13/24 and 10/16/24, until the assessment by the dietician on the morning of 10/16/24. The DON's documentation on 10/16/24 revealed the resident's vital signs were stable, however there was no documentation of vital signs or assessment of the resident other than when found unresponsive, with [NAME] Stokes respirations. The resident's record did not reveal any documentation that the physician was notified of the resident's limited and sometimes refused oral intake. The last recorded blood sugar in the record was obtained on 4/19/23, 145 mg/dl (milligrams per deciliter). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident arrived at the nearest hospital's emergency room (ER) at approximately 9:00 p.m. on 10/16/24, minimally responsive, in a metabolic crisis with blood sugar of 667 mg/dl obtained at 9:07 p.m. (normal range 70 to 110 mg/dl). The resident was treated for Hyperosmolar Hypoglycemic State, or HHS, a life-threatening emergency manifested by marked elevation of blood glucose and hyperosmolarity (high blood sugar with high sodium level) with little or no ketosis (when the body burns fat instead of blood sugar for energy), usually caused by an infection, left lower lobe pneumonia, dehydration and acute renal failure. The resident required transfer to a larger hospital within 3 hours due to the critical nature of his condition and care requirements, hospitalized in the Intensive Care Unit for 4 days, and discharged to the facility from the hospital on 10/24/24. The facility's Change in a Resident's Condition or Status policy, dated as revised February, 2021, directed staff: 1. Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. 2. The nurse will notify the resident's attending physician when there has been a significant change in the resident's physical/emotional/mental condition, or need to alter the resident's medical treatment significantly. 3. A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; and requires interdisciplinary review and/or revision to the care plan. 4. Prior to notifying the physician, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including information prompted by the Interact SBAR Communication Form. 5. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. The resident's POA, interviewed 10/29/24 at 9:34 a.m. stated they had not seen the resident since before he had Covid due to their own health issues, the facility would usually call when he was sick, but had not notified them of the bruise/sore on his left heel, and the first they knew of the resident being so sick was on 10/16/24 when staff called at 4:42 p.m. and said he wasn't responding like he normally did and asked them to come to the facility. The POA directed the facility to notify a family member who lived closer to come, as the POA lived over an hour away. The POA didn't hear anything more until 8:50 p.m., when the facility called and said the resident was non-responsive and asked what they should do. The POA directed the staff to call the doctor and take the resident to the hospital. The POA drove to the hospital where she saw the resident and spoke to the doctor, the doctor told them he was in critical condition and had to go to a larger hospital as they couldn't provide the care he needed there, and the doctor warned that he may not make it to the next hospital as he was that sick and dehydrated, his blood sugar was over 650. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's family member, interviewed 10/30/24 at 12:02 p.m. stated they visited the resident on the afternoon of 10/16/24 and hadn't seen the resident since before he had Covid. They didn't know exactly what to expect, the resident slept throughout most of the visit and they thought he was tired from having Covid, didn't realize he was so sick and would have to go to the hospital that evening. The resident stayed in bed, he didn't want to get up. At one time the resident said he was so tired and just wanted to sleep, the family member thought that's what the resident needed and stayed near the resident as he slept, then had to leave around supper time. Staff interviews revealed: 10/29/24 at 10:14 a.m., Staff H, Certified Medication Aide (CMA), stated she administered breathing treatments to residents and had administered them to the resident before he went to the hospital, there wasn't anything in the directives that she had that told her the nurse had to assess the resident when she gave the breathing treatments, like when she gave a pain medication and the nurse had to assess the resident for that. 10/29/24 at 10:17 a.m., Staff J, RN, Assistant Director of Nursing (ADON) stated if a resident had breathing treatments ordered, the nurse should assess the resident's breath sounds at least daily, if the resident had abnormal breath sounds, or had a cough, or mucous production with a cough the nurse should check the resident's breath sounds before and after their breathing treatments, and other assessments as indicated such as O2 Sat, vital signs, how the resident was feeling. 10/29/24 at 12:07 p.m., the facility's RDLD stated she had last seen the resident about a month before she saw him on 10/16/24. On 10/16/24 he definitely appeared malnourished, had no interest in food, he was seated in a wheelchair in the Dining Room when she saw him. He wouldn't eat even with much staff encouragement. Over the last 3 to 4 months he didn't have much interest in food, but that got much worse when he had Covid. She had put several dietary interventions in place, with quite a variety offered, but the resident just didn't want to eat. 10/29/24 at 1:03 p.m. Staff A, LPN, stated the resident had not been eating or drinking, even before he had Covid, but did better with drinks, staff could usually get him to drink something. She worked on 10/16/24, when she left work that day the resident was talking, he was more tired and told his family he was worn out, but he did respond to questions. There had not been any change in his breath sounds, she had not heard him coughing or wheezing. Staff A stated she documented breath sounds in the Nursing Progress Notes when she assessed them. 10/29/24 at 2:08 p.m. Staff F, a DON at a different facility owned by the same corporation and who was at the facility during the facility's DON's absence stated if a resident had an order for Oxygen to maintain O2 Sat's at a certain level, and had to have the Oxygen in order to do that, the nurse should assess the resident's O2 Sat at least daily and as needed. Staff should assess resident breath sounds when they had breathing treatments ordered to treat respiratory conditions, before and after the breathing treatments, continue to make the assessments until the resident's breath sounds were normal, and the assessments should be documented in the resident's record. Staff should continue to assess the breath sounds as needed with the resident's condition, and document the findings in the record. (continued on next page)

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