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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165349 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/14/2025 |
| NAME OF PROVIDER OR SUPPLIER Belle Plaine Specialty Care | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44512</p> <p>Based on observations, clinical record review, staff interviews, and policy review, the facility failed to respect resident dignity throughout all care provided and in speaking to them for 2 out of 6 residents reviewed (Residents #3 & #6). The facility reported a census of 39 residents.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified the diagnoses of Parkinson's, muscle wasting right and left lower legs, abnormal mobility, & repeated falls, and a Brief Interview for Mental Status score of 4 suggesting severely impaired cognition. <p>The Care Plan identified Resident #3 was dependent on staff for ambulation, required assistance with a wheeled walker, gait belt, and to be followed with a wheelchair.</p> <p>The Progress Note for Resident #3 dated 4/1/25 at 6 PM revealed:</p> <ol style="list-style-type: none"> 1. An annual wellness visit was completed with an assessment by the provider. 2. An increased fall risk and non-compliance of healthcare plan. 3. Cognitively does not understand important safety measures with use of call light or waiting and asking for help. 4. The patient may become agitated due to lack of comprehension and behavior may lead the patient to become noncompliant. 5. A diagnoses of dementia, psychotic disturbance, mood disturbance, anxiety, and had behaviors on and off. 6. The patient was seen by psych services. <p>During an observation on 4/8/25 at 10:52 AM, Resident #3 was assisted by a CNA to a recliner in the small living room. She was alert and had bruises to her left side of her face above her ear and left forehead in her hair line, both were yellow in color. Resident #3's hair was clean with small braids and her body had involuntary movements.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 4/8/25 at 10:52 AM, Resident #3 said she falls often and had hit her head this last time. She said the staff treat her well here.</p> <p>A document titled Unwitnessed Fall dated 4/1/25 at 23:30 for Resident #3 documented by the Director of Nursing (DON) on 4/2/25 revealed:</p> <ol style="list-style-type: none"> 1. A CNA saw Resident #3 lying on the floor. 2. The nurse assisted the resident off the floor by one staff member and placed in a chair. 3. No injuries observed at the time of incident. 4. Pain level, mental status was not documented. 5. Predisposing physiological factors listed were gait imbalance, impaired memory and weakness/faints. 6. Predisposing situation factors were listed as ambulating without assistance. 7. No statement found. 8. The physician was notified on 4/2/25 at 10:30 am. 9. The guardian was notified on 4/2/25 at 10:58 am. <p>During an interview on 4/8/25 at 2:20 PM, Staff J, Certified Medication Assistant (CMA) stated on 4/1/25 during the 2-10 PM shift, Resident #3 fell and Staff B, Registered Nurse (RN) watched her fall and did not assess her or do vitals. Staff J stated Staff B picked Resident #3 up off the floor under her arms, put her back into the wheelchair and told her that he was tired of her shit and she knew better. Staff J stated Resident #3 had severe dementia and thought she had to go to work, she was a nurse, and she thought she needed to do someone's vital signs.</p> <p>(continued on next page)</p> | | |

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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 4/8/24 at 2:47 PM Staff D, Certified Nursing Assistant (CNA) stated she had worked the night that Resident #3 fell on [DATE]. Staff D stated she saw Resident #3 on the floor on her right hip and she was crying, Staff B, Registered Nurse (RN) was facing the computer in the nurses station, not paying attention. Staff D stated she notified Staff B that Resident #3 was on the floor and he said, Oh Jesus and he picked her up cursing, this is fucking ridiculous and (name) Administrator was not taking care of this, we don't have the staff for this shit. Staff D stated Staff B didn't count it as a fall and did not assess her. Staff D stated she left the area to find Staff K, CMA and they found Resident #3 was on the floor again and Staff B picked her up again, put his hands under her arm pits and dragged Resident #3 back to the recliner. Staff D stated Staff K joined her, went to a room to talk since Staff B manhandled her, second fall in 5 minutes and did not conduct assessments. Staff D stated she heard Staff B saying (Resident #3) I'm [AGE] years old and I'm sick of this shit. Resident #3 said she was [AGE] years old too, was crying a bit and she looked really uncomfortable. Staff D and Staff K moved Resident #3 to her room and stayed with her. Staff D stated Staff K called the DON at shift change to report the incident, and the DON called Staff D at home. Staff D stated they were scared and were not sure if management was going to take them seriously since Staff B was a nurse. Staff D stated Staff B had been rude and weird toward Resident #3 because she falls often and rude to coworkers about sexist things and that was not ok.</p> <p>During an interview on 4/10/25 at 7:33 AM, Staff K, CMA stated on 4/1/25 about 9:30 PM she was at the medication cart directly in front of Staff B, RN and Resident #3 was on the opposite side of the nurses station in a wheelchair and she tried to stand two times when Staff B told her to sit down. Staff K stated Resident #3 tried to stand up and Staff B ran over to her and verbally reprimanded her. Staff B got a recliner and Staff K stated she transferred Resident #3 and Staff B said sorry I should have not lost my temper, but did not apologize to Resident #3. Staff K stated she situated Resident #3 with a color book and she calmed down. Staff K stated she went to answer a call light when Staff D, CNA stated Resident #3 was on the floor and Staff B was on his phone but helped her up. Staff K stated when they exited that room, they saw Resident #3 on the floor again and Staff B picked her up under her arms saying stuff to her and drug her away both of her feet dragging the ground and her knees bent Staff K stated he didn't have Resident #3 up high enough for her to walk and her feet flipped backwards and he dragged her about 5-10 feet, out of line of sight. Staff K stated both her and Staff D were moving quickly and found Resident #3 visibly shaking at that point and wanting to separate the situation, they put her in a wheelchair and took her to her room. Staff K stated they were shaken up. Staff K stated she sat with Resident #3 for 45 minutes until she was asleep. Staff K stated Resident #3 was so intelligent, a nurse who thinks she was doing rounds. Staff K stated Staff B verbally said he was not going to document her falls and in the morning, her falls were not mentioned during the report. Staff K stated she stepped out of the nursing station and called the DON at 8:54 AM, aware it was more than 2 hours and she told me to write a statement.</p> <p>On 4/9/25 at 11:14 AM, Staff B, RN declined to be interviewed.</p> <p>2. The MDS dated [DATE] for Resident #6 revealed diagnoses of muscle weakness & dementia, and required total assistance from staff for dressing, toileting, personal hygiene, and transfers from bed to chair. Not attempted to stand or walk. Resident #6 had a BIMS score of 3 which suggested severe cognitive impairment.</p> <p>The Care Plan for Resident #6 identified she was non ambulatory and directed staff to utilize a mechanical lift with the assistance of 2 staff for transfers.</p> <p>(continued on next page)</p> | | |

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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Progress Notes for Resident #6 dated 4/5/25 incident, nurse was notified that resident had bruising to bilateral upper extremities (BUE), observed bruising to right outer forearm and left outer forearm. The resident denied pain, confused and forgetful and unable to verbalize how bruising occurred, no further injuries identified.</p> <p>A document titled wound assessment evaluated 4/5/25 at 22:07 Resident #6 identified a bruise to the right outer forearm, a new in-house acquired, no measurement. The picture revealed a dark purple bruise to the right forearm that started from above the right elbow to wrist. The practitioner was notified.</p> <p>A document titled wound assessment evaluated 4/5/25 at 22:13 for Resident #6 identified a bruise to the left outer forearm, a new in-house acquired measured area 7.03 centimeters (cm), 3.51 cm long and 2.65 cm wide. The picture revealed a dark purple bruise to the left forearm, above the wrist. The practitioner was notified.</p> <p>A document titled incident report dated 4/5/25 at 21:56 for Resident #6 revealed:</p> <ol style="list-style-type: none"> 1. The nurse was notified Resident #6 had bruises on BUE. 2. The nurse observed bruising to the right outer forearm and left outer forearm. 3. Resident #6 denied pain, confused, forgetful, unable to verbalize how the bruising happened. 4. No further injuries identified. 5. No predisposing situation factors. 6. The resident was agitated, swinging arms at staff. 7. The physician was notified on 4/5/25 at 22:58. 8. The Director of Nursing was notified on 4/5/25 at 21:46. 9. The guardian was notified on 4/5/25 at 22:26. <p>(continued on next page)</p> |

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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 4/9/25 at 9:16 AM Staff F, CNA stated on Saturday, 4/5/25, she was at the nurses station with Staff M, CNA and heard Resident #6 screaming, what are you doing to me, you're hurting me, why are you doing this to me. Staff F stated she opened the door and found Staff G, CNA in front of Resident #6, her bottom was barely on the wheelchair without a mechanical sling or lift on site. Staff F stated Resident #6 was shaken up and Staff G would not let her help as she went to the back of the chair and grabbed Resident #6 by her pants and roughly pulled her back into the wheelchair. Staff F stated Resident #6 was [AGE] years old and looked fearful, shaking, compared to her normal self. She kept saying what are you doing to me? Staff F stated Resident #6 did get worked up during transfers but she had never heard her scream like that. Staff F stated Resident #6 normally transfers with a Hoyer lift per the Care Plan. Staff F stated Staff M left to get the nurse since Staff G refused to let them do anything to help and Staff L, RN stood by the door. Staff F stated both her and Staff M voiced their concerns and felt that Staff G should not have hands on other residents after that to Staff L, who called the DON. Staff F stated Staff G was sent home after 6 PM but was allowed to return the next afternoon, the Administrator stated she was allowed to work. Staff F stated she and Staff M made sure they took care of the cognitively impaired residents including Resident #6, and Staff G was allowed to take care of the people who could defend themselves.</p> <p>During an interview on 4/8/25 at 2:20 PM, Staff J, CMA stated she was passing medication and heard Resident #6 yelling, you're hurting me, stop. Staff G, CNA was providing care and transferred Resident #6 without a mechanical lift. Staff J stated Resident #6 looked frightened, eyes wide and did not want anyone to touch her, and at bed time, found bruises all the way up her right arm. Staff J stated the DON was notified by Staff L, RN. Staff J stated Staff G continued to work the next day.</p> <p>During an interview on 4/10/25 at 7:33 AM, Staff K, CMA stated she was told in report on 4/5/25 that Staff G, CNA transferred Resident #6 without a mechanical lift and at 10 PM found bruises to both arms when her sweater was removed. Staff K stated the nurse was notified, made an assessment, and notified the DON.</p> <p>During an interview on 4/8/25 at 3:32 PM Staff L, RN stated that on 4/5/25, Staff M, CNA and Staff F, CNA told her they were concerned as they could hear Resident #6 screaming, and Staff F went into the room and the resident was sitting on the edge of the wheelchair and Staff G, CNA roughly sat the resident back into the wheelchair. Staff L asked Staff G if she had transferred Resident #6 without the mechanical lift and she said yes, and she was educated not to do that again.</p> <p>During a follow up interview on 4/9/25 at 9:55 AM, Staff L, RN stated on 4/5/25, Staff M, CNA and Staff F, CNA continued to say that they had concerns about Staff G, CNA and Staff L stated she believed them due to the inability to locate Staff G earlier in the shift, found in a resident's room, on her phone. Staff L stated Resident #6 screaming and over heard things falling in the room, the unsafe transfer and Resident #3 getting her fingers in the brakes on her wheelchair when Staff G was pushing her. Staff L stated she felt too much had happened and called the DON and sent Staff G home at 6:30 PM for the day.</p> <p>(continued on next page)</p> | | |

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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 4/14/25 at 8:52 AM, Staff G, CNA stated she had only worked at the facility for 2 months and only had 2 days of training before she had to work on her own. Staff G stated she usually gets Resident #6 up for supper, it was hard, she was [AGE] year and would hit, pinch or grab at staff. Staff G stated she would scream at staff. Staff G stated she got Resident #6 dressed, was hitting her hard and when she nudged Resident #6 over to the wall to pull up her brief, Resident #6 hit the wall. Staff G stated she turned the call light on for 2 minutes but no one came so she went to look for another CNA to help. Staff G stated she could not find any staff so she returned to Resident #6's room, it was about 5:20 PM, put the gait belt on, put the wheelchair close to the bed and did a pivot transfer. Staff G stated Resident #6 could not stand so she body lifted her, Staff F, CNA entered the room as she was pulling Resident #6's pants up. Staff G stated that Staff F asked if she needed help and replied she was already done by that time.</p> <p>During an interview on 4/14/25 at 10:47 AM, the DON stated that the CNA should call if they are not comfortable with the nurse. The DON stated a couple of CNA's had mentioned that Staff B, RN had inappropriate conversations with staff and I told him that was not appropriate. The DON stated that her expectation was that the nurses should treat every one with respect, talk appropriately with residents and appropriate conversations at the nurses station as residents are listening. The expectation of falls was the CNA gets a nurse, an assessment completed and transfers the resident with a gait belt to get them off the floor. The DON stated if the staff notice other things that are different, tell the nurse again, or notify her as she was on call 24/7.</p> <p>Policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program revealed:</p> <p>Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.</p> <p>Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including facility staff.</p> <p>Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems.</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44512</p> <p>Based on observation, clinical record review, resident and staff interviews, the facility failed to appropriately provide an assessment for Resident #2 after a fall that inadvertently pulled out the resident's suprapubic urinary catheter from a surgical opening in her abdomen and failed to provide an intervention for 7 hours for a transfer to the hospital for the catheter to be replaced. The facility reported a census of 39 residents.</p> <p>Findings include:</p> <p>Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified the diagnoses of diabetes mellitus, retention of urine, & chronic kidney disease, dependent upon staff for transfers, personal hygiene, and toileting and a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition.</p> <p>The Care Plan identified a suprapubic catheter and directed staff to provide catheter care every shift. The Care Plan failed to provide direction for staff if the catheter was pulled out.</p> <p>During an interview on 4/8/25 at 10:16 AM, Resident #2 stated she remembered that she had a catheter in her stomach and the staff cleaned it. Resident #2 stated she could not remember the specifics about the fall on 1/2/25, just that she did not feel well, an out of body feeling. She stated she gave the Emergency Medical Technician's (EMT) a hard time, that she didn't want to go to the hospital, but her abdomen felt full and the facility staff encouraged her to go. Resident #2 stated EMT's returned, transported her to the hospital, where she refused to be admitted and have the catheter replaced into her abdomen but agreed to a Foley catheter placement.</p> <p>During an interview on 4/9/25 at 10:09 AM, Staff C, Certified Nursing Assistant (CNA) stated she had provided care for Resident #2 on 1/2/25 2 PM to 10 PM shift. Resident #2 was weak, unable to stand and Staff A, Registered Nurse (RN) assisted with the mechanical lift transfer to a commode, the catheter was in her abdomen at that time, then she was transferred to the recliner. Staff C stated within 15 minutes, she heard Resident #2 screaming and found her on the floor. Staff C stated that Staff D, CNA notified Staff A and Staff E, CNA assisted as it took 4 staff to assist Resident #2 off the floor and into the recliner. Staff C stated that she and Staff D noticed the suprapubic catheter was not in Resident #2's abdomen and reported this to Staff A. Staff C stated the CNA's began assisting other residents and when it was time to assist residents to bed, Resident #2 was bleeding from her abdomen and she notified the 3rd shift nurse Staff B, RN who said he was unaware that the suprapubic catheter was missing. Staff C stated that Staff B did not call for the EMT's until after 10 PM and Resident #2 refused to go, but within an hour, she agreed to go to the hospital.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 4/8/25 at 2:47 PM Staff D, CNA stated she worked on 1/2/25 when Resident #2 fell , she had been confused and agitated for a few days. Staff D stated Staff C, CNA was with her and heard Resident #2 yelling for help, found her on the floor and called for Staff A, RN. Staff D stated after they got the resident up and the bowel movement cleaned off, she noticed the suprapubic catheter was missing. Staff D notified Staff A but did not witness her assess Resident #2. Staff D stated later in the shift, after 6 PM, when Staff B, RN was in charge, she asked why Resident #2 was not being treated, it was a suprapubic catheter and it was emergent. Staff D stated Staff B was mad as he was not informed of that in report and assessed Resident #2 but did not call the EMT's until after 10 PM. Staff D stated that she and her coworkers were confused, it fell out at 2:30 PM and it was 7 hours before she was treated by a nurse.</p> <p>The Skilled Progress Note on 1/2/25 at 8:51 AM revealed an assessment that identified Resident #2 was alert, experienced weakness, lethargic at most times, poor food and drink intake and active bowel sounds, completed by Staff A, RN.</p> <p>The next Progress Note, unusual occurrence note, dated 1/2/25 at 7:51 PM revealed that a CNA informed the nurse that the suprapubic catheter came out around 2 PM and the previous nurse was informed. The note was completed by Staff B, RN,</p> <p>During an interview on 4/9/25 at 2:22 PM, Staff A, Registered Nurse (RN) stated Resident #2 had a mental status change on 1/2/25 and the CNA's informed her that the resident fell . Staff A stated she completed a fall assessment, assisted the resident off the floor but was unaware that the suprapubic catheter was pulled out and did not include that in the report to the 6 PM nurse.</p> <p>During an interview on 4/9/25 at 11:14 AM, Staff B, RN stated that on 1/2/25 he came to work at 6 PM and did not remember if he was told in report that Resident #2 fell . Staff B stated that the CNA's told him that Resident #2's catheter came out at 2 PM, he assessed the resident, called the physician and received an order to transport the resident to the hospital. Staff B stated that Resident #2 refused to go with the EMT's, then later agreed to go to the hospital and the EMT's returned. Staff B stated the opening into the abdomen (stoma) was not leaking urine and felt the catheter was out for so long, that the stoma may have closed.</p> <p>During an interview on 4/7/25 at 2:02 PM, Staff H, EMT stated that he and the ambulance driver, Staff I, EMT, responded to a call for a sick person on 1/2/25 at 9:30 PM. Staff H stated that when they entered the facility, they were met by Staff B, RN who reported Resident #2 fell about 2 PM and the suprapubic catheter had been pulled out. Staff H stated Resident #2's room smelled of urine and her clothes were wet from urine leaking from the abdominal opening. Staff H stated when they loaded Resident #2 to the cot, she refused to go to the hospital and she was alert and oriented so they could not take her. Staff H stated he contacted the Director of the Emergency Medical Services (EMS) and the Medical Director of the EMS who spoke with Resident #2, who notified her of the consequences of not receiving treatment. Resident #2 continued to refuse and the EMT's returned to base. Staff H stated one hour later at 11:30 PM, they received another call for Resident #2, she had agreed to be transported to the hospital. Staff H stated that during transport, Resident #2 stated the facility staff was not taking care of her catheter today, she was confined to a bed for 8 hours, leaking urine, with no one providing care. Staff H stated Resident #2 was alert, oriented and hypertensive (high blood pressure) 200/80.</p> <p>A document titled ED (Emergency Department) Provider Notes for Resident #2 revealed:</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <ol style="list-style-type: none"> 1. Resident #2 was alert and oriented x 3 (person, place, and time). 2. Assessment in regard to a fall and no fractures were identified. A concern for a possible syncope (temporary loss of consciousness) vs TIA (transient ischemic attack, a mini stroke). 3. The suprapubic catheter was displaced for too long and was unable to replace it. 4. A plan to admit to the hospital for further evaluation that the resident declined against medical advice. 5. A Foley catheter was placed. <p>During an interview on 4/14/25 at 10:47 AM, the Director of Nursing (DON) stated that if the CNA was not getting what they needed from the nurse, they should call her as she was on call 24/7. The DON state the facility nursing staff are to send the residents who have a suprapubic catheter to the hospital for replacement due to the nurses training not including replacing those catheters.</p> |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165349 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/14/2025 |
| NAME OF PROVIDER OR SUPPLIER Belle Plaine Specialty Care | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for 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** 44512</p> <p>Based on observation, clinical record review, and staff interviews, the facility failed to safely transfer 1 of 1 residents (Resident #6) according to the Care Plan resulting in bruising injuries to the resident's arms. The facility reported a census of 39 residents.</p> <p>Findings include:</p> <p>The MDS dated [DATE] for Resident #6 revealed diagnoses of muscle weakness & dementia, and required total assistance from staff for dressing, toileting, personal hygiene, and transfers from bed to chair. Not attempted to stand or walk. Resident #6 had a Brief Interview for Mental Status (BIMS) score of 3 which suggested severe cognitive impairment.</p> <p>The Care Plan for Resident #6 identified she was non ambulatory and directed staff to utilize a mechanical lift with the assistance of 2 staff for transfers.</p> <p>Progress Notes for Resident #6 dated 4/5/25 incident, nurse was notified that resident had bruising to bilateral upper extremities (BUE), observed bruising to right outer forearm and left outer forearm. The resident denied pain, confused and forgetful and unable to verbalize how bruising occurred, no further injuries identified.</p> <p>A document titled wound assessment evaluated 4/5/25 at 22:07 Resident #6 identified a bruise to the right outer forearm, a new in-house acquired, no measurement. The picture revealed a dark purple bruise to the right forearm that started from above the right elbow to the wrist. The practitioner was notified.</p> <p>A document titled wound assessment evaluated 4/5/25 at 22:13 for Resident #6 identified a bruise to the left outer forearm, a new in-house acquired measured area 7.03 centimeters (cm), 3.51 cm long and 2.65 cm wide. The picture revealed a dark purple bruise to the left forearm, above the wrist. The practitioner was notified.</p> <p>A document titled incident report dated 4/5/25 at 21:56 for Resident #6 revealed:</p> <p>The nurse was notified Resident #6 had bruises on BUE.</p> <p>The nurse observed bruising to the right outer forearm and left outer forearm.</p> <p>Resident #6 denied pain, confused, forgetful, unable to verbalize how the bruising happened.</p> <p>No further injuries identified.</p> <p>No predisposing situation factors.</p> <p>The resident was agitated, swinging arms at staff.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The physician was notified on 4/5/25 at 22:58.</p> <p>The Director of Nursing was notified on 4/5/25 at 21:46.</p> <p>The guardian was notified on 4/5/25 at 22:26.</p> <p>During an observation on 4/8/25 at 2:47 PM Staff D, Certified Nursing Assistant (CNA) was assisting Resident #6 to her room and removed her sweater and the coverings to both arms to reveal Resident #6's right arm, from above her elbow, mid upper arm, to her right wrist, was a dark purple bruise. The left lower arm above her wrist had a circular dark purple bruise.</p> <p>During an interview on 4/8/25 at 2:20 PM, Staff J, CMA stated she was passing medication and heard Resident #6 yelling, you're hurting me, stop. Staff G, CNA was providing care and transferred Resident #6 without a mechanical lift. Staff J stated Resident #6 looked frightened, eyes wide and did not want anyone to touch her, and at bed time, found bruises all the way up her right arm. Staff J stated the DON was notified by Staff L, RN. Staff J stated Staff G continued to work the next day.</p> <p>During an interview on 4/9/25 at 9:16 AM Staff F, CNA stated on Saturday, 4/5/25, she was at the nurses station with Staff M, CNA and heard Resident #6 screaming, what are you doing to me, you're hurting me, why are you doing this to me. Staff F stated she opened the door and found Staff G, CNA in front of Resident #6, her bottom was barely on the wheelchair without a mechanical sling or lift on site. Staff F stated Resident #6 was shaken up and Staff G would not let her help as she went to the back of the chair and grabbed Resident #6 by her pants and roughly pulled her back into the wheelchair. Staff F stated Resident #6 was [AGE] years old and looked fearful, shaking, compared to her normal self. She kept saying what are you doing to me? Staff F stated Resident #6 did get worked up during transfers but she had never heard her scream like that. Staff F stated Resident #6 normally transfers with a Hoyer per the care plan. Staff F stated Staff M left to get the nurse since Staff G refused to let them do anything to help and Staff L, RN stood by the door. Staff F stated both her and Staff M voiced their concerns and felt that Staff G should not have hands on other residents after that to Staff L, who called the DON. Staff F stated Staff G was sent home after 6 PM but was allowed to return the next afternoon, the Administrator stated she was allowed to work. Staff F stated she and Staff M made sure they took care of the cognitively impaired residents including Resident #6, and Staff G was allowed to take care of the people who could defend themselves.</p> <p>During an interview on 4/10/25 at 7:33 AM, Staff K, CMA stated she was told in report on 4/5/25 that Staff G, CNA transferred Resident #6 without a mechanical lift and at 10 PM found bruises to both arms when her sweater was removed. Staff K stated the nurse was notified, made an assessment, and notified the DON. Staff K stated the mechanical lift sling it was in the recliner, Staff M, CNA and Staff F put it under her when they put her back to bed.</p> <p>During an interview on 4/8/25 at 3:32 PM Staff L, RN stated that on 4/5/25, Staff M, CNA and Staff F, CNA told her they were concerned as they could hear Resident #6 screaming, and Staff F went into the room and the resident was sitting on the edge of the wheelchair and Staff G, CNA roughly sat the resident back into the wheelchair. Staff L asked Staff G if she had transferred Resident #6 without the mechanical lift and she said yes, and she was educated not to do that again.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During a follow up interview on 4/9/25 at 9:55 AM, Staff L, RN stated on 4/5/25, Staff M, CNA and Staff F, CNA continued to say that they had concerns about Staff G, CNA and Staff L stated she believed them due to the inability to locate Staff G earlier in the shift, found in a resident's room, on her phone. Staff L stated Resident #6 screaming and over heard things falling in the room, the unsafe transfer and Resident #3 getting her fingers in the brakes on her wheelchair when Staff G was pushing her. Staff L stated she felt too much had happened and called the DON and sent Staff G home at 6:30 PM for the day.</p> <p>During an interview on 4/14/25 at 8:52 AM, Staff G, CNA stated she had only worked at the facility for 2 months and only had 2 days of training before she had to work on her own. Staff G stated she usually gets Resident #6 up for supper, it was hard, she was [AGE] year and would hit, pinch or grab at staff. Staff G stated she would scream at staff. Staff G stated she got Resident #6 dressed, was hitting her hard and when she nudged Resident #6 over to the wall to pull up her brief, Resident #6 hit the wall. Staff G stated she turned the call light on for 2 minutes but no one came so she went to look for another CNA to help. Staff G stated she could not find any staff so she returned to Resident #6's room, it was about 5:20 PM, put the gait belt on, put the wheelchair close to the bed and did a pivot transfer. Staff G stated Resident #6 could not stand so she body lifted her, Staff F, CNA entered the room as she was pulling Resident #6's pants up. Staff G stated that Staff F asked if she needed help and replied she was already done by that time. Staff G stated she was aware that Resident #6 required the use of a mechanical lift and 2 person assist due to watching others as she did not know how to access a resident's Care Plan.</p> <p>A document titled Education given to Staff G, CNA dated 4/5/25 revealed:</p> <ol style="list-style-type: none"> 1. Make sure to follow the Care Plan for each resident. If you don't know how someone transfers, ask another staff member. 2. Never transfer a resident that needs a Hoyer without 2 people. Make sure if no one comes to help with a transfer, you make sure the resident is safe and go and find a 2nd person. 3. Also, educated by the nurse on duty on that shift. <p>Signed by Director of Nursing.</p> <p>During an interview on 4/14/25 at 10:47 AM, the DON stated that the CNA should call if they are not getting what they need or not comfortable with the nurse. The DON stated the CNA's get a packet to train with their mentor, to include transfers and mechanical lifts. The DON stated they try to provide 5-6 days of training and if they feel they need more, then we give them more time, more if they are new CNA. The DON stated Staff D was the mentor on the 2-10 shift and she informed her that Staff G was lazy, hiding, but no one told me she was unsafe. The DON stated Staff G did not tell me or others that she did not know how to access a Care Plan. The DON stated if the staff notice other things that are different, tell the nurse again, or notify her as she was on call 24/7.</p> | | |