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	10/17/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42134 Based on observation and resident interview the facility failed to provide a resident room tray until early afternoon for 1 resident (Resident #5) and when the tray was served the facility failed to provide metal eating utensils. The facility reported a census of 37 residents. Findings include: During an observation on 10/15/24 at 12:33 PM the administrator approached Resident #5's room to ask if she was coming to the dining room. Resident #5 requested a room tray. The resident's tray was delivered to her room at 1:38 PM. When her tray was delivered she was given plastic eating utensils. During an interview on 10/15/24 at 1:47 PM the resident stated she wished the facility would have given her regular eating utensils, not the plastic.

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 40907 Based on interviews, personal health record reviews and pharmacy recommendation reviews, the facility failed to have a provider respond to a monthly pharmacy recommendation in July and in August for 1 of 5 residents reviewed (Resident #8). The facility reported a census of 37 residents. Findings include: A Physician Recommendation dated 7/10/24 and A Physician Recommendation dated 8/7/24, sent from the Consultant Pharmacist to the provider both requested the provider consider a reduction in Sertraline (antidepressant medication) to 150 milligrams (mg). These 2 recommendations went without a provider response. A Physician Recommendation dated 9/9/24, documented this was the third request and requested the provider consider a reduction in Sertraline (antidepressant medication) to 150 mg. The response from the Mental Health Nurse Practitioner documented the patient had been stable and a dose reduction in therapy may impair function and/or cause patient distressed behavior or to be of psychiatric instability by exacerbating this resident's psychiatric disorders. This response was dated 9/18/24. On 10/16/24 at 4:40 p.m., the DON brought the 9/18/24 response to Sertraline. She did not have responses to GDR (Gradual Dose Reduction) requests from 7/10/24 or 8/7/24. The DON stated that the Nurse Practitioner who follows his psychiatric medications doesn't see him as often and she was the one who responded on 9/18/24. A 9.1 Medication Regimen Review policy revised on 3/30/20, directed the following: This Policy 9.1 sets forth procedures relating to the medication regimen review (MRR). The Consultant Pharmacist will conduct MRR's if required under a Pharmacy Consultant Agreement and will make recommendations based on the information available in the residents' health record. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR and the Director of Nursing to act upon the recommendations contained in the MRR. For those issues that require Physician/Prescriber intervention, Facility should encourage Physician/Prescriber to either accept and act upon the recommendations contained within the MRR or reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected. The attending physician should document in the residents' health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If the attending physician has decided to make no change in the medication, the attending physician should document the rationale in the residents' health record. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility should alert the Medical Director where MRR's are not addressed by the attending physician in a timely manner.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 42134 Based on observation, document review, and resident and staff interview the facility failed to maintain hot foods above 135 degrees Fahrenheit and cold beverages below 41 degrees Fahrenheit for 1 of 1 test trays. The facility failed to address the food temperatures on room trays despite residents voicing their concerns about cold food during Food Council Meetings on 2/20/24, 3/12/24, 4/15/24, 5/21/24 and 1 undated meeting. The facility reported a census of 37 residents. Findings include: During an interview on 10/14/24 at 2:30 PM, Resident #5 explained her food was sometimes cold when she got her room trays. During the lunchtime meal service, a test tray was temperature checked immediately following the last room tray served on the 100 hall. The food temperatures included fish at 149.0 degrees Fahrenheit, rice at 133.7 degrees Fahrenheit, peas at 121.0 degrees Fahrenheit. The chocolate milk temped at 46.6 degrees Fahrenheit and the juice temped at 43.2 degrees Fahrenheit. Staff A explained hot food should be 165 degrees Fahrenheit and cold food and drinks should be below 40 degrees Fahrenheit. She stated that's not good when the milk was temped. Food items were tasted by the surveyor. The fish and rice tasted lukewarm and the peas tasted cold. The milk and juice were not sampled for temperature and palatability. The Food Council minutes for February, March, April, May, and 1 undated report all documented food temperatures, specifically food being cold or warm, not hot. The February, March, April, and May Food Council minutes were signed by facility staff. The undated Food Council minutes report was unsigned.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 40907 Based on observations, interviews, and record review, the facility served 1 resident the wrong diet (Resident #27) and failed to initially set up the appropriate diets for 4 other residents with the intention to serve them prior to the Dietician stopping the kitchen staff from serving the wrong diets (Residents #12, #18, #26 and #28). The facility served 37 residents on the day of kitchen observation. The facility reported a census of 37 residents. Findings include: 1. A physician's diet order dated 2/20/24, documented that Resident #12's diet was to be mechanical soft texture. 2. A physician's diet order dated 10/1/21, documented that Resident #18's diet was to be mechanical soft texture. 3. A physician's diet order dated 12/12/23, documented that Resident #26's diet was to be mechanical soft texture. 4. A physician's diet order dated 3/12/24, documented that Resident #27's diet was to be mechanical soft texture. 5. A physician's diet order dated 5/7/24, documented that Resident #28's diet was to be mechanical soft texture. A Therapeutic Spread Report-Spring/Summer Menu '24 signed as approved by the Registered Dietitian on 4/8/24, documented the following for week 1 Tuesday's lunch: Regular diet: baked fish 3 ounces, rice pilaf 1/2 cup, green peas 1/2 cup, apple crisp 1/2 cup, and 1 slice of whole wheat bread with margarine. Mechanical Soft diet: 3 ounces of ground fish, rice pilaf 1/2 cup, wax beans 1/2 cup, apple crisp 1/2 cup, and 1 slice of whole wheat bread with margarine. On Tuesday, 10/15/24 at 11:57 a.m., Staff B, Cook, took temperatures on the following food prior to the start of lunch service: fish patties 176.0 Fahrenheit (F), peas 168.0 F, waxed beans 175.8 F, apple crisp 176.4 F, rice pilaf 209.2 F and mechanical soft rice 205.0 F (no almonds). On 10/15/24 at 11:59 a.m., Staff B set up Resident #27's tray to be delivered to his room. Staff B placed a whole fish patty, waxed beans, rice without almonds, and apple crisp on a paper plate. This was sent out to Resident #27's room. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/15/24 at 12:41 p.m., the Registered Dietitian told Staff B to grind up Resident #26's fish patty that was already on the plate and ready to be served. When the Registered Dietitian was asked if all residents with mechanical soft diets should have their fish ground, this Dietitian answered yes. When told that Resident #27 was served regular fish, this Registered Dietitian acknowledged this and stated she was going to go check on Resident #27. On 10/15/24 at 12:44 p.m., Staff B ground up 3 more fish patties. He then placed the ground fish on plates with peas and rice with no almonds. Staff B then placed the plates on a cart to send out to the dining room for service. When asked about the peas Staff B stated he should have put waxed beans on the plates. Staff B then changed all three plates out by removing the peas and adding waxed beans. These plates were for Resident #12, Resident #18 and Resident #28. On 10/15/24 at 12:48 p.m, the Dietary Manager stated that Resident #27 had not eaten his meal yet as he needed assistance, so Resident #27 hadn't eaten the fish. On 10/15/24 at 12:55 p.m., the Dietary Manager came back in to the kitchen and said she was mistaken, and that Resident #27 had eaten. This Dietary Manager brought Staff C, Certified Nurse Aide (CNA), along and stated that Staff C had assisted Resident #27 to dine. Staff C stated she cut the fish up in to small pieces and mixed It with tartar sauce. On 10/15/24 at 3:10 p.m., the Administrator and the Nurse Consultant acknowledged that Resident #27 was served a whole fish patty from the kitchen when it should have been ground, that Staff B was going to serve Resident #26 a whole fish patty and would have served it if the Dietitian would not have intervened, and that Staff B was going to serve Resident #12, Resident #18, and Resident #28 peas instead of waxed beans. The Administrator and the Nurse Consultant acknowledged that all 5 of these residents were to receive a mechanical soft altered diet and whole fish patties and peas should not have been served to residents who were on a mechanical soft diet. On 10/16/24 at 10:32 a.m, the Registered Dietitian stated she had consistent communication with the Dietary Manager. She stated she was in the building 1-2 times a month and then they communicate weekly through phone calls and emails. She stated she came to the facility on this morning and implemented a Nutrition Management program available through their electronic health records that prints off each resident's diet slip. She stated they utilized the strips this morning and it worked well and this is what they will be using from here on out. This will ensure all residents receive a meal and receive the appropriate diet. When asked about the wrong diets being served up on to plates and the fish not being ground, the Dietitian stated she had never seen that before at this facility. A Therapeutic Diets policy revised on 10/2017, directed: Therapeutic diets are prescribed by the Attending Physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. A 'therapeutic diet' is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet. The dietitian, nursing staff, and attending physician will regularly review the need for, and resident acceptance of, prescribed diets.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 40907 Based on observations, interviews, and record review, the facility failed to obtain a doctor's order for a change in diet for 1 of 6 resident's reviewed (Resident #16). Speech Therapy recommended a diet change from pureed to mechanical soft. A Doctor's/Provider's order was not obtained for a diet change and the facility served a mechanical soft diet to the resident without the order. The facility reported a census of 37 residents. Findings include: A Diet Type Report dated 10/14/24 at 12:38 p.m., documented that 2 residents were to receive a pureed textured diet. Resident #16 was one of the 2 residents. A physician's diet order dated 9/19/24, documented that Resident #16's diet was to be pureed texture. On 10/15/24 at 9:35 a.m., the Dietary Manager (DM), stated serving started at 11:45 a.m. The DM stated they only had one resident that was on a pureed diet and that resident had asked for broth for lunch. A Therapeutic Spread Report-Spring/Summer Menu '24 signed as approved by the Regional Dietitian on 4/8/24, documented the following for week 1 Tuesday's lunch: Regular diet: baked fish 3 ounces, rice pilaf 1/2 cup, green peas 1/2 cup, apple crisp 1/2 cup and 1 slice of whole wheat bread with margarine. Mechanical Soft diet: 3 ounces of ground fish, rice pilaf 1/2 cup, wax beans 1/2 cup, apple crisp 1/2 cup and 1 slice of whole wheat bread with margarine. Pureed: baked fish 3 ounces pureed, rice pilaf pureed 1 serving, wax beans pureed 1 serving, whole wheat bread pureed 1 serving, and apple crisp pureed 1 serving. On Tuesday, 10/15/24 at 11:57 a.m., Staff B, Cook, took temperatures on the following food prior to the start of lunch service: fish patties 176 Fahrenheit (F), peas 168 F, waxed beans 175.8 F, apple crisp 176.4, rice pilaf 209.2 F and mechanical soft rice 205 F (no almonds). There was no food altered into puree texture. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 11:59 a.m., the kitchen started serving their first trays. When it came time to serve Resident #16, Staff B, Cook, placed on her plate bread and butter, a fish patty, waxed beans, and rice. When asked about Resident #16 having an order for a pureed texture diet, the Dietary Manager stated they were trialing a mechanical soft diet for Resident 16. The Registered Dietitian stated that on her list it showed Resident #16 was to receive pureed. The Dietitian asked 'when did it change to a trial?' The DM stated that she would go and check. The DM then left the kitchen and brought back a Nursing/Therapy communication. A Nursing/Therapy communication dated 10/8/24 at 1:00 p.m., documented the following: therapy to nursing. Problem and/or change in diet texture. Recommending upgrade to mechanical soft. Continue thin liquids. Assist with feeding as needed. A physician's diet order dated 10/15/24 at 12:32 p.m, documented that Resident #16's diet was to be mechanical soft texture. The previous physician's order for pureed texture was discontinued on 10/15/24 at 12:30 p.m., with a note that diet was upgraded. On 10/15/24 at 03:10 p.m., the Administrator and the Nurse Consultant acknowledged the concern with Resident #16's diet order not being obtained for an upgrade from pureed to mechanical soft until today 10/15/24. The Administrator and the Nurse Consultant acknowledged the recommendation was given by Speech Therapy on 10/8/24. She stated that the kitchen should not have changed the diet without an order. The Director of Nursing (DON) stated that they were trialing the mechanical soft diet first. The Nurse Consultant stated that a trial could be done but could not last longer than 3 days and this had gone on longer than 3 days. An Interdepartmental Notification of Diet (Including Changes and Reports) policy revised 10/2017, directed the following: Nursing services shall notify the food and nutrition services department of a resident's diet orders, including changes in the resident's diet, meal service and food preferences. A Therapeutic Diets policy revised on 10/2017, directed: Therapeutic diets are prescribed by the Attending Physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. A 'therapeutic diet' is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet. The dietitian, nursing staff, and attending physician will regularly review the need for, and resident acceptance of, prescribed diets.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40907 Based on observations, interviews, and policy review, the facility failed to safely handle food when preparing sandwiches. The staff put on gloves then touched other items with gloved hands prior to touching bread with the same gloved hands. The facility reported a census of 37 residents. Findings include: On 10/15/24 at 1:05 p.m., Staff B, Cook, dumped a slice of bread out of the bread bag on to a plate then moved it more center on the plate with his fingers. Staff B put peanut butter on the bread while holding it with his fingers. Staff A, Dietary Manager for another facility, had Staff B start over. Staff B then put 2 gloves on his right hand. He then took one glove off and grabbed bread and spread peanut butter on it. Staff B then opened cupboard doors with both hands, took a plastic knife out then grabbed the slice of bread with his left hand and held it while he put butter on. On 10/15/24 at 1:16 p.m., Staff D, Cook, put gloves on and spread butter on bread, he then touched the plate and after touching the plate spread butter again on to bread while grabbing bread to make a grilled cheese. On 10/15/24 at 1:19 p.m., Staff B had gloves on and touched the peanut butter container then the jelly container then a plate. He then picked up bread and put the peanut butter and jelly on bread to make a sandwich while wearing the same gloves. Staff B then touched a potato chip bag, reached into the bag grabbed chips and placed in bowl all while wearing the same gloves. On 10/15/24 at 3:10 p.m., the Administrator and the Nurse Consultant acknowledged the issue with using gloved hands and touching food after touching other objects with the same gloved hands. A Preventing Foodborne Illness - Food Handling policy revised on 7/2014, directed the following: Food will be stored, prepared, handled and served so that the risk of foodborne illness is minimized. 1. This facility recognizes that the critical factors implicated in foodborne illness are: a. Poor personal hygiene of food service employees; b. Inadequate cooking and improper holding temperatures; c. Contaminated equipment; and d. Unsafe food sources. 2. With these factors as the primary focus of preventative measures, this facility strives to minimize the risk of foodborne illness to our residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. All employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents.