STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165352	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emmetsburg Care Center	2405 21st Street Emmetsburg, IA 50536

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056 Based on clinical record review, observations, staff interviews, and facility policy review, the facility failed to protect resident from the use of physical restraint that the resident could not remove on their own (Resident #28). The facility reported a census of 39 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #28 documented diagnoses of Alzheimer's Disease, anxiety disorder, history of falling. The MDS showed a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment. The MDS showed Resident #28 was able to roll independently. Observation on 9/9/24 at 10:37 AM., revealed a pillow under the fitted sheet on Resident #28's right side of her back under the fitted sheet. On 9/12/24 at 10:20 AM interview with Staff J, Certified Nursing Assistant (CNA) revealed they are using the body pillow with Resident #28 so she doesn't roll out or bed. Staff J reported that she places it underneath the fitted sheet next to her. Staff J reported that she is not sure when the body pillow was implemented. On 9/12/24 at 10:40 AM, interview with Staff H, CNA, revealed they tuck the body pillow under the fitted sheet and cover it up. Staff H reported that they use the body pillow for safety hazards, because Resident #28 likes to get up and walk. On 9/12/24 at 10:49 AM, during interview the MDS Coordinator acknowledged and verified that the body pillow was not on the care plan and had no order for it. She reported they have since added it to the care plan. MDS coordinator verified how it should be placed outside of the bed or by the wall. MDS coordinator explained that she expected Resident #28 should be able to remove it, if it is under the fitted sheet it is a restriction. She revealed they are using it more for comfort. On 9/12/24 at 11:00 AM the Director of Nursing (DON) revealed the expectation of the body pillow is to be beside her in bed. The DON revealed she would never expect the body pillow to be placed under the fitted sheet because this is considered a restraint. She voiced that they have educated the staff on how to place the body pillow in bed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy named Physical Restraint Usage revised May 2005 instructed that physical restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts the freedom of movement or normal access to one's body. Physical restraints include tucking in or using velcro to hold a sheet, fabric or clothing tightly so that the resident's movement is restricted.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46875 Based on clinical record review and staff interviews the facility failed to develop a care plan to address risk factors and interventions for 2 out of 14 residents (Residents #35 and #6) reviewed for comprehensive care plans.The facility reported a census of 39 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #35 dated 7/5/24 identified a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS included diagnoses of anemia, atrial fibrillation (irregular heart rhythm), congestive heart failure (inability for the heart to pump blood), urinary tract infection (UTI) in the last 30 days, arthritis, osteoporosis, chronic pain, and low back pain. The MDS indicated Resident #35 was occasionally incontinent of urine. The MDS documented Resident #35 received diuretic and opioid medications during the assessment period (last 7 days). A Hospital Discharge Instruction form dated 6/28/24 documented Resident #35 had ongoing problems with recurrent UTIs. A Physician Order dated 6/28/24 directed staff to administer furosemide (diuretic medication) 20 mg (milligrams) one tablet one time a day every other day related to congestive heart failure. A Physician Order dated 7/21/24 directed staff to administer cefdinir (antibiotic) 300 mg twice a day for 7 days for UTI. A Physician Order dated 7/24/24 directed staff to administer oxycodone hcl 5 mg, give one tablet two times a day for pain and give one tablet by mouth as needed for pain. A Physician Order dated 8/27/24 directed staff to administer cefdinir (antibiotic) 300 mg twice a day for 7 days for UTI. Review of the current Care Plan with a target date of 10/13/24 did not address Resident #35 was at risk for urinary tract infections, what signs and symptoms to monitor for and interventions to reduce the risk for UTI. The Care Plan also did not address Resident #35 was taking high risk medication such as diuretic and opioid medications and what to monitor for including side effects while taking the medication. On 9/11/24 at 1:10 PM, The MDS Coordinator acknowledged and verified Resident #35 risks for UTIs and interventions were not addressed on the care plan. She reported she thought she had addressed it on the care plan as she had educated Resident #35 on proper toileting hygiene. She also acknowledged and verified the diuretic and opioid medications were not addressed on the care plan. She reported it was an expectation for high risk medications to be addressed on the care plan and that the medications had been missed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The MDS assessment for Resident #6 dated 6/10/24 identified a BIMS score of 14, which indicated intact cognition. The MDS included diagnoses of atrial fibrillation, hypertension (high blood pressure), and renal disease. The MDS documented Resident #6 received anticoagulant medication (blood thinner) during the assessment period (last 7 days). A Physician Order dated 6/3/24 directed staff to administer apixaban (anticoagulant) 5 mg two times a day for hypertension. Review of Resident #6's Care Plan with a target date of 9/20/24 revealed the anticoagulant medication, potential side effects and what to monitor for while taking the high risk medication was not addressed on the comprehensive care plan. On 9/11/24 at 1:15 PM, the MDS Coordinator acknowledged and verified the anticoagulant medication was not addressed on Resident #6's Care Plan. She reported it was an expectation for high risk medications to be addressed on the care plan and that the medications had been missed. On 9/11/24 at 1:20 PM, The Administrator reported the facility does not have a policy on comprehensive care planning.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056 Based on clinical record review, resident and staff interview and facility record review the facility failed to provide bathing assistance per resident preference for 1 of 8 residents reviewed for bathing (Resident #2). The facility reported a census of 39 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 revealed the Brief Interview for Mental Status (BIMs) score of 14, which indicated cognitively intact. Resident #2 had diagnoses of diabetes, major depressive disorder, and anxiety disorder. The MDS revealed the resident required substantial/maximal assistance (helper does more than half the effort) with bathing. The Care Plan with a target date of 10/31/24 identified Resident #2 required extensive assistance of 1 person to provide baths daily. The untitled Electronic Health Record (EHR) bathing record documented completed baths from 8/12/24 to 9/10/24. The record documented baths were completed only on 8/12/24, 8/19/24, 8/23/24, 8/25/24, 8/29/24, 9/5/24, 9/6/24 and 9/10/24. The clinical record for the resident lacked documentation of any other attempts to encourage the resident to bathe or refusals to bathe. On 9/10/24 at 12:18 PM interview with Staff C, Certified Nursing Assistant (CNA) revealed typically they are not able to provide bathing to the residents due to staffing. Staff C revealed at time they choose the residents and try to give them a bed bath, Staff C stated this is better than nothing, then we will reschedule the baths, and if necessary I will try to stay after to try to get them completed. They get pretty stacked up when we reschedule them to the next day, we will try to gather enough staff to get them done. On 9/10/24 at 2:56 PM during interview with Staff G, CNA reported they couldn't give showers because there was no staff. Staff G reported residents were complaining they weren't getting bathed. During interview on 9/11/24 at 9:46 AM with Staff B, CNA revealed that it is day by day with being able to do baths, we try to work them in the next day to get them complete, if they refuse, I would try to go back and reapproach them, the 1st refusal we document in the electronic health record, but if they refuse again I would tell the nurse. During interview on 9/11/24 at 1:37 PM with Staff I, CNA revealed that bathing the residents is day by day and sometimes we don't always have enough staff. The residents get pushed to another day or the next day and there have been times where residents weren't able to have a bath because we are just too short of staff. The facility reported they do not have a policy regarding bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 with the Director of Nursing (DON) revealed all baths are documented in the Electronic Health Record and they do not document on any other forms. The DON stated that she keeps track of the baths and goes through them each day.

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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** 46875 Based on clinical record review, staff interviews, and policy review the facility failed to provide assessment and interventions necessary for the care and services, to maintain the residents' highest practical physical well- being for 1 of 14 residents reviewed (Resident #18). The facility failed to complete a follow up assessment after the resident had complaints of headache, chest pain, jaw pain with an increased blood pressure and pulse. The facility also failed to notify the Physician and family of the condition change in a timely manner. The facility reported a census of 39 residents. Findings include: Resident #18's MDS (Minimum Data Set) assessment dated [DATE] identified a BIMS (Brief Interview for Mental Status) score of 07, indicating moderately impaired cognition. The MDS identified Resident #7 required partial to moderate assistance with bed mobility and transfers including toileting. The MDS included diagnoses of cancer, anemia, heart failure (inability of the heart to pump blood), hypertension (high blood pressure), and non-alzheimer's dementia. A Progress Note created on 4/30/24 at 6:40 AM for an effective date of 4/28/24 at 6:33 PM completed by Staff A, LPN (License Practical Nurse) revealed Resident #18 was experiencing symptoms of cardiopulmonary nature. The note documented Resident #18 had a nonproductive cough and chest pain with pressure, tightness and aching without radiation. The note also documented Resident #18 was experiencing a new or worsening ability to sleep while laying down. A Progress Note dated 4/28/24 at 6:35 PM revealed Resident #18 had complaints of headache, jaw pain, and chest pain. The note documented the following vital signs: blood pressure 160/89, temperature 98.4 degree fahrenheit, pulse 99 beats per minute, respirations 16 breaths per minute and oxygen saturation 96% (oxygen in the blood). The note indicated Resident #18's blood pressure and pulse were elevated according to her baseline. Resident #18's pain level was a 7 (pretty bad) on a scale 1-10. The note documented Staff A, LPN asked Resident #18 if she wanted to go to the emergency room (ER) and the residnet said no. The note further documented Staff A told the resident if it continued and she changed her mind to let the Staff A know. A Progress Note dated 4/29/24 at 6:46 AM documented the nurse called the ER to report on Resident #18 status. The note revealed Resident #18 had complaints of pain, discomfort all over. The note documented the following vital signs: blood pressure 148/74, pulse 110 beats per minute, respirations 24 breaths per minute, oxygen saturation 87% on room air and temperature 100.9 degrees fahrenheit. A PAINAD (pain assessment in advanced dementia) assessment completed revealed a pain score 10 out of 0-10. At 7:02 AM, the facility received a call from a triage nurse with direction to send Resident #18 to the ER. The note documented the family had not answered phone calls. A Progress Note dated 4/29/24 at 7:15 AM documented Resident #18 left the facility to the ER via facility van. A Progress Note dated 4/29/24 at 11:28 AM revealed Resident #18 was admitted to acute care for a diagnosis of Pneumonia. Resident #18's husband was made aware of hospitalization and gave consent to hold the bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Hospital History Physical Report dated 4/29/24 documented Resident #18 was admitted for pneumonia, hypoxia (low oxygen levels), anemia, and chest pain. The report revealed Resident #18 complained of some chest discomfort during an exam and an EKG (electrocardiography) and troponin level (test completed that may indicate a heart attack) had been completed. The note documented troponin levels x 2 were in the 40's and Resident #18 was stable at her baseline. The clinical record lacked documentation Resident #18's family or Physician was notified of the condition change on the evening of 4/28/24. The clinical record lacked follow up documentation, assessments, intervention after Resident #18 complaints of headache, jaw pain, and chest pain until the following morning on 4/29/24 at 6:56 AM. On 9/11/24 at 2:37 PM, the MDS Coordinator reported she recalled working on the morning of 4/29/24 and Resident #18 was not feeling well. She stated she completed a assessment, tried to call Resident #18's husband who did not answer and then sent her to the emergency room . The MDS Coordinator reviewed Resident #18's Progress Notes from 4/28 to 4/29 and stated she remembered thinking why are we waiting so long to send Resident #18 out. When asked if she would expect the Physician and family to be notified when a resident had complaints of headache, jaw pain and chest pain, she stated definitely. On 9/11/24 at 3:45 PM, the DON acknowledged and verified she would expect the Physician and family to be notified regarding complaints of chest and jaw pain. She stated Resident #18 does have a history of lung cancer and breast cancer. She stated she recalled coming to work on Monday morning (4/29) reading Resident #18's Progress Note from the night before and deciding to send her out. On 9/12/24 at 10:30 AM, the DON reported she had provided education to Staff A, LPN. The DON provided a employee counseling form dated 5/1/24. The counceling form documented the problem was concerns with documentation related to lack of assessment and family notification. The employee statement on the counseling form documented the employee will notify family and do more re-assessments and chart them. The form was signed by the DON and Staff A on 5/1/24. The DON acknowledged Resident #18 had dementia and cannot make medical decisions herself. A facility policy titled Family and Physician Notification related to Accident or Change in Medical Condition revised April 2012 documented the facility would immediately notify the resident, the resident's responsible party, and physician of an accident resulting in injury or a change in the resident's medical condition. The policy further documented the facility to notify the attending Physician or on-call MD (doctor of Medicine), Nurse Practitioner, Physician Assistant on call as soon as possible if the resident experience new or abrupt onset of chest pain, pressure tightness, unrelieved by current medication or accompanied by diaphoresis, change in vital signs or new EKG changes.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056 Based on observation, resident and staff interviews the facility failed to ensure residents received the proper diet texture to meet the residents needs in 1 of 1 residents reviewed (Resident #31). The facility reported a census of 39 residents. Finding Include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #31 revealed the Brief Interview for Mental Status (BIMs) score of 12, indicating moderate cognitive impairment. Resident #31 had diagnoses of hypertension (high blood pressure), renal insufficiency and difficulty in walking. The MDS revealed the resident was coded for a mechanically altered diet. The Care Plan with a target date of 12/20/24 identified Resident #31 to have a mechanical soft ground meat diet. Physician Orders dated 2/7/24 included an order for general diet, mechanical soft ground meat only texture, regular fluid consistency. Observation on 9/11/24 at 12:00 PM, with Staff C, Cook, plated and served a regular pork chop to Resident #31. Resident #31 had an order for a mechanical soft ground meat diet only. The CDM stated they know Resident #31 and she would prefer a regular pork chop. CDM stated we just cut it up because she likes it this way. CDM stated when we send her ground meat she changes her mind and sends it back to the kitchen. Observation on 9/11/24 at 12:30 PM, Resident #31 was eating the cut up pork chop in her room without supervision. Resident #31 stated this is how she liked her pork chop. Resident #31 stated the facility does a good job. Resident #31 reported she is on a ground meat diet because she has very little teeth. Resident #31 reported that she always eats her meals in her room. The facility policy named Ground Meat Diet Orders, with a file date of 7/03 revealed it is the purpose to provide appropriate texture meat products to enhance resident satisfaction, oral consumption and safety due to chewing or swallowing problems. Interview on 9/11/24 at 2:02 PM with the Dietician reported that she would expect the staff to notify her so we could get it on the care plan and write it on the diet card. Interview on 9/11/24 at 2:30 PM with the DON reported that she educated the CDM and that they need to notify the physician if a resident doesn't agree with the diet order. The DON reported they will get an order for Speech Therapy to evaluate Resident #31.