STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165358	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thomas Rest Haven	217 Main Street Coon Rapids, IA 50058

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and policy review the facility failed to use universal infection control measures (hand hygiene), and Enhanced Barrier Precautions (EBP) during catheter cares/wound cares for 5 of 5 residents reviewed for infection control (Residents #1, #3, #10, and #26). The facility reported a census of 31 residents.Findings include: 1. Review of Resident #10's Minimum Data Set (MDS) dated [DATE] revealed diagnoses of progressive neurological conditions, Alzheimer's disease, Non-Alzheimer's dementia, and obstructive uropathy. The MDS further revealed Resident #10 utilizes an indwelling catheter. Review of Resident #10's Electronic Healthcare Record (EHR) page titled, Clinical Physician Orders, revealed an order to change catheter every 30 days and as needed dated 6/24/24. Observation 9/16/25 at 12:31 PM Staff L Certified Nursing Assistant (CNA), and Staff M CNA completed hand hygiene, donned gloves and gowns. Staff L then raised Resident #10's bed while wearing gloves and proceeded to complete catheter cares. Staff L then cleansed Resident #10's thighs, penis, and down the catheter tubing. Staff L then doffed gloves and donned new gloves without hand hygiene. Staff L then drained Resident #10's catheter drainage bag. Staff L and Staff M doffed gloves and gowns and completed hand hygiene. Staff L then revealed that she should have changed her gloves after raising the bed. On 09/16/2025 at 11:45 AM during lunch observed Hospice Registered Nurse (RN) Staff N and Hospice Certified Nurse Assistant (CNA) Staff O enter the dining room and walked directly to the assisted feeding table. Staff N sat down next to Resident #10 and started pulling her hair back to put it into a ponytail. She did not wash her hands and she did not apply hand sanitizer on her hands and she started feeding Resident #10. She then stopped, opened her backpack, took some sort of barrier out, laid the barrier on the floor. She then sat her back pack on top of the barrier that she laid on the floor. She then pulled out her laptop from the back pack, opened the laptop and typed onto the keypad, and then resumed feeding Resident #10. She did not utilize any hand sanitizer on her hands at that time. Staff O proceeded to sit down next to Resident #9, she started feeding him without using any hand sanitizer on her hands or washing her hands prior to her feeding Resident #9. On 09/16/2025 at 1:53 PM interviewed the Administrator on her expectations of hand hygiene for outside contracted staff. She said she would expect them to wash their hands or at least use hand sanitizer prior to feeding the resident. She would expect them not to fiddle (touch or mess around with) around with their hair while in the dining room, and to use hand sanitizer after doing so. She stated, that's just the nursing standard of care. The facility policy Titled Hand Washing Policy stated its purpose was to prevent the spread of (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infection and protect the health of residents, staff and visitors by ensuring proper hand hygiene practices. The policy stated all employees, contractors, volunteers, and visitors must perform hand hygiene according to the following standards before direct contact with a resident. Before preparing, serving or eating food. The facility policy Titled Infection Prevention and Control Manual: Enhanced Barrier Precautions stated gowns and gloves (PPE) will be worn while providing high contact care activities. The facility policy Titled Infection Prevention and Control Manual: Catheter Care was to prevent infection and irritation by washing hands, wearing gloves and obtaining clean equipment for catheter care procedures. 2. Review of Resident #26's MDS dated [DATE] revealed a Brief Interview for Mental status (BIMS) score of 14 indicating intact cognition. The MDS further revealed diagnoses of cancer, hypertension, and progressive neurological conditions. Observation on 9/15/25 at 11:16 AM Resident #26 observed to have a dressing on the left hand. When asked Resident #26 revealed he is not sure what happened there. Review of Resident #26's EHR page titled, Progress notes, revealed an entry dated 9/3/25 at 1:50 PM. The entry revealed that Resident #26 had returned from the dermatologist who had completed Microscopically Oriented Histographic Surgery (MOHS) to the top of Resident #26's left hand. Review of Resident #26's EHR page titled, Clinical Physician Orders, revealed an order for a dressing change to the left hand dated 9/5/25. The order revealed to remove the old dressing and cleanse with mild soap, water and Q-tip. Remove drainage/scabbing with dry Q-tip. Apply firm pressure. Apply Vaseline with a clean Q-tip to the wound and cover with a non-stick gauze and secure with paper tape. Observation 9/17/25 at 9:54 AM Staff G Licensed Practical Nurse (LPN) set up sterile area on bed side table of Resident #26. Staff G then donned a gown. Staff G completed hand hygiene and donned gloves. Staff G then removed Resident #26's old dressing on the left hand. Staff G then doffed her gloves and donned new gloves without hand hygiene. Staff G then cleansed the area to the left hand per the physician order. Staff G again doffed her gloves and donned new gloves without hand hygiene. Dressing change then completed per the physician order. Staff G then doffed her gloves and gown and completed hand hygiene at that time. Interview 9/17/25 at 10:05 AM with Staff G revealed she should have sanitized between glove changes during the dressing change. 3. The MDS for Resident #1 dated 7/17/25 revealed a BIMS score of 15/15 indicating normal cognition. The document provided diagnoses of diabetes mellitus, pressure ulcer of right buttock Stage 3 and pressure ulcer of left buttock Stage 3. The document revealed 2 Stage 3 pressure ulcers. Resident #1's Care Plan dated 7/1/25 revealed a focus area of actual impaired skin integrity related to fragile and thin skin, incontinence, friction and shearing potential and Stage 3 pressure injuries initiated on 12/2/22 and revised 6/1/23. Interventions included positioning needs, resident's non-compliance with treatment and interventions, resident sleeping in recliner by choice, following orders and weekly documentation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan failed to identify the need for EBP. The hard chart provided a medical diagnosis of squamous cell carcinoma of the right external ear and external auricular canal. The Clinical Physician Orders revealed the following orders: Zinc Oxide External Paste 20% apply to right/left buttock topically two times a day for care and after every bowel movement, start date 8/29/24. Clean drainage from the external ear canal using Vashe moistened gauze and finger swab just around the outside of the external ear canal as needed, start date 8/18/25. Apply Vashe to gauze and place on wound for 3-5 minutes; remove old drainage from wound and peri wound; apply skin prep around wound; apply Aquacel Ag to wound and secure with Mepilex Border dressing start date 8/18/25. Observed on 9/15/25 at 11:26 AM Resident #1 with a bandage covering the right (R) ear. The resident's room did not contain a U.S. Department of Health and Human Services Centers for Disease Control and Prevention EBP sign. Observed on 9/16/25 at 10:14 AM Staff G, Licensed Practical Nurse (LPN)/Infection Preventionist (IP) complete wound dressing to Resident #1's R ear. The staff stated the resident had ear cancer and had been going to the wound care clinic. Staff G brought in the dressing supplies, and placed a barrier on the resident's night stand. The staff sanitized wound scissors, completed hand hygiene and donned gloves. The staff removed the bandage from the ear. Vashe applied to the gauze and placed it on the ear. After 4 minutes the gauze was removed. Staff removed gloves, completed hand sanitizing and donned new gloves. The staff utilized finger swabs for drainage removal, as well as gauze and Vashe. The staff removed gloves, went to the bathroom to obtain more gloves, completed hand sanitizer and donned gloves. The Aquacel Ag was cut to size, Skin Prep applied to skin around the ear, the Aquacel Ag placed, and the Mepilex Border dressing placed on top. Gloves removed and hand sanitizer completed. The staff failed to utilize EBP by not using a gown. Observed on 9/17/25 at 6:30 AM Resident #1 sleeping in the recliner with a U.S. Department of Health and Human Services Centers for Disease Control and Prevention EBP sign on the bathroom door. Observed on 9/17/25 at 10:20 AM Staff G complete wound care to Resident #1's buttocks. The staff washed hands and donned gloves. Resident #1 walked with a walker to the bathroom. Staff G cleansed the area to the buttocks and patted dry. Zinc Oxide 20% placed to the open areas on the buttocks. The staff failed to wear a gown for EBP during the treatment. 4. Review of Resident #3's MDS dated [DATE] revealed a BIMS score of 8/15 indicating moderate cognitive deficit. The document provided diagnoses of benign prostatic hyperplasia, renal insufficiency, and obstructive uropathy. The resident had an indwelling catheter and urinary continence was not rated. Resident #3's Care Plan dated 6/26/25 revealed a focus area of self care deficits revised 6/16/25 contained interventions of toileting 1 assist with emptying catheter, suprapubic catheter and wears a leg bag for urinary drainage initiated on 6/6/24 and revised on 6/20/24. An additional focus area of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	suprapubic catheter and at increased risk for infections was initiated on 10/2/23. The interventions included assisting with emptying the leg drain bag every shift and as needed (PRN) initiated 5/8/24 and revised 1/3/25 and observing on routine rounds for proper positioning and urine flow initiated 10/2/23. The Care Plan failed to identify the need for EBP. On 9/15/25 at 12:29 PM observed Resident #3 seated in his wheelchair (w/c) with a full catheter leg bag. The room did not have a U.S. Department of Health and Human Services Centers for Disease Control and Prevention EBP sign. Staff L, Certified Nursing Assistant (CNA), came into the resident's room and acknowledged the leg bag required emptying. Staff L went into the bathroom, came back with gloves donned, a gradient cylinder, a container to hold the cylinder, and a barrier to place the container on. The staff proceeded to empty the catheter, stating I hope this doesn't overflow. Observed the urine output to fill the 1100 ml cylinder. The staff failed to wear a gown for EBP during the care. On 9/17/25 at 6:30 AM observed U.S. Department of Health and Human Services Centers for Disease Control and Prevention EBP sign on the bathroom door. On 9/17/25 at 7:20 AM observed Staff G complete cares with Resident #3. The staff completed hand hygiene and donned a gown and gloves. During the continuous observation of application of absorbent pads to lower extremities, hygiene, catheter and peri care and dressing the staff exhibited inconsistent hand hygiene during glove changes. On 9/17/25 at 11:22 AM the Interim Director of Nursing (DON) stated staff should be utilizing EBP during catheter care. The staff disclosed she was unsure whether EBP should be utilized during all dressing changes or if a wound was chronic over 6 weeks. On 9/17/25 at 12:00 PM Staff G stated EBP should be utilized during catheter care and it was recently brought to the facility's attention that EBP should be utilized with all wound care. The U.S. Department of Health and Human Services Centers for Disease Control and Prevention EBP sign on Resident #1 and Resident #3's door revealed providers and staff must wear gloves and gown during high contact resident care activities including dressing, bathing, transferring, hygiene, changing briefs or assisting with toileting, and wound care.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to acquire a physician's signature on an Advance Directive in 1 of 3 residents (Resident #29) reviewed. The facility reported a census of 31 residents.Findings Includes: Resident #29's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. Resident #29's MDS documented active diagnoses: seizure disorder or epilepsy, traumatic brain injury (brain dysfunction caused by an outside force), malnutrition, anxiety disorder, depression, bipolar disorder, psychotic disorder, schizophrenia, post traumatic stress disorder, asthma, chronic obstructive pulmonary disease or chronic lung disease, respiratory failure, type 2 diabetes, atherosclerosis of aorta (build up of fat,cholesterol and other substances in and on the artery walls), rheumatoid arthritis, bilateral primary osteoarthritis of the hip, muscle weakness.The Care Plan with a targeted completion date of [DATE] indicated Resident #29 and or his Representative requested their code status to reflect Do Not Resuscitate (DNR).During the record review, revealed that there was not a physician's signature on the document titled Care Directive Determination that the resident or residents representatives signed at admissions. The policy was a document that all parties involved signed to determine if the resident was found without a pulse or respirations would they like Cardiopulmonary Resuscitation (CPR) started. There was an X next to the option indicating that Resident #29 does not want CPR initiated. Resident #29 wife signed the Care Directive Determination Form on [DATE]. A faxed dated [DATE] was sent to Nurse Practitioner. The fax was sent from the Social Services Director (SSD), with a message to please review and sign Thank You!.In an interview on [DATE] at 10:20 a.m., Staff K stated, when the nurse completes the advanced directive paperwork we would get the signatures of the resident or the power of attorney and then we would fax it to the physician for their signature and they would then fax it back to us. But the social worker usually does it with all the paper work. We usually just do the medical stuff, like the assessments, medications and stuff like that.In an interview on [DATE] at 10:31 a.m., the SSD replied that the nurses are responsible for obtaining the advanced directive signatures and faxing them out to the doctors for their signatures as well, not her.In an interview on [DATE] at 1:09 p.m., the Director of Nursing acknowledged it her expectations of the nurses to make sure the signatures' are on the advance directive's, and that if a fax goes out that they should be checking for the fax to be returned back with in 24-48 hours.Review of the provided facility policy undated and titled Care Directive Determination: Our facility will ensure that all resident rights regarding the use of CPR and other life sustaining measures are carried out. At the bottom of the policy that each resident or resident representative and physician was a place for each individual to sign and date, acknowledging their understanding of the policy.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on personnel file review, staff interviews, and policy review, the facility failed to ensure that current background checks had been completed for 1 of 4 staff reviewed. The facility reported a census of 31 residents. Findings include:A review of the file for Staff A, Certified Nurse Aide (CNA) revealed that the last Single Contact License and Background Check completed for her was dated 12/3/2020.On 9/16/25 at 2:30 PM, Staff J, Administrative Assistant, said that Staff A was first hired on 12/16/20 and terminated on 11/15/23. She was rehired on 3/1/24 but the file lacked a background check for the rehire. Staff J acknowledged that it hadn't been done and she started the process to run one for the staff member.On 9/18/25 at 3:30 PM the Administrator acknowledged that a second background check should have been completed for Staff A before rehire.According to the facility policy titled: Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated July of 2019, The facility would conduct an Iowa criminal record check and dependent adult/child abuse registry check on all prospective employees and other individuals engaged to provide services to resident, prior to hire.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview, staff interview, and policy review the facility failed to notify the Long-Term Care Ombudsman of a transfer to a hospital for 2 of 3 residents (Residents #3, and #32) reviewed. The facility reported a census of 31 residents. Findings include: 1. Review of Resident #32's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. The MDS further revealed a reentry back to the facility on 4/18/25 from a short-term general hospital stay. Interview on 9/15/25 at 11:06 AM with Resident #32 revealed that she was in the hospital in April of this year. Review of a facility provided document titled, Notice of Transfer Form to Long Term Care Ombudsman for the month of April 2025 revealed Resident #32 was not included on the form. Interview on 9/16/25 at 11:58 AM with the Social Services Manager revealed that the residents should be on the report and she was unsure why they weren't. The Social Services Manager then revealed that residents who have transferred out of the facility would be expected to be on the report. Interview on 9/16/25 at 12:26 PM with the Administrator/DON revealed that her expectation would be for Ombudsman notification to be completed correctly each month, and when residents are transferred or discharged they should be on the list. The Administrator further revealed that they do not have a policy for the Ombudsman notification, but the facility does follow the regulations. 2. Review of Resident #3's MDS dated [DATE] revealed Resident #3 had reentered into the facility from a short-term general hospital stay 6/16/25. The MDS further revealed a BIMS score of 4/15 indicating severe cognitive impairment. Review of Resident #3's EHR Progress Notes revealed that Resident #3 was in the hospital from [DATE] through 6/16/25. Further review of the EHR page titled Clinical Census, confirmed that Resident #3 was in the hospital on these dates. Review of a facility provided document titled, Notice of Transfer Form to Long Term Care Ombudsman dated June 2025 revealed that Resident #3 was not on the form.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, staff interview, and policy review the facility failed to provide a professional standard of quality of care by not completing catheter cares for 1 of 2 residents reviewed (Resident #3). The facility reported a census of 31 residents. Findings include:Review of Resident #3's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 8/15 indicating moderate cognitive deficit. The document provided diagnoses of benign prostatic hyperplasia, renal insufficiency, and obstructive uropathy. The resident had an indwelling catheter and urinary continence was not rated. Resident #3's Care Plan dated 6/26/25 revealed a focus area of self-care deficits revised 6/16/25 contained interventions of toileting 1 assist with emptying catheter, suprapubic catheter and wears a leg bag for urinary drainage initiated on 6/6/24 and revised on 6/20/24. An additional focus area of suprapubic catheter and at increased risk for infections was initiated on 10/2/23. The interventions included assisting with emptying the leg drain bag every shift and as needed (PRN) initiated 5/8/24 and revised 1/3/25 and observing on routine rounds for proper positioning and urine flow initiated 10/2/23.Review of Clinical Physician Orders dated 1/1/25 to 9/17/25 for use of antibiotics revealed the following:Cefpodoxime Proxetil Oral Tab 200 milligram (mg) 2 times/day for urinary tract infection (UTI) for 7 days. Start 1/10/25, end 1/17/25.Ceftriaxone Sodium Injection Solution Reconstituted 1 gram (g), inject 1 g 1 time for UTI for 1 day mix with 1 milliliter (ml) lidocaine start 3/12/25.Ceftriaxone Sodium Injection Solution Reconstituted 1 g, inject 1 g 1 time for UTI. Start 3/14/25.Levofloxacin Oral tablet 750 mg every 48 hours for UTI until 3/22/25, 750 mg every other day for 7 days. Start 3/15/25, end 3/22/25.Amoxicillin-Pot Clavulanate Oral Tablet 875-125 mg 1 tab two times a day (BID) for UTI for 10 days. Start 4/25/25, end 5/5/25.Ceftriaxone sodium injection solution reconstituted 1 g inject 1 g intramuscularly at bedtime related to history of UTI for 1 administration. Start 5/23/25.Cephalexin Oral tablet give 500 mg three times a day (TID) for UTI for 5 days. Start 5/24/25, end 5/27/25.Ceftriaxone sodium injection solution reconstituted 1 g inject 1 g intramuscularly at bedtime related to history of UTI for 2 administrations. Start 5/27/25.Ceftriaxone sodium injection solution reconstituted 1 g inject 1 g intramuscularly at bedtime related to history of UTI for 7 administrations. Start 6/16/25.Cephalexin Oral tablet 500 mg 1 tab BID for elevated white blood cells (WBC) and left shift for 5 days. Start 7/30/25, end 8/4/25.Doxycycline Hyciate Oral 100 mg 1 tab BID for chronic kidney disease, history of UTI. Start 8/21/25, end 8/28/25.The clinical record Point of Contact (POC) Response History for bowel and bladder, catheter care and suprapubic for the past 29 days revealed 9 days where cares were only provided twice in a single day:8/21/25 4:57 AM, 1:59 PM8/22/25 4:52 AM, 9:38 PM8/24/25 11:45 AM, 7:48 PM8/25/25 11:55 AM, 8:44 PM8/31/25 5:21 AM, 9:33 PM 9/9/25 5:26 AM, 7:53 PM9/13/25 5:59 AM, 9:18 PM9/14/25 5:13 AM, 9:52 PM9/16/25 5:26 AM, 7:56 PMObserved on 9/15/25 at 12:29 PM Resident #3 in a wheelchair (w/c) moving around the hallway independently returning to his room. The resident's catheter leg bag was attached to the left lower extremity (LLE) and observed to be very full and expanded. The resident's call light was on and Staff L, Certified Nursing Assistant (CNA), entered the room, observed the resident's leg bag, said it needed to be emptied and hoped it didn't burst. Staff L went into the bathroom, came back with gloves donned, a gradient cylinder, a container to hold the cylinder, and a barrier to place the container on. The staff proceeded to empty the catheter, stating I hope this doesn't overflow. Observed the urine output to fill the 1100 ml cylinder. Observed the urine to be slightly cloudy, have a strong smell and the staff requested vinegar spray to the resident's room. Observed on 9/16/25 at 1:19 PM Resident #3's catheter leg bag 1/2 full while the resident was in the main hallway by the nurses station self propelling his w/c. Observed on 9/16/25 at 2:00 PM Resident #3 in the hallway, the catheter leg bag was over 1/2 full, interacting with multiple CNA's during shift exchange. Observed on 9/16/25 at 3:09 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM Resident #3's leg bag to be full with the resident self propelling in w/c up and down the hall independently passing various nursing staff.On 9/16/25 at 1:27 PM Staff M, CNA, stated catheter cares were completed each shift and as needed.On 9/16/25 at 3:05 PM Staff P, CNA, stated catheter cares should be completed almost every 2 hours. The staff stated this was learned as part of CNA training and part of the facility expectations. On 9/16/25 at 11:22 AM the Interim Director of Nursing (DON), as of 9/16/25, stated catheter bags and care should be emptied each shift or PRN as per the facility's policy. The staff stated she would have a concern if a catheter bag was emptied only twice daily. The staff stated she couldn't remember if the resident would not be receptive to catheter care, but did acknowledge if he was aversive to catheter care then it should be on the Care Plan. On 9/17/25 at 12:00 PM Staff G, Licensed Practical Nurse (LPN)/Infection Preventionist (IP), stated catheters should be emptied once per shift as a minimum. The staff stated catheter drainage bags should be checked during any cares, transfers and if a resident was independent the resident should be checked/monitored throughout the day. The LPN/IP stated the CNA's may empty a catheter multiple times during a shift but only document once per shift. When asked if there was no documentation during a shift, the staff stated if there was no documentation then the task was not completed. The staff stated that she did have a concern with a catheter only being emptied twice daily as it could be a contributing cause to urinary tract infections. On 9/17/25 at 12:30 PM the Administrator stated catheter bags should be emptied minimum of every shift and PRN. The Administrator concurred a lack of emptying a catheter bag and a very full catheter bag could be a contributing factor to UTI's. The facility's Catheter Care Policy did not provide guidance for the frequency of emptying a catheter bag. The Mount [NAME] Hospital Reference Guide provided that a leg bag should be emptied at least two or three times a day, or when it is a third to half full.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews, and policy review the facility failed to provide respiratory care and services in accordance with professional standards of practice for 3 of 4 residents reviewed (Residents #2, #3, and #10) requiring the use of oxygen. The facility reported a census of 31 residents. Findings include: 1. Review of Resident #10's Minimum Data Set (MDS) dated [DATE] revealed diagnoses of progressive neurological conditions, Alzheimer's disease, Non-Alzheimer's dementia, and anxiety disorder. The MDS further revealed the use of continuous oxygen therapy. Observation 9/15/25 at 11:24 AM revealed the oxygen tubing set ups in Resident #10's room were dated 8/31 on both nasal cannulas. Review of Resident #10's Electronic Healthcare Record (EHR) page titled, Clinical Physician Orders, revealed an order to change and date oxygen tubing, nasal cannula, and bag weekly and as necessary with a start date of 3/5/23. Interview on 9/16/25 at 10:11 AM with Staff G Licensed Practical Nurse (LPN) revealed that oxygen tubing should be changed weekly on Sunday night shifts, and dated with initials when changed. Interview on 9/16/25 at 10:17 AM with the Administrator/Director of Nursing (DON) revealed that oxygen tubing should be changed weekly and initialed. A follow up interview 9/16/25 at 11:27 AM with the Administrator/DON revealed that the facility does not have a policy on oxygen tubing change, but the facility does follow nursing standards of care. 2. The MDS for Resident #2 dated 8/14/25 identified a BIMS score of 14/15 indicating normal cognition. The MDS documented a diagnosis of respiratory failure. The document indicated the resident required oxygen. Resident #2's Care Plan dated 8/14/25 contained a focus area of altered respiratory status/difficulty breathing related to acute respiratory failure with hypoxia. The date initiated was 8/2/22 with a revision on 9/9/22. Interventions included change and date oxygen tubing and nasal cannula weekly and as needed (PRN) per orders every Sunday night with a date initiated of 3/5/23; clean and soak nebulizer mask with half vinegar and half water for 10 min per orders nightly and replace nebulizer mask weekly every Sunday night per orders with an initiation date of 11/27/23. The Clinical Physician Orders revealed an order to change and date oxygen tubing and nasal cannula weekly and PRN every night shift every Sunday with a start date of 3/5/23. An additional order was noted to replace the nebulizer mask every Sunday night every night shift with a start date of 11/26/23. The Medication Administration Record (MAR) - Treatment Administration Record (TAR) 9/25 revealed documentation indicating the change and date of oxygen tubing order had been completed on 9/7 and 9/14/25. Observation on 9/15/25 at 10:36 AM revealed Resident #2's oxygen tubing and cannula with a date of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165358	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thomas Rest Haven	217 Main Street Coon Rapids, IA 50058

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/31. The concentrator was set at 3 L with the cannula in the resident's nose. Observation on 9/16/25 at 8:19 AM revealed Resident #2's concentrator turned on with the nasal cannula and tubing wrapped and placed in an attached pouch. The tubing had a date of 8/31. 3. The MDS for Resident #3 dated 8/28/25 identified a BIMS score of 81/5 indicating moderate cognitive deficit. The MDS documented diagnoses of heart failure, chronic obstructive pulmonary disease (COPD), acute on chronic systolic and diastolic heart failure and dyspnea unspecified. A Health Condition identified shortness of breath. Resident #3's Care Plan dated 6/26/25 identified a focus area of diagnosis of congestive heart failure (CHF) and A-Fib and at risk for shortness of breath, chest pains, increased edema, and elevated blood pressure initiated 10/2/23 and revised 10/4/23. Interventions included administration of medications, observations and monitoring for side effects. An additional focus area identified altered respiratory status/difficulty breathing related to COPD and CHF initiated 5/23/24. Interventions included monitoring for signs/symptoms of respiratory distress, level of consciousness, and abnormal breathing patterns. The Clinical Physician Orders revealed an order to clean the nebulizer mask nightly and change out mask and tubing weekly on Sunday overnights. Be sure to label and date the mask and tubing, every night with a start date of 5/23/24. The 9/25 MAR - TAR disclosed documentation indicating the nebulizer mask order had been completed daily. Observed on 9/15/25 at 11:27 AM Resident #3's nebulizer mask and tubing did not have a label with a date. Observed on 9/16/25 at 8:22 AM Resident #3's nebulizer mask and tubing did not have a label with a date. Observed on 9/17/25 at 6:30 AM Staff L, Certified Nursing Assistant (CNA), removed the nebulizer mask from Resident 3's room and returned with a mask. Observed on 9/17/25 at 7:47 AM oxygen tubing for nebulizer dated 9/16/25. The facility did not have a policy related to oxygen tubing.