STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165359	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Methodist Manor Retirement Com	1206 West Fourth Street Storm Lake, IA 50588

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review and staff interview, the facility failed to notify the family/responsible party of a change in the resident's condition requiring physician's notification for 2 of 3 residents reviewed (Resident #2 and #3). The facility reported a census of 90 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #2 scored 10 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident's diagnoses included diabetes. The Care Plan initiated 4/19/24 identified Resident #2 had increased nutritional needs for healing and maintenance of skin. Interventions included giving diabetic medications and insulins as ordered, monitoring for hyper/hypoglycemia: shakiness,dizziness, sweating,increased thirst, fatigue,and blurred vision. The resident used a continuous glucose monitor, change as ordered and read blood sugars as ordered. The Clinical Resident Profile page showed Resident #2 had 3 family members with phone numbers to contact, and they were listed in priority order. The resident's Orders tab included Resident #2 had the following orders: a. Change Libre glucose monitoring system every 14 days. b. Blood Glucose Monitoring 4 times a day (QID) with sliding scale. Call the doctor if Blood Sugar (BS) <70 OR > 400. c. Humalog KwikPen Inject as per sliding scale: 141 - 220 = 2 units; 221 - 260 = 3 units; 261 - 300 = 5 units; (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	301 - 360 = 6 units; 361 - 400 = 8 units; 401 - 500 = 12 units; above 500 call physician; and inject 17 units three times a day. The Progress Notes dated 12/11/24 at 10 p.m. documented at approximately 4:30 p.m. the nurse did a glucose check on Resident #2. The resident was diaphoretic (sweaty) and her face flushed. The resident's BS was 43. The nurse gave 6 ounces (oz) of juice and rechecked the BS at 4:45 p.m. reading 59. The resident was hard to wake up at the table and ate minimal supper. She did drink Glucerna and another glass of juice. The resident refused medications at supper. A recheck BS at 5:30 p.m. raised to 169. Administered insulin. Check of BS at 9:05 p.m. dropped back down to 84. Administered 6 oz of juice. Sent a fax to the Primary Care Provider (PCP). The clinical record lacked documentation the facility attempted to notify the family. The Progress Notes dated 12/14/24 at 7:20 p.m. documented at 4:21 p.m. the Certified Medication Aide (CMA) reported to the nurse that Resident #2 had a BS of 37. The resident was awake, alert and aware. Per the CMA, the resident was able to drink fluids and the nurse instructed the CMA to give the resident 8 ounces (oz) of orange juice. At 4:24 p.m. The resident's blood sugar checked with a reading of 41. The nurse provided the resident with 8 oz of apple juice. At 4:28 p.m. the blood sugar rechecked with reading of 46. The nurse provided the resident with 8 oz of orange juice. At 4:36 p.m. the blood sugar recheck reading 64. The Resident had scheduled Glucerna 3 oz given at that time. At 4:41 p.m. the resident's blood sugar rechecked with a reading of 95. At 4:53 p.m. a call placed to the emergency room (ER), and they would notify the doctor on call. At 4:57 p.m. received a call from the ER with a new order to hold the Humalog 17 units, no insulin that night, and update the Primary Care Provider (PCP). Sent a fax to the resident's physician. The clinical record lacked documentation the facility attempted to notify the family. The Progress Notes dated 12/18/24 at 5:45 p.m. documented the hypoglycemia protocol followed and rechecked BS 15 minutes after administering OJ with sugar and Glucerna supplement. The resident's blood sugar continued to be low at 57. Call placed to the emergency department for further instructions. At 6:59 received a call back with new orders to hold scheduled Humalog 17 units due to low blood sugar of 54 prior to supper. Received an order to administer 10 units if eating. Resident #2 ate approximately 25% of supper. The last blood sugar was 109 and administered 10 units of Humalog. The clinical record lacked documentation the facility attempted to notify the family. On 1/2/25 at 2:18 p.m. the Nurse Manager stated staff could call Resident #2's son and leave a message, because he never answered the phone. She confirmed the resident did have other contacts, and they could document their attempts. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Assessment of Changes in Condition documented the policy for managing condition changes identified a significant change in a residents status referred to observed changes in the resident's condition which warranted immediate nurse assessment, intervention and appropriate follow up. Examples of a condition change included a noted reaction to a medication. The notifications included the nurse would notify the resident's attending physician and the family and/or responsible party. 2) According to the MDS assessment dated [DATE] Resident #3 scored 10 on the BIMS indicating moderate cognitive impairment. The resident's diagnoses included atrial fibrillation, coronary artery disease, heart failure, hypertension, renal insufficiency and diabetes. The resident experienced a 5% or more weight gain in the previous month or a 10% or more weight gain in the previous 6 months. The Care Plan initiated 5/9/24 identified Resident #3 received small portions at meals. The interventions included weight to be taken per acuity protocol. The Care Plan initiated 8/9/24 identified the resident with compromised skin and interventions included diuretic use, to watch for weight change and/or edema. The Clinical Resident Profile page showed Resident #3 had 3 contacts other than himself with phone numbers. The Progress Notes dated 10/18/24 at 12:32 p.m. documented Resident #3 returned from an appointment with a physician with new orders: 1) Call PCP if edema gets worse, 2) Bumex 0.5mg a day, 3) Calcitriol 0.25 once a week (Saturdays), 4) Continue with spironolactone, 5) Follow up on 1/31/2025, 6) NO need for dialysis. Pharmacy Faxed, Medication Administration Record (MAR) updated, and the resident aware. The clinical record lacked documentation the facility notified the resident's family/responsible party of the resident's new orders. The Progress Notes dated 10/31/24 at 2:37 p.m. documented the resident weighed 188.6# and had an 11. 8%, 19# significant weight gain in the past 180 days. A fax notification sent to the physician per policy. The clinical record lacked documentation the facility notified the resident's family/responsible party of the resident's significant weight gain. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Notes dated 11/7/24 documented Resident #3 weighed 193# a 6.6%, 12# significant weight gain in 30 days. The physician aware of the resident's weight gain. The clinical record lacked documentation the facility notified the resident's family/responsible party of the resident's continued weight gain. The Progress Notes dated 11/29/24 at 1:07 p.m. documented Resident #3 weighed 203.4# an 18%, 31# weight gain over the previous 180 days. Fax notification of weight change per policy. The Progress Notes dated 11/30/24 at 8:54 p.m. documented a fax sent to the primary care provider regarding notification to the physician of the significant weight gain. The clinical record lacked documentation the facility notified the resident's family/responsible party of the resident's continued weight gain. On 1/2/24 at 2:30 p.m. the Nurse Manager stated when they had a care conference they go through everything, and the family attended the care conference in November. An email received from the Director of Nursing (DON) 1/2/25 at 2:12 p.m. regarding a policy documented their dietician followed the MDS weight loss/gain protocol. She reviewed with MDS's and monthly for a loss or gain of 5% or more in the last month or 10% or more in last 6 months.