

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165359	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2025
NAME OF PROVIDER OR SUPPLIER Methodist Manor Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. (continued on next page)

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide timely assessment and interventions for 1 of 3 residents reviewed. Resident #1 reported signs and symptoms of a Urinary Tract Infection (UTI) and staff did not follow through to get a urinalysis (UA) order until 6 days later. The clinical chart lacked vital signs and nursing notes during this timeframe. The facility reported a census of 84 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE] Resident #1 had a Brief Interview for Mental Status (BIMS) score of 8 (moderate cognitive deficits) She was totally dependent on staff for toileting hygiene, dressing, and transfers. She was always incontinent of urine and bowel. Her diagnoses included: anemia, dementia, stress incontinence and pain. The Care Plan updated on 1/24/25 showed Resident #1 required staff assistance with activities of daily living. Staff were to check and change and provide peri cares. On 3/16/25 and on 9/13/25 found to have UTI. Staff were to check at least every 2 hours for incontinence, wash, rinse and dry soiled area. Monitor vital signs and notify doctor of abnormalities. Monitor for signs and symptoms of UTI, including foul smelling urine, and urgency. On 10/16/25 at 8:30 AM, Resident #1 was sitting in a recliner in her room. She did not respond while her husband answered questions. He said that she has been very tired since she came back from the hospital. On 10/16/25 at 11:53 AM Family Member (FM) for Resident #1 said that she was visiting the resident on Saturday, 9/6/25 when she reported to the nurse that Resident #1 was having some burning when she urinated. The response from the nurse was that because it was a weekend, they would have to wait until Monday before they could talk to the doctor. The FM said that they tried to tell Staff D, Registered Nurse (RN) that the resident needed a UA but the conversation became confrontational. On 10/16/25 at 12:32 PM, Staff A, RN said that she had worked the Saturday of 9/6/25, and she did not get any reports from the previous shift that Resident #1 was having UTI symptoms. She said there was another family member that was in the resident's room when she administered medications to Resident #1 and her husband the morning of 9/6/25. The family member asked if anyone had passed on that the resident was having burning with urination. Staff A responded that she was not aware of that, then asked the resident if she was having abdominal pain or burning when she urinated. The resident told her she had a little burning. Staff A then told the family that she would go back and look at the nursing notes and charting to see if there was anything noted. Staff A maintained that the resident was a-febrile (no elevated temperature) and she did not have abnormal confusion. Staff A said that since it was a Saturday, the only option they had was to send Resident #1 to the Emergency Department (ED) and she did not show symptoms that warranted an ED visit. Staff A said that they do not have an on-call doctor to get treatment orders after hours, and this situation did not warrant going to the ED. Staff A said that she passed it on in report on the 6th to continue to monitor for UTI symptoms. On 10/16/25 at 12:30 PM Staff C, RN said the family had a history of requesting UA's when the resident was having confusion only and not any other symptoms. She said that the doctor did not want to order UA's when confusion was the only complaint. On 10/16/25 at 1:15 PM, Staff B, Certified Nurse Aide (CNA) said that she worked with Resident #1 in the days leading up to her hospitalization and she provided incontinence care. She said that the resident had reported that it was hurting when they wiped her, and her skin was pink. She had also noticed that her urine had a stronger odor than normal. Staff B said that she told Staff D, RN and nurses' response was to continue to do peri care and let her know if it got worse and to push fluids. The chart for Resident #1 lacked Nursing Progress Notes from 9/4/25 - 9/10/25. The chart for Resident #1 lacked any vital signs from 9/3/25 - 9/13/25. A Urinalysis Laboratory Report dated 9/13/25 at 2:37 PM, showed Resident #1 had a UA that was positive for bacteria. The Orders tab showed on 9/13/25 at 6:00 PM Resident #1 was started on an antibiotic for a UTI. A Performance Improvement Plan dated 9/17/25, showed Staff D was presented with performance concerns including communication with residents and families. The expectation was to ensure all interactions with resident and or resident families were respectful, timely and professional. A hand written note on the bottom of the document showed that Staff D did not sign the document and terminated her employment at that time. On 10/16/25 at 3:30 PM, the Director of Nursing (DON) acknowledged that the nurses should put notes in the residents' chart regarding changes such as burning with urination or odorous urine. She said she had talked to several staff members and none reported to her that Resident #1 had any symptoms before they discovered the UTI. With a change in condition, the DON said that she would expect a note and vital signs if applicable. She said that there were some conflicts between a nurse and the family that caused a</p>		