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	05/09/2024

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. 26527 Based on record review and staff interview, the facility failed to complete the appropriate Minimum Data Set (MDS) assessment for 1 resident reviewed for discharge (Resident #87). The facility reported a census of 90 residents. Findings include: The Clinical MDS page dated 5/7/24 showed Resident #87 entered the facility on 12/28/23. The resident had an Admission assessment completed 1/1/24. The Progress Notes dated 2/29/24 at 1:34 p.m. documented the resident discharged home with her spouse. The Clinical MDS page dated 5/7/24 documented the discharge assessment reference date (ARD) of 2/29/24, to be completed by 3/14/24. No additional assessments were completed. On 5/8/24 at 10:00 a.m. Staff K, Nurse Manager (NM) stated she did not do MDS's, but the discharge MDS should have been completed. On 5/8/24 at 10:25 a.m. Staff J, NM looked on her list for the date the resident discharged and did not have Resident #87 on her list, so she did not do the discharge MDS for her. She did not know if Staff H, NM had the resident on her list, but she could see she did not have her discharge MDS completed. She said they missed it. On 5/8/24 at 10:33 a.m. Staff H checked her list for the date Resident #87 discharged , and did not have her on the list. She said typically when a resident discharged an email was sent to notify them. She thought possibly the email did not get sent, and the resident's MDS was not completed.

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on record review and staff interview, the facility failed to submit a Level 2 Preadmission Screening and Resident Review (PASSR) evaluation for 1 of 2 resident reviewed with a new mental health diagnosis and medication revision (Resident #5). The facility reported a census of 90. Findings include: The Minimal Data Set (MDS) dated [DATE] documented Resident #5 had a Brief Interview for Mental Status (BIMS) of 11 indicating a moderate cognitive impairment. The MDS further documented the resident had diagnoses including anxiety, depression, & psychotic disorder. The MDS reports the use of high-risk medications including an antipsychotic, antidepressant, diuretic, and antiplatelet medications. Clinical record review of the current medication orders, as of 5/9/24, include Sertraline HCl 50 mg, Give 1 tablet by month one time a day related to anxiety disorder and Seroquel 50mg, give tablet by mouth two times per day related to delusional disorders. Resident #5's current Care Plan, dated 4/19/24, indicated a focus area of psychosocial with a goal to visit with staff daily. Interventions include: 1.Monitor for adverse consequences of Seroquel. 2.Monitor for adverse consequences Sertraline. 3.Monitor for increased anxiety, paranoia, refusing cares, feeling down and feeling bad about self-redirect as able-give 1:1 and offer activities. 4.Sees a practitioner on psych round. The only documented PASSR located in the clinic record is dated 10/23/15, which noted a depression diagnosis and the use of Sertraline HCl 25mg daily. Unit Manger interviewed on 5/8/24 and reported all PASSRs are located in the resident's permanent record and nowhere else. The manager was alerted the PASSR for Resident #5 was from 2015 and questioned if it had been updated. The manager indicated that PASSRs are updated when, for example, medications are updated. Reviewed that Resident #5 had additional mental health diagnoses and medication added since the initial PASSR from 2015. The manger did not believe an updated PASSR has been submitted if it was not located in the chart. Per the undated facility policy PASSR: Each quarter and as needed, the MDS Coordinator will review the PASRR to determine if any diagnosis or medication changes need to be updated. If it is determined that a change has taken place, a new PASRR assessment will be submitted.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review, staff interview and policy review the facility failed to develop a care plan to address risk factors and interventions for 2 out of 18 residents (Residents #22 and #15) reviewed for comprehensive care plans.The facility reported a census of 90 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #22 dated 2/12/24 identified a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. The MDS included diagnoses of urinary tract infection in the last 30 days, neurogenic bladder (lack bladder control due to brain, spinal cord or nerve problems) and parkinsonism. The MDS documented Resident #22 received antibiotic medication during the assessment period (last 7 days). A Physician Order dated 11/16/23 directed staff to administer Cephalexin (antibiotic) 500 mg (milligrams) by mouth one time a day for chronic cystitis (bladder infection) without hematuria (blood in urine). A Physician Order dated 11/18/23 directed staff to administer Methenamine Hippurate (anti-infective) 1 gram by mouth every 12 hours each day for chronic cystitis (bladder infection) without hematuria (blood in urine). Review of Resident #22 ' s Care Plan revised 2/15/24 revealed the prophylactic antibiotic and anti-infective medication, potential side effects and what to monitor for while taking the high risk medication was not addressed on the comprehensive care plan. The Care Plan did not address Resident #22 was at risk for bladder infections and what signs and symptoms to observe for that would be an indicator of an infection. On 5/8/24 at 2:56 PM, Staff H, RN (Registered Nurse)/Nurse Manager acknowledged/verified that the antibiotic/anti-infective medication and history of bladder infections were not addressed on the care plan. She stated she would update the care plan. The undated facility policy titled Care Plan Development and Process documented the interdisciplinary team shall develop a comprehensive, individualized plan of care that guides the care and treatment for each resident. The policy further documented that the care plan is reviewed and updated quarterly or with any change in the resident's condition. 49056 2. The MDS assessment dated [DATE] for Resident #15 documented diagnoses of hypertension, Alzheimer ' s Disease, and depression. The MDS showed a Brief Interview for Mental Status (BIMS) score of 5 which indicated severe cognitive impairment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the May 2024 Medication Administration Record (MAR) revealed an order for sertraline (antidepressant medication) with an order date of 11/30/23 and lorazepam (anti anxiety medication) with an order date of 2/14/23. Review of the MDS dated [DATE] revealed the resident was taking antianxiety and antidepressant medication in the review period. Review of the Care Plan with a revision date of 4/8/24 lacked information regarding the usage and side effects of the antidepressant and antianxiety medication. Interview with Staff H on 5/9/24 at 12:30 PM revealed Staff H acknowledged the medications were not on the care plan and the expectation would be that the antidepressant and antianxiety be addressed on the care plan.

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49056

Based on clinical record review, staff interviews, and facility record review, the facility failed to provide adequate nursing supervision to prevent a fall for 1 of 1 residents reviewed (Residents #89). The facility reported a total census of 90 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated [DATE] for Resident #89 documented diagnoses of hypertension, renal failure, hyperlipidemia and chronic respiratory failure with hypoxia. The MDS showed the Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS revealed Resident #89 utilized a walker daily.

Review of facility provided document titled Fall Risk assessment dated [DATE] scored a 15 indicating high risk for falls.

Review of Resident #89's Care Plan dated 3/28/24 revealed under Assistance of Daily Living (ADL) Resident #89 was assistance of one with a walker for ambulation.

Review of facility provided document titled Fall Investigation dated 4/30/24 at 6:15 AM, revealed Resident #89 had a fall in her room. Resident #89 was up at her dresser with a staff member getting clothes prior to a shower. Resident was found lying on her right side, with right upper extremity bent at the elbow and underneath her head. Her left upper extremity was extended straight beneath her. Resident #89 reported I got dizzy.

Review of handwritten documentation by Staff D, Certified Nursing Assistant (CNA) revealed Staff D had gone into the room to give Resident #89 a shower. Staff D and Resident #89 walked to the closet. Resident #89 was in front of the closet and Staff D was next to her, on the right side. Staff D went to put clothes away in Resident ' s dresser, but before Staff D opened the drawers, Staff D heard a bump and Resident #89 was on the floor. Staff D asked Resident if she was okay and then went and got the nurse.

Review of a facility provided document titled Fall Committee Review revealed staff alerted a nurse to Resident #89 on the floor by the closet, her walker by her feet, and the fall was witnessed by the staff member. Staff D left Resident #89 to go put clothes away in the dresser and Resident #89 fell . Resident #89 stated I got dizzy. Resident #89 received abrasion to head, skin tear to left thigh and skin tear to right elbow. The review revealed Staff D was written up for no gait belt and left resident unattended.

Review of Progress Notes dated 4/30/24 at 4:13 PM Resident #89 reported pain when moved but is tolerable when rested in an upright position. There were no bruising or swelling noted to the right ribs. Nurse offered Resident #89 to be further evaluated by the emergency room (ER) three times, Resident #89 refused to go to the ER three times. Nurse encouraged Resident #89 to be evaluated and asked if she would prefer a doctor's appointment tomorrow on 5/1/24. Resident #89 in agreement. Resident #89 was able to take in deep breaths with no pain.

(continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Progress Notes dated 4/30/24 at 7:48 PM Resident #89 noted to be resting in bed laying on the left side in fetal position. Nurse assisted Resident #89 into a sitting position and observed Resident #89 to be very uncomfortable. Resident #89 grimaced and moaned, rated pain a 10/10. Nurse offered Resident #89 to be transferred to ER to be further evaluated, Resident #89 refused. Resident #89 stated I'm just stubborn. Resident #89 lung sounds to the right lower lobe are diminished, her left lung clear. There were no bruising or swelling noted to the right ribs. Resident #89 assisted in bed, laid on back with head of bed elevated (HOB). Resident #89 reported pain relief when position changed. Nurse administered Tylenol as needed for right rib pain. Resident #89 continued on back with HOB elevated. Stated I'm more comfortable like this. Review of Progress Notes dated 5/1/2024 at 9:29 AM This nurse made an appointment with a physician for follow up from fall yesterday 4/30/24. Resident #89 continued to complain of rib pain and blood pressure noted to be low. Appointment for today 5/1/24 at 11:10 AM. Review of Progress Notes dated 5/1/2024 at 6:03 PM revealed Resident #89 returned from ER with two rib fractures, rib number 7 and 8 posterior. Resident #89 had new orders for pain medication and new orders for incentive spirometer every two hours while awake for one week. Review of the undated facility policy titled Accidents and Incidents revealed that all resident accidents and incidents are properly assessed and reviewed. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate investigation of the accident or incident. The resident shall be assessed as they were found. When the nurse deems it is safe to do so, they may instruct the staff how to safely assist the resident. The following data, if applicable, shall be documented in the nurse ' s notes: The date and time the accident or incident took place. The nature of the injury/illness (e.g., bruise, fall, nausea, etc.). The circumstances surrounding the accident or incident. Where the accident or incident took place. The name(s) of witnesses and their accounts of the accident or incident. The injured person ' s account of the accident or incident. The time the injured person ' s Attending Physician was notified, as well as the time the physician responded and his or her instructions. The date/time the injured person ' s family was notified and by whom unless the resident is their own representative. The condition of the injured person, including his/her vital signs; range of motion, pain, observable injuries, and neuros for all falls with head injury, or if the fall was unwitnessed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The disposition of the injured (i.e., transferred to hospital, put to bed, sent home, returned to work, etc.); Any corrective action taken. Follow-up information. Other pertinent data as necessary or required; and The signature and title of the person completing the report. Following the occurrence of an accident or incident the clinical leadership team will review the circumstances and as appropriate put interventions in place and update the care plan. This facility follows current rules and regulations governing accidents and/or incidents involving a medical device. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall complete or review a Fall Committee Form or skin investigative form to use for discussion with appropriate team members. For all incidents that occur offsite while participating in a facility sponsored event, the driver of the van will call the facility for directions from the charge nurse. If nursing staff is available, they will come to the site of the incident. If nursing is not available, 911 will be called. The facility reported they do not have a gait belt policy, they follow the standard of practice. Interview on 5/8/24 at 10:24 AM with Staff D revealed Resident #89 ' s assistance level was independent. Staff D stated she gave Resident #89 the walker to help her walk, but Staff D did not have a hold of Resident #89. Staff D reported that Resident #89 would refuse care and to wear the gait belt. Staff D reported that she did not attempt or offer the gait belt because in the past Resident #89 refused it. Staff D reported that changes in Residents are communicated from physical therapy, verbal report, or report form in a binder. Interview on 5/8/24 at 10:51 AM with Staff E revealed Staff D did not use a gait belt on Resident #89. Staff E reported Resident #89 is assisted by one staff member with a gait belt and front wheeled walker. Staff E reported Staff D received a written warning for not utilizing the gait belt with Resident #89. Staff E explained that she did remind staff in the neighborhood that they need to utilize the gait belt when transferring residents.

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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. 46875 Based on observations, record review, staff interviews, resident interview and policy review, the facility failed to change oxygen tubing for 1 of 2 resident reviewed (Resident #8) for respiratory services. The facility reported a census of 90 residents. Findings Include: The Minimum Data Set (MDS) assessment for Resident #8 dated 3/9/24 identified a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS included diagnoses of heart failure (inability for the heart to pump enough blood), chronic respiratory failure with hypoxia, pneumonia and obstructive sleep apnea. The MDS documented Resident #8 was on oxygen therapy while a resident at the facility. The Care Plan dated 4/22/24 identified Resident #8 wore continuous oxygen and a CPAP machine (continuous positive airway pressure) (machine that used mild air pressure to keep breathing airways open while you sleep) at night. The April 2024 Treatment Administration Record (TAR) directed staff to change the oxygen tubing on the 15th of each month and to mark the tubing with the date using paper tape. The TAR documented Resident #8's oxygen tubing was changed on 4/15/24. On 5/6/24 at 11:09 AM, Resident #8 reported she did not recall the oxygen tubing getting changed. On 5/7/24 at 3:15 PM observed Resident #8's oxygen tubing connected to the oxygen concentrator had a piece of paper tape marked/dated 3/15/24. The oxygen tubing connected to the portable concentrator on the wheelchair had a piece of paper tape marked/dated 3/18/24. The oxygen tubing connected to the CPAP machine on the bedside table was not dated. On 5/7/24 at 4:00 PM, the Director of Nursing (DON) acknowledged while in Resident #8's room that the oxygen tubing had not been changed. She reported she expected the tubing to be changed monthly as directed on the TAR. Resident #8 reported to the DON that nobody had changed her oxygen tubing. On 5/8/24 at 9:40 AM, the DON reported she changed Resident #8's oxygen tubing yesterday (5/7/24) and charted it in the nurses notes. The undated facility policy titled Administration of Oxygen directed the staff to change the oxygen cannula and tubing monthly.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 49056 Based on clinical record review, staff interview and facility policy review, the facility failed to provide an appropriate clinical rationale for a gradual dose reduction (GDR) declination for 1 out of 3 residents reviewed for unnecessary medications. (Resident #14) The facility reported a census of 90 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #14 dated 4/29/24 identified a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderately impaired cognition. The MDS included diagnoses of anxiety and depression. The MDS documented Resident #14 received an antidepressant and antianxiety medication 7 days during the assessment period (last 7 days). A Physician Order dated 2/3/2023 directed staff to administer Risperdal (antipsychotic) 1mg (milligrams) by mouth every night. A Physician Order dated 2/3/2023 directed staff to administer Sertraline (antidepressant) 150mg by mouth daily. A facility form named Physician Information/Request dated 12/3/23 documented the physician response for a gradual dose reduction (GDR) request for Resident #14 ' s Risperdal was denied. The Physician Information/Request form lacked a clinical rationale for not making any changes in the orders. The Physician signed the form on 12/13/23. A facility form named Physician Information/Request form dated 2/4/24 documented the physician response for a GDR request for Resident #14 ' s Risperdal was denied. The Physician Information/Request Form lacked a clinical rationale for not making any changes in the orders. The Physician signed the form on 2/14/24. On 5/8/24 at 10:00 AM, Staff J acknowledged and verified the Physician Information/Request form lacked a clinical rationale for continuing the Risperdal and Sertraline without any changes. Staff J reported the facility has a hard time getting a clinical rationale from the physician. The undated facility policy titled Unnecessary Medication and Gradual Dose Reductions revealed this facility will provide each resident with a therapeutic dose of medication as prescribed by the primary physician. Periodically, a reduction will be attempted on certain medications if the primary care physician, pharmacy consultant, and nursing team determines that a lesser dose or discontinuation of medication would be beneficial for the resident. Residents that use antipsychotic medications shall participate in gradual dose reductions and behavioral interventions unless clinically contraindicated. A rationale must be provided by the Physician or Practitioner to support an attempted reduction or if clinical symptoms indicate a need to continue the medication.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on observations, staff interview, and policy review, the facility failed to provide appropriate puree main entree portion size to ensure adequate calorie and protein intake for 2 of 3 residents observed (Residents #48 and #76). The facility reported a census of 90 residents. Findings include: 1. Puree food preparation on 5/8/24 at 9:45am was observed. The entree was hamburger on a bun. The serving size listed on diet spread sheets indicated 1 serving for the entree. After pureeing the entree, staff measured out the entree to determine the appropriate serving size for each resident. For the puree diets on Northshore, [NAME], and Sunset Cove units, staff had a total volume of 6c and needed a total of 7 servings. The appropriate scoops size needed were a #8 and #12. For the puree diets on the Breezy and Crosswinds unit, staff measured out a total volume of 6 1/4c and needed a total of 7 servings. The appropriate scoop size needed were a #6 and #30. The entree was divided up into separate kitchen pans, covered with foil, & labeled with the unit name, food item, & the appropriate scoop size to be used. Staff indicated scoop sizes were written on the foil to alert the unit dietary staff as to what scoops should be use. Staff obtained all of the scoops needed and separated out the different units to ensure unit dietary aides had the appropriate equipment. Lunch service and tray preparation observed on 5/8/24. The Breezy unit had one resident receiving a puree diet. Staff observed using a #6 and #30 scoops to portion out the entree. Staff interview completed with Staff I, Dietary Manager, on 5/9/24 at 10:45 am indicated unit dietary staff have been educated to look at the foil for the appropriate scoops size for service. Education also completed to roll the foil back instead tearing open the foil as not destroy the labeling on the foil. The undated policy titled Pureed Food Process indicated that staff should mark the serving size measurement on the top of each container so staff know what size to use. 26527 2. An email dated 5/8/24 from the Administrator documented the facility had 1 resident on the lower level with a pureed diet (Resident #48). The Clinical Physician's Orders dated 5/9/24 documented Resident #48 had an order for a pureed texture diet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/24 at 11:49 a.m. food for the noon meal arrived to the lower level. Staff transferred food to the steam table and took temperatures of the food. Staff M, [NAME] stated having 1 pureed diet on the lower level, Resident #48. Staff M sorted menus and the dietary aide served resident's liquids. Staff M put on pink gloves and started serving the resident's food. Staff M served the resident on a pureed diet a #12 scoop of pureed meat. When the meal service ended, Staff M verified only serving the resident on a pureed diet a #12 scoop of pureed meat. There were 2, #12 scoops of pureed hamburger remaining. On 5/9/24 at 2:00 p.m. during the exit conference the Dietary Manager confirmed the resident should have received a #8 and a #12 scoop of the pureed hamburger at the noon meal on 5/8/24. The undated Pureed Food Process policy documented once food was pureed to the correct consistency, measure all servings in a measuring container. Use a puree portion chart to find the correct single serving measurement, marking this portion on the top of the serving container. 49056 3. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #76 documented diagnosis of thyroid disease, non-alzheimer ' s dementia and weakness. The MDS showed the Brief Interview for Mental Status (BIMS) was not completed due to Resident #76 is rarely/never understood. The MDS indicated Resident #76 needed substantial or max amount of assistance with meals. On 5/8/24 at 11:50 AM observation completed with Staff G, dietary aid, during noon meal service, observed Staff G serve Resident #76 puree hamburger with scoop #8. Interview on 5/8/24 at 1:15 PM with Staff G, reported that she used scoop #8 for the puree hamburger and had a scoop of puree hamburger left over after meal service. Interview on 5/9/24 at 10:45 AM Staff I and Staff L revealed the scoop sizes for Resident #76 were to be #8 and #12 to get the correct amount of puree hamburger. Staff L revealed when setting up the hot cart, Staff L wrote on top of the foil what size scoops the staff are to use. Staff L said the kitchen staff have been taught to roll the foil on the kitchen pan instead of ripping the foil from the middle. Staff I reported they also have a color coded chart in the neighborhood kitchens that shows what size serving utensil to utilize, this is called Portion Control Menu Planner.

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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	05/09/2024

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on staff documentation, staff interview, policy review, & observations, the facility failed to ensure resident dishes and kitchen equipment reached the appropriate sanitizing hot temperature when utilizing the dish machine to reduce the risk of bacteria growth and cross contamination with 3 out of 4 dish machines in the facility. The facility failed to ensure food thermometers were sanitized appropriately when obtained food temperatures. The facility reported a census of 90 residents. Findings include: 1. During kitchen observations on 5/8/24at 12:30pm, the first-floor kitchen dish machine temperature log reviewed. For the month of May (the 1st through the 7th), 4 days were completely filled out, 2 days were left completely blank, and 1 day partially completed. No temperatures were documented for May 8th. Rinse temperatures that were written down noted between 160-185 . For the month of April, 24 days were completely filled out, 5 days were partially completed, and no temperatures documented for 1 day. Rinse temperatures written down noted between 170-185 . For the month of March, 26 days were completely filled out and 5 days were partially completed. Rinse temperatures noted between 170-185 . No documentation noted indicating the use of high temperature test strips to ensure the dish machine reached 180 . With staff present, dish machine ran twice with a rinse temperature noted at 180 . The second-floor kitchen dish machine temperature log reviewed. For the month of May (the 1st through the 7th), 2 days were completely filled out and 5 days were partially completed. No temperatures were documented for May 8th. Rinse temperatures noted between 170-180 . For the month of April, 3 days were completely filled out, 26 days were partially completed, and no temperatures documented for 1 day. Rinse temperatures noted between 160-180 . No documentation noted indicating the use of high temperature test strips to ensure the dish machine reached 180 . No temperature logs could be found for the months of March or February. With staff present, dish machine ran twice with a rinse temperature noted at 180 . The lower level dish machine temperature logs reviewed for the months of May and April. Temperatures were documented appropriately with rinse temperatures within the appropriate range. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The kitchen dish machine temperature logs reviewed. For the month of May (the 1st thru the 7th) 7 days were completely filled out. May 8th noted partially completed for the day. Rinse temperatures noted between 170-184 . For the month of April, 30 days were completely filled out. Rinse temperatures noted between 170-190 . For the month of March, 31 days were completely filled out. Rinse temperatures noted between 164-191 . No documentation noted indicating the use of high temperature test strips to ensure the dish machine reached 180 . The dish machine was ran twice. During the washing and rinsing process, the rinse temperature gauge did not move and unable to obtain the final rinse temperature. When asking dietary staff about the temperature gauges and which gauged was used for documenting temperature, staff was not able to accurately report which gauge was used to documented the rinse temperature. Staff pointed to both the final rinse temperature gauge and the rinse holding tank temperature. When asked about the rinse temperature not working properly, staff voiced he had told them about it not working. Staff did not indicate who exactly was notified. The dish machine was ran one time using at a high temperature test strip. After the cycle, the test strip observed to be orange, indicating the rinse temperature was at least 180 . During staff interview with Staff I, Dietary Manager, on 5/8/24 from 1230pm- 130pm, dish machine temperature logs are to be completed with each shift, 3 times per day. Staff I verbalized rinse temperatures were to reach 180 to properly sanitize. Documented temperatures should reflect that dish machines reach 180 . If machines do not reach the appropriate temperature, staff should inform her for further follow-up. Staff I was not aware of any issues with the floor dish machines nor the rinse temperature gauge on the kitchen machine. With regards to the improper temperatures documented, Staff I was unsure if these temperatures were reading from the first run of the dish machine for the day or after it had been sitting idle for some time. If this was the case, the expectation would be for staff to run the machine several times to ensure the proper rinse temperature was reached. At that point, staff should document that temperature. During a follow-up visit on 5/8/24 at 4pm, Staff I reported that a [NAME] Brothers technician came out this afternoon, repaired the kitchen's dish machine rinse temperature gauge, and increased the water temperature of the dish machine on the second floor. A second observation of the kitchen dish machine made and the machine ran. The rinse temperature gauge was working with a rinse temperature of >180 obtained. The undated policy Cleaning Dishes & Utensils: Dish Machine Operations regarding dish machine temperatures indicates that the final rinse temperature for a high temperature dish machine should reach minimum of 170 . Signs posted in the kitchen areas on each resident floor as well as the dish machine itself all show that final rinse temperatures should be 180 . This policy does not meet requirements for the appropriate sanitize dishes as set forth by the Food and Drug Administration Food Code 2017 (4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures), which should be 180-194 . 2. On 5/6/24, lunch service on the lower level dining room observed. Dietary aide seen utilizing the same alcohol prep pad to wipe off the food thermometer after each food temped. The dietary aide changed out the prep pad once when it was visibly soiled. Approximately 7 temperatures were obtained. (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/8/24, lunch service on the first-floor dining room observed. Dietary staff seen utilizing the same alcohol prep pad to wipe off the food thermometer after each hot food temped. Staff changed out the prep pad once when it was visible soiled. Another staff member, Staff I, Dietary Manager, observed taking cold food temperatures before service and then all the hot and cold foods after service. Staff I utilized the same alcohol prep pad while taking temperatures. Staff I, Dietary Manager, was interviewed on 5/8/24 at 12:30pm. Staff I acknowledged utilizing the same prep pad while taking temperatures without changing out. Discussed the necessity of changing out prep pad after each food temperature obtained to avoid cross contamination. 49056 3. On 5/8/24 at 12:00 PM observation was completed for a noon meal in the neighborhood. Observed Staff G temp food with a thermometer probe. Staff G used the same alcohol wipe to clean the probe after temping foods on the steam cart, then got a new alcohol wipe to clean the probe and then used that wipe for cleaning the probe after temping foods. Observed Staff G putting on gloves before the start of the noon meal. Staff G observed placing the utensils out for the meal to serve. Staff G removed her gloves and did hand hygiene, then reapplied gloves. Staff G touched the serving utensils, the plates, then proceeded to grab the outside of the hotdog bun bag and reached in with her soiled gloved hand and grabbed the hotdog bun, then held the hotdog bun with a soiled gloved hand and placed the hotdog in the bun and pushed the hotdog down with her soiled gloved thumb, then placed it on the residents plate. Staff G reached into the hamburger bag and grabbed a hamburger bun, put it on the plate and opened it up, then placed the hamburger on the bun with tongs, then picked up a slice of tomato and lettuce with her soiled gloved hand and placed them on the residents plate. This was done throughout the meal service. An undated policy name Infection Control revealed the facility will follow Standard Precautions for Infection Control and Prevention to protect residents, staff, and visitors to ensure staff do not carry pathogens on hands via equipment during resident care. The facility will do the following: Appropriate hand hygiene with soap and water or alcohol gel in between residents. Use of personal protective equipment. Proper cleaning and disinfection. Appropriate screening during infectious outbreaks not limited to COVID. Routine education and return demonstration on donning/doffing, handwashing and use of personal protective equipment. Interview on 5/8/24 at 2:45 PM Staff I revealed the staff are expected to wash their hands in between gloving and to use a new alcohol wipe each time to clean the probe after staff temp the food.

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50500

Based on observations, record review and staff interview, the facility failed to provide infection prevention practices by not performing appropriate cleaning of the tube adaptor for 1 of 1 resident (Resident #53). The facility reported a census of 90.

Findings include:

The Minimum Data Set (MDS) dated [DATE] indicated the Brief Interview for Mental Status (BIMS) should not be completed on Resident #53. The MDS documented the Resident was dependent on staff for all cares and relies on tube feeding to meet 51% or more of total calories and fluid intake daily. Medical diagnoses on the MDS included diabetes, renal insufficiency, cerebral palsy, seizure disorder/epilepsy, asthma/chronic obstructive pulmonary disease (COPD)/chronic lung disease, hypoxemia, and gastroparesis.

Clinical records review indicated Resident #53 had a diet order of nothing by mouth (NPO). Dietary needs are provided through a gastric tube (g-tube). Resident #53 receives Glucerna 1.5 120ml 1x/day; Glucerna 1.5 at 70ml/hour for 12 hours. Review of May 2024 Medication Administration Report, medications are administered via the g-tube in one bolus dose 2x/day. Water flushes are ordered for 65ml before and after medication administrations as well as 200ml 2x/day.

Medication administration was observed for Resident #53 on 5/8/24 with Staff O, Licensed Practical Nurse (LPN). A tube adapter, dated 5/5, was utilized, after medications were administered appropriate, a cup and syringe accidently fell to the floor. Staff O, LPN, picked the items from the floor with gloved hand and threw away in the trash can. No glove change observed. Staff O, LPN, took the graduate and feeding tube adaptor to the bathroom sink to rinse off and clean out, still wearing the same gloves used to pick up and throw away items that had fallen to the floor. During this time, a dried, yellowish substance, was observed on the feeding pump, feeding pole, and stethoscope.

During Resident #53's prescribed free water administration on 5/8/24, Staff O, LPN, verbally acknowledged the use of the same tube adapter, dated 5/5, for the free water. The free water administration was stopped and Staff O, LPN was informed of the observations made earlier with cleaning the adapter with compromised gloves. Staff O, LPN threw out the adapter and obtained a new one dated 5/8.

On 5/8/24 at 3:20 PM, Staff N, Registered Nurse, (RN), completed bolus feeding. Observed the feeding pole, pump and stethoscope visibly soiled with dried yellow substance (formula). Staff N, RN, acknowledged the pole, pump and machine was visibly dirty. She reported there was not a routine cleaning schedule. She stated the staff would clean the equipment as needed.

The undated Infection Control policy states:

14. The facility will follow Standard Precautions for Infection Control and Prevention to protect residents, staff, and visitors to ensure staff do not carry pathogens on hands via equipment during resident care.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review and staff interview, the facility failed to maintain a system to monitor long term use of antibiotics for 2 of 3 residents reviewed (Resident #61 and #15). The facility reported a census of 90 residents. Findings include: 1. Resident #61's Order Details report dated 11/12/22 documented the order for Bactrim DS (double strength) give 1 tablet by mouth one time a day related to bacteriuria (presence of bacteria in the urine) with no end date. The (current) Clinical Physician's Orders dated 5/9/24 for Resident #61 documented Resident #61 continued with the order for Bactrim DS give 1 tablet by mouth one time a day related to bacteriuria. The clinical record lacked documentation the facility monitored the long term use of Resident #61's antibiotic. On 5/9/24 at 9:25 a.m. the Infection Preventionist stated they had not had a system in place to monitor long term use of antibiotics to assure they were still necessary. The undated facility policy, Antibiotic Stewardship Program identified the purpose to establish directives for antimicrobial stewardship at the facility in order to develop antibiotic use protocols and systems for monitoring antibiotic use. The Consulting and/or Dispensing Pharmacist would review antibiotics prescribed to residents during their monthly medication review, considering both ongoing and completed courses. The Consulting and/or Dispensing Pharmacist would also make recommendations to the Antibiotic Stewardship Committee based on the review. 49056 2. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #15 documented diagnoses of hypertension, Alzheimer ' s Disease, and depression. The MDS showed a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment. Per this MDS, the resident was always incontinent of urine. Review of the Care Plan with a revision date of 4/8/24 revealed Resident #15 was often incontinent of the bladder and manages this with incontinence pads. Resident #15 takes Cephalexin daily for history of chronic urinary tract infections (UTI) and to watch for any side effects like diarrhea, upset stomach and signs and symptoms of a UTI. Resident #15 was admitted to the facility on [DATE] on a prophylactic antibiotic Cephalexin for chronic cystitis without hematuria.