

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 03/27/2025
NAME OF PROVIDER OR SUPPLIER Methodist Manor Retirement Com		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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056</p> <p>Based on clinical record review, staff interviews, and facility policy, the facility failed to notify the physician regarding a change in a resident's condition after a fall (Resident #5). The facility reported a census of 89 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #5 documented diagnosis of anemia, neurogenic bladder and chronic obstructive pulmonary disease (COPD). The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment.</p> <p>The Progress Notes on 1/23/25 at 9:48 PM revealed a nurse was called to Resident #5's room by the certified nursing assistants(CNA). Resident #5 was noted to be on her left side on the floor. Resident #5 stated she slid forward from her wheelchair prior to transferring to the toilet. Resident #5 stated she landed on her knees and then her left side/hip. Resident #5 received a bruise/contusion to her left hand third digit. Resident #5 denies pain. The facility Progress Notes further revealed Resident #5 had no shortening or internal/external rotation to bilateral lower extremities and no other bruising or injuries noted on inspection of the body. Resident #5 was assisted to her wheelchair with gaitbelt and assist x 3.</p> <p>The Progress Notes on 1/24/25 at 12:39 PM revealed Resident #5 was noted with swelling to the left hand and bruising to the middle finger on the left hand.</p> <p>The Progress Notes on 1/24/25 at 7:14 PM revealed Resident #5 had complained of pain and discomfort throughout the left shoulder/arm and had bruising/swelling to the left hand.</p> <p>The Progress Notes on 1/25/25 at 3:55 PM revealed Resident #5 complained of pain and rated it a 4/10. The facility Progress Notes revealed Resident #5 had mild swelling to the left hand and diffused bruising to the middle finger/palm on the left hand.</p> <p>The Progress Notes on 1/26/25 at 00:24 AM revealed Resident #5's left hand is slightly swollen and tender.</p> <p>The Progress Notes on 1/26/25 at 10:53 AM revealed Resident #5 complained of pain to the left shoulder and left upper extremity, rating the pain a 4/10.</p> <p>(continued on next page)</p>

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Progress Notes on 1/28/25 at 8:40 AM revealed Resident #5 continued with bruising to the left third digit, the bruise is diffused and purple in color. Resident #5 complained of pain to the left hand, left shoulder and left arm.</p> <p>The Progress Notes on 1/29/25 at 8:05 AM revealed Resident #5 complained of pain to the left elbow, rated pain 10/10. At 9:49 AM the facility updated the physician on Resident #5's pain to the left elbow. At 1:00 PM Resident #5 sent to the physician.</p> <p>Review of x-ray report dated 1/29/25 revealed Resident #5 had an intra-articular digital humerus fracture (a break in the lower part of the humerus bone that extends to the elbow joint).</p> <p>Review of the January 2025 Medication Administration Report revealed Resident #5 had received as needed pain medication one time during the month prior to the fall on 1/11/25. Resident #5 had received as needed pain medication on 1/24/25, 1/25/25 and 1/26/25 due to pain to the left upper extremity. Resident #5 rated pain a 4/10.</p> <p>Review of electronic health records lacked documentation of notifying the physician of the pain and swelling to Resident #5's left upper extremity and hand.</p> <p>On 3/27/25 at 11:11 AM, the DON acknowledged and verified that the facility didn't notify the physician with the change of increased pain and swelling to the left upper arm. The DON stated that she went through the timeline of the incident and felt they were monitoring the situation and when needed they sent her to the doctor. The DON stated that her expectation would be to have the staff notify the physician of changes, but in this situation she felt monitoring was enough.</p> <p>Review of the facility provided policy named Assessment of Changes in Condition dated 2023 revealed a condition change is defined as: alteration from normal status. A significant change in resident status refers to observed changes in the resident's condition which warrants immediate Licensed Nurse assessment, intervention, and appropriate follow-up. Clinical record documentation, assessment and follow-up is necessary.</p> <p>Examples of Condition Changes could include, but are not limited to:</p> <ol style="list-style-type: none"> 1. Accidents where there is direct harm to the resident. 2. A noted reaction to a medication. 3. A physical decline in resident's condition. 4. An emotional change in the resident. 5. Any condition change for which the physician directs staff to notify him/her, regarding the resident. <p>Assessment Process:</p> <ol style="list-style-type: none"> 1. Identification of acute changes: <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/27/25 at 11:11 AM, the DON acknowledged and verified that the facility didn't notify the physician with the change of increased pain and swelling to the left upper arm. The DON stated that she went through the timeline of the incident and felt they were monitoring the situation and when needed they sent her to the doctor. The DON stated that her expectation would be to have the staff notify the physician of changes, but in this situation she felt monitoring was enough.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>46875</p> <p>Based on clinical record review, staff interview, facility investigation review and policy review the facility failed to report an allegation of abuse within 2 hours to the Iowa Department of Inspections, Appeals and Licensing (DIAL) for 2 of 2 residents reviewed (Residents #21 and #49). The facility also failed to report the allegation of abuse/suspected crime to the law enforcement center. The facility reported a census of 89 residents.</p> <p>Findings include:</p> <p>A facility investigation titled Resident to Resident Incident documented that on 3/21/24 during the supper meal Resident #21 was sitting at his table and made a negative comment to Resident #49 as he was walking by to sit in the dining room. Resident #49 heard the comment, made a negative comment back, and went over and slapped Resident #21 on the right side of his neck. The nurse was present, intervened and directed both men away from each other.</p> <p>Review of document titled Intake Information revealed the facility filed an allegation for abuse to DIAL related to a Resident to Resident Altercation for Resident #21 and Resident #49 on 3/24/25 at 2:24 PM.</p> <p>Review of the facility investigation lacked documentation law enforcement was notified of the allegations of abuse/suspected crime.</p> <p>On 3/26/25 at 11:10 AM, the DON (Director of Nursing) reported she was notified by the charge nurse regarding the incident with Resident #21 and Resident #49 around Noon on 3/22/25. She verified she filed the online self report to DIAL on the afternoon of 3/24/25. The DON acknowledged the allegation of abuse was not reported to DIAL within 2 hours according to the facility policy. The DON reported she thought she had 24 hours or the next business day to report the allegation of abuse.</p> <p>On 3/27/25 at 8:35 AM, the DON verified law enforcement was not notified.</p> <p>The undated facility policy titled Abuse Prevention, Identification, Investigation and Reporting Policy documented all allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative. All allegations of resident abuse shall be reported to the Iowa Department of Inspections and appeals not later than two (2) hours after the allegation was made. The policy further documented that if there was a reasonable suspicion that the allegation of abuse also constitutes a crime committed against the resident by any person, whether or not the alleged perpetrator was employed by the facility, the Elder Justice required the matter must also be reported to law enforcement. If the allegation of abuse that results from a crime results in serious bodily injury to a resident, a report must be made to law enforcement not later than two (2) hours after the allegation was made. If the allegation of abuse does not result in serious bodily injury, a report must be made to law enforcement not later than twenty-four (24) hours.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527</p> <p>Based on record review and staff interview, the facility failed to ensure the resident's Minimum Data Set (MDS) assessment accurately reflected the resident's status for 1 of 21 residents reviewed (Resident #78). The facility reported a census of 89 residents.</p> <p>Findings include:</p> <p>According to the MDS assessment dated [DATE], Resident #78 scored 12 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident's diagnoses included schizophrenia.</p> <p>The MDS documented no to question A1500 indicating the resident was not currently considered by the state level 2 Preadmission Screening and Resident Review (PASRR) process to have serious mental illness.</p> <p>The Notice of Level 2 PASRR Outcome dated 8/2/24 documented the resident met inclusion for PASRR based on her diagnosis of paranoid schizophrenia and delusional disorder, and her need for help taking care of herself.</p> <p>Since the evaluation determined the resident had a PASRR condition, the facility should mark yes for question A1500 on the MDS.</p> <p>On 3/26/25 at 8:18 a.m. Staff C Nurse manager stated she read the front page of the PASRR and it said approved without specialized services, so she thought she didn't have to do more.</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527</p> <p>Based on record review and staff interview, the facility failed to incorporate the recommendations from the Pre-Admission Screening and Resident Review (PASRR) evaluation report into a resident's assessment, care planning, and transition of care for 1 resident reviewed (Resident #78). The facility reported a census of 89 residents.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #78 scored 12 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident's diagnoses included schizophrenia.</p> <p>The MDS documented no to question A1500 indicating the resident was not currently considered by the state Level 2 PASRR process to have serious mental illness.</p> <p>The Notice of Level 2 PASRR Outcome dated 8/2/24 documented the resident met inclusion for PASRR based on her diagnosis of paranoid schizophrenia and delusional disorder, and her need for help taking care of herself.</p> <p>Since the evaluation determined the resident had a PASRR condition, the facility should mark yes for question A1500 on the MDS.</p> <p>The resident fell into the category of having a diagnosis that the PASRR program was designed to assess. The condition was likely to require treatment in the future. The diagnosis was a mental health condition.</p> <p>The resident needed the following services and/or supports:</p> <p>a. Evaluation for a diagnosis of neurocognitive disorder/dementia, or other organic mental disorder.</p> <p>(1) The resident would benefit from having an evaluation of dementia or other organic mental disorder due to your increased confusion and memory loss.</p> <p>b. The individual needed to designate [NAME] of Attorney for Healthcare and Financial matters in order to serve as substitute decision makers in the event of incapacity, assist with decision making, and support.</p> <p>(1) If the resident did not already have a designated Power of Attorney with individuals who could and would assist in keeping her safe and engaged in her own treatment, she may need help in order to consider whether she had any family members or others in her support network who could be designated powers of attorney for health care and/or financial matters.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>c. Obtaining archived psychiatric/behavioral health treatment records to clarify history and then make those past records available to all medical and behavioral health service providers.</p> <p>(1) Obtaining archive psychiatric records from you previous psychiatric hospitalization s and collateral information from family was recommended to clarify diagnostic history, symptomology and past treatments. Obtaining records could provide useful insights into effective treatment strategies and potential triggers of decompensation.</p> <p>d. Ongoing evaluation of the effectiveness of current psychotropic medications on target symptoms, could be offered by a non-behavioral health specialist - physician.</p> <p>(1) The resident would need ongoing psychiatric medication management to make sure her medications were helping treat her mental health symptoms.</p> <p>The clinical record lacked documentation the facility utilized the PASRR report when assessing, care planning, or the resident's transition to care.</p> <p>On 3/26/25 at 8:18 a.m. Staff C Nurse manager stated she read the front page of the PASRR and it said approved without specialized services, so she thought she didn't have to do more.</p> <p>The undated facility PASRR policy identified the purpose to ensure residents admitted were appropriate for placement in a long-term care setting. Each resident would have a resident centered Care Plan that addressed the services required by the PASRR. It would include diagnosis, medications, and interventions used for the management of behavioral symptoms.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875</p> <p>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 4 out of 21 residents reviewed for comprehensive care plans (Residents #21, #73, #33, and #78).The facility reported a census of 89 residents.</p> <p>Findings include:</p> <p>1. Resident #21's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 03, indicating severe cognitive impairment. Resident #21's MDS included diagnoses of non-alzheimer's dementia, depression, alcohol dependence with alcohol-induced persisting dementia, restlessness and agitation. The MDS documented Resident #21 was taking antipsychotic medication during the 7 day look back period.</p> <p>A Physician Order dated 9/10/24 directed staff to administer Risperdal (antipsychotic medication) 0.5 MG (milligrams) one time a day related to increased behaviors.</p> <p>Review of the Care Plan with a target date of 6/2/25 revealed the antipsychotic medication, target behaviors, potential side effects and what to monitor for while taking the high risk medication was not addressed on the comprehensive care plan.</p> <p>On 3/26/25 at 9:20 AM, Staff A, Nurse Manager verified Resident #21's Risperdal medication was not addressed on the care plan. She said she would expect high risk medications to be addressed on the care plan.</p> <p>2. Resident #73's MDS dated [DATE] identified a BIMS score of 5, indicating severe cognitive impairment. The MDS identified Resident #73 was independent with bed mobility, transfer and ambulation without an assistive device. Resident #73's MDS included diagnoses of non-alzheimer's dementia, anxiety disorder and insomnia. The MDS documented Resident #73 had a wander/elopement alarm that was used daily.</p> <p>Review of Census tab in electronic medical record revealed Resident #73 resided in room [ROOM NUMBER].</p> <p>A Progress Note dated 10/10/24 documented Resident #73 was redirected out of room [ROOM NUMBER] a few times this morning. According to the note Resident #73 said, I have to go in there, my clothes are there. Resident #73 was shown to her room and closet. Resident #73 said, That's only some of my stuff.</p> <p>A Progress Note dated 12/8/24 documented Resident #73 was redirected out of another resident's room one time during the shift. Resident #73 was redirected to the living area where music was playing.</p> <p>A Progress Note dated 12/31/24 documented Resident #73 was found sitting on another resident's bed (Resident #10) with no clothes on at approximately 2:30 PM. Resident #10 was not in the room at the time. Resident #73 was assisted back to her room and was cooperative.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A Progress Note dated 1/2/25 documented the door bell engaged in another resident's room to alert staff of a person going into the room. Resident #73 found in the room that was not hers and redirected without concerns.</p> <p>A Progress Note dated 1/22/25 documented Resident #73 wandered in the halls and redirected away from other resident rooms.</p> <p>A Progress Note dated 2/17/25 documented Resident #73 wandered up and down the halls.</p> <p>A Progress Note dated 2/26/25 documented Resident #73 was ambulatory in halls and required reminders, redirection, guidance not to go into other residents' rooms and bathrooms.</p> <p>Review of the Care Plan with target date 5/19/25 revealed Resident #73's wandering behavior, interventions to reduce wandering and going into other resident's rooms were not addressed on the care plan.</p> <p>On 3/25/25 at 3:00 PM, Staff A, Nurse Manager verified Resident #73's wandering behaviors and interventions were not addressed on the care plan and should be. She said she would update the care plan at this time.</p> <p>49056</p> <p>3. The MDS assessment dated [DATE] for Resident #33 documented diagnoses of chronic obstructive pulmonary disease (COPD), hypertension, and depression. The MDS showed the BIMS score of 10, indicating moderate cognitive impairment.</p> <p>The clinical Physician Order dated 11/15/24 directed staff to change the oxygen tubing on the 15th of the month and mark it with the date using paper tape.</p> <p>The clinical Physician Order dated 10/30/24 directed staff to administer oxygen as needed via nasal cannula to keep stats above 90%. Staff may titrate 1-5 liter via nasal cannula.</p> <p>Review of Resident #33's Care Plan with an initiated date of 2/29/24 failed to document the oxygen.</p> <p>On 3/26/25 at 3:30 PM, the DON stated the expectation would be to have the oxygen addressed on the care plan.</p> <p>26527</p> <p>4. According to the MDS assessment dated [DATE], Resident #78 scored 12 on the BIMS indicating moderate cognitive impairment. The resident's diagnoses included schizophrenia.</p> <p>The Notice of Level 2 Preadmission Screening and Resident Review (PASRR) Outcome dated 8/2/24 documented the resident received approval without specialized services.</p> <p>The PASRR Outcome Explanation Notice of Nursing Home Approval documented the results of the evaluation were:</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. The resident required the level of services provided in a nursing facility.</p> <p>b. The resident did not require specialized services for her behavioral health. Rehabilitative services and/or community placement supports had been identified and were described in an attached report.</p> <p>c. The nursing facility would be required to Care Plan in a PASRR compliant fashion for all identified services including Rehabilitative Services.</p> <p>The Care Plan lacked any identification of the residents inclusion in the PASRR.</p> <p>On 3/26/25 at 8:18 a.m. Staff C Nurse manager stated she read the front page of the PASRR and it said approved without specialized services, so she thought she didn't have to do more.</p> <p>The undated facility PASRR policy included each resident would have a resident centered Care Plan that addressed the services required by the PASRR. It would include diagnosis, medications, and interventions used for the management of behavioral symptoms.</p> <p>The undated facility Care Plan and Development and Process policy directed the interdisciplinary team should develop a comprehensive, individualized plan of care for each resident. The Care plan should be reviewed and revised in accordance with State and Federal regulations and professional standards of nursing care. The Care Plan guided the care and treatment provided to each resident.</p> <p>Development of the Care Plan began at admission, utilizing information gathered from the resident, family, admission assessments completed by each discipline, and records from the transferring facility or referral source. Every effort was made to ensure that the comprehensive Care Plan incorporated the resident's individual history, patterns, preferences, and choices.</p> <p>The Comprehensive Care Plan would specifically address medical, nutritional, psychological, physical, functional, social, educational, spiritual, condition impairments, and disability/disease.</p> <p>The Care Plan was reviewed and updated quarterly or with any change in the resident's condition.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056</p> <p>Based on observations, record review, staff interviews and policy reviews, the facility failed to change and label oxygen tubing for 1 of 2 residents reviewed (Resident #33). The facility reported a census of 89.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #33 documented diagnoses of chronic obstructive pulmonary disease (COPD), hypertension, and depression. The MDS showed the Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment.</p> <p>Observation on 3/24/25 at 2:03 PM, revealed Resident #33 had a date of 11/15/24 on the oxygen tubing with initials of a staff member.</p> <p>Observation on 3/25/25 at 1:46 PM, revealed Resident #33 had a date of 11/15/24 on the oxygen tubing with initials of a staff member.</p> <p>Interview on 3/24/25 at 2:03 PM, with Resident #33 revealed she doesn't need to have the oxygen on all the time, stating she can wear it when she wants or needs to.</p> <p>Review of the November 2024 TAR revealed the oxygen tubing was changed on the 15th and matched the date and initials for this day.</p> <p>Review of facility provided undated policy titled O2 Tubing Replacement and Storage revealed the purpose of this procedure is to ensure O2 is maintained in a clean and functional manner. Tubing will be inspected and changed on a monthly basis and/or as needed by the nursing department. When not in use, tubing will be stored in a bag.</p> <p>Interview on 3/26/25 at 10:10 AM, with Staff B, Registered Nurse (RN) revealed they change the oxygen tubing the 15th of every month and it is on the TAR for staff changing it to record it.</p>

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 03/27/2025
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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875</p> <p>Based on clinical record review, staff interviews, Centers for Disease Control and Prevention (CDC) guidelines and facility policy review, the facility failed to screen for eligibility, offer, provide education and document vaccine consent or refusal for the COVID-19 (coronavirus disease) immunization for 4 of 5 resident reviewed (Resident #12, #21, #40 and #77). The facility reported a census of 89 residents.</p> <p>Findings include:</p> <p>1. Resident #12's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 04, indicating severe cognitive impairment. The MDS documented Resident #12 was not up to date with the COVID-19 vaccination.</p> <p>Review of the clinical record revealed Resident #12 had received a COVID vaccination on 10/24/21. The clinical record lacked documentation that Resident #12 or responsible party was educated, offered a consent for or refusal of an additional COVID-19 vaccination since 10/24/21.</p> <p>2. Resident #21's MDS dated [DATE] assessment identified a BIMS score of 03, indicating severe cognitive impairment. The MDS documented Resident #21 was not up to date with the COVID-19 vaccination.</p> <p>Review of the clinical record revealed Resident #12 had received a COVID vaccination on 12/21/21. The clinical record lacked documentation that Resident #21 or responsible party was educated, offered a consent for or refusal of an additional COVID-19 vaccination since 12/21/21.</p> <p>3. Resident #40's MDS dated [DATE] assessment identified a BIMS score was not completed. A Staff Assessment for Mental Status documented Resident #40 cognitive skills for daily decision making were severely impaired. The MDS documented Resident #40 was not up to date with the COVID-19 vaccination.</p> <p>Review of the clinical record revealed Resident #40 had received a COVID vaccination on 10/17/22. The clinical record lacked documentation that Resident #40 or responsible party was educated, offered a consent for or refusal of an additional COVID-19 vaccination since 10/17/22.</p> <p>The clinical record revealed Resident #40 tested positive for COVID-19 on 9/4/24 and was hospitalized from 9/4/24 to 9/11/24 related to COVID-19.</p> <p>4. Resident #77's MDS dated [DATE] assessment identified a BIMS score of 13, indicating intact cognition. The MDS documented Resident #77 was not up to date with the COVID-19 vaccination.</p> <p>The Clinical Record revealed Resident #77 was admitted to the facility on [DATE].</p> <p>Review of the clinical record revealed Resident #77 had received a COVID vaccination on 1/13/23. The clinical record lacked documentation that Resident #77 was educated, offered a consent for or refusal of an additional COVID-19 vaccination since admission to the facility on [DATE].</p> <p>(continued on next page)</p>

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The clinical record revealed Resident #77 tested positive for COVID-19 on 2/9/25.</p> <p>On 3/26/25 at 11:15 AM, the DON reported the previous pharmacy the facility used would not do a COVID clinic onsite and would not send the vaccine to the facility to be given. The DON reported the facility switched to a long term care pharmacy in December 2024 for all residents. She said the facility was working on a plan with the Pharmacy to either do an onsite clinic or obtain the vaccine from the pharmacy to give the injections. The DON reported if a resident wanted or asked for the COVID vaccine, the facility would direct the resident to go to the Physician office to get it. She said the facility would help set up the appointment if needed. The DON verified the facility did not have any documentation to show Resident #12, #21, #40 and #77 or resident representatives had been offered the vaccine, declined the vaccine, or been educated regarding the COVID-19 vaccination.</p> <p>The CDC Vaccines and Immunizations last updated 10/31/24 instructed people [AGE] years and older, vaccinated under the routine schedule, are recommended to receive 2 doses of any 2024-2025 COVID vaccine separated by 6 months regardless of vaccination history with one exception. Unvaccinated people who initiate vaccination with the 2024-2025 Novavax COVID-19 vaccine are recommended to receive 2 doses of Novavax followed by a third dose of any COVID-19 vaccine 6 months later. The CDC instructed people ages 5-[AGE] years not immunocompromised should receive one 1 dose of an age-appropriate 2024-2025 COVID-19 vaccine. The CDC instructed people ages 5-[AGE] years who are moderately or severely immunocompromised and had previously completed an initial series should receive 2 doses of an age appropriate 2024-2025 COVID-19 vaccine, spaced 6 months apart.</p> <p>The undated facility policy titled COVID-19 Vaccination Policy and Procedure documented the following:</p> <p>Upon admission to the nursing home each resident will be assessed for vaccination status for COVID-19. If through assessment it was determined that the resident had not previously been vaccinated against COVID-19 and the resident was medically able to receive the COVID-19 vaccine the facility would educate and encourage vaccination to the resident and/or their representative. Vaccination status assessment would include individuals that have received their primary series and eligibility for an additional dose or booster dose per current CDC guidance.</p> <p>Prior to consenting for the vaccination, each resident and/or representative would receive education regarding the current COVID-19 vaccinations approved or authorized by the FDA. Education would include the benefits of the COVID-19 vaccination, the potential risks including possible side effects and common and rare reactions to the COVID-19 vaccination.</p> <p>Once residents and/or representatives receive information and have an opportunity to ask questions regarding vaccination the resident and/or their representative would either consent or decline the COVID-19 vaccine. If the vaccine was declined, residents and/or their representatives have the right to change their decision at any time and would notify facility nurse that they would like to receive the vaccine. The nurse manager would provide the resident and/or their representative with educational information and the opportunity to consent to the vaccine again.</p> <p>Upon consenting to the vaccine, the nursing home will coordinate administration of the vaccine via the Federal Retail Pharmacy Program, local public health, or other means of obtaining the vaccine.</p> <p>(continued on next page)</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The resident would be provided educational information at the time of the first dose as well as subsequent doses as well as the opportunity to decline subsequent doses.</p> <p>If a resident has been fully vaccinated the facility would obtain documentation to confirm vaccination status.</p> <p>If the resident has not been fully vaccinated, the resident's consent/declination form or information on administration, including vaccination dates and follow up assessments will be maintained in the resident ' s medical record.</p> <p>In the event that the facility was not unable to coordinate vaccination on-site, information on obtaining vaccination opportunities off-site will be provided to residents and/or representatives. Documentation by the facility will be maintained of efforts made to make the vaccine available on-site to the residents. In the event there were manufacturing delays, evidence of this delay will be maintained.</p> <p>All residents will be assessed for an additional dose or booster dose. If the CDC recommendation for an additional dose or booster dose was pertinent to a resident, the facility will assist with coordinating the vaccine. Additional dose/booster dose records will be maintained in the resident's medical record.</p>