| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165364 | A. Building<br>B. Wing | 09/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Concord Care Center | 490 West Lyons Street<br>Garner, IA 50438 |

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) |
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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, and resident interview, the facility failed to ensure adequate assessment and timely intervention of a resident's complaints, and adequate monitoring of a resident on Intravenous (IV) antibiotics for 1 resident reviewed (Resident #26). The facility reported a census of 35 residents.Findings include:According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #26 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident's diagnoses included heart failure, peripheral vascular disease, benign prostatic hyperplasia, diabetes, stroke, pacemaker, and a below the knee right leg amputation. The resident had an indwelling urinary catheter, and Intravenous (IV) access. The Care Plan identified the resident required the use of an indwelling catheter related to urinary retention (resolved due to no longer having a catheter), with a goal the resident would remain free of complications related to the catheter. Interventions included monitoring for pain/discomfort due to catheter use, providing catheter care, and urology consult as needed. The resident's Progress Notes documented the following:On 8/14/25 at 12:25 p.m. the nurse was called to the resident's room for the resident requesting to speak with her. The resident stated he was pissing straight blood, and he needed to be seen today. He said he had an appointment with urology the next day, but he could not wait. The nurse explained she would get ahold of the provider for further guidance.On 8/14/25 at 1 p.m. placed a call to the provider's office and a voicemail left for the nurse to return this nurse's call in regards to bright red blood noted in the resident's catheter bag, and the resident complaints it hurt like hell. The resident did receive as needed (PRN) Morphine at 12:30 p.m.On 8/14/25 at 1:23 p.m. the resident transferred himself into his wheelchair and came to the nurses station with the same complaints. The nurse explained that she had a call out to his provider and waiting on call back. The resident became very angry and shouted, he had heard that so much, and the last time it took 5 days. He said he would just call 911 himself and sped off in the wheelchair back to his room. The Director of Nursing (DON), Social Worker (SW), and the Administrator went to the resident's room and attempted to speak with the resident.On 8/14/25 at 1:28 p.m. call placed (to provider) and asked for any available nurse to speak with in regards to the resident's complaint. The nurse sat on hold for 12 minutes before the receptionist got back on the line and stated that she would have a nurse call this nurse back when she got out of a patient room.On 8/14/25 2:13 p.n. the provider returned call with the new order to transfer to to the hospital for urinary pain and bleeding.On 8/14/25 at 3:25 p.m. called and spoke with first call and gave the nurse report in regards to the resident coming to the emergency room (ER). On 8/14/25 at 3:28 p.m. transportation left to transport the resident to the ER.On 8/15/25 at 1:30 a.m. the resident returned to the facility at 10:30 p.m. The resident was diagnosed with urinary retention. The catheter the resident had in place prior to the ER visit was replaced with a larger catheter, and had been draining freely according to the progress update written by the physician. The clinical record lacked documentation the facility did any assessment related to the resident's complaints of pain or bleeding. On 9/22/25 at 12:09 p.m. Resident #26 was very upset about one of the times he went to the hospital. He was having severe pain low in his abdomen and blood in his catheter. He wanted to go to the hospital and told by the Administrator that he could not go by ambulance because it wasn't a life<br>(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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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | threatening condition. He was very upset and waited several hours to get there, and he was in severe pain. He said when he got to the hospital his bladder was blocked. They had to do several procedures to get it open again. The resident said he had a bad heart and this kind of stress did not do good for it. This bothered him ever since it happened. The resident no longer had a catheter. On 9/22/25 at 1:11 p.m. the resident's family member stated all she knew was the resident called her and begged her to call the facility and tell them he needed to go to the hospital. She thought she talked with Administrator and was told he could not go by ambulance because it was not life threatening. She was told they had to wait for a physicians order, then had to wait for the transport van to return. They thought the resident had played with his catheter and his penis was sore. On 9/23/25 at 1:50 p.m. Staff A Licensed Practical Nurse (LPN) stated she worked 8/18/25 when the resident said he was bleeding in the catheter bag. She said she did not see blood, she just went by what the resident said. She called the provider's office and left a message. Before she had heard back from them, the resident came to the nurses station, very upset, and said he would call 911 himself. The DON (currently off), the SW, and the Administrator (on leave) went to talk to the resident to try and calm him down. She said there was something said about the resident not being transferred by ambulance because it was not life threatening. Staff A stated she did not take Vital Signs (VS) or check the resident's catheter bag, but she thought the DON had. She didn't know where she might have documented that. On 9/25/25 at 8:29 a.m. the Administrator (currently off) stated she became involved the day the resident wanted to go to the hospital because she was informed that he was very upset that he had to wait. She went and talked to the charge nurse, Staff A. She stated that she had tried to call the provider and left a message and was waiting for a call back. The Administrator went and talked to the resident and said that they didn't know if this would be the kind of thing that would require the ambulance and that the transport vehicle would be coming back soon and they would get him to the hospital. The Administrator remembered asking the charge nurse if they had assessed the resident and she said they had and that his vital signs were okay. The Administrator didn't know or remember if the catheter was draining or had blood in it. She herself did not see any part of it to know. She said they sent him and brought him back later. She had talked to his family after he went to the hospital, and she had voiced concern that they had to wait for the doctor to get back to them, and was not very happy about that. She doesn't recall telling the resident he couldn't go by ambulance because it wasn't life threatening. She didn't feel that it came out exactly that way. She said the resident had been transferring himself that day and that he may have pulled the catheter, causing discomfort and bleeding. On 9/25/25 at 10:30 a.m. the Nurse Consultant stated she had attempted to reach the DON, but she had just recently had surgery. 2) The Care Plan identified the resident on Enhanced Barrier Precautions (EBP) related to a Peripherally Inserted Central Catheter (PICC) Line, and diabetic ulcer wounds, with a goal to minimize the risk for transmission during high contact care activities with a target date of 11/17/25. The Medication Administration Record (MAR) for August 2025 documented the resident had an order for Vancomycin intravenous solution 1000 mg per 200 ml every 12 hours for infection with a start date of 8/6/25 and a stop date of 8/25/25. The Progress Notes documented the following:On 8/20/25 at 10:19 a.m. the resident left the facility for an appointment with infectious disease.On 8/20/25 at 1:13 p.m. transportation returned to the facility with the resident's wheelchair, and the following statement: Sent to the ER due to fever, dizziness, and abdominal pain. Questioned Urinary Tract Infection (UTI) and Sepsis, and signed by the Dr. On 8/20/25 at 6:15 p.m. received call from the ER notifying the resident would be admitted overnight due to a UTI. On 9/24/25 at 10:32 a.m. the Infection Preventionist (IP) stated when residents were on antibiotics they were on Hot Charting so they would be monitored and documented on at least daily. She said with a PICC line they would have VS daily and the documentation of VS would be on the MAR/TAR. She didn't know if there was a policy. The Treatment Administration Record (TAR) for August 2025 showed the resident had vital signs recorded on 8/7/25, and no other dates. The clinical record lacked documentation the facility monitored the resident related to the use of IV antibiotics via<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | a PICC line. The facility policy, Alert Charting Guidelines revised 10/2023, documented the purpose to provide a guideline for monitoring documentation that may be needed following a change in resident condition or status. The Alert Charting Log is a tracking and communication system to alert licensed nurses to changes in a patient's condition that warrants continued observation. Examples of situations typically included on the Alert Charting Log included an acute or significant change of patient condition. Patients are entered on the Alert Charting Log when they are identified as requiring continued follow-up and documentation. Patients should remain on the log for a minimum period of 72 hours unless their condition has improved. Patients are removed from the Alert Charting Log when the resident's status had stabilized or the condition or symptom prompting the initial placement on the log had been resolved/stabilized. |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>Based on record review and staff interview, the facility failed to ensure the Quality Assessment and Assurance committee (QA) was attended by the required members to include 1) the Nursing Home Administer (NHA) or representative, 2) Director of Nursing (DON), 3) the Medical Director (MD) or representative and 4) 2 other members of the facility's staff present on a minimum of a quarterly basis. The facility reported a census of 77. Findings include: The Quality Assurance Committee Meeting Sign In sheets were provided by the facility since the facility's last recertification survey on 10/24/25. The first QA committee meeting was held on 2/28/25. The Medical Director or a designee for the Medical Director was not present. On 9/25/2025 at 2:24 PM Administrator acknowledged the concern that the Medical Director or his/her designee was not in attendance for the February QA meeting. A QAPI Quality Assurance Performance Improvement) Policy dated 10/2023, directed the following: Purpose: To describe the process steps for identification and resolution of actual or potential areas affecting qualityProcedure:1. The facility must maintain documentation and demonstrate evidence of its ongoing QAPI program.2. QAPI team must develop and implement appropriate plans of action to correct identified quality of care, quality of life or safety problems.3. QAPI team will monitor medical errors and adverse events and will systematically identify, report, track, investigate, analyze, and use data related to medical errors/adverse events within the facility to develop activities to prevent medical errors/adverse events.4. QAPI program must include the following five (5) elements:Design and scopeGovernance and leadershipFeedback, data systems and monitoringPerformance improvement plans (PIPs)Systematic analysis and systematic action5. Facilities QAPI must address all systems of care and management practices and include clinical care, quality of life, and resident choice. It should utilize the best available evidence to define and measure performance indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents. Facilities will use tools as defined in the Facility QAPI Plan to develop, monitor, and evaluate performance indicators.6. Input from direct care staff, other staff, residents, and resident representatives will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. The facility may use staff interviews, small group meetings, buddy program audit tools, and observations to aide in obtaining feedback. The feedback will be used to assist in Performance Improvement Plan (PIP) development.7. The QAPI team must regularly review and analyze data, including data collected under the QAPI program, including but not limited to the facility assessment and will act upon findings/data collected to improve performance. The members of the QAPI committee must meet at least quarterly and as needed to coordinate and evaluate effectiveness of activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program. The facility will have a facility specific QAPI Plan that is reviewed annually at a minimum. |