

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165375	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2025
NAME OF PROVIDER OR SUPPLIER Anamosa Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1209 East Third Street Anamosa, IA 52205	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and family interviews, and facility policy review the facility failed to treat 1 out of 1 residents reviewed with dignity telling them to be incontinent in the bed after they asked to use the restroom (Resident #47). The facility reported a census of 55 residents.</p> <p>Finding include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE], included diagnoses of Parkinson's disease, non-Alzheimer's dementia, and anxiety. The MDS reflected a Brief Interview for Mental Status (BIMS) score of 5 (severely impaired cognition). The MDS identified Resident #47 as dependent on staff for toileting, transfer, and toileting hygiene.</p> <p>The Care Plan for Resident #47 date initiated 04/19/2024, directed staff to assist to toilet, before and after meals, at bedtime, and as needed. The Care Plan directed staff to provide incontinence (the inability to control bodily functions, specifically urination) care after each incontinent episode.</p> <p>The Care Card undated, hung on the wall in Resident #47's room marked T for toilet.</p> <p>On 6/09/25 at 1:06 PM, Resident #47's family reported on 6/8/25 at bedtime after the Certified Nurses Aids (CNA) put Resident #47 in the bed, Resident #47 told Staff C, CNA he needed to use the restroom. Staff C directed Resident #47 be incontinent in the bed and told him she would come back later and clean him up. The family reported being very upset with that direction from Staff C.</p> <p>On 6/11/25 at 1:00 PM, Resident #47's family reported she talked to the facility about her concern and the Director of Nursing (DON) told her it will be addressed.</p> <p>On 6/11/25 at 4:51 PM, the Director of Nursing (DON) reported she expected the staff to take a resident to the bathroom before they are put to bed at night. She confirmed telling a resident to go to the bathroom in the bed is unacceptable.</p> <p>On 6/11/25 on 7:51 PM, Staff B CNA, reported the Care Card on the wall in the residents room tells the staff how to care for the residents. How the resident transfers if they are toileted or check and change and other key care needs. Staff B stated the normal bedtime routine included taking the resident to the bathroom before bed, oral cares and getting them in bed safely.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/12/25 at 7:18 AM, the Restorative Nurse reported the T on the Care Sign indicated the residents use the toilet, or a bed pan, or a urinal.</p> <p>On 6/12/25 at 7:44 AM, Staff D, CNA reported if a resident is in bed and tells someone they need to go to the bathroom, you get them to the bathroom. She confirmed you don't tell them to go in the bed and clean them up after.</p> <p>On 6/12/25 at 9:38 AM Staff E, CNA reported why would you ever tell a resident to go to the bathroom in their bed, you take them to the bathroom, or use a bedpan or a urinal. She said that's not treating them right to tell them to go in the bed.</p> <p>The facility provided a policy titled Residents' [NAME] of Rights dated 12/2023, the resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment, that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and family interviews, and facility policy review the facility failed to provide staff assistance in a timely manor for 2 out of 2 residents reviewed (Residents #32 and #47). The facility reported a census of 55 residents.</p> <p>Finding include:</p> <p>1. The Minimum Data Set (MDS) assessment dated [DATE], included diagnoses of Parkinson's disease, non-Alzheimer's dementia, and anxiety. The MDS reflected a Brief Interview for Mental Status (BIMS) score of 5 (severely impaired cognition). The MDS identified Resident #47 as dependent on staff for toileting, transfers, and toileting hygiene.</p> <p>The Care Plan for Resident #47 date initiated 04/19/2024, directed staff to assist to toilet, before meals, after meals, at bedtime, and as needed.</p> <p>On 6/09/25 at 1:06 PM, Resident #47's family reported last night 6/8/25 Staff C, Certified Nurses Aid (CNA) walked by his room when his call light was on. The family revealed 35 minutes later she went to the lobby area to finds a staff to help Resident #47.</p> <p>2. The MDS assessment for Resident #32 dated 4/23/25, included diagnoses of heart failure and diabetes mellitus (DM). The MDS reflected the BIMS score of 2 (severely impaired cognition).</p> <p>The Care Plan dated 1/20/25, directed staff to provide toileting assistance before and after meals, at bedtime, and as needed.</p> <p>On 06/11/25 at 4:13 PM, Resident#32 called out she needed to go to the bathroom. Two nurses were in and out of the area and two CNAs were in and out of the area helping other residents. Staff F, CNA's told Resident #32 they were busy, but would help her in a few minutes. Resident #32 continued to call out for help until 4:34 PM Twenty-one minutes later the Staff F helped Resident #32.</p> <p>On 6/10/25 at 4:38 PM, Staff A, CNA stated some residents do complain about the time it takes to get to the call light. She revealed they are checking the call light and are helping other residents.</p> <p>On 06/11/25 at 7:51 PM Staff B, CNA reported the time to get to the call lights are 15 minutes or sooner. She reported they try to make that happen. She reported at times they do tell the resident they will be right back, because they are helping another resident.</p> <p>On 6/11/25 at 4:51 PM, the Director of Nursing reported the expected call light maximum time is 15 minutes. She reported when a resident is calling out for help she expected the staff to immediately help them. The DON confirmed when a resident called out for help in the lounge without a call light she would expect the resident be taken care of within 15 minutes like a call light.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/12/25 10:59 AM the Assistant Director of Nursing (ADON) reported she completed a job fair that included going over the CNA Competency with the staff and they signed a paper acknowledging the expectation to answer call lights in 15 minutes. The ADON revealed she thought Staff C failed to complete that training. Staff C's employee file lacked the CNA Competency.</p> <p>The Facility provided a copy of the CNA Competency that included call light response time.</p> <p>The facility provided a Preceptor Checklist for Staff C dated 12/7/2024, that identified training for call light response and toileting.</p> <p>The facility provided a Preceptor Guidance undated, that directed call lights must be answered in 15 minutes.</p>