STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165386	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Manor of Elma	407 9th Street Elma, IA 50628

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 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42133

Based on clinical record review, policy review, resident and staff interviews, the facility failed to treat a resident with dignity and respect for 1 of 3 residents sampled (Resident #4). The facility identified a census of 30 residents.

Findings include:

Resident #4 Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition.

During an interview on 2/11/25 at 4:01 PM Resident #4 reported Staff B, Certified Nursing Assistant (CNA) came into her room during the night and started mouthing off yelling Staff A, Licensed Practical Nurse (LPN), that fucking fat ass he doesn't do anything, repeatedly. He sits on his butt all night and then goes outside to smoke every two hours. Then Staff B left the room. Resident #4 voiced Staff B is rude at times and she doesn't feel that Staff B should be talking to her about other employees or residents. She is always complaining how she can't take care of Resident #27 because she doesn't want her taking care of her and Resident #19 and one other resident always have their call lights on all night long and she is tired of that. Resident #4 voiced she was really disappointed when Staff A cut down hours and then quit. Staff A was a good nurse to her. He was always on time with her medications and took good care of her. At 4:04 PM Resident #4 verbalized she was offended when Staff B used offensive language and started to yell about a nurse that she liked in her own room. Staff B had provided care to her twice in the past week without using profanity, but Resident #4 added if it happens again, she would be uncomfortable with Staff B taking care of her.

During an interview on 2/11/25 at 4:28 AM Staff B reported on 1/26/25 shortly after the start of shift she went in to Resident #4 room to check on her roommate to be sure she wasn't crawling out of bed. While in Resident #4 room, Staff B verbalized, that fat ass upset me. Resident #4 asked her who and Staff B responded Staff A had upset her. Staff B reported she knows she should not have said that to Resident #4 but she was really upset. Staff B voiced they are not to use profanity at work.

On 2/11/25 at 4:50 PM the Director of Nursing (DON) reported Staff A had reported that Staff B would not follow instructions on the night shift. She had gotten a report from Staff A that Staff B had called him a fat ass. She had talked with Resident #4 just last week and Resident #4 was okay with Staff B taking care of her.

(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

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165386	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Manor of Elma	407 9th Street Elma, IA 50628

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/25 at 11:20 AM Staff A reported he had multiple altercations with Staff B. The last incident was 1/26/25. He had been working with another resident that was having difficulty breathing and Staff B was in the room freaking, making the resident more anxious, so he told her to leave the room. He then went up to the nurses' station to chart. Staff B was at the nurses' station telling Staff C, CNA that Staff A was lazy and wouldn't do anything to help the residents. Staff A reported he came out of the nurses' station and told Staff B that was not true and to stop saying those things or she could go home. He verbalized Staff B told him he was not a regular nurse there and couldn't tell her what to do, she didn't have to listen to him. On 1/27/25 on his next night shift, Resident #4 told him that Staff B was in her room yelling the night before (1/26/25) that he was a lazy fat fuck repeatedly. Resident #4 apologized to Staff A that staff would call him names and voiced she felt bad for him. It felt awful that a resident had to apologize for her. A 2/12/25 review of employee time cards showed the following: a. Staff A worked 1/26/25 time in 5:54 PM; time out 6:33 AM. b. Staff B worked 1/26/25 time in 10:08 PM; time out 6:03 AM. On 2/13/25 at 9:29 AM Staff F, Registered Nurse (RN) voiced the use of profanity in front of a resident is not acceptable. She would correct the employee right away, write the employee up, and report the incident to the DON. On 2/13/25 at 9:45 AM the DON reported regarding dignity, profanity is not to be used in front of residents. Interview 2/13/25 at 9:58 AM the Administrator reported staff are to follow resident rights with privacy and respect. They are to promote a homelike environment. It is inappropriate and unprofessional for staff to use profanity in front of residents. The 4/2024 Resident Rights - Dignity and Respect Policy documented a purpose to lay the foundation for treating all residents with dignity and respect and maintaining and enhancing his or her self-esteem and self-worth. The procedure directed: Each Resident has the right to considerate and respectful care and to be treated with honesty, dignity, respect and with reasonable accommodation of individual.

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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 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on clinical record review, Centers for Medicare and Medicaid Services (CMS) Long-Term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User's Manual review, and staff interview, the facility failed to complete a Significant Change Status Assessment (SCSA) Minimum Data Set (MDS) within 14 days of hospice election for 1 of 1 residents reviewed for hospice care (Resident #23). The facility reported a census of 30 residents. Findings include: Resident #23 SCSA MDS dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 00 indicating severe cognitive loss. The MDS documented Resident #23 as dependent upon staff to provide for her activities of daily living (ADLs). The MDS listed diagnoses of cancer, end stage renal disease, diabetes mellitus, and Non-Alzheimer's Dementia. The MDS lacked documentation Resident #23 received hospice care services. A Hospice Election Statement and Hospice Admission Consent Form signed by Resident #23 family representative showed the family signed Resident #23 into hospice care on 1/13/25. Resident #23 Electronic Healthcare Record (EHR) Census showed Resident #23 on hospice care 1/13/25. A Hospice Medication Order Sheet signed by the Provider on 1/15/25 documented 1/13/25 admit to (Hospice) services. A 2/11/25 review of Resident #23 Electronic Healthcare Record (EHR) MDS page lacked documentation Resident #23 had a SCSA MDS set up within 14 days from the hospice election date of 1/13/25. On 2/11/25 at 3:25 PM the MDS Coordinator reported she usually becomes aware of who is admitted to hospice at the daily meetings they have Monday through Friday. She then sets up a SCSA MDS that has to be completed within 14 days. She reviewed Resident #23 EHR and reported she was aware that Resident #23 went on hospice care. She further voiced the SCSA MDS just got missed. She follows the RAI to complete the MDS. During an interview on 2/11/25 at 3:30 PM the DON reported hospice provides them with a slip notifying them of admission to hospice, but she does not keep those slips. She reviewed Resident #23 MDS's and reported she expects the MDS Coordinator to complete a SCSA MDS per the RAI. The LTC RAI 3.0 User's Manual Version 1.19.1 October 2024 Chapter 2, Page 2- 17 of the RAI manual specifies the SCSA MDS completion date is 14 days from the determination that a significant change in resident status has occurred (determination date plus 14 calendar days). Page 2-25 specifies a SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The Assessment Reference Date (ARD) must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident.

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NAME OF PROVIDER OR SUPPLIER Colonial Manor of Elma		STREET ADDRESS, CITY, STATE, ZIP CODE 407 9th Street Elma, IA 50628	

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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 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** 48003 Based on observation, policy review, clinical record review, and staff interview, the facility failed to utilize appropriate EBP per the CDC during the provision of catheter care to minimize the risk of cross contamination that may lead to the spread of multi-drug resistant organisms for 3 of 3 residents sampled (Residents #5, #4, and #10). The facility reported a census of 30 residents. Findings include: 1. Resident #5 Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 09 out of 15 indicating moderate cognitive impairment. It documented Resident #5 had diagnoses of renal insufficiency, neurogenic bladder, and Cerebral Palsy. The MDS further documented Resident #5 utilized an indwelling catheter for a diagnosis of neurogenic bladder. A 8/26/23 review of Resident #5 Electronic Healthcare Record (EHR) listed a Physician Order for a 16 French (size) Foley catheter to be continued. The Care Plan with an undated focus date directed Resident #5 required Enhanced Barrier Precautions (EBP) related to the Foley catheter. The Care Plan directed staff to maintain proper EBP per the facility policy. Observation on 2/11/25 at 12:26 PM Staff G, Certified Nurse Aide (CNA) entered Resident #5 room, washed her hands, put on gloves, and obtained a plastic bag and a graduate container to empty Resident #5 urinary drainage bag. Staff G emptied Resident #5 urinary drainage bag, stored the graduate container, removed gloves, washed her hands and exited Resident #5 room. Staff G failed to apply an isolation gown prior to emptying Resident #5 urinary drainage bag as required for EBP. Throughout observation no EBP sign noted in or out of the room. During an interview on 2/11/25 at 4:00 PM Staff C, CNA said they do not have any current residents that they need to wear gowns when doing care. Staff C reported if there were any residents there would be a sign hanging outside the door and they would have reported it in the shift meeting prior to getting to the floor. During an interview on 2/11/25 4:12 PM Staff H, CNA reported there are no residents currently that staff need to wear gowns for. If they needed any Personal Protective Equipment (PPE) besides gloves there would be a three drawer container with PPE and a sign outside the door to the room. If they have anyone they need to wear gowns and such they will discuss it at the shift meeting. During an interview 2/11/25 04:17 PM Staff B reported currently there are no residents who they use gowns for that she is aware of. The facility will have a posting outside the door of the resident's room if they did and would say it at the shift meeting at the beginning of the shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 2/11/25 at 4:46 PM the DON initially reported they did not have any residents that require the use of isolation gowns in the facility. Then she stated all residents that have urinary catheters are to be on EBP. The EBP are communicated to staff through the resident Care Plan and kardex (care guide). Maintenance is supposed to place a PPE cart in the resident's room so the PPE is available for EBP. The residents all should have the Center for Disease Control and Prevention CDC sign up for EBP, but they don't stick to the walls and come down. She expects gloves and isolation gowns to be utilized when emptying urinary drainage bags. The facility policy titled Enhanced Barrier Precautions with revised date of 3/2024 directed staff EBP will be used in conjunction with standard precautions for residents with any of the following (if/when Contact Precautions requirements are not in place): Wounds and/or indwelling medical devices (even if the resident is not known to be infected or colonized with a targeted MDRO). CDC guidelines dated 6/12/2022 documented EBP expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. 42133 2. Resident #4 MDS assessment dated [DATE] showed a BIMS score of 15 out of 15 indicating intact cognition. The MDS documented Resident #4 utilized an indwelling catheter for a diagnosis of neurogenic bladder. A 2/10/25 review of Resident #4 Electronic Healthcare Record (EHR) listed a Physician Order for a 20 French (size) Foley catheter to be changed once a month. The Care Plan with an undated focus date directed Resident #4 required EBP related to the Foley catheter. The Care Plan directed staff to maintain proper EBP per the facility policy. Observation on 2/10/24 at 9:45 AM revealed a CDC sign directing staff how to apply and remove gloves and an isolation gown hanging on the wall to the left of Resident #4 room door. Observation on 2/10/25 at 1:33 PM Staff D, CNA entered Resident #4 room, washed her hands, put on gloves and obtained a plastic bag and a graduate container to empty Resident #4 urinary drainage bag. Staff D emptied Resident #4 urinary drainage bag, stored the graduate container, removed gloves, washed her hands and exited Resident #4 room. Staff D failed to apply an isolation gown prior to emptying Resident #4 urinary drainage bag as required for EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/11/25 at 1:08 PM Staff E, CNA reported they are required to use gloves when performing catheter care and when emptying the urinary drainage bag. The use of an isolation gown is optional and the gowns are not in the resident rooms. If they want an isolation gown, they have to go get one from supply. On 2/11/25 at 4:05 PM Resident #4 reported she has never seen any of the CNA's staff wear isolation gowns when they empty her urinary drainage bag. Interview on 2/11/25 at 4:46 PM the DON initially reported they did not have any residents that require the use of isolation gowns in the facility. Then she stated all residents that have urinary catheters are to be on EBP. The EBP are communicated to staff through the resident care plan and kardex (care guide). Maintenance is supposed to place a PPE cart in the resident's room so the PPE is available for EBP. Resident #4 should have a gown hanging up in her room and a plastic cart with PPE in her bathroom. The residents all had CDC signs up, but they don't stick to the walls and come down. She expects gloves and isolation gowns to be utilized when emptying urinary drainage bags. Observation on 02/11/25 at 5:04 PM of Resident #4 bathroom with the DON revealed a PPE cart with a CDC Contact Precaution Sign laying on top of the cart. The isolation cart contained five disposable isolation gowns. The DON reported the PPE was available for staff to use. 3. Resident #10 MDS assessment dated [DATE] showed a BIMS score of 14 out of 15 indicating intact cognition. The MDS documented Resident #10 utilized an indwelling catheter for a diagnosis of benign prostatic hyperplasia (BPH, enlarged prostate) and obstructive uropathy (flow of urine is blocked within the urinary tract). A 2/11/25 review of Resident #10 EHR revealed a physician order to replace a 20 French Foley catheter every 30 days and as needed. Resident #10 undated Care Plan included a Focus detailing he required EBP related to the use of a urinary catheter. The Care Plan directed the staff to wear a gown and gloves while performing high-contact care activities which included when caring for an indwelling urinary catheter. Observation on 2/11/25 at 12:59 PM Staff E washed her hands, applied gloves, set up a plastic barrier and a graduate and emptied Resident #10 urinary drainage bag without applying a isolation gown per the Care Plan and CDC guidelines for EBP. During an observation on 2/11/25 at 5:06 PM the DON inspected Resident #10 bathroom and reported he did not have a PPE isolation bin in his room for EBP or an EBP sign on his door. Resident #10 voiced he didn't recall any staff wearing isolation gowns when they emptied his urinary drainage bag.