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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165390	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER: State Center Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 702 Third Street NW State Center, IA 50247	

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 Based on observations, clinical record review, staff interview, resident interview and policy review the facility failed to ensure resident call light within in reach for 2 of 16 residents reviewed (Resident #13, #28). The facility reported the census is 35. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #28 documented a Brief Interview of Mental Status (BIMS) of 15 indicated intact cognitive impairment. The MDS documented diagnoses included cerebral infarction, cancer, diabetes, pain and anxiety disorder. The Care Plan initiated 12/16/23 documented Resident was at risk for falls, interventions included encourage to use call light for assistance. An observation on 11/18/24 at 11:46 AM, Resident #28 in room recliner in residents private room. A call light hung on the wall behind resident's television in front of the recliner, not reachable, television in front of the call light. In an interview on 11/18/24 at 11:47 AM, Resident #28 in room recliner did not have a call light within reach, relayed does not like to bother staff, and would get what she wanted. Resident #28 agreed in the event of a fall or emergency the call light was not within reach. In an observation on 11/19/24 resident viewed in room recliner throughout the day, no call light was within reach. In an observation on 11/20/24 at 1:46 PM with Resident #28 who sat in her recliner without a reachable call light, resident relayed there is one behind me at the head of the bed, acknowledged in the event of a fall or emergency may not be able to get to the call light. In an interview on 11/20/24 at 2:00 PM with the Director of Nursing (DON) agreed call lights should be accessible to residents. Facility policy titled Answering the Call Light, not dated, documented upon admission and periodically as needed, explain and demonstrate use of the call light to the resident, ask for return demonstration, be sure the call light is plugged in and functioning at all times, when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	44972 2. The MDS assessment dated [DATE] revealed Resident #13 had a BIMS of 15 which indicated intact cognition and had diagnoses that included atrial fibrillation, heart failure, diabetes, anxiety disorder, depression, respiratory failure, muscle weakness and shortness of breath. The resident used a wheelchair or walker for mobility and needed moderate assistance with toileting and personal hygiene and supervision with transfers. The Care Plan dated 10/10/24 revealed the resident was at risk for falls and had an activities of daily living (ADL) deficit. The Care Plan indicated the resident needed standby assistance with a walker for mobility and was independent in bed mobility, personal hygiene and toileting. In an observation on 11/18/24 at 3:04 PM, Resident #13 was seated in her recliner near the foot of her bed facing the wall watching TV. The call light was attached to the wall located at the head of the bed and not in the residents reach. The resident reported she sometimes attached the call light to the bottom of her bed so it was more easily accessible but stated she thought she could get up and get to it if needed. In an observation on 11/20/24 at 1:09 PM, Resident #13 was seated in her recliner eating her lunch. The recliner was located near the foot of the bed facing the wall. The call light was attached to the wall located at the head of the bed and not in the residents reach. The resident stated she was able to independently walk to the call light using her cane if she should need it. The resident acknowledged she was at times weak and at risk for falls and stated maybe she should ensure the call light was within her reach in the recliner. The resident stated the staff did not put the call light in her reach when she was seated in her recliner. In an observation on 11/21/24 at 9:26 AM, Resident #13 was seated in her recliner watching TV. The call light was attached to the wall at the head of the bed and not within the residents reach.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 44972 Based on facility document review, staff interview and policy review, the facility failed to comply with all applicable Federal Regulations regarding Medicare requirements governing billing practices by failing to serve a Skilled Nursing Facility (SNF) Advanced Beneficiary Notice (ABN) form 48 hours before the resident ended skilled services for 1 of 3 residents reviewed for liability and appeal notices (Resident #90). The facility identified a census of 35 residents. Findings include: Review of facility documentation for Resident #90 revealed the resident received Medicare benefits for skilled services 6/6/24 through 6/26/24. The facility failed to provide the required SNF ABN (Centers for Medicare and Medicaid Services (CMS) form 10055), to inform the resident of the potential liability if skilled serves continued, 48 hours prior to skilled services ending. In an interview on 11/20/24 at 9:47 AM, the Administrator stated it was the expectation the ABN's be completed timely and accurately. He reported there had been a change in staff and 1 of the 3 residents reviewed was not completed timely or accurately. He reported training had been initiated to ensure the ABN's were completed appropriately moving forward. In a facility provided policy titled Medicare Advanced Beneficiary Notice dated 4/21, it stated the following: If the admissions coordinator or business office manager believes (upon admission or during the resident's stay) that Medicare (Part A of the Fee-for-Service Medicare Program) will not pay for an otherwise covered skilled service(s), the resident (or representative) is notified in writing why the service(s) may not be covered and of the resident's potential liability for payment of the non-covered service(s). a. The facility issues the Skilled Nursing Facility Advanced Beneficiary Notice (CMS form 10055) to the resident prior to providing care that Medicare usually covers, but may not pay for because the care is considered not medically reasonable and necessary, or custodial. b. The resident (or representative) may choose to continue receiving the skilled services that may not be covered, and assume financial responsibility.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 Based on record review, resident interview, staff interview and policy, the facility failed to ensure quarterly interdisciplinary team meeting with inclusion of the resident to discuss resident changing goals and revisions to the care plan for 1 of 2 residents reviewed, (#28). The facility reported a census of 35 residents. Findings included: The Minimum Data Set (MDS) dated [DATE] for Resident #28 documented a Brief Interview of Mental Status (BIMS) of 15 indicated intact cognitive impairment. The MDS documented diagnoses included cerebral infarction, cancer, diabetes, pain and anxiety disorder. The Care Plan included initiated 12/15/23 documented intervention to review resident choices quarterly and as needed. In an interview on 11/18/24 at 11:48 AM, Resident #28 relayed recalled going to only one care conference meeting. Stated, wanted to attend and inquired about how to know when the meetings occurred. On 11/20/24 at 10:15 AM, Social Services, Staff D relayed she is now responsible for ensuring care conference meetings for quarterly review and MDS updates. Relayed started the process about three months ago. Staff D stated had a new process and not sure how process was handled in the past, could not locate a meeting book or sign in sheets to verify the care conference meetings were done. On 11/21/24 at 9:00 AM, the Administrator revealed two documents to support resident involvement in a care conference on 12/15/23 and on 8/29/24. Administrator relayed could not locate any other documents to indicate Resident #28 was invited or took part in any other quarterly care conferences. The Administrator stated the expectation is the resident should have been included in quarterly reviews. Policy titled, Resident Participating, Assessment/Care Plans, revised February 2021 documented: The social services director or designee is responsible for notifying the resident/representative and for maintaining records of such notices to include a. Date, time and location of the conference. b. Name of each person contacted and the date was contacted. c. Method of contact. d. Input from the resident/representative if not able to attend. e. Refusal of participation if applicable. f. The date and signature of the individual making the contact.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 Based on resident interview, staff interview, record review and policy the facility failed to follow professional standards of medication administration leaving medication at bedside for 1 of 1 resident's (Resident #6). The facility reported a census of 35. Findings include: 1. A Minimum Data Set (MDS) dated [DATE], documented the diagnoses for Resident #6 included diabetes, seizure disorder or epilepsy, psychotic disorder, schizophrenia, pain, respiratory disease, and depression. The resident's Brief Interview for Mental Status (BIMS) score was 14, indicated is cognitively intact. A Care Plan initiated 5/28/21 for Resident #6 documented resident had a mood problem related to schizophrenia, delusional disorders, and major depressive disorder requires medications included antidepressants, anticoagulant a term for blood thinners, antianxiety, antipsychotic, hypoglycemic and antihypertension medications. Staff to administer the medications as ordered observe for adverse side effects, document and report to the physician. During an observation on 11/19/24 at 8:45 AM two clear medication cups with various pills of different color and sizes sat on Resident #6 bedside. Resident #6 was lying in bed appeared to be sleeping with eyes closed. On 11/19/24 at 8:46 AM Resident #6 quired about the pills observed in two separate cups on the bedside table. Resident #6 relayed they are mine and am not ready to get up yet, nursing staff summoned. On 11/19/24 at 8:47 AM Certified Medication Aide, (CMA) Staff A came to the room, resident took all pills. Staff A relayed did set up resident medications this morning in two separate medication cups because there are so many. Stated gave resident the nasal spray, inhaler, eye drops and left. Stated resident is usually good to get up and take them right away, did not see her take the pills, had assumed resident would take them. On 11/19/24 PM at 4:00 PM Administrator and Director of Nursing (DON) notified, feedback relayed that medications should not be left unattended, staff to wait and observe to ensure medications are taken. Resident #6 is not approved to self administer own medications. Facility policy titled Administering Medications, not dated revealed residents may self administer their own medications only if the attending physician in conjunction with the team has determined resident have the decision making capacity to do so safely.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 Based on observations, clinical record review, staff interview and resident interview. The facility failed to ensure resident treatment per the physician order for 1 of 3 residents reviewed (Resident #28,). The facility reported the census is 35. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #28 documented a Brief Interview of Mental Status (BIMS) of 15 indicated intact cognitive impairment. The MDS documented diagnoses included cerebral infarction, cancer, diabetes, pain and anxiety disorder. The Care Plan included initiated 12/16/23 documented focus had potential for impairment to my skin related to fragile skin and at risk for potential skin and soft tissue infection, interventions included to assess for signs and symptoms of infection. The Medication Administration Records (MAR) documented an order to start on 10/24/24 for salicylic acid external liquid, apply to toes topically one time a day for wart, soak wart in warm water for 5 min, dry area and apply one drop, let dry. The treatment was not done as ordered daily from 10/24/24 to 11/21/24. The Progress Notes documented revealed drug was unavailable. On 11/18/24 at 11:57 AM, Resident #28 stated has pain in her toe, scaled at 2 or 3 on a scale of 10. Resident #28 stated staff looked at it, not sure if it was a podiatrist, did recall was said, would get something for it, no one ever did, relayed it is going on two months. In an interview on 11/19/21 at 2:30 PM, the Director of Nursing (DON) queried about process's when a medication is not available from the pharmacy. The DON relayed had another provider if that provider could not ensure delivery the provider would be notified to get another alternative order or to hold. In a follow up interview on 11/21/24 at 12:45 PM the DON acknowledged resident had not had the treatment ordered on 10/24/24 and called the pharmacy yesterday and was told by the pharmacy needed additional approval and thought they would be sending it out today. Also relayed, thought had called the pharmacy about this prior, could not provide documentation of any alerts to the provider or the pharmacy that the medication was not available.

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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.

44972

Based on clinical record review, observation, staff interview and facility policy review, the facility failed to maintain proper infection control practices to prevent cross contamination and potential infection of residents when providing medications and treatments. The facility reported a census of 35 residents.

Findings include:

1. In an observation on 11/19/24 at 7:23 AM, Staff A, Certified Medication Aide (CMA) failed to perform hand hygiene prior to donning gloves to administer Timolol medicated eye drops to Resident #4. She was further observed to touch several items with gloved hand prior to administering the eye drops to the resident. Upon completion of administration per facility protocol, Staff A, removed her gloves but failed to perform hand hygiene.

2. In an observation on 11/19/24 at 7:25 AM, Staff A, CMA was observed to drop Resident #24's Amlodipine tablet on the top of the medication cart. Staff A picked the tablet up with her ungloved hand and placed it into the medication cup with the resident's other medications and administered them to the resident. She failed to discard the tablet and obtain a new one for the resident.

3. In an observation on 11/19/24 at 7:25 AM, Staff A, CMA failed to perform hand hygiene prior to setting up and after administering Resident #24's morning medications. She further failed to perform hand hygiene prior to donning gloves to assist resident with Fluticasone nasal spray. She was observed to touch several items with donned gloves prior to administering the nasal spray. Upon completion of administration per facility protocol, Staff A removed her gloves but failed to perform hand hygiene.

4. In an observation on 11/19/24 at 7:37 AM, Staff A, CMA failed to perform hand hygiene prior to setting up and after administering Resident #35's morning medications. She further failed to perform hand hygiene prior to donning gloves to assist resident with Stiolto Respimat inhaler. She was observed to touch several items with donned gloves prior to assisting the resident with the inhaler. Upon completion of administration per facility protocol, Staff A removed her gloves but failed to perform hand hygiene.

5. In an observation on 11/19/24 at 7:48 AM, Staff A, CMA failed to perform hand hygiene prior to setting up and after administering Resident #31's morning medications. She further failed to perform hand hygiene prior to donning gloves to assist resident with Refresh eye drops. She was observed to touch several items with donned gloves prior to administering the eye drops. Upon completion of administration per facility protocol, Staff A removed her gloves but failed to perform hand hygiene.

In an interview on 11/21/24 at 10:30 AM, the Director of Nursing (DON) stated it was the expectation all medication staff perform hand hygiene prior to and after each medication pass. The DON stated staff were to perform hand hygiene before and after donning gloves as well. If a medication was dropped during a medication pass, staff were to don a glove and dispose of it per policy and obtain a new medication to administer to the resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility provided policy titled Administering Medications revised April 2019 stated staff were to follow established infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 Based on observations, staff interview, resident interview and policy review the facility failed to ensure a clean, sanitary environment in a kitchen storage room and failed to ensure a clean comfortable environment for 1 of 14 resident rooms (Resident #28). The facility reported the census is 35. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #28 documented a Brief Interview of Mental Status (BIMS) of 15 indicated intact cognition. The MDS documented diagnoses included cerebral infarction, cancer, diabetes, pain and anxiety disorder. The Care Plan included initiated 12/16/23 documented Resident is at risk for falls, interventions included needed a safe environment without clutter. An observation on 11/18/24 at 11:46 AM Resident #28 in room recliner, next to the recliner on the floor was a pile of paper, books, clothing items, open candy, open box of snack food and additional clutter. On the sink counter was more candy, open food, clothing and papers piled. A small square counter refrigerator observed on the floor. In an interview on 11/18/24 at 11:48 AM Resident #28 reported wished staff would sweep or mop once in a while, had not done cleaning since arrived, relayed takes own trash to the larger receptacle, hated to bother staff. On 11/19/20 at 3:20 PM Resident #28 sat in room recliner observed again the counter top, both sides of the sink were piled with food, open caramel popcorn, various kinds of candy boxes and open packages, decor, papers and other personal items piled. Resident relayed staff have never ever come to help me clean my room, would love if could get help sorting some of that, pointing to the counter. In addition relayed maintenance staff is very busy, does not want to bother anyone. On 11/20/24 at 4:00 PM resident in room recliner, acknowledged again, no housekeeping had been done in the room and could not recall ever having help with cleaning. In an interview on 11/21/24 at 10:23 AM with Maintenance Supervisor, Staff B relayed was responsible for housekeeping schedule, all rooms were clean alternating schedule with two housekeepers that collaborated so no rooms were missed. Staff B expected a resident to have staff assistance with organization as the wanted. Relayed all rooms are deep cleaned on a rotating schedule. Staff B entered Resident #28 room and acknowledged work was needed with the clutter. Resident #28 present and expressed her desire to have housekeeping and assistance with organization. 2. In an observation on 11/18/24 at 10:00 AM during a tour of the kitchens dry storage room viewed a (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	steel rolling rack against the wall, visible crumbs, powder, plastic cup lids, spoon and an open torn package of rodent poison on floor. A desk next to rack had a paper debris underneath. Also observed appearance of mice droppings along the baseboard. In an interview on 11/18/24 at 11:00 AM with the Kitchen manager, Staff C who relayed has not had any issues with mice in months, issue corrected with replacement of door strips on bottom of doors that were missing, acknowledged concern of debris and mouse droppings in the food storage room and responded the storage room should have been clean. In an interview on 11/18/24 at 4:00 PM with the Administrator relayed pest control was called and resolved mice issue quickly months ago, would be forwarding pest control report and invoices, would have expected the floor to have been clean. Facility policy titled, Cleaning and Disinfecting Residents room, Revised August 2013 included housekeeping of floors, tabletops will be cleaned on a regular basis, included disinfected. Personnel should remain alert for evidence of rodent activity (droppings) and report such findings.