STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165399	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care Center	815 High Road Norwalk, IA 50211

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42134 Based on clinical record review, policy review and staff interview the facility failed to report an allegation of abuse to the Department of Inspections, Appeals and Licensing (DIAL) (state survey agency) within 24 hours of the allegation for 1 of 1 incident reviewed (Resident#1). The facility reported a census of 79 residents. Findings Include: The Admission Minimum Data Set (MDS) dated [DATE] for Resident#1 documented a score of 12 out of 15 for the Brief Interview for Mental Status (BIMS), which indicated moderately impaired cognitive skills. The MDS documented that the resident had no behaviors, and diagnoses including high blood pressure, quadriplegia (paralysis of all four limbs), and anxiety. Progress Note written on 11/20/24 at 3:30 PM documented Resident #1 had concerns about Staff C, Certified Nursing Assistant (CNA), being rough with him while positioning the resident and he requested she not work with him in the future. Progress Note written on 11/20/24 at 3:40 PM documented Resident #1 explained to the nurse managers that Staff C had put him in a headlock and pulled on his neck to push him over. He further explained he asked her to stop and he heard cracking noises in his neck. The resident was assured that staff would be educated on proper positioning techniques. Staff C's personnel file contained a coaching form dated 11/20/24 documenting education related to the need to be gentle with repositioning. The file also contained a 1 paragraph typed statement documenting coaching on proper positioning techniques and safe handling of residents. Education provided relating to resident's head and neck sensitivity, positioning needs and expressing extra compassion due to age and comorbidities when a resident has a tracheostomy. The facility Event Investigation Summary dated 11/21/24 documented upon completion of the investigation the facility was unable to substantiate that abuse had occurred. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled Abuse Prevention last revised 10/21/22 defines abuse including physical abuse: using more force than necessary for proper control and mistreatment: inappropriate treatment of a resident. The policy documents the facility will initiate an investigation to determine cause and effect. The policy directs staff to report the alleged abuse immediately but not more than 24 hours to the state survey office and report the results of all investigations to the state survey agency within 5 working days of the alleged incident. During an interview on 12/16/24 at 3:40 PM the Administrator confirmed the incident had not been reported to the state survey agency. She explained the reason it was not reported was education was provided to the CNA. They did not feel it was an allegation of abuse.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 48452 Based on clinical record review, bathing documentation, interviews, and facility policy the facility failed to provide residents at least two showers or bed baths per week for 4 of 4 residents reviewed (Residents #1, #2, #5, and #6). Documentation determined residents went as long as 10 days without a shower. The facility reported a census of 79 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #1 dated 8/26/24 revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated moderate cognitive impairment. The MDS documented diagnoses including neurogenic bladder (bladder control issues due to damage to the brain, spinal cord, or nerves), septicemia (bacteria in the blood causing systemic infection), and quadriplegia. Resident #1 was dependent on staff for cares. The Care Plan for Resident #1 initiated 8/22/24 indicated Activities of Daily Living (ADL) self-care performance deficits due to quadriplegia and tracheostomy. Interventions included offering bathing/showering twice weekly and as necessary, and to provide a sponge bath when a full bath could not be tolerated. The facility provided documentation of Resident #1's bathing during October and November 2024. An untitled ADL document dated October 2024 revealed the resident received no showers during the month. Additional documentation titled Shower Audit, provided 12/17/24 at 12:36 PM, revealed the resident was scheduled to receive 6 showers in November. He received 3 and refused or missed 3. The resident was scheduled for 9 showers in October. Showers on 10/2/24 and 10/29/24 were not given, 10/16/24 was documented as the resident was hospitalized when he was not, and 10/23/24 was documented as given while resident was in the hospital. The facility was unable to provide progress notes supporting refusals, rescheduling, or offer of bed baths. 2. The Minimum Data Set (MDS) for Resident #2 dated 11/12/24 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 which indicated no cognitive impairment. The MDS documented diagnoses of cancer, polyneuropathy, and multiple sites of muscle wasting and atrophy. The Care Plan for Resident #2 initiated 10/22/24 indicated Activities of Daily Living (ADL) self-care performance deficit. Interventions included offering bathing/showering twice weekly and as necessary, and to provide a sponge bath when a full bath could not be tolerated. Documentation titled Shower Audit, provided by the facility 12/17/24 at 12:36 PM, indicated the resident received 1 shower between 12/2/24 and 12/17/24. November documentation revealed the resident missed showers on 11/9/24, 11/27/24, and 11/30/24. The facility was unable to provide progress notes supporting refusals, rescheduling, or offer of bed baths. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The Minimum Data Set (MDS) for Resident #5 dated 10/18/24 revealed a Brief Interview for Mental Status (BIMS) score of 8/15 which indicated moderate cognitive impairment. The MDS documented diagnoses of non-Alzheimer's dementia, adult failure to thrive, and developmental disorder of speech and language. The resident required partial to moderate assistance with bathing. The care plan for Resident #5 initiated 12/8/23 indicated an Activities of Daily Living (ADL) self-care performance deficit. Interventions included offering bathing/showering twice weekly and as necessary. A document titled POC Response History from the resident's electronic health record documented bathing on 12/4/24, 12/8/24, and 12/9/24. Bathing on 12/11/24 and 12/16/24 was documented as not applicable. The Shower Audit document revealed the resident missed bathing on 11/20/24, 12/7/24, 12/11/24, and 12/14/24 without rescheduling. Bathing on 12/8/24 and 12/9/24 was not recorded. The facility was unable to provide additional documentation. 4. The Minimum Data Set (MDS) for Resident #6 dated 10/28/24 revealed a Brief Interview for Mental Status (BIMS) score of 5/15 which indicated severe cognitive impairment. The MDS documented diagnoses of Parkinson's disease, seizure disorder, and non-Alzheimer's dementia. The resident was dependent on staff for bathing. The care plan for Resident #6 initiated 10/20/23 indicated an Activities of Daily Living (ADL) self-care performance deficit. Interventions included assistance of 1 with a second staff member present due to requiring 2 staff with all interactions, twice weekly and as necessary. The resident's electronic health record documented showers were not applicable from 12/4/24 through 12/16/24. The Shower Audit listed a missed shower on 11/16/24. The facility was unable to provide additional documentation of bathing or offer of an alternate date. During an interview with Staff D, Registered Nurse (RN) on 12/17/24 at 9:34 AM she stated most residents take a bath twice a week and as needed. Before the recent transition to the electronic health record a few weeks ago there used to be a book with all of the resident's ADL sheets and a bath sheet that was signed off every day. When asked what happened if a resident refused, she stated the aide would get a nurse, the nurse would assess the resident and determine if the resident would take a shower, might need a bed bath, or if it was a refusal. For refusals, bathing would be moved to the next day. On 12/17/24 at 9:40 AM during an interview with Staff E, Certified Medication/Nursing Aide (CMA, CNA), she revealed shower sheets were completed for residents and put in a box for the Director of Nursing (DON). Residents received 2 showers a week and as needed. At 12:39 PM on 12/17/24 the DON provided the spreadsheet for bathing that tallied all of the shower sheets she and the ADON received. She confirmed it was color coded according to the days residents were supposed to receive bathing. It was documented with refusals (R) and hospital (H) stays. The X indicated the service was provided. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/17/24 at 1:40 PM the Administrator stated she didn't know the CNAs were still using the shower sheets and binder. She stated they should hold CNAs accountable to completing the ADL sheets that included bathing. She reported she looked at them and confirmed there was no documentation on them regarding bathing. When she started asking about it during the survey was when she found out they were still using the binder. She stated it was probably a system issue they needed to address. A policy titled ADL Care Bathing, last reviewed 7/21/22 documented nursing assistants, the charge nurse, nursing administration, and the director of nursing were responsible for bathing. The charge nurse would be made aware of residents who refused bathing.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 49976 Based on observation, clinical record review, and resident and staff interviews the facility failed to provide routine perineal cares of incontinent residents for 1 of 4 residents observed for cares (Res #2). The facility reported a census of 79 residents. Findings Include: The Minimum Data Set (MDS) report dated 11/12/24 documented Resident #2 had a Brief Interview for Mental Status (BIMS) score of 13/15 which indicated no cognitive impairment. The MDS reported the resident required substantial/maximal assistance for toileting and toilet transfers. The Medical Diagnosis list initiated 10/22/24 documented diagnoses including: malignant neoplasm of colon (cancer), need for assistance with personal cares, and difficulty walking. The Care Plan dated 10/22/24 for Resident #2 instructed staff to use an EZ stand with assist of 2 staff for toileting, and documented a check and change audit was initiated 10/28/2024 due to the resident and family denying cares were being provided. It further noted the resident had bowel incontinence and instructed staff to observe the pattern of incontinence and initiate a toileting schedule if indicated. A review of the Check and Change Audit forms started 11/11/24 revealed staff were instructed to document and complete a check and change for Resident #2 every 2 hours and PRN (as needed). They further noted the resident was to sign off on all cares completed as of 11/25/24. The forms exposed a lack of documentation from staff for 27 out of 35 days on various shifts. It further revealed staff failed to check and change the resident within the 2-hour time frame for 23 out of 35 days, with the resident going up to 8 hours without cares. The resident did not sign off on cares 17 times, and a note from staff dated 12/03/24 revealed overnight cares were falsely documented and the resident had not been changed at all on third shift the prior evening. In an interview on 12/17/24 at 7:48 AM Resident #2 stated she was not changed from Friday night (12/13/24) to Saturday morning (12/14/24). A review of the audit sheets revealed there was no documentation of check and changes from third shift that evening. In an interview on 12/17/24 at 8:30 AM Staff A, Certified Nursing Assistant (CNA) explained staff were expected to check and change incontinent residents every 2 hours. She noted she did not feel the staff had enough time to get everyone checked and changed. She stated Resident #2 was leaving the facility because of this. She reported it could be all over the place for when residents were checked and changed- sometimes over two hours for sure. Every resident was complaining. She felt there were not enough staff to get cares done on time. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/17/24 at 9:07 AM Staff B, CNA/Certified Medication Aide explained staff were expected to check and change incontinent residents every two hours. She did not feel she had enough time or help to do that consistently. She believed residents have had to wait as long as 5-6 hours for this, especially on third shift as in the morning residents were soaked with urine. She noted residents have complained of not being checked and changed. She explained Resident #2 was supposed to be toileted every 1-2 hours and staff were to sign off on all cares but this was not being done all of the time. She stated there were not enough CNA's as they could not answer call lights and get everyone checked and changed as needed. In an interview on 12/17/24 at 12:42 PM the Director of Nursing (DON) explained she expected staff to check and change incontinent residents every 2 hours and PRN. The facility policy titled Incontinent Care, reviewed 7/21/22 failed to address the required frequency of checking and changing incontinent residents.