STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165405	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Happy Siesta Health Care Center	423 Roosevelt St Remsen, IA 51050

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to notify the physician in a timely manner of a change in condition for 1 of 15 residents reviewed (Resident #22). The facility reported a census of 50 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #22 had a Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. Diagnoses included aphasia (language disorder affecting the ability to communicate), schizophrenia, and adverse effects of unspecified antipsychotics and neuroleptics. The Care Plan initiated 3/9/22 identified the resident used an opioid medication. The interventions included observing and reporting changes in usual routine, sleep patterns, decrease in functional abilities, decreased range of motion (ROM), withdrawal or resistance to care. The Care Plan dated 6/21/22 documented the resident took psychoactive medications related to schizophrenia, anxiety, and depression. The interventions included observing for and reporting as needed any adverse reactions to: Depakote; including lethargy. Antidepressant; including fatigue, appetite loss. Antipsychotic; including fatigue, loss of appetite. Antianxiety; including drowsiness, slow reflexes, The Progress Notes documented: a. On 5/29/25 at 1:17 p.m. the resident found to have lowered herself to the floor next to her bed and resting her head on the bed. She responded slowly and appeared sleepy. Resident's hands were warm to touch and cheeks flushed. Assisted the resident with removing her sweater. She had a temperature of 98.2. The resident requested to lay back down in bed. Assisted the resident to bed and rest with her eyes closed. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 5/30/25 at 3:06 p.m. the resident had been lethargic and weak during the shift. She said she didn't feel very good, but could not be specific about what didn't feel well. She required 2 assist with transfers on and off the toilet. She had a difficult time holding an upright position while on the toilet. Vital signs (V/S) were temperature (T) 97.6, pulse (P) 81 respirations (R) 20, blood pressure (BP) 91/53 oxygen (O2) saturation (sat) 93% on room air (RA). She had no coughing noted or signs and symptoms of shortness of breath (SOB). Her bilateral arms/hands had tremors at times and had a difficult time holding a glass of liquid. Staff assisted her with both meals. The resident laid down from 10 a.m. until 12:30 p.m. Staff assisted her to the bathroom and asked her if she was hungry and she nodded her head yes. Staff brought the resident out and assisted with lunch. No foul odor noted to urine. Unable to get the resident to take deep breaths to assess lung sounds effectively. The nurse reached out to the resident's Power of Attorney (POA) and updated her. At 3:18 p,m. unable to reach the resident's POA due to being out of the office until Monday. Would call her Monday. c. On 5/31/25 at 12:49 a.m. the resident continued to appear lethargic. She rested in bed and exhibited periods of apnea (temporary cessation of breathing). Her skin was cool to the touch and her room was also cold. She responded to verbal stimuli and was able to move all extremities, though her movements were slow. She was unable to take deep breaths for a proper lung assessment. The resident responded to a few questions when prompted. She denied experiencing cough, sore throat, or body aches. However, she was confused, consistent with her baseline due to dementia. VS B/P, 112/81, P 92, O2 95%, tympanic temp 97.6, R 18. d. On 5/31/25 at 1:42 p.m. the resident was lethargic and not very talkative that shift. Her vital signs were stable and the resident unable to verbalize if she was not feeling well. The resident pocketed food at meals, and appetite poor. She did not drink much fluids even when asked by staff. She did take medications without any incident. Resident not her normal self. e. On 6/1/25 at 10:20 a.m. the resident had been sleepy during the shift. She was helped in the morning with cares, and came out for breakfast, eating 50%. Vital signs within normal ranges. The resident did not complain of, or show signs of pain. f. On 6/1/25 at 8:48 p.m. the resident continued to be very lethargic, pale, and cool to the touch. with periods of apnea noted. Her eyes were open during the assessment. When asked her if she felt sick, she whispered yes. Vital signs taken. The resident did take her pills with much encouragement and drank about 2 ounces of water. The resident rested in her bed. Would continue to monitor. g. On 6/2/25 at 8:11 a.m. house supplement held due to lethargy. h. On 6/2/25 at 9:47 a.m. called and spoke with the POA about changes noted with the resident. The resident continued to be lethargic. She sat with eyes open during shower and responded very little. The resident unable to maintain an upright position on the shower chair and leaned to the right. Sent a fax to the physician updating him, and asking if he would advise any testing. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. On 6/2/25 at 12:50 p.m. the resident found to have lowered herself onto the floor next to her bed. Required assistance of 2 with a gait belt to get her up into her wheelchair and into the bathroom. The resident continued to have difficult time maintaining upright posture while sitting on the toilet, and was incontinent of urine. Incontinence cares provided. Urine continued with no foul odor. When asked if she was thirsty resident softly answered yes. Assisted the resident with a glass of water and a cup of pudding, eating almost all of the pudding and drinking about 3/4 of the water. While assisting her, the resident drooled a few times. The resident sat with her eyes open and didn't speak. Call placed to the physician's office about the fax sent that morning to make sure they received it. Left a detailed message on the physician's nurse's voicemail. j. On 6/2/25 at 2:17 p.m. the resident's medications held due to being lethargic. k. On 6/2/25 at 4:31 p.m. the resident lethargic and not taking fluids. l. On 6/3/25 at 9 a.m. telephone order (T.O.) received to hold medications if the resident lethargic and unable to take. m. On 6/3/25 at 9:15 a.m. fax received back (from the physician) with orders to obtain a Complete Blood Count (CBC), Comprehensive Metabolic Panel (CMP) and Urinalysis (UA). T.O. received to obtain UA with microscopic via mini catheter. n. On 6/3/25 at 9:35 a.m. obtained samples for labs. The resident rested in bed. She continued to be lethargic, laying with eyes open and responding very little. Tried pudding and water and the resident let both run back out of her mouth. o. On 6/3/25 at 12:30 p.m. call received from the physician's nurse reporting a critical value on res blood work. Her sodium was at 175 (reference 136 to 145). The physician's nurse stated the resident's POA would need to decide if she would like the resident seen in the emergency room (ER) for possible treatment, or look at end of life care. Call placed to res POA and would like the resident evaluated at ER. The physician notified of the POA decision. T.O. received to have the resident transferred by ambulance to the ER for evaluation. p. On 6/3/25 at 8 p.m. call received from the hospital stating the resident would be admitted to the hospital. A Physician Communication Form dated 6/2/25 at 9:40 a.m. documented the res. showed a decline over the last week. She responded very little that day and was lethargic. Required 2 assist for transfers. VS remained stable. Had a small amount of clear nasal drainage early last week, and complained of not feeling well. No cough or cold symptoms. The resident would sleep significantly more for a few days, then return to normal self. They were not seeing any improvement. Asked if the physician would advise any testing. Urine clear without foul odor. Has ate and drank very poorly since 5/27/25. The physician responded CBC, CMP, UA with micro dated 6/3/25. The hospital History and Physical dated 6/3/25 documented the resident had shown a gradual decline in her clinical condition the previous few months, but a drastic change the past couple of days. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident had been less active and talkative lately, but showed a dramatic change over the last couple of days. The nursing facility reached out about obtaining labs. Her white blood count (WBC) was slightly elevated at 12.9, hemoglobin 17.3, sodium 175, BUN 121 (reference range 7 to 18) and creatinine 4.75 (reference range 0.55 to 1.02). Calcium mildly elevated at 10.7 (reference range 8.5 to 10.1). The resident admitted for continued care while they worked with her guardian to determine final course of care. On 6/11/25 at 1 p.m. Staff A Licensed Practical Nurse (LPN) said on 5/30/25, a Friday, (she worked Monday through Friday) she knew the resident was sleepy, but she'd had that before, so waiting a day before doing anything, was appropriate at the time. When she returned to work on 6/2/25 she could see the resident had not improved from Friday, so she tried to get hold of the doctor. She sent a fax out and called the office 2 to 3 times. Staff A said if she had worked the weekend she would have gotten something going sooner. On 6/11/25 at 1:40 p.m. Staff G Certified Nursing Assistant (CNA) stated prior to the hospitalization the resident was lethargic, and seemed to be in pain. On 6/11/25 at 1:45 p.m. Staff E Certified Nursing Assistant (CNA) stated prior to the hospitalization she was declining from Thursday (5/29/25) on. The nurses on the weekends were not as familiar with the resident. She ate very little. They had to wake her, but she was drinking. She didn't seem to be in pain. On 6/11/25 at 2:05 p.m. Staff B CNA stated prior to the hospitalization she had not been herself. They were wondering if she may have bumped her head sometime when getting down on the floor. On 6/11/25 at 4:50 p.m. Staff C RN stated when she worked in the unit prior to the resident's hospitalization, she was fatigued and didn't feel good. On 6/11/25 at 4:58 p.m. Staff D CNA stated prior to the hospital, the resident was very sleepy and not eating or drinking. On 6/12/25 8:31 a.m. the resident's Physician stated ideally they would have reported sooner. If they had notified him sooner, caught (the hypernatremia) earlier, and successfully treated it, he thought she would have died within 6 months. He said the resident had some dehydration, but there could be other causes of hypernatremia. He could not specify at the time. On 6/12/25 at 9:42 a.m. the Administrator stated the doctor and the psych ARNP were on vacation that week. They also knew the resident had been having a gradual decline. On 6/12/25 at 10:10 a.m. the resident's Physician stated when is on vacation the facility can send a fax to the office and the nurse would pass it along to another provider as necessary. If it was after hours they would call the ER on call. He said they usually responded to faxes the same day unless it was sent late afternoon. The facility undated Notification of Change Policy included the facility nursing staff should be responsible in notifying the resident's physician of changes in a resident's condition.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure staff implemented resident specific interventions for psychotropic medications for 1 of 6 residents reviewed (Resident #22). The facility reported a census of 50 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #22 had a Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. Diagnoses included aphasia (language disorder affecting the ability to communicate), schizophrenia, and adverse effects of unspecified antipsychotics and neuroleptics. The Care Plan dated 6/21/22 documented the resident took psychoactive medications related to schizophrenia, anxiety, and depression. The interventions included observing for and reporting as needed any adverse reactions to: Depakote; including lethargy. Antidepressant; including fatigue, appetite loss. Antipsychotic; including fatigue, loss of appetite. Antianxiety; including drowsiness, slow reflexes, The Psych Advanced Registered Nurse Practitioner (ARNP) managed the resident's medications. An Outpatient Psychiatric/Mental Health Progress Note dated 5/14/25 documented the resident's medications included Divalproex (anticonvulsant), Risperdal (antipsychotic), Sertraline (antidepressant), and Lorazepam (antianxiety). Treatment recommendations and orders included increasing Lorazepam 0.5 mg 3 times a day, to Lorazepam 1 mg every morning and 2 p.m. and continuing Lorazepam 0.5 mg at bedtime. Discharge instructions included calling with concerns or questions. The Progress Notes documented : (continued on next page)

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. On 5/30/25 at 3:06 p.m. the resident had been lethargic and weak during the shift. She said she didn't feel very good, but could not be specific about what didn't feel well. She required 2 assist with transfers on and off the toilet. She had a difficult time holding an upright position while on the toilet. Vital signs (V/S) were temperature (T) 97.6, pulse (P) 81 respirations (R) 20, blood pressure (BP) 91/53 oxygen (O2) saturation (sat) 93% on room air (RA). She had no coughing noted or signs and symptoms of shortness of breath (SOB). Her bilateral arms/hands had tremors at times and had a difficult time holding a glass of liquid. Staff assisted her with both meals. The resident laid down from 10 a.m. until 12:30 p.m. Staff assisted her to the bathroom and asked her if she was hungry and she nodded her head yes. Staff brought the resident out and assisted with lunch. No foul odor noted to urine. Unable to get the resident to take deep breaths to assess lung sounds effectively. The nurse reached out to the resident's Power of Attorney (POA) and updated her. At 3:18 p,m. unable to reach the resident's POA due to being out of the office until Monday. Would call her Monday. b. On 5/31/25 at 12:49 a.m. the resident continued to appear lethargic. She rested in bed and exhibited periods of apnea (temporary cessation of breathing). Her skin was cool to the touch and her room was also cold. She responded to verbal stimuli and was able to move all extremities, though her movements were slow. She was unable to take deep breaths for a proper lung assessment. The resident responded to a few questions when prompted. She denied experiencing cough, sore throat, or body aches. However, she was confused, consistent with her baseline due to dementia. VS: 112/81, P 92, O2 95%, tympanic 97.6, 18. c. On 5/31/25 at 1:16 p.m. the aide came to get the writer to evaluate the resident's right foot and right hip due to bruising. The writer noted a purplish/gray, 6 cm x 6 cm bruise to the top of her right foot. Also noted purple/gray diffuse bruising to the right hip. Due to the residents condition, unable to get description of what happened. d. On 5/31/25 at 1:42 p.m. the resident was lethargic and not very talkative that shift. Her vital signs were stable and the resident unable to verbalize if she was not feeling well. The resident pocketed food at meals, and appetite poor. She did not drink much fluids even when asked by staff. She did take medications without any incident. Resident not her normal self. e. On 6/1/25 at 10:20 a.m. the resident had been sleepy during the shift, she was helped in the morning with cares, and came out for breakfast, eating 50%. Vital signs within normal ranges. The resident did not complain of, or show signs of pain. f. On 6/1/25 at 8:48 p.m. the resident continued to be very lethargic, pale, and cool to the touch. with periods of apnea noted. Her eyes were open during the assessment. The writer asked her if she felt sick and she whispered yes. Vital signs taken. The resident did take her pills with much encouragement and drank about 2 ounces of water.The resident rested in her bed. Would continue to monitor. g. On 6/2/25 at 8:11 a.m. house supplement held due to lethargy. h. On 6/2/25 at 9:47 a.m. called and spoke with the POA about changes noted with the resident. The resident continued to be lethargic. Sat with eyes open during shower and responded very little. Unable to maintain an upright position on the shower chair and leaned to the right. Fax sent to the physician updating him, and asking if he would advise any testing. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. On 6/2/25 at 12:50 p.m. the resident found to have lowered herself onto the floor next to her bed. Required assistance of 2 with gait belt up into her wheelchair and into the bathroom. The resident continued to have difficult time maintaining upright posture while sitting on the toilet, and was incontinent of urine. Incontinence cares provided. Urine continued with no foul odor. When asked if she was thirsty resident softly answered yes. Assisted the resident with a glass of water and a cup of pudding, eating almost all of the pudding and drinking about 3/4 of the water. While assisting her the resident drooled a few times. The resident sat with her eyes open and didn't speak. Call placed to the physician's office about fax sent that morning to make sure they received it. Detailed message left on the physician's nurses voicemail. j. On 6/2/25 at 2:17p.m. the resident's meds held due to being lethargic. k.On 6/2/25 at 4:31 p.m. the resident lethargic and not taking fluids. l. On 6/3/25 at 9 a.m. telephone order received to hold medications if res if lethargic and unable to take. m. On 6/3/25 at 9:15 a.m. fax received back with orders to obtain Complete Blood Count (CBC), Complete Metabolic Panel (CMP) and Urinalysis (UA) with microscopic. T.O. received to obtain UA via mini catheter. n. On 6/3/25 at 9:35 a.m. obtained samples for labs. The resident rested in bed. She continued to be lethargic, laying with eyes open and responding very little. Tried pudding and water and the resident let both run back out of her mouth. o. On 6/3/25 at 12:30 p.m. call received from the physician's nurse reporting a critical value on res blood work. Her sodium was at 175 (reference 136 to 145). The physician's nurse stated the resident's POA would need to decide if she would like the resident seen in the ER for possible treatment, or look at end of life care. Call placed to res POA and would like the resident evaluated at ER. The physician notified of the POA decision. T.O. received to have the resident transferred by ambulance to the ER for evaluation. p. On 6/3/25 at 8 p.m. call recieved from the hospital stating the resident would be admitted to the hospital. On 6/11/25 at 1 p.m. Staff A Licensed Practical Nurse (LPN) said on 5/30/25, a Friday, (she worked Monday through Friday) she knew the resident was sleepy, but she'd had that before, so waiting a day before doing anything, was appropriate at the time. When she returned to work on 6/2/25 she could see the resident had not improved from Friday, so she tried to get hold of the doctor. She sent a fax out and called the office 2 to 3 times. Staff A said if she had worked the weekend she would have gotten something going sooner. The clinical record lacked documentation the facility notified the psych ARNP of the resident's condition change after the increase in psychotropic meds. On 6/12/25 at 9:17 a.m. the psych ARNP stated she checked her record and she had not received notification about the resident in that timeframe. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility undated Psychotropic Medication Monitoring policy documented the facility would administer psychotropic medications appropriately working with the interdisciplinary team to ensure the appropriate use, evaluation, and monitoring.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to complete assessment after incidents for 1 of 2 residents reviewed (Resident #22). The facility reported a census of 50 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #22 had a Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. Diagnoses included aphasia (language disorder affecting the ability to communicate), schizophrenia, and adverse effects of unspecified antipsychotics and neuroleptics. The resident had 2 or more falls with no injury and 2 or more fall with injury since the previous assessment. The Care Plan initiated 6/21/21 identified a focus of Activities of Daily Living (ADL's). The interventions included the resident had a past history and current behavior of putting herself on the floor or ground. She was able to get herself up off the floor at times, but may need assistance getting up at times. The Care Plan initiated 7/5/21 identified the resident had cognitive impairment related to paranoid schizophrenia. The resident observed with behavior of putting self on the floor and crawling around, then getting herself to a standing position independently. The Care Plan initiated 11/2/23 identified the resident had impulsive and frequent position changes. She often declined assistance during these transfers. Safety awareness and spatial judgement was poor. Interventions included encouraging res to wear shoes during the day. The resident was noted to lower herself to the floor, usually in her bedroom, assure safety of the area, and free of objects that may cause harm, and encouraging her to sit in her recliner. On 5/29/25 at 1:17 p.m. the resident was found to have lowered herself to the floor next to her bed and resting her head on the bed. The resident was slow to respond to the writer and appeared sleepy. Her hands were warm to touch and cheeks flushed. The writer assisted the resident with removing her sweater. T-98.2. The resident requested to lay back down in bed. Assisted the resident to bed and rested with her eyes closed. On 5/31/25 at 1:16 p.m. the aide came to get the nurse to evaluate the resident's right foot and right hip due to bruising. The nurse noted a purplish/gray, 6 cm x 6 cm bruise to the top of her right foot, and purple/gray, diffuse bruising to the right hip. Due to the resident's condition, unable to get a description of what happened. On 6/2/25 at 12:50 p.m. the resident was found to have lowered herself onto the floor next to her bed. She required assistance of 2 with a gait belt to get her up into her wheelchair and into the bathroom. The resident continued to have a difficult time maintaining an upright posture while sitting on the toilet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/25 at 1 p.m. Staff A Licensed Practical Nurse (LPN) said they usually saw the resident when she would put herself on the floor. It was usually out in the main area. If she put herself on the floor in her room it would be from the bed down to the floor, and usually she would get back up on her own. Staff A said if the resident was found on the floor, and no one could see that she had done it herself, that would be an incident report with the appropriate investigative management. She said she saw her going down to the floor as she walked by her room on 5/29/25 and 6/2/25. 6/11/25 at 1:45 p.m. Staff E, CNA stated they helped the resident up from the floor when she couldn't get up on her own. They didn't always see her get down. On 6/11/25 at 2:05 p.m. Staff B, Certified Nursing Assistance (CNA) stated if they found the resident on the floor they helped her up, if they witnessed it or not. On 6/11/25 at 4:50 p.m. Staff C, RN stated the resident put herself on the floor repeatedly. She said they were mostly witnessed. If they were witnessed, they didn't do an incident report. On 6/11/25 at 4:58 p.m. Staff D, CNA stated they helped the resident off the floor if they witnessed her putting herself on the floor or not. They didn't tell the nurse every time, because that's what she did. On 6/12/25 at 9:42 a.m. the Administrator stated the resident put herself on the floor continually. She would put herself down and get herself back up. It was a very unique situation. The Director of Nursing (DON) stated the bruising (5/31/25) could have been caused by her rolling around on the floor. The undated facility policy, Resident Safety, Accidents and Incidents identified the purpose to ensure all resident accidents and incidents were properly assessed and reviewed. The following data, as applicable, shall be documented in the Risk Management section of Point Click Care: a. The date and time the accident or incident took place; b. The nature of the injury/illness (e.g., bruise, fall, nausea, etc.); c. The circumstances surrounding the accident or incident; d. Where the accident or incident took place; e. The name(s) of witnesses and their accounts of the accident or incident; f. The injured person's account of the accident or incident; g. The time the injured person's attending Physician was notified h. The date/time the injured person's family was notified (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165405	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Happy Siesta Health Care Center	423 Roosevelt St Remsen, IA 51050

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. The condition of the injured person, including his/her vital signs; range of motion, pain, observable injuries and neuros for all falls with head injury, or if the fall was unwitnessed. j. Any corrective action taken k. Intervention to prevent reoccurrence is added to care plan l. Other pertinent data as necessary or required; and m. The signature and title of the person completing the report.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165405	A. Building B. Wing	06/12/2025

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, the facility failed to prepare and serve food with professional standards for food service safety. The facility had a census of 50 residents. Findings include: During observation in the kitchen: a. On 6/11/25 at 9:45 a.m. Staff F, [NAME] wore gloves, handled utensils, obtained milk from the refrigerator, put her gloved hand in the bread bag, placed 4 slices of meat in the Robot coupe, and the 4 slices of bread tearing the bread with the gloved hands. b. At 10:30 a.m. Staff F started plating food for the special care unit. During the meal service Staff F wore gloves. She plated the hot food and the Dietary Manager (DM) who also wore gloves, picked up buttered bread and folded it with both hands and placed it on the plate. She touched the hot plate and pushed the tray over (on the counter top) with her left hand, then picked up another slice of bread and folded and put on the plate. She continued through plating the the unit trays, then changed gloves. c. At 11:02 a.m. Staff F wore gloves when plating food for the main floor. Staff let them know who was in the dining room (DR). Staff F touched the serving utensils, going through the utensil drawer several times. At the start of serving the main floor, Staff F used a utensil to pick up the bread and put on the plates. After plating several, Staff F started picking up the bread with the gloved hand. She reached in the bread bag to make sandwiches. Staff F changed gloves several times without washing her hands. At the end of meal service, Staff F stated she knew they shouldn't touch the food. She said she was doing it that way (using a utensil) awhile when she thought about it. The DM confirmed they should not touch food, if other surfaces were touched with gloves on. The FDA Food Code 2022, 3-304.15 gloves, use limitation, directed if used, single use gloves should be used for only one task such as working with ready to eat food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occurred in the operation.