STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165428	A. Building B. Wing	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careage Hills Rehabilitation and Healthcare	725 North Second Street Cherokee, IA 51012

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 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. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews and policy review, the facility failed to complete a wound treatment for 1 of 3 residents reviewed (Resident #1) and failed to complete an assessment for 1 of 3 residents reviewed (Resident #2). The facility reported a census of 34 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 revealed a Brief Interview Mental Status (BIMS) of 15 indicating intact cognition. The MDS revealed diagnoses including type 1 diabetes, pressure ulcer of the right buttock and sacral region. The MDS further revealed the resident was dependent on staff for toileting assistance and personal hygiene. The Care Plan for Resident #1 initiated [DATE] revealed the resident had actual pressure ulcer development and directed staff to administer treatments as ordered. Review of Physician Orders for Resident #1 revealed an order effective [DATE] to treat left ischium (lower and back of the hip bone) with 1/2 strength peroxide and 1/2 strength normal saline (NS) then rinse with NS, apply 1/4 strength Dakins solution, cover secure with abdominal (ABD) pad and secure with Medipore tape two times a day and as needed if soiled. During an interview [DATE] at 2:30 PM, Resident #1 revealed on [DATE] around 4:30 AM, Staff A, Certified Nurse Aide (CNA) had removed the dressing to the wound on his ischium after he had a bowel movement. The resident further revealed the wound treatment did not get completed until 9:30 AM that morning. During an interview [DATE] at 8:30 AM, the Director of Nursing (DON) revealed she received a call from Staff A, CNA around 5:00 AM on [DATE] reporting the dressing change for Resident #1 needed to be completed as Staff B, Registered Nurse (RN) did not know how to complete it. The DON stated Staff B had completed the dressing change in the past. The DON further revealed she spoke to Staff B on the phone and walked her through the treatment process and directed Staff B to review the physician orders as well and Staff B had replied, I can do that. The DON stated that was the end of the conversation and she didn't hear anything else and when she arrived at work that day around 6:30 AM-6:45 AM, Staff B was still working and was not showing signs of not feeling well. During an interview on [DATE] at 11:36 AM, Staff B, RN revealed she was not able to complete the treatment to Resident #1's ischium on [DATE] as she didn't feel like she could stand long enough to complete the treatment. Stated she talked to the DON on the phone the morning of [DATE] and the DON had said, That is your problem and you need to figure it out in regard to Resident #1's treatment being completed. Staff B reported she told the staff she would wait until the next shift came in and she would help turn the resident. During an interview on [DATE] at 11:15 AM Staff C, CNA revealed she went to clean Resident #1 up the morning of [DATE] around 7:30 AM and one of the dressings for one of his wounds to his bottom was missing. Staff C reported she could tell he had had a bowel movement and wished someone would have alerted the nurse so that the treatment could have been completed sooner as it was obvious the treatment was missing. Clinical record review revealed the treatment to Resident #1's ischium was completed [DATE] at 9:30 AM by Staff D, RN. 2. The MDS dated [DATE] for Resident #2 revealed a BIMS had not been completed as the resident was rarely/never understood. The MDS revealed the resident's diagnoses included Alzheimer's disease and a seizure disorder and the resident was dependent on staff for all activities of daily living. The Care Plan initiated [DATE] revealed Resident #2 had seizure-like activity and directed staff to assess the resident as soon as possible if seizure activity occurred. During an interview on [DATE] at 11:36 AM, Staff B, RN reported on [DATE] the CNA's had reported Resident #2 was having seizures. Staff B reported she had gone down to look at the resident and the resident looked like her normal baseline and her eyes were open. Staff B reported that based on her assessment she was going to administer intramuscular (IM) Ativan but it had expired so she did not administer it. Staff B reported she did not go back and assess the resident as she wasn't feeling well and could not walk. Review of Progress Notes for Resident #2 revealed on [DATE] at 3:22 AM, Staff B, RN documented the CNA had reported the resident was having pre-seizure behavior. The Progress Notes lacked assessments related to the pre-seizure activity. Review of facility policy revised [DATE] and titled, Resident Assessment and Associated Processes, revealed it is the policy of this facility that residents will be assessed and the findings documented in their clinical health record. Review of facility policy revised [DATE] and titled, Physician Orders, revealed all physician orders will be followed through with upon the written order by personnel licensed to write orders and/or take verbal orders from the provider. During an interview on [DATE] at 11:45 AM, the DON revealed she would expect an assessment to be completed when a resident had seizure-like activity and treatments to be completed as ordered.