STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165431	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Titonka Care Center	312 First Avenue NW Titonka, IA 50480

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 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** 48003 Based on observation, record review, policy review, resident and staff interviews, the facility failed to administer medications per physician orders and failed to accurately record follow up to a medication for 1 of 1 residents reviewed (Resident #9). The facility reported a census of 21 residents. Findings include: Resident #9's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14 indicating intact cognition. The MDS include diagnoses of Seizure disorder or Epilepsy, hypertension and peripheral autonomic neuropathy. The MDS documented Resident #9 was taking anticonvulsant medications during the 7 day look back period. During an observation on 4/15/25 at 7:50 AM, Resident #9 reported to Staff B, Registered Nurse (RN) that her medications from 4/14/25 evening are still in her room on her tray table. Resident #9 reported she must have fallen asleep and the nurse had brought them in but didn't wake her for them so she never took them. Resident #9 reported she knew they were her evening medications because her seizure medication was in it. During an interview on 4/15/25 at 8:00 AM the Assistant Director of Nursing (ADON) reported Staff C, RN was the nurse last evening and that she has Resident #9's medications from last night pointing to the medications on her desk. The ADON reported Resident #9's seizure medication, Tylenol and cold medication is what she had. She reported Staff C should not have left the medications for the resident to take. Review of the Resident #9's April 2025 Medication Administration Record documented the Phenytoin (anticonvulsant for seizures), Tylenol and DayQuil Severe medications were signed that they were taken. It further documented Staff C, RN also did a follow up to the cold medication that was not taken saying it was effective. During an interview on 4/15/25 at 3:10 PM the Director of Nursing (DON) reported Resident #9's last lab for her seizure medication was low so they are rechecking it since the medication was not taken last night. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/25 at 9:45 AM the DON reported she was the one who called Staff C, RN about the medications not taken and Staff C, RN reported to the DON she normally doesn't leave the medications in the room and for follow ups to as needed medications such as cough medication the nurse should follow up with the resident to see that it was effective. The facility policy Medication Variance dated 4/16/25 documents the purpose is to manage accountability of the staff involved in the medication system.

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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 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** 49056 Based on clinical record reviews, staff interviews and policy review, the facility failed to do neurological assessments with unwitnessed falls for 1 of 1 residents reviewed (Resident #1). Resident #1 had 14 falls since May 2024, out of those 14 falls the facility failed to do neurological assessments on 7 of those unwitnessed falls. Findings include: The Minimum Data Set (MDS) dated for 1/23/25 for Resident #1 included diagnoses of Alzheimer 's dementia, anxiety disorder, depression and bipolar disorder. Resident #1's MDS dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 00, indicating severe impaired cognition. The Facility Incident Reports (IR) documented from 7/30/24 to 12/5/24 revealed Resident #1 had unwitnessed falls on these dates 7/30/24, 8/12/24, 8/18/24, 9/21/24, 9/22/24, 10/7/24, and 12/5/24 and the facility failed to do neurological assessments each time. Review of the IR dated 7/30/24 at 8:08 PM revealed Resident #1 had an unwitnessed fall in his room. Resident #1 was found in his room sitting on the floor in front of his recliner. Resident #1 denied hitting his head. The IR revealed neurological assessment completed within normal limits for Resident #1. The facility failed to complete neurological assessments for this fall. Review of the IR dated 8/12/24 at 5:55 PM revealed Resident #1 had an unwitnessed fall in his room. Resident #1 he had slid out of his recliner and was found on the floor. The facility failed to complete neurological assessment for this fall. Review of the IR dated 8/18/24 at 6:50 PM revealed Resident #1 had an unwitnessed fall in the lobby. Resident #1 was found on his knees with his w/c behind him. The facility failed to complete neurological assessment for this resident. Review of the IR dated 9/21/24 at 5:00 PM revealed Resident #1 had an unwitnessed fall in his room. Resident #1 was found on the floor in front of his recliner. Resident #1 denied hitting his head. The facility failed to complete neurological assessment for this resident. Review of the IR dated 9/22/24 at 2:02 PM revealed Resident #1 had an unwitnessed fall in his room. Resident #1 was found on the floor next to his recliner. The facility failed to complete neurological assessment for this resident. Review of the IR dated 10/7/24 at 4:54 PM revealed Resident #1 had an unwitnessed fall in his room. Resident #1 was found sitting on the floor in front of his recliner. The facility failed to complete neurological assessment for this resident. Review of the IR dated 12/5/24 at 5:37 PM revealed Resident #1 had an unwitnessed fall in the hallway. Resident #1 was found sitting on the floor in the hallway. The facility failed to complete neurological assessment for this resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy named Neurological assessment dated [DATE] revealed: The neurological assessments must be completed on any resident with a suspected head injury and all unwitnessed falls. If a resident is alert and oriented and has a BIMS score of 12 or higher, neuro checks do not have to be done if they tell you they did not hit their head and no head injury is noted or suspected. The first neuro check must be done before moving the resident after the fall. Neuro checks must be performed as follows: a. Initial, then every 30 minutes times 3 b. Every hour times 2 c. Every four hours times 2 d. Every eight hours times 2 If any abnormal findings are present, neuro checks must be done more frequently. Notify the primary care physician of the incident/accident as soon as possible. Notify the primary care physician of any abnormal findings immediately. Notify the Director of Nursing (DON) and Administrator of all falls. Document all vital signs from neuro check worksheet into electronic health record. a. File a new assessment (listed as neurological Assessment) for each of the vital signs. b. Save each assessment in the electronic health record with the time that the assessment was done so it matches the time of the vital signs During interview on 4/16/25 at 1:48 PM the Director of Nursing (DON) stated that the expectation is to do neurological assessment when the resident has an unwitnessed fall. During interview on 4/16/25 at 2:30 PM the DON acknowledged and verified the neurological assessments were not completed for these seven falls. The DON stated that five of them were documented as he denied hitting his head, so the DON felt they didn't do the neuro's due to this. The DON stated she knows the facility has not been doing the neuro's like they are supposed to. The DON stated that she has redone the neuro policy as of 4/3/25 and will be educating the staff regarding this.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056 Based on observations, record review, staff interviews and policy reviews, the facility failed to change and label oxygen tubing for 1 of 1 residents reviewed (Resident #2). The facility reported a census of 21. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 documented diagnoses of heart failure, hypertension (high blood pressure), diabetes mellitus. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. On 4/14/25 at 1:03 PM an observation was made regarding Resident #2's oxygen tubing. The oxygen tubing lacked a date of when it was last changed. On 4/15/25 at 7:30 AM during medication administration Resident #2 reported to the nurse he needed new oxygen tubing because his tubing was hard and made a sore in his nose. Resident #2 told the nurse he wears it every night so needs it changed. On 4/15/25 at 3:55 PM the Director of Nursing (DON) stated it should be on the medication administration sheet (MAR) or the treatment administration sheet (TAR) to give directions to the staff to change the oxygen tubing. Review of the MAR for March and April of 2025 lacked information regarding changing the oxygen tubing or when to change it. On 4/15/25 at 4:05 PM, an interview with Resident #2 revealed he had not had his tubing changed as of yet today. Resident #2 stated he did say something about it this morning to the nurse because the tubing is getting hard and giving him a sore in his nose. Resident #2 stated he didn't think it had changed in the last thirty days. Resident #2 stated he would like to have it changed every two weeks. Observations made at this time, oxygen tubing had not been changed, and continued with no date on it. Review of the undated facility provided policy titled Administration of Oxygen Therapy revealed the purpose is to administer oxygen to prevent or due to hypoxia, to deliver low flow oxygen concentration with nasal cannula, to deliver medium concentration of oxygen by mask, to deliver high humidity to the upper respiratory tract. The policy stated to change water in the humidifier bottle daily and to change the mask, cannula and bottle weekly. Interview with DON on 4/16/25 at 2:29 PM revealed she is not sure how that was missed, it is in the standing orders and should have been pulled over to put on the TAR to give guidance to the staff.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 48003 Based on facility record review and staff interviews, the facility failed to employ a licensed Administrator. The facility reported a census of 21 residents. Findings include: During an interview on 4/14/25 at 10:31 AM, the Director of Nursing (DON) reported she has applied for Provisional Administrator and has not been approved yet. She reported the prior Administrator had left back in October around 18th-21st but not sure of the date. During an interview on 4/17/25 at 9:11 AM, the DON reported the former Administrator was available by phone if they would need her but she was not employed by the facility and had not been in the building since October 20th. She reported the facility was not actively looking for an Administrator and has not been.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 49056 Based on observation, infection control policy and staff interview, the facility failed to initiate a legionella water program for the facility. The facility reported a total census of 21 residents. Findings include: During interview on 4/17/25 at 10:30 AM., with Staff A, Maintenance, was unable to explain what the facility was currently doing to prevent Legionella growth in the facility. Staff A stated he wasn't sure what needed to be done for the legionella water program. Staff A stated the previous Administrator was in charge of the Legionella water program. Staff A stated this person left the facility in June 2024. Staff A stated there has not been any temperatures taken of the hot water system since June of 2024. Staff A stated he does run water down the drains at random times but does not have any documentation of this. Staff A stated the city does test for Legionella. Review of facility provided policy titled Legionella Prevention Policy and Procedure with a date of 1/2/24 revealed Legionella is usually spread through water droplets in the air. Legionella lives in fresh water, but can live in man-made settings if water is not properly maintained. It becomes a problem when small droplets of water contain the bacteria and get into the air and people breath them in. It grows best in building water systems that are not well maintained. The key to preventing Legionnaires ' disease is to make sure that building owners and managers maintain building water systems in order to reduce the risk of Legionella growth and spread. Examples of building water systems that might grow and spread Legionella include: Hot tubs Hot water tanks and heaters Large Plumbing systems Cooling towers (structures that contain water and a fan as part of centralized air-cooling systems for building or industrial processes) Decorative fountains During interview on 4/17/25 9:25 AM the Director of Nursing (DON) reported that maintenance doesn't know what needs to be done for water testing or what needs to be done for Legionella. The DON reported she just got information on what needs to be in the Legionella policy as to what the facility needs to be doing.