STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165440	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winslow House Care Center	3456 Indian Creek Road Marion, IA 52302

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 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** 48452 Based on observation, record review, resident interviews, staff interviews, and policy review the facility failed to ensure comprehensive Care Plans were reviewed and revised in a timely manner for 2 of 12 residents reviewed. Resident #27's Care Plan lacked goals, triggers, and interventions related a diagnosis of schizophrenia. Resident #25's Care Plan lacked goals and interventions related to hearing impairment. The facility reported a census of 46 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #27 dated 7/25/24 documented a Brief Interview for Mental Status score (BIMS) of 15/15 indicating intact cognition. Diagnoses included depression, schizophrenia, and schizoid personality disorder. During an interview with the resident on 08/26/24 at 10:40 AM, the resident confirmed the diagnosis of schizophrenia and indicated he had it for 'a long time.' He said staff didn't do anything about it. On 08/26/24 at 12:27 AM observed resident in the dining room, raising his hand for assistance. Staff responded in less than a minute. At about 12:32 PM the resident put his hand up again. After about a minute he put it down with no response. A document from the resident's mental health provider with a visit date of 12/15/23 documented the resident denied active psychosis but had a history of paranoia and thought processes were questionable at times. A section titled DX (diagnosis)/Assessment Plan included diagnoses of undifferentiated schizophrenia, unspecified anxiety disorder, autism spectrum, and schizoid personality. Resident #27's Care Plan, with an admitted [DATE], included focus areas for Asperger's Syndrome, schizoid personality disorder, and depression as well as for psychotropic medications (antianxiety and antidepressant) and monitoring. The Care Plan lacked reference to the resident's diagnosis of schizophrenia such as focus areas, goals, interventions, or triggers. The resident's Progress Notes lack documentation of the new diagnosis, communication with the provider, or discussion with the resident for care planning. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The electronic health record (EHR) diagnosis tab revealed the resident was diagnosed [DATE] and the entry created 6/14/24. On 8/28/24 at 9:26 AM Staff C, Social Services, revealed she had been in her social work role since May and was scheduled for one day per week. She received her list of people to visit from the Administrator or the Administrative Assistant. She was not responsible for updating the Care Plan. On 8/28/24 at 9:28 AM Staff B, MDS Nurse Coordinator stated she received information from the Director of Nursing when Care Plans needed to be updated. During an interview Staff A, Registered Nurse (RN) on 8/29/24 at 11:11 AM stated changes that need to be made in a resident's Care Plan were reported to the Director of Nursing. She was responsible for passing the information along to those who needed it. When asked for a policy or procedure for Care Planning, the facility provided a document dated 8/6/24 with a focus area titled comprehensive care plan. It documented the following plan: o MDS Nurse re-educated on the comprehensive care plan policy on 7/17/24. o Comprehensive Care Plan will be completed for each resident per regulation. o MDS Nurse will ensure timely update to the comprehensive care plan as needed. o MDS Nurse will ensure most up to date information is on the care plans through a variety of ways including but not limited to: -Morning meeting -Care Conferences -Therapy recommendations -Change of conditions -Resident preferences/requests -Dr. appointments 2. The Minimum Data Set (MDS) for Resident #25 dated 7/23/24 documented a Brief Interview for Mental Status score (BIMS) of 14/15 indicating intact cognition. Diagnoses included Meniere's disease, bilateral (causes hearing loss, ringing, and dizziness), unspecified hearing loss in the left ear, and anxiety. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the resident on 8/28/24 at 10:46 AM, when asked if staff accommodated for her hearing, she said 'hell no.' She clarified that the nurses were good about getting close to her, but the aides were in too much of a hurry. They didn't speak clearly or make sure she could hear while providing cares. The resident stated the facility did not ask about her hearing for Care Planning and staff didn't understand what it was like. She also reported concerns with her vision and glasses and indicated family was assisting with that. She revealed the nose pieces of her glasses had been damaged and someone had tried to fix them with pliers. She was currently unable to get them to sit right on her nose, and therefore could not see the small holes in her hearing aide to make sure they were clean. Resident #25's Care Plan included an intervention dated 7/30/24 to ensure the resident was wearing glasses which were clean, free from scratches, and in good repair. Damage should be reported to the nurse/family. The Care Plan lacked documentation related to the resident's hearing, hearing aide care, goals, or interventions. During an interview on 8/29/24 at 10:59 AM Staff E, Nurse Consultant for the facility acknowledged that the Care Plans needed to be reviewed and updated to reflect the resident's needs, and the MDS coordinator had already started working on them.

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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 observation, staff interviews, record review, and policy review the facility failed to follow professional standards of medication administration for 1 of 1 resident that required medications via gastric tube (Resident #20). Medications were given late without physician notification, an extended release tablet was crushed and Enhanced Barrier Precautions (EBP) were not followed appropriately. The facility reported a census of 46 residents. Findings include: The MDS dated [DATE] for Resident #20 was coded for a feeding tube. The Care Plan completed 6/6/24 for Resident #20 documented: Resident NPO status referred to nothing by mouth, directed to provide tube feeding and administer medications as ordered. The Medication Administration Record (MAR) dated August 2024 for Resident #20 documented the following medications to be given at 8:00 AM, enterally or per gastric tube: Potassium chloride solution, give 15 milliliter (ML) via gastric tube Omeprazole suspension, give 10 ML liquid via gastric tube Levetiracetam solution, give 15 ML via gastric tube Metformin 1000 milligram (MG) tablet, give via gastric tube Methenamine 1-gram tablet, give via gastric tube Gabapentin 300 milligram (mg) capsules, give two capsules via gastric tube Aspirin 81 Oral Tablet Chewable, give 1 tablet via gastric tube Vitamin C Oral Tablet 500 MG, give 500 mg via gastric tube Myrbetriq Oral Tablet Extended Release 24 Hour 50 MG, give 50 mg enterally During an observation on 8/28/24 began at 9:56 AM ended at 10:23 AM. Staff F, Registered Nurse, (RN) removed the medications prescribed for 8:00 AM from the medication cart. Staff F measured the liquid medications, added to a cup, opened the Gabapentin capsules and added the powder to the liquids in the cup, crushed the remaining pills and also added them into the cup. Staff F addressed the resident, ensured proper tube placement, flushed the tube with 100 ml of water, administered the medications from the cup into the gastric tube via syringe and flushed with another 100 cc of water. Staff F wore a mask and gloves, she did not wear a protective gown (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24 at 10:24 AM, Interview with RN, Staff F following medication administration regarding enhanced barrier precautions. Staff F relayed she had forgotten to put on a gown per the EBP education and per directions on the room door. Staff F acknowledged the EBP process with tube feeding included wearing a gown. RN Staff F acknowledged the medication time on the MAR directed medications to be administered at 8:00 AM or one hour before or one hour after 8:00 AM On 08/29/24 at 09:35 AM, interview with RN, Staff G, stated they had prepared 8:00 AM medications in the cup and was ready to administer the 8:00 AM medications via gastric tube. Relayed all pills were crushed, including the extended release, twenty-four-hour medication. Staff G acknowledged extended release medications should not be crushed and had not questioned the physician order. On 8/29/24 at 9:38 AM, Interview with Administrator designee, Staff D and designated Director of Nursing (DON) Staff H relayed medications are to be given within an hour before or an hour after they are scheduled otherwise they expected that staff notify the doctor and confirmed notification was not done on 8/28/24. Staff D and Staff H relayed the expectation is that staff follow EBP that included wearing a gown with tube feeding process, and also acknowledged it is standard of care that extended release medications should not be crushed and planned to reach out to the physician right away. Document titled Help keep our resident safe, Enhanced Barrier Precautions in Nursing homes outlined staff training dated 4/10/24, directed staff to wear a gown and gloves while caring for residents with gastric tubes. Policy titled Medication Administration revised 4/1/23 documented, medications may be administered one hour prior and one hour after the scheduled administration time. If occurred outside the time frame, physician notification is required.