STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165447	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlands Living Center L L C	2452 North Broadway Council Bluffs, IA 51503

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on clinical record review, observation and staff interviews the facility failed to develop a comprehensive care plan related to the need for Enhanced Barrier Precautions (EBP) for 3 of 5 residents reviewed (Resident #29, #39 and #40). The facility reported a census of 63 residents. Finding include: 1. The Minimum Data Set (MDS) dated [DATE] documented Resident #39 entered the facility on 1/25/23. The MDS also documented a Brief Interview for Mental Status (BIMS) score of 8 indicating moderate cognitive impairment. The MDS revealed diagnoses retention of urine. The MDS revealed use of catheter. Review of Resident #39's Care Plan dated 1/26/23 revealed no focus, goals or interventions related to the need for EBP. Review of Resident #39's Medication Administration Record (MAR) documented a physician's order to change foley catheter 20Fr 10cc monthly. 48004 2. Review of Resident #29's MDS dated [DATE] revealed diagnosis of benign prostatic hyperplasia (a noncancerous condition that causes the prostate to enlarge), renal insufficiency, neurogenic bladder (a condition that affects bladder control due to nerve damage in the brain), and stroke. The MDS further revealed that Resident #29 relies on the utilization of an indwelling catheter. Review of Resident #29's Electronic Healthcare Record (EHR) page titled, Physician's Orders revealed an order for an 18fr suprapubic catheter to be changed on the 11th of each month with no late night or weekend changes with an order date of 2/22/24. Review of Resident #29's Care Plan revealed no Comprehensive Care Plan for Enhanced Barrier Precautions (EBP) related to the utilization of a supra pubic catheter. Interview on 1/14/25 at 9:54 AM with Staff C MDS Coordinator revealed she completed care plans at the facility and that her expectation would be for EBP to be on care plans. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/14/25 at 11:17 AM with the Director of Nursing (DON) revealed her expectation would be for EBP to be on care plans. Interview on 1/14/25 at 11:41 AM with the Administrator revealed the facility does not have a care plan policy, the expectation is for the facility to follow the State Operations Manual (SOM) and Code of Federal Regulations (CFR). 41785 3. According to the MDS dated [DATE], Resident #40 was admitted on [DATE] with a BIMS score of 13 (moderate cognitive deficit.) The resident had an indwelling catheter and diagnosis that included heart failure, hypertension, renal insufficiency and obstructive uropathy. In an observation on 1/12/25 at 2:39 PM, outside the room for Resident #40 was a supply of Personal Protective Equipment and a sign that indicated to staff to use EBP when providing care. The Care Plan for Resident #40, updated on 7/8/24, showed that Resident #40 had self-care deficits related to weakness. He was incontinent of bowel and had a Foley urinary catheter for urinary retention. The Care Plan lacked reference to EBP related to catheter use.

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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** 41785 Based on observation, staff interview and clinical record review the facility failed to update care plans for 2 of 17 residents. Resident #22 had edema, and Resident #12 was receiving antidepressant medications. These concerns were not addressed on the care plans. The facility reported a census of 63 residents. Findings include; 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #22 was admitted to the facility on [DATE] and had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive ability.) The resident was independent with eating, toileting, dressing and ambulating. His diagnosis included heart failure, conduct disorder, adjustment disorder and edema. On 1/12/25 at 1:48 PM, Resident #22 was in his recliner in his room. The resident was wearing shorts and gripper socks. His lower extremities were tightly wrapped with blue elastic bandages half way up the calves. The legs were edematous and the resident said the treatments were completed about every-other day. A review of the record showed an order dated 12/2/24 at 2:45 PM, for Bilateral Lower Extremity (BLE) daily treatments, to cover areas with heavy drainage with ABD (absorbent pads used for large wounds) secure with gauze and tape. An order dated 5/22/24 at 7:30 PM, to remove TED hose (stockings used to prevent swelling) every night related to edema. The Care Plan updated on 7/5/24, showed that Resident #22 was at risk for skin breakdown. He had self-care performance deficit related to intellectual disability. The Care Plan lacked information or goals related to edema and/or subsequent skin issues. 2) According to the MDS dated [DATE], Resident #12 was admitted to the facility on [DATE], she had a BIMS score of 3 (severe cognitive deficit.) The resident was totally dependent on staff for eating, toileting and dressing. Diagnosis for Resident #12 included non-traumatic brain dysfunction, thyroid disorder, Alzheimer's' Disease, and depression. The Medication Administration Record (MAR) for January showed an order for sertraline 25 milligrams (mg) dated 11/2/24, used for depression. Also included on the MAR was an order for Lorazepam 2mg/ml as needed for anxiety related to Alzheimer's Disease. The Care Plan for Resident #12, updated on 10/23/24 showed that she had self-care deficit related to Alzheimer's Disease and impaired mobility. She was dependent on others for meeting emotional, intellectual, physical, and social needs related to cognitive deficits. The Care Plan lacked focus area or interventions related to antidepressant and antianxiety medication use. On 1/14/25 at 12:35 PM, Staff C, Care Plan and MDS nurse, acknowledged the medication use for Resident #12 should be on the Care Plan, and that Resident #22 had significant edema with subsequent skin breakdown that also should be included on the Care Plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/17/25 at 7:01 AM, the Director of Nursing said that the facility did not have a policy on establishing a care plan or updating the care plans.

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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** 41785 Based on observation, resident interview, staff interviews and clinical record review the facility failed to follow physician's orders for 3 of 17 residents. Residents #160 and #55 had orders directing staff to hold a medication when the Blood Pressures (BP) were outside of parameters. The medications were administered outside the established parameters. Resident #39 had an order for respiratory treatments via nebulizer three times per day and the facility failed to provide them as ordered by the physician. The facility reported a census of 63 residents. Findings include: 1. According to the Minimum Data Set (MDS) dated [DATE], Resident #160 had a Brief Interview for Mental Status (BIMS) score of 7 (severe cognitive deficit.) The resident was totally dependent on staff for toileting, dressing, and bed to chair transfers. Diagnosis included; atrial fibrillation, coronary artery disease, heart failure, orthostatic hypotension and multiple fractured ribs. The Care Plan initiated on 10/9/24, showed that Resident #160 was at risk for falls related to orthostatic hypotension (low blood pressure) spinal stenosis and multiple fractures. He had the potential for complications related to congestive heart failure, staff were to administer medications as ordered and monitor vitals. A review of the clinical record revealed an order dated 10/16/24, for metoprolol 25 milligrams (mg) take one-half tab by mouth daily. Hold for systolic (top number) BP less than 100. The Medication Administration Record (MAR) revealed the metoprolol was administered on the following dates: a. 11/23/24 with a BP: 73/50 b. 11/22/24 with a BP: 98/63 c. 11/17/24 with a BP: 98/56 An order dated 10/16/24, included; midodrine 5 mg (for hypotension) one tab three times daily hold for systolic BP of more than 120. The MAR revealed medication was given when the BP was outside the parameters on the following dates: a. 12/7/24 with a BP: 129/55 b. 12/8/24 with a BP: 128/59 c. 12/20/24 with a BP: 127/65 d. 12/30/24 with a BP: 121/52 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. 1/5/25 with a BP: 124/52 f. 1/6/25 with a BP: 130/72 2. According to the MDS dated [DATE], Resident #55 was admitted on [DATE] with a BIMS score of 14 (intact cognitive ability.) The resident was independent with sit to stand, toilet transfers, eating and dressing. She had diagnosis that included heart failure, hypertension (high blood pressure) and anxiety. The Care Plan for Resident #55, last updated on 1/6/25, showed that she was at nutritional risk due to decrease in food intake, and staff were to monitor weights. She had impaired mobility with lymphedema in bilateral legs due congestive heart failure and she was admitted to hospice care due to decline in health. The resident was on diuretic therapy, staff were to administer medications as ordered by the physician and to monitor for adverse reactions to diuretic therapy such as hypotension and fatigue. On 1/12/25 at 10:43 AM, Resident #55 was sitting in the recliner and said that she hadn't been going out of her room for meals because it was getting too difficult for her to get up and walk. The resident's feet and legs were extremely swollen. The resident said that she had struggled with edema for a long time. A review of the record revealed a signed doctors order dated 12/23/24, with parameters for blood pressure and weights. Staff were to hold atenolol (hypertensive medication) and furosemide (diuretic to help get rid of extra water) with a systolic BP less than 90 or less than 60 diastolic (bottom number). Daily weights and notify doctor with a weight gain of 3 pounds in 1 day or 5 pounds in a week. The MAR revealed the following blood pressures out of parameters and the furosemide and atenolol were administered: a. 12/16/24 at 5:53 AM, BP 102/56 b. 12/28/24 at 3:20 PM, BP 126/55 c. 12/31/24 at 10:54 AM, BP 90/48 d. 1/1/25 at 4:23 PM, BP 131/58 e. 1/6/25 at 3:15 PM, BP 97/53 f. 1/7/25 at 4:03 PM, BP 87/50 The chart lacked weight documentation on 12/27, 12/28, 12/30, and 12/31/24. On 1/15/25 at 8:38 AM, Staff F Registered Nurse (RN) said that the parameter orders for Resident #160 were confusing and it was difficult to know when to give the hypertension and/or hypotensive medications. Sometimes they would end up giving both of the medications and that seemed counterproductive. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 8:58 AM, Staff E, RN, said she would retake a blood pressure if she got a reading with less than 100 systolic and less than 40 diastolic. On 1/15/25 at 9:26 AM, Staff G, LPN said that Resident #16 would have some low BP readings. She said she would retake a BP if it was lower than 100/50. She acknowledged that the two medications with the parameters was very confusing. On 1/14/25 at 12:43 PM, the Director of Nursing (DON) acknowledged that some of the doctor's orders were confusing and staff usually called for clarification. On 1/17/25 at 7:01 AM, the DON said that the facility did not have a policy on monitoring blood pressures. 47673 3. The MDS dated [DATE] documented Resident #39 entered the facility on 1/25/23. The MDS also documented a BIMS of 8 indicating moderate cognitive impairment. The MDS revealed diagnoses of asthma. On 1/12/25 at 12:22 AM an observation of clear liquid in a nebulizer machine next to Resident #39's bed. On 1/12/25 at 12:23 PM Resident #39 stated Staff H, Licensed Practical Nurse (LPN) told her that she did not need her breathing treatment this afternoon. Resident #39 stated she did not have her breathing treatment this morning either. Review of Resident #39's MAR documented a physician's order for ipratropium / albuterol solution to inhale 1 vial via nebulizer three times a day. On 1/12/25 at 12:35 PM Staff H stated she worked 201 - 212-2 on the morning of 1/12/25. Staff H stated she did not work on that floor very often. Staff H acknowledged Resident #39 was in room [ROOM NUMBER] bed 2. Staff H stated she had been in that room on 1/12/25. Staff H acknowledged Resident #39 had a nebulizer treatment that morning but did not give Resident #39 the treatment at noon because Resident #39 did not want the treatment. Staff H stated when she gave a breathing treatment she would take the medication down to the resident's room, put the medication into the nebulizer machine, apply the mask to the resident's face, return about 10 minutes later and remove the mask. Staff H stated she then would take the mask apart, use a wet paper towel to wipe the mask out and turn the pieces of the nebulizer upright so the nebulizer equipment can dry. Staff H stated she gave Resident #39 the breathing treatment that morning and when she returned to the room the machine was not on and the mask was lying inside the machine itself. Staff H stated she did not clean the mask out at that time. Staff H stated she did set it upright in the machine's stand. Staff H stated the room was dark this morning. Staff H stated there was no medication in the machine when she entered the room. Staff H acknowledged medication present in the nebulizer mask reservoir at that time. Staff H stated she forgot to come back in 10 minutes that morning. Staff J reported it was 20 - 30 minutes later when she returned to Resident #39's room. Staff H stated she did not physically look at the nebulizer at that time or take it off Resident #39's face. Staff H stated Resident #39 must not have completed the treatment. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/12/25 at 2:30 PM the DON stated her expectation was the medication would have been administered per physician's orders and if the resident refused, documented as a refusal. On 1/15/25 at 8:29 AM the Administrator stated the facility had no policies or procedures on following physician's orders or medication administration. The Administrator stated the facility's expectation was to follow professional standards.

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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** 41785 Based on observation, interview and clinical record review the facility failed to provide safe transfer techniques for 1 of 3 residents reviewed. Staff D, Certified Nurse Aide (CNA) was observed to assist Resident #44 with ambulation without the use of a gait belt. The facility reported a census of 63 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #44 had a Brief Interview for Metal Status (BIMS) score of 15 (cognitive ability) She was independent with transfers, toilet, and sit to stand. After a decline in status, a follow up BIMS assessment was conducted on 12/24/24 at 10:28 AM, and the resident scored 10 (moderate cognitive deficit.) The Care Plan last revised on 11/1/24, showed that Resident #44 required substantial assist for transfers, and supervision/touch assistance for ambulation using a front wheel walker. She was on an anti-anxiety medication, staff were to monitor for side effects such as drowsiness, clumsiness, and slow reflexes. According to an Incident Report dated 12/10/24 at 2:23 PM, Resident #44 had an unwitnessed fall in her room. She was found lying on her right side, with no injuries. The resident was confused, had impaired memory and she was ambulating without assistance. A Fall Risk Evaluation dated 12/10/24 at 2:35 PM, showed that Resident #44 was at high risk for falls related to diseases that included: hypotension, vertigo, Parkinson's Disease, seizures, osteoporosis, and delirium. She had balance problems while walking. The Nursing Progress Notes included the following documentation: a. On 12/5/24 at 12:16 PM, the resident had decrease in intake, was down 10 pounds and had increased confusion. b. On 12/12/24 at 6:05 PM, the resident was ambulated to and from the bathroom and to and from dining room with gait belt and one assist. c. On 12/21/24 at 2:18 AM, the resident had a harsh nonproductive cough with wheezes. d. On 12/28/24 at 11:45 AM, the resident had an increased level of confusion and productive cough. e. On 1/8/25 at 7:55 PM, the resident was very confused, agitated, refused cares and dinner. On 1/12/25 at 11:56 AM, Resident #12 ambulated to the dining room with a front wheeled walker. Staff D, Certified Nurse Aide (CNA) walked behind the resident and held onto the elastic on the back of her pants. The resident was not wearing a gait belt. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/25 at 12:38 PM, the Director of Nursing (DON) said that Resident #12 was independent in her room and used a walker on her own. She acknowledged that the resident was experiencing some increased weakness and if a staff member had the need to hold onto the resident, the CNA should have used a gait belt and not held onto her pants. On 1/17/25 at 7:01 AM, the DON indicated that the facility did not have policies on gait belt use or on safe transferring techniques.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48004 Based on clinical record review, observation, staff interviews, and facility policy review the facility failed to use Enhanced Barrier Precautions (EBP) during catheter care for 1 of 3 residents reviewed for infection control (Resident #29). The facility reported a census of 63 residents. Findings include: Review of Resident #29's Minimum Data Set (MDS) dated [DATE] revealed diagnosis of benign prostatic hyperplasia (a noncancerous condition that causes the prostate to enlarge), renal insufficiency, neurogenic bladder (a condition that affects bladder control due to nerve damage in the brain), and stroke. The MDS further revealed that Resident #29 relies on the utilization of an indwelling catheter. Review of Resident #29's Physician's Orders revealed an order for an 18fr suprapubic catheter to be changed on the 11th of each month with no late night or weekend changes with an order date of 2/22/24. Continuous observation 1/13/25 at 12:37 PM Staff A Certified Nurses Aide (CNA), and Staff B CNA completed hand hygiene and repositioned Resident #29 into bed while utilizing a mechanical lift. Staff A, and Staff B then completed peri cares, and drained Resident #29's suprapubic catheter with no Enhanced Barrier Precautions (EBP). Interview 1/13/25 at 12:53 PM with Staff A revealed that she had been trained on Personal Protective Equipment (PPE) for EBP, and just did not wear them as she forgot to don gowns. Staff then revealed that she just keeps forgetting to apply PPE for residents with EBP. Interview 1/13/24 at 3:15 PM with the Director of Nursing (DON) revealed her expectation is for staff to wear EBP while providing care for residents with catheters. Review of a facility provided policy titled, Enhanced Barrier Precautions Policy with a review date of 5/6/24 revealed: EBP are indicated for residents with any of the following: Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Centers for Disease Control and Prevention website titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), visited 1/14/25 and updated 7/12/22 revealed recent changes included, additional rationale for the use of Enhanced Barrier Precautions (EBP) in nursing homes, including the high prevalence of multidrug-resistant organism (MDRO) colonization among residents in this setting. Expanded residents for whom EBP applies to include any resident with an indwelling medical device or wound (regardless of MDRO colonization or infection status). Expanded MDROs for which EBP applies. Clarified that, in the majority of situations, EBP are to be continued for the duration of a resident's admission. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status and Infection or colonization with an MDRO. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care.