STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165448	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Drumm Retirement Center	5837 Winwood Drive Johnston, IA 50131

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 - 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 48888

Based on observation, staff interview, clinical record review, and facility policy review, the facility failed to perform post dialysis assessment and failed to assess for side effects of missed medication doses for Resident #2 on 3/22/25. Resident #2 later transferred to the hospital on 3/22/25 for abnormal vital signs, lethargy, and hypothermia. Resident#2 was 1 of 3 residents reviewed for assessment and intervention. The facility additionally failed to document a post fall assessment, greater than 24 hours, following a fall on 4/02/25 (Resident #9) for a witnessed fall without injury. Resident#9 was 1 of 3 residents reviewed for falls. The facility reported a census of 119 residents.

Findings include:

1. The Minimum Data Set (MDS), dated [DATE], revealed Resident #2 had been admitted to the facility on [DATE], and had an unplanned discharge to an acute care hospital on 3/22/25 with return to facility anticipated. The MDS identified the following active diagnosis: Diabetes Mellitus, malnutrition, fracture of left lower leg, End Stage Renal Disease (ESRD), acute respiratory failure with hypoxia (low oxygen saturation), chronic diastolic heart failure, and anemia in Chronic Kidney Disease. Resident #2 required antidepressant, opioid, and antiplatelet medications.

The Care Plan, initiated 3/15/25, revealed a focused area for hemodialysis three times per week. Interventions instructed staff to assess for thrill and bruit at fistula (dialysis access site), complete dialysis treatments as ordered, obtain dry weights from dialysis center, observe for bleeding at dialysis access site, and provide therapeutic diet as ordered. The Care Plan identified Resident #2 at risk for weight fluctuations related to current health status with intervention to encourage fluids with meals and between meals.

The Treatment Medication Record (TAR), dated March 2025, revealed an order for Hemodialysis in the morning every Tuesday, Thursday, and Saturday with transportation at 9:45 AM, initiated on 3/15/25. The TAR instructed staff to check Resident #2 ' s weight and vitals signs on days of hemodialysis appointments. Documentation on 3/22/25 included one entry of weight and vital signs.

The Medication Administration Record (MAR), revealed an order, initiated 3/13/25, for nursing to monitor thrill and bruit to dialysis access site every shift daily. A negative result (thrill/bruit not felt at access site) recorded on 3/15/25 and 3/19/25. Review of Resident #2's Electronic Health Records lacked documentation of reassessment or physician notification related to negative results.

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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: 165448	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025

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F 0684

Level of Harm - Actual harm

Residents Affected - Few

The MAR revealed an order, initiated 3/13/25, for fluid restriction every shift and lacked the amount of fluid allocated per day. Review of Resident #2's Electronic Health Records lacked physician notification for fluid restriction order clarification. The Resident's Care Plan also lacked direction for staff for how to follow fluid restriction.

The Medication Administration Record (MAR), dated March 2025, revealed a number 3 had been coded for each of the following morning medications to be given on 3/22/25, The code 3 indicated, medications not administered due to Resident #2 away from home.

1. Amlodipine Besylate 10 milligrams (mg), with instructions to give one tablet one time a day, scheduled at 9:00 AM, related to hypertensive emergency.

2. B Complex Vitamins Oral Tablet, with instructions to give one tablet in the morning, scheduled at 7:00 AM, related to muscle weakness and other specified abnormal findings of blood chemistry.

3. Escitalopram Oxalate 10 mg, with instructions to give one tablet one time a day, scheduled at 9:00 AM, related to nicotine dependence, cigarettes.

4. Lisinopril Oral Tablet 40 mg, with instructions to give one tablet, one time a day, scheduled at 9:00 AM, related to hypertensive emergency.

5. Rosuvastatin Calcium 40 mg, with instructions to give one tablet one time a day, scheduled at 9:00 AM, related to arteriosclerotic heart disease.

6. Aspirin Low Dose Chewable 81 mg, with instruction to give one tablet twice a day, scheduled at 9:00 AM and 6:00 PM, related to fracture of left lower leg.

7. Dulera Inhalation Aerosol 200-5 micrograms per actuation (mcg/ACT), with instructions to inhale 2 puffs twice daily, scheduled at 9:00 AM and 6:00 PM, related to acute respiratory failure with hypoxia.

8. Metoprolol Tartrate Oral Tablet 50 mg, with instructions to give one tablet twice daily, scheduled at 9:00 AM and 6:00 PM, related to hypertensive emergency.

9. Senna-S Oral Tablet 8.6-50 mg, with instructions to give one tablet twice daily, scheduled at 9:00 AM and 6:00 PM, related to fracture of left lower leg.

10. Renvela (Sevelamer Carbonate) 800 mg, with instructions to give 4 tablets three times daily, scheduled at 8:00 AM, 2:00 PM, and 7:00 PM, related to End Stage Rental Disease.

The MAR revealed Resident #2 additionally had an order for Insulin Aspart Injection Solution 100 units per milliliter, with instructions to inject insulin subcutaneously following sliding scale protocol with meals related to Type 2 Diabetes Mellitus with Chronic Kidney Disease. The start date for this order was documented as 3/20/25.

For blood sugars between 0-199, no insulin given.

For blood sugars between 200-249, give 2 units of insulin.

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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 - Actual harm Residents Affected - Few	For blood sugars between 250-299, give 4 units of insulin. For blood sugars between 300-349, give 6 units of insulin. For blood sugars between 350-399, give 8 units of insulin. For blood sugars greater than 400, physician to be called. The 3/22/25 12:00 PM blood sugar check and sliding scale insulin administration coded as 3 for Resident #2 away from home. Review of Resident #2's Electronic Health Records lacked physician notification of missed medication doses on 3/22/25 or follow up assessments of Resident #2 for potential side effects related to missed medication doses. Review of Resident #2's list of assessments revealed a Skilled Assessment, completed 3/22/25 at 1:44 PM, that lacked Resident #2's post dialysis weight, vitals, or an assessment of fistula access site. Review of Resident #2's Nursing Progress Notes, revealed an entry on 3/22/25 at 3:16 PM, Note informed that Resident #2 was in the Sunshine Room and family came in to visit, Family took Resident #2 to his room and requested assistance to transfer Resident #2 to bed. The Note informed that Resident #2 had been very lethargic and hypothermic, cold to touch and not at baseline. Blood sugar was noted to be 272, heart rate 130 beats per minute, blood pressure 98/58, temperature 97.6 degrees Fahrenheit, 16 respirations per minute, and oxygen saturation at 70% (normal being greater than 90%). Supplemental oxygen initiated at 5 liters per minute which increased oxygen saturation to 88%. Note revealed physician was notified of Resident #2 change in status and orders received to send Resident #2 to the emergency room via ambulance. On 4/02/25 at 11:00 AM, the Director of Nursing (DON) reported the expectation of nursing staff to check the weight and vital signs of residents who required dialysis before and after the procedure. DON reported that Resident #2's weights and vitals should be reflected in his medical record and informed that the facility would normally send a paper with residents to dialysis and stated sometimes the dialysis center didn't send the paper back. DON confirmed that nursing staff did not call the dialysis center if paper had not been sent back, but would do an assessment of resident upon return to facility. DON stated it was probably an oversight not to put post dialysis assessment on the MAR and informed that it was a standard of practice to do post dialysis assessments. The DON identified a Skilled Assessment had been documented at 1:44 PM, confirmed this assessment lacked the check of vital signs, weight, or check of dialysis access site. When queried about Resident #2's allocated amount of fluid per day related to fluid restriction order, DON revealed this order had been part of a general order set for dialysis patients and no amount had been put in because there had been no specific recommendation received. (continued on next page)

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F 0684

Level of Harm - Actual harm

Residents Affected - Few

On 4/02/25 at 2:45 PM, Staff G, Licensed Practical Nurse (LPN), confirmed working the morning of 3/22/25 with Resident #2, and reported being unaware of Resident #2's dialysis appointment until a driver showed up to transport Resident #2. Staff G revealed Resident #2 returned to the facility close to 2:00 PM and Staff G requested driver to put Resident #2 at a table in the Sunshine Room. Staff G stated that the MAR did not have orders for post dialysis vitals and revealed they had forgotten to do vitals on Resident #2 when he got back to the facility.

On 4/03/25 at 10:58 AM, the DON confirmed that a number 3 coded on the Medication Administration Record (MAR) indicated that the medication had not been administered due to Resident #2 away from home.

The facility policy, titled Hemodialysis, dated 3/28/25, revealed the following compliance guidelines listed:

1. The facility will coordinate and collaborate with the dialysis facility to assure that documentation requirements are met to assure that treatments are provided as ordered by nephrologist, attending practitioner, and dialysis team; and there is ongoing communication and collaboration for the development and implementation of the dialysis care plan by nursing home and dialysis staff.

2. The licensed nurse will communicate to the dialysis facility via telephonic communication or written format, such as a dialysis communication form or other form, that will include, but not limit itself to:

Timely medication administration (initiated, held or discontinued) by the nursing home and/or dialysis facility.

Physician/treatment orders, laboratory values, and vital signs.

Nutritional/fluid management including documentation of weights, resident compliance with food/fluid restrictions or the provision of meals before, during and/or after dialysis and monitoring intake and output measurements as ordered.

Dialysis treatment provided and resident ' s response, including declines in functional status, falls, and the identification of symptoms that may interfere with treatments.

Dialysis adverse reactions/complications and/or recommendations for follow up observations and monitoring, and/or concerns related to the vascular access site.

Changes and/or decline in conditions unrelated to dialysis.

3. The nurse will monitor and document the status of the resident ' s access site upon return from the dialysis treatment to observe for bleeding or other complications.

4. The facility will communicate with the dialysis facility, attending physician, and/or nephrologist any medication administration or withholding of certain medications prior to the dialysis treatment and document such orders.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	5. The nurse will ensure that the dialysis access site is checked before and after dialysis treatments and every shift for patency by auscultating for a bruit and palpating for a thrill. If absent, the nurse will immediately notify the attending physician, dialysis facility, and/or nephrologist. The facility policy titled, Medication Administration, dated 12/30/24, instructed staff to administer medications within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician. 2. The Minimum Data Set (MDS), dated [DATE], for Resident#9 documented a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated intact cognition. Resident #9 had impairment to bilateral lower extremities, required substantial to maximal amount of staff assistance with bed mobility and dependence upon staff for transfers. Resident #9 unable to ambulate at time of MDS assessment. Resident #9 had no falls since previous MDS assessment. Diagnoses included urinary tract infection, urinary retention, Diabetes Mellitus, and malnutrition. The MDS documented that the Resident had lower extremity impairment to both sides, and required substantial/maximal assistance with dressing the lower body. The Care Plan, initiated 1/02/25, revealed Resident #9 at risk for falls and injury related to deconditioning, gait/balance problems, pain, repeated falls in the community, right patellar fracture, and right lower extremity cellulitis. Interventions instructed staff to ensure call light is within reach, appropriate footwear is on, floor is free of clutter, and non-skid strips in front of bed and recliner. The Care Plan revealed Resident #9 had an actual fall due to weakness and impaired balance, staff instructed to continue interventions on the at risk plan and to determine/address causative factors of the fall. On 4/02/25 at 8:15 AM observation of Resident #9 on the floor in his room with Staff H, Infection Prevention Nurse, and 3 other direct care staff present in the room. Resident #9 lying flat on his back, feet pointed towards the bathroom and head/upper body visible through the doorway from the hallway. Review of Resident #9's Nursing Progress Notes for 4/02/25 lacked documentation of fall incident or post fall assessment. Review of Resident #9's Assessment List lacked assessments completed on 4/02/25. Review of Resident #9's Weights and Vital Signs list lacked entry of vital signs documented on 4/02/25. On 4/03/25 at 9:00 AM, Staff I, Registered Nursing (RN), confirmed working on 4/02/25 morning shift on Resident #9's unit. Staff I confirmed Resident #9 fell due to weakness with staff present in his room, who assisted him to the floor. On 4/03/25 at 8:45 AM, Staff H, Infection Prevention Nurse, confirmed being present in Resident #9's room to assist with getting him up from the floor. Staff H reported she had checked Resident #9's vitals, pain, and orientation. Staff H denied documentation of fall assessment and stated she had reported Resident #9's fall assessment to Staff J, Registered Nurse (RN), who had been charge nurse for Resident #9 on 4/02/25. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 4/03/25 at 9:38 AM, Staff J, Registered Nurse (RN) confirmed working as charge nurse for Resident #9 on 4/02/25 at the time of his fall. Staff J denied documentation of fall or post fall assessment in Resident #9's medical record, but stated the fall had been documented into the facility's risk management system. Staff J reported she had been notified by Director of Nursing (DON) of missed documentation related to Resident #9's fall on 4/02/25 and would be coming into the facility to complete a late entry of the incident. Review of a Nursing Progress Note, with effective date of 4/03/25 at 9:56 AM, documented by Staff J, revealed a late entry of nurse being alerted by nursing assistant that Resident #9 was on the floor in front of the toilet. Note indicated Resident #9's vital signs were within normal limits, denied pain, and had not hit head. Note informed that the family had been notified and no other concerns were noted. On 4/03/25 at 10:58 AM, the Director of Nursing (DON) revealed expectation of Staff J to document Resident #9's fall on 4/02/25 with vital signs and fall assessment in the medical record and confirmed this had not been documented until 4/03/25 in Resident #9's medical record. The DON explained the that facility's risk management system documentation could only be viewed by the Facility Executive Director, Director of Nursing, and Assistant Director of Nursing. The facility policy titled, Incident and Accidents, dated 4/03/25, revealed the nurse would enter the incident/accident information into the appropriate form or system within 24 hours of occurrence and would document all pertinent information. The policy revealed the expectation of documentation to include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications, and orders obtained or follow up interventions. The facility policy titled, Documentation in Medical Record, dated 4/03/25, revealed the expectation that documentation be completed at the time of service, but not later than the shift in which the assessment, observation, or care service occurred. The policy revealed when documentation occurs after the fact, outside of acceptable time limits, the entry must be clearly indicated as a late entry.

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F 0689 Level of Harm - 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** 47673 Based on record review, observation, policy review, resident interview and staff interview the facility failed to ensure the resident received adequate supervision and assistance devices to prevent accidents for 2 of 3 residents reviewed (Resident #3 and #7) requiring mechanical equipment device transfers. The facility reported a census of 117 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #7 documented a Brief Interview for Mental Status (BIMS) of 15 which indicated no cognitive impairment. MDS documented Resident #7 was dependent on staff for upper body/lower body dressing, application of footwear and completion of personal hygiene. MDS also documented Resident #7 was dependent on staff for position changes from lying to sitting, sitting to standing, and chair to bed. Review of Resident #7's Care Plan documented Resident #7 required 1 staff to assist him with all transfers using a platform walker with start date of 1/2/25. On 4/2/25 at 8:06 AM Resident #7 stated he was having a terrible morning. An observation on 4/2/25 at 8:07 AM revealed Staff A, Certified Medication Assistant (CMA) and Staff D, Certified Nurses Assistant (CNA) complete a transfer with gait belt on Resident #7. Staff D applied anti slip socks on Resident #7. Staff D was on the left side of Resident #7 with Staff A on the right side. Staff D applied a gait belt to Resident #7. Staff A lifted Resident #7 by the waist of his pants and under his shoulder and Staff D lifted with the gait belt and under Resident #7's shoulder. Resident #7 was transferred to the wheelchair this way. On 4/2/25 at 12:52 PM the DON stated she would expect that a gait belt would have been applied during transfers with Resident #7. Stated can always go up with assistance and she would have preferred the staff to use the gait belt and not his pants for transfer and would like to have the staff have a conversation with Resident #7 about the use of the walker for transfers. 2. The MDS for Resident #3 dated 2/1/24 documented a BIMS of 13 which indicated intact cognitive function. The MDS documented diagnosis of hemiplegia or hemiparesis, non-Alzheimer's dementia, cancer, anemia, and orthostatic hypotension. The MDS reflected a total dependence on staff for transfers and most of the activities of daily living. In an interview with the family on 4/2/25 at 10:30 am, it was confirmed Resident #3 sustained an injury during a transfer due to staff using an incorrect mechanical lift and only 1 person instead of 2 person lift as required. The family member stated the resident was transferred using a sit-to-stand mechanical lift instead of a mechanical full body lift. A Verbal Communication Order from the Nurse Practitioner dated 3/22/25 at 2:16 pm documented the following order; Ace wrap to the lump on top of the right hand as tolerated by the resident until seen by the provider on Monday. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A Follow Up Note (Orders for Resident) by the provider dated 3/24/25 documented Raised area soft, surrounding bruising healing, continue to monitor. An Electronic Health Record review documented an Interdisciplinary Note on 3/20/25 at 11:46 am a bruise occurred on 3/14/25 at 4:20 pm. The note documented a conclusion of the incident was due to a Certified Nurse Assistant (CNA) assisted Resident #3 and told her to hold onto the bars of the mechanical lift (sit to stand) during the transfer. Resident #3 was to be transferred using a mechanical full body lift and not the mechanical lift (sit to stand). Resident #3 was prescribed Plavix and Aspirin for a blood thinner and it increased risk for bruising. Resident#3 stated she did have slight discomfort with movement. Orders received to increase pain medications, X-ray, and ice to the hand as tolerated. The note further documented the facility, reported the incident and findings to the family members and provided education to the team members. In an interview with the Director of Nursing (DON) on 4/3/25 at 11:05 am, she confirmed Resident #3 was transferred improperly by CNA using a mechanical lift (sit to stand) instead of a mechanical full body lift. The DON stated Resident #3 did not have a good core strength and the physical therapy department was working with the resident to improve mobility and used a mechanical lift (sit to stand) during therapy sessions but was not successful and CNA's were not given instructions to use a mechanical lift (sit to stand) for transfers, only a mechanical full body lift. The DON stated the staff member was removed from providing hands-on assistance to Resident #3 per family's request and was disciplined. A review of Staff E, Certified Nursing Assistant (CNA) personnel file revealed a Corrective Action Report signed by Staff E on 3/24/25 with the details of violation: you did not follow the plan of care when transferring a resident. You must always review the plan of care for each resident and then follow it. The plan of improvement was 1:1 coaching by a nurse. An observation on 4/3/25 at 11:50 am of a mechanical lift (sit to stand), revealed a severely damaged foam padding on the handles, exposing sharp metal edges on the right side where hands were to be placed during use. In an interview with the Administrator and the DON on 4/3/25 at 11:50 am they both visualized and confirmed the mechanical lift (sit to stand) stand-mechanical lift had a compromised integrity and removed it from the floor to replace the foam piece. A review of the facility policy titled Safe Resident Handling/Transfers revised 4/3/2025 documented directives to staff as follows; It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. The document also revealed Damaged, broken, or improperly functioning lift equipment will not be used and tagged out according to facility policy.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on observation, electronic health record (EHR) review, resident interview and staff interview the facility failed to provide nursing staff to assure residents safety by not responding to call lights in a timely manner for 4 of 6 resident reviewed (Resident #5, #6, #7 and #11). The facility reported a census of 117 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #6 documented a Brief Interview for Mental Status (BIMS) of 10 which indicated moderate cognitive impairment. The MDS documented diagnosis of wedge compression fracture of fourth lumbar vertebra, with subsequent encounter for fracture with routine healing. Review of Resident #6's EHR titled, Care Plan documented Resident #6 was unable to get out of bed and was on strict bedrest for at least 3 months. On 4/1/25 at 3:42 PM Resident #6 stated the staff rarely come promptly. Resident #6 explained it took about 15 or 20 minutes for the staff to answer the call lights frequently. Resident #6 stated her call light was on a couple of times today and nobody ever came. Resident #6 said she could shut the call light off and would frequently when it is not answered in 30 or 40 minutes. Resident #6 reported the current time as 12 minutes to 4. Resident #6 stated she knew how long it took for staff to answer the call light because she could read the clock. 2. The Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #7 documented a Brief Interview for Mental Status (BIMS) of 15 which indicated no cognitive impairment. The MDS documented Resident #7 was dependent on staff for upper body/lower body dressing, application of footwear and completion of personal hygiene. MDS also documented Resident #7 was dependent on staff for position changes from lying to sitting, sitting to standing, and chair to bed. On 4/3/25 at 7:45 AM Resident #7 stated that on 4/2/25 he was upset because it had taken the staff a very long time to answer the call light that he turned on. Resident #7 said he wanted to get out of bed to go to breakfast. Resident #7 explained that frequently it took longer than 15 minutes for his call light to be answered. Resident #7 expressed that he liked to get out of bed at the same time every day and he usually turned his call light on at 7:00 AM in hopes to get up at 8:00 AM. Resident #7 stated that it could take at times up to an hour for the staff to answer his call light. Resident #7 said the staff usually told him they were working short and that was the reason the call light took so long to answer. Review of Resident #7's EHR documented resident resided in room [ROOM NUMBER]-1. A continuous observation on 4/2/25 at 7:37 room [ROOM NUMBER]'s call light on. At 7:53 AM a CNA entered the room to answer the call light. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 4/2/25 at 8:04 AM Staff A, Certified Nursing Assistant (CNA) spoke to Resident #7 and stated the reason it took a little while to answer the call light was because there were a lot of other residents to assist. Staff A told Resident #7 that staff were working short that morning. On 4/2/25 at 12:52 PM DON stated call lights were addressed in the last visit by the state in February. The DON said there was a decrease in trends with complaints about call light response times. The DON stated there were not as many grievances about call light responses. The DON explained that the facility's guardian angel rounds had not had any complaints of call light response time. The DON stated the facility's expectation was that the call light would be answered in less than 15 minutes. The DON stated call light response was increased during peak hours such as breakfast, lunch, dinner and bedtime. The DON stated Wednesdays were the hardest day to staff. The DON stated was not optimal staffing 2.5 on central 3 on northeast and 4 on west as was the situation 4/2/25. The DON stated she felt that there was enough staff to provide adequate care to the residents that day. The DON explained the expectation was not that the call light would be shut off and then provide the service 30 minutes later. The DON stated the facility expectation was that the service would be provided prior to the call light being shut off. On 4/3/25 at 1:00 PM the Administrator stated the facility's expectation was the staff would prioritize call lights. The Administrator stated he would like to see the call lights in under 15 minutes. Review of policy revised 2/11/25 tilted, Call Lights: Accessibility and Timely Response documented all staff members who saw or heard an activated call light were responsible for responding. If the staff member could not provide what the resident desired, the appropriate personnel should be notified. Call lights would directly relay to a staff member or centralized location to ensure appropriate response. 48888 3. The Quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition. The MDS revealed Resident #5 had been dependent upon staff for toileting hygiene, lower body dressing, and toilet transferring. The MDS identified Resident #5 as always incontinent of bowel and bladder. Diagnoses included neurogenic bladder and Benign Prostatic Hyperplasia (BPH) with lower urinary tract symptoms. The Care Plan, initiated 10/01/24, revealed Resident #5 had been totally dependent on staff for toileting due to incontinence of bowel and bladder. Interventions instructed staff to check Resident #5 for incontinence, wash, rinse, and dry perineum, and change clothing as needed after incontinence episodes. On 4/01/25 at 12:37 PM, a staff member brought Resident #5 to the nurses station via wheelchair, the staff member stated, he is soaking wet, to other staff who sat behind the nurses station. Resident #5 then transported from the nurses station to his room via wheelchair and left alone in his room. Resident #5 observed wearing grey sweatpants with visible saturation across his lap. On 4/01/25 at 12:55 PM, Resident #5 continued to sit in wheelchair in his room and grey sweatpants remained visibly wet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165448	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Drumm Retirement Center	5837 Winwood Drive Johnston, IA 50131

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/01/25 at 1:00 PM, after 23 minutes, two staff members entered Resident #5's room and stated, we' re going to change you. On 4/03/25 at 10:58 AM, the Director of Nursing (DON), revealed expectation of staff to assist residents with an incontinence episode within 15 minutes. 4. The Minimum Data Set (MDS), dated [DATE], revealed Resident #11 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Resident #11 required substantial to maximal staff assistance with transfers and partial to moderate assistance with bed mobility. Resident #11 had an indwelling urinary catheter. Diagnoses included neurogenic bladder, acute respiratory failure with hypoxia (low oxygen saturation) and sepsis. The Care Plan, initiated 3/22/25, revealed Resident #11 had potential for alteration in comfort and was at risk for skin breakdown and rehospitalization . On 4/02/25 12:35 PM, Resident #11 activated call light. Call light observed on outside of Resident #11's room. On 4/02/25 at 12:51 PM, 16 minutes after light activated, Resident #11 observed lying in bed. Resident #11 reported he had pressed the call light to request assistance getting up from bed. Resident #11 stated he had not been out of bed as of this time, on 4/02/25, due to waiting on removal of indwelling urinary catheter. A Nursing Assistant entered the room and answered call light. Nursing Assistant informed Resident #11 she would notify the nurse of his request and return to assist him up from bed. Review of a Nursing Progress Note, dated 4/02/25 at 10:44 PM, revealed Resident #11's indwelling catheter was discontinued on this shift. The facility policy titled, Call Lights: Accessibility and Timely Response, dated 2/11/25,

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	165448	A. Building B. Wing	04/03/2025

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on observation, Electronic Health Record review (EHR), resident interviews and staff interviews the facility failed to maintain an effective pest control program so that the facility was free of pest and rodents for 2 of 3 residents reviewed (Resident #1 and #10). The facility reported a census of 117 residents. Finding include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #1 documented a Brief Interview for Mental Status (BIMS) of 15 which indicated no cognitive impairment. On 4/1/25 at 3:17 PM Resident #1 stated she had seen a mouse in her room. Resident #1 explained there was only 1 that had been in the facility but had been around for the last 4 months. Resident #1 stated the traps in her room were set and got set off but, no mouse on the trap. Resident #1 revealed she had bought sticky traps and the traps disappeared. Resident #1 said she did not know what happened to them. Resident #1 said she told Staff F, Director of Maintenance and facilities about the mouse and he said he would call pest control. An observation on 4/1/25 at 3:20 PM revealed an armed wooden mouse trap with creamy brown substance present behind Resident #1's recliner. Observation of small black specks around the mouse trap possible mouse droppings. Review of Resident #1's EHR documented resident resided in room [ROOM NUMBER]-A Review of undated document title, Front Desk Copy of Floor Plan documented room [ROOM NUMBER] and 231 were across the hall from each other at the end of the west wing hall. The floor plan also documented an exit door at the end of the west wing hall between rooms [ROOM NUMBERS]. An observation on 4/2/24 at 9:13 AM revealed the exit door at the end of the west wing hall between rooms [ROOM NUMBERS] had a visible gap at the bottom of the door leading outside. Also revealed a circular gap near the corner of the door where the weather guard was missing or had been separated. Observation revealed an area of building structure missing near the lower left corner of the door on the outside entrance of the door. Observation further revealed a trail of missing bristles from the weather guard out to the area of missing building structure in the lower left corner of the building at the entrance. 2. The MDS dated [DATE] for Resident #10 documented a BIMS of 15 which indicated no cognitive impairment. Review of Resident #10's EHR documented resident resided in room [ROOM NUMBER]-A. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Bishop Drumm Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5837 Winwood Drive Johnston, IA 50131	

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 2:42 PM Resident #10 stated he lived across the hall from Resident #1. Resident #10 said he had a mouse that lived in his closet. Resident #10 explained his closet door did not shut all the way and the mouse would go in there. Resident #10 stated he had told Staff F. Resident #10 stated Staff F told him the exterminator had already been there. Resident #10 revealed he told Staff F about it last week. On 4/2/25 at 10:47 AM Staff B, President of the pest and termite control services stated he had been coming to the facility for about [AGE] years. Staff B stated he got a mouse concern today in room [ROOM NUMBER]. Staff B stated he had not had any concerns about mice at the facility reported to his company in the last 6 months. Staff B stated he had not completed any mice inspections or treatments in the last 6 months. On 4/2/25 8:45 AM Staff C, Certified Medication Assistant (CMA) stated Resident #1 had complained about mice in her room. Staff C stated he had seen mice running from room to room at the end of the hall between from 230 and 231. Staff C revealed he had reported the mice issue to the maintenance guy but did not remember his name. On 4/2/25 at 12:52 PM DON stated Resident #1 had been complaining about mice in her room for 4 months. The DON stated she had turned in reports to the computer reporting system at the facility related to mice in Resident #1's room. The DON stated it was not in her scope of practice to investigate or rid the facility of mice. On 4/3/25 at 12:05 PM Staff F, Director of Maintenance and Facilities stated no CMA or staff had reported mice in the facility. Staff F stated he had no reason not to report and call the pest control service. Staff F stated he had looked in room [ROOM NUMBER] but Resident #10 had never reported any mice issues to him. Staff F revealed there were moths reported in December but not mice. Staff F acknowledged if a pest problem was reported it should be reported to the pest control as soon as possible. Staff F stated the pest control services were at the facility usually in 3 days. Staff F explained the pest control service stated 4/2/25 there was no evidence of mice in the room. On 4/3/25 at 1:00 PM the Administrator stated he would expect a work order would have been created for the pest control issue so that maintenance is aware of the concern and in this situation if the work order was submitted the maintenance would have notified the pest control management company. The Administrator revealed once notified the maintenance should notify the pest control by the next business day. The Administrator stated he would expect the pest control services to triage the concern based on what the report is. Review of policy revised 4/3/25 titled, Pest Control Program documented the facility would maintain a report system of issues that may arise in between scheduled visits with the outside pest service and treat as indicated.