STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165448	A. Building B. Wing	05/29/2025

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 - 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** 46873 Based on clinical record review, hospital record review, staff and physician interview, the facility failed to promptly notify a medical provider in a timely manner of a change of condition for 1 of 4 residents reviewed (Resident #2). Resident #2 was exhibiting symptoms of hyperglycemia (high blood sugar) two days prior to physician notification and had an elevated heart rate for several days prior. The resident was hospitalized with diagnoses including sepsis (infection in the bloodstream) and diabetic ketoacidosis (also known as DKA, a serious complication of diabetes causing a buildup of ketones and a significant rise of blood sugar). The facility reported a census of 117 residents. Findings include: The Quarterly Minimum Data Set (MDS) of Resident #2, dated 4/3/25 coded the resident to be non verbal and could sometimes make herself understood. The MDS documented diagnoses that included anemia, hypertension, diabetes, aphasia (a communication disorder that impairs a person's ability to process language resulting in difficulty speaking or understanding), stroke, and seizure disorders. The MDS recorded the presence of a feeding tube and that the resident received 51% or more of her total calories through the tube feeding. The MDS recorded the resident received insulin daily during the lookback period. The Care Plan of Resident #2 identified a focus area of tube feedings, secondary to stroke, dated 1/13/20. The Care Plan additionally identified focus areas of communication problems related to language barrier and aphasia and diabetes with daily insulin with risk of complications of hypo or hyperglycemia (low or high blood sugar). The Medication Administration Record for Resident #2 for April of 2025 documented a blood sugar of 437 on the evening of 4/17/25. The following evening her blood sugar was recorded as 296, and on 4/16/25 her morning blood sugar was 413 and evening blood sugar was 397. Neither the MAR nor the Treatment Administration Record (TAR) reflected the resident receiving any additional insulin outside of her normal daily scheduled insulin. The Progress Notes failed to reveal any medical provider had been notified of the resident's high blood sugars. There were no nursing notes entered for 4/4/25 through 4/15/25. The only note written on 4/16/25 documented a physician note dated 4/4/25 had been received with no new orders. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165448	A. Building B. Wing	05/29/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	The MAR recorded the resident had an order for Metoprolol, a blood pressure medication, three times daily which required documentation of the residents blood pressure and pulse at administration. The resident's blood pressure was noted to be trending slightly below her baseline and her pulse was noted to be at 100 beats per minute or higher, up to 126 beats per minute on 4/13/25 through 4/16/25. (Tachycardia, a rapid heart rate, is defined as greater than 100 beats per minute). Staff C, RN documented a blood pressure of 119/84 with a pulse of 126 at 6:00 am on 4/16/25. Staff B, RN, documented the exact same vital signs at 1:00 pm that day with no documentation of notifying a provider of tachycardia maintaining for seven hours. (Early signs of sepsis can include low blood pressure and rapid heart rate). The report from an area hospital dated 4/17/25 at 10:10 am documented Resident #2 presented to the emergency department febrile, tachycardic, tachypneic and hypotensive (having a fever, having an increased heart rate and respiratory rate and low blood pressure). The report documented her blood pressure as 92/70, her temperature as 103.6 degrees, a heart rate of 125 and pulse rate of 24. Labs taken at 10:28 am documented a blood glucose of 695. A chest xray was ordered which was consistent with pneumonia. The note documented the resident received multiple rounds of Intravenous (IV) fluids but remained with a low blood pressure and an insulin drip was started to lower her blood sugar levels. An additional report dated 4/17/25 at 3:30 pm documented the resident was admitted to the hospital with DKA, and septic shock secondary to pneumonia and a UTI. This note documented the resident presented from the nursing facility having been more somnolent and having decreased responsiveness since the prior day. The Admission Summary of the facility dated 4/24/25 identified the resident readmitted to the facility on [DATE] at 2:50 pm following a week-long hospital stay. On 5/28/25 at 7:53 am, Staff C, RN stated when she was working the overnight shift of 4/16/25-4/17/25, she recalled receiving in shift report that Resident #2's blood sugars had been running high. During her shift, she went to check on the resident and said that she just didn't look like her normal self. She stated that while the resident is baseline non verbal, she would normally smile and her eyes would make contact. Staff C performed an additional blood glucose check and the glucometer could only read high, meaning the blood sugar was too high for the glucometer to not be able to obtain a reading which would indicate severe hyperglycemic (high blood sugar). She stated she called the oncall provider who failed to give any orders for insulin. Staff C stated she did ask for insulin orders but the provider was a medical resident and only gave orders to stop the resident's continuous tube feeding and to draw labs. She stated the provider told her due to the glucometer not giving a specific blood sugar number, she was not ordering insulin. She stated when the day shift arrived for shift exchange, they checked her blood sugar again which still read high and they attempted to draw the ordered labs but were unsuccessful in obtaining the blood draw. She stated the day shift nurse again notified the provider and at that time received orders to send the resident to the ER. She stated when she has worked with Resident #2 in the past her blood sugars most often run in the high 100's into the 200's, occasionally being higher. On 5/28/25 at 11:08 am, Staff B, RN stated not all diabetic residents have parameters listed in their orders of when to notify a physician. He stated he would normally notify a physician if a resident's blood sugar is running higher than their normal baseline or higher than 300. He stated he did not recall having any concerns about Resident #3 on that shift or recall her vital signs being abnormal, but that it didn't surprise him when he heard she was hospitalized . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165448	A. Building B. Wing	05/29/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	On 5/28/25 at 11:56 am, the Director of Nursing (DON) stated Resident #2 is followed by the Residency group of one of the local hospitals. She stated the facility's Medical Director overall is able to prescribe medications or treatments for any of the facility residents but he does not follow Resident #2 for her normal visits. She stated she would expect the staff to notify a medical provider anytime a resident's blood sugar is greater than 400 but some staff may do so when it's more like 350. She stated she reviewed the progress notes and agreed there was no notification made to a provider prior to 4/17/25. On 5/28/25 at 1:40 pm, the Medical Director stated that Resident #2 is followed by the Hospital Residency Group but if staff can either not get ahold of that group or has further concerns, they can always reach out to him as well. He stated if there is a concern for the safety of any resident, he would want the staff to call himself or whoever is on call for him. He stated in this case, he would have reached out to the Residency Group himself and gotten the resident taken care of. On 5/29/24 the DON stated the facility will be reaching out to their medical providers regarding obtaining parameters of when the providers wish to be notified of changes in vital signs or blood sugars. She stated they will be updating their education for their nursing staff and using a change of condition form within the electronic health charting. She also stated they would be speaking to the providers about obtaining orders for sliding scale insulin for Resident #2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165448	A. Building B. Wing	05/29/2025

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 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. 46873 Based on observations, clinical record review, staff interview and facility policy review, the facility failed to provide adequate supervision and follow the care plan for 1 of 3 residents reviewed, resulting in Resident #3 suffering a fall. The facility reported a census of 117 residents. Findings include: The Quarterly Minimum Data Set (MDS) Assessment of Resident #3 dated 3/22/25 identified a Brief Interview for Mental Status Score of 5, which indicated severe cognitive impairment. The MDS documented diagnoses which included humerus fracture, non Alzheimer's dementia, and anxiety disorder. The MDS revealed the resident had an impairment to one upper extremity, and used a walker for a mobility device. The MDS documented that the resident required substantial/maximal assistance with the following activities; toilet transfer, chair/bed-to-chair transfer, sit to stand, lying to sitting on side of bed, sit to lying, and roll left and right in bed. The MDS documented the resident had had one fall with no injury and one fall with injury since the prior MDS assessment. The Care Plan, last reviewed 4/1/25, identified a Focus Area of Activities of Daily Living (ADL) Self Care Performance. The Care Plan directed staff that Resident #3 required assistance with transfers, with hand held assistance, revision date of 10/25/24. The Care Plan also directed staff the resident needed assistance with all toileting tasks, revision date of 10/25/24. The Nurse's Note dated 4/23/25, authored by Staff B, Registered Nurse (RN) documented he was alerted by another nurse that the resident had slipped returning from the bathroom heading to her chair. The Note documented the resident received a skin tear in the fall measuring 5 cm by 10 cm on her left forearm. The resident also complained of pain to her right big toe and it was noted her left shin was bruised. The medical provider was notified and an order obtained to x-ray her toe. The Interdisciplinary Note dated 5/5/25 authored by the Director of Nursing (DON) documented the Interdisciplinary Team (IDT) met to review the fall which occurred on 4/23/25 at 3:00 pm. This note documented the resident was walking herself from the bathroom to the main area of her room and she had fallen, obtaining a 5 cm x 10 cm skin tear and complaining of pain in her right big toe. The x-ray of the toe showed no injury noted. The note detailed the resident later complaining of pain and discomfort to her left arm on 5/2/25. An x-ray was obtained on 5/5/25 noting a fracture of the arm. The note detailed the resident was sent to the emergency room where she received a splint and an ace bandage wrap was applied and she received new orders and was to have a follow up visit with orthopedics. On 5/22/25 at 2:30 pm, Resident #3 was observed resting in the lounge area of the facility, near the nursing station with three other residents nearby. No staff were in the room with direct observation of the resident, but were noted to be nearby. Approximately 30 minutes later, Resident #3 was observed starting to get restless and a staff member came and assisted her and took her for a walk. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165448	A. Building B. Wing	05/29/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/23/25 a nurse from the Orthopedic physician office verified the fracture seen on the x-rays was the same prior fracture from several months back which had previously not healed and the fracture was not a new fracture from this fall. On 5/28/25 at 8:23 am, the DON stated that the facility was not going to provide the incident report regarding the fall with the State Agency as requested. The DON provided the names of the staff members who were assigned to care for Resident #3 that day. Staff D, CNA was assigned to care for her until 3:00 pm and Staff E, CNA was assigned to care for her beginning at 3:00 pm. On 5/28/25 at 9:50 am, Staff E, Certified Nurse Aide (CNA) stated she was not on duty the day Resident #3 fell . She stated she was not in the building until the following day. The schedule reflected Staff E was assigned to work on the day of the fall although no charting by any CNA was completed that shift. On 5/28/25 at 11:08 am, Staff B, RN stated the resident's fall was right at shift exchange. He stated he was walking down the hall and Staff A, RN was coming down another hall and she told him Resident #3 had just fallen. He stated he felt that Resident #3 really needed to be a one to one resident since he had started working at the facility several months prior. He stated she has had multiple falls over several months. But he stated she was care planned to be up independently. He stated she goes to the bathroom on her own but if staff sees her, then they try to go with her. He stated he remembered she obtained a skin tear during the fall and it was bandaged sometime shortly after the fall but he did not remember other details of the fall. On 5/28/25 at 11:30 am, Staff D, CNA, stated she worked the day of the fall but was not assigned to care for Resident #3. She stated she was working a different hall and did not know anything about the fall until the following day. Charting reflected that Staff D had charted cares for Resident #3 that shift. On 5/28/25 at 11:35 am, the DON stated Resident #3 is to be assisted for her tasks including walking and toileting. She stated she uses her walker and often is found furniture surfing walking independently in her room and outside of her room. She stated based on the notes from the fall, a staff member was aware she was in the bathroom. She stated normally a staff member will assist her to the bathroom and onto the toilet and then leave her to provide privacy to use the toilet. She stated the resident's room is right near the nursing station and she would expect a staff member to stay nearby until Resident #3 was done in the restroom. She stated the IDT determined the root cause analysis of the fall was the resident's impulsiveness and not using the call light for assistance. She stated she did not feel the Care Plan was correct in stating she needed assistance as she thought that therapy had deemed her to be independent for transfers and toileting prior to discharging her from therapy. She stated the portion of the care plan of needing assistance with toileting tasks was more about providing prompting to use the restroom. She stated Resident #3 had multiple changes since her fall in October and the Care Plan had not been updated. She also stated it did not surprise her that the two CNAs denied caring for Resident #3 on that day as she stated this was a cultural thing and she had experienced the same sort of issues when providing either education or discipline to staff at times. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165448	A. Building B. Wing	05/29/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/25 at 9:10 am, Staff A, RN stated on 4/23/25, the day of Resident #3's fall there was staff education training and she signed up for training from 3:00 pm to 4:00 pm. She stated she had asked Staff B, RN to stay later in the day so she could attend training and he agreed to do so. She stated she arrived at the nursing station to drop off her things prior to attending training and the Admission Coordinator was at the desk. She stated the Admission Coordinator told her he had observed Resident #3 walking in her room from the restroom and then heard a noise just before Staff A arrived at the nursing station. She stated she went into Resident #3's room and saw she had fallen. She stated she saw Staff B coming down the hall and she informed him of the fall. She stated she needed to go to training and left Resident #3 with Staff B assessing her and she returned to the nursing station approximately one hour later after training. She stated when she returned Resident #3's daughter was there and Staff B informed her that the resident had obtained a skin tear from the fall. She stated he told her he had called the provider on call and gotten an order to dress the skin tear per the wound protocol for the facility. She said when she went in to see the resident, the bandage was soiled which she removed. She noted the resident's skin was not pulled over the wound and there were no steri strips in place as the wound protocol calls for. She stated the resident's daughter informed her she had come in and found her bleeding and had to go find Staff B for him to treat the wound. She stated she cleansed the wound, placed the skin over the wound, and secured with steri strips and then gauze. She stated the resident was also complaining of pain to her toe so she got her an ice pack for that and then called the provider and obtained an order for x-rays of the toe. On 5/29/25 at 11:03 am, F, CNA stated Resident #3 walked with a walker and staff help her. She stated if staff see her up on her own, or going into the restroom on her own, staff are to go in and assist her. On 5/29/25 at 11:10 am, Staff G, Restorative Aide, stated Resident #3 gets very confused and tearful at times. She stated it can be difficult to redirect her sometimes. She stated if she witnesses this, she will often take her for a walk to calm her. She stated she is to be an assist of one staff member and is not supposed to be independent but that she forgets and she gets up on her own. She said she is sometimes found going to the bathroom or making her bed or other things and staff try to bring her out of her room into a common area or at the nursing station. On 5/29/24 at 11:24 am the DON stated she talked to the MDS Coordinators and with the clinical team about how Resident #3 was currently doing and they updated the Care Plan to reflect her to be independent to transfer and to require assistance with toileting hygiene/incontinence cares. She stated on the prior care plan to note she needed one assistance for toileting, that was more in regards to peri care (toileting hygiene) as she wasn't able to do that when she had fractured her arm several months prior. She also stated the resident has had medication changes to help calm her down and she appears to be more content at this time. She stated the care plan which was updated in October of 2024 was regarding how the resident was before some changes were made and did not reflect her current status and it had now been updated. The Facility Policy Falls and Fall Risk, Managing, revised March 2018, documented the following under Resident-Centered Approaches to Managing Falls and Fall Risk : Point 4: In conjunction with the consultant pharmacist and nursing staff, the attending physician will identify and adjust medications that may be associated with an increased risk of falling, or indicate why those (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165448	A. Building B. Wing	05/29/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications could not be tapered or stopped, even for a trial period. Point 5: If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. Point 6: If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. The Policy documented the following under Monitoring Subsequent Falls and Fall Risk: Point 3: If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. The Facility Policy Activities of Daily Living (ADLs), Supporting, revised March, 2018 documented the following: Point 5: A resident's ability to perform ADLs will be measured using clinical tools, including the MDS. Functional decline or improvement will be evaluated in reference to the assessment reference date (ARD) and the following MDS definitions: a. Independent - Resident completed activity with no help or staff oversight at any time during the last 7 days. b. Supervision - Oversight, encouragement or cueing provided 3 or more times during the last 7 days. c. Limited Assistance - Resident highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight bearing assistance 3 or more times during the last 7 days. d. Extensive Assistance - While resident performed part of activity over the last 7 days, staff provided weight-bearing support. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165448	A. Building B. Wing	05/29/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Total Dependence - Full staff performance of an activity with no participation by resident for any aspect of the ADL activity. Resident was unwilling or unable to perform any part of the activity over entire 7-day look-back period. Point 6: Interventions to improve or minimize a resident ' s functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice. Point 7: The resident ' s response to interventions will be monitored, evaluated and revised as appropriate.