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	07/21/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, facility work orders, resident and staff interviews, and policy review, the facility failed to provide a safe, clean, comfortable and homelike environment. The facility identified a census of 107 residents. Findings include:Observations revealed the following: a. On 7/14/25 at 3:00 PM, the door to resident's room [ROOM NUMBER] and room [ROOM NUMBER] would not close even though the surveyor pulled on the door repeatedly in attempt to close the door to the room. b. On 7/16/25 at 12:30 PM, room [ROOM NUMBER] had a board for the window sill lying on the floor by the resident's bed.c. On 7/17/25 at 8:50 AM, the door to resident's room [ROOM NUMBER] and room [ROOM NUMBER] sprung open several times as the surveyor and staff attempted to close the door. room [ROOM NUMBER] continued to have a board for the window sill lying on the floor by the wall and bed. The platform (by the window) for the window sill had hard, dried glue and a rough surface. The bathroom call light in room [ROOM NUMBER] was not working. The 4-plex electrical outlet had a dorm sized refrigerator, a charger for a motorized wheelchair, and a charger for electronic devices plugged into 3 of the 4 outlets. Work Orders reviewed 4/18/25 to 7/17/25 revealed no open or active work orders for rooms [ROOM NUMBER]. A Work Order for room [ROOM NUMBER] revealed the windowsill lifted up due to the bed rising and the windowsill needed glued down. The work order was created and completed on 6/18/25. A Work Order for room [ROOM NUMBER] created on 7/15/25 and completed on 7/17/25 revealed the (electrical) outlet was not working.In an interview on 7/15/25 at 8:22 AM, Resident #40 reported the windowsill in her room had laid on the floor by her bed for more than a month. Resident #40 stated staff told her they would fix it but it didn't get done. In an interview on 7/14/25 at 2:57 PM, Resident #5 reported the bathroom call light was not working. The plug-in by the wall threw out sparks when staff plugged something into it. At the time a large dorm-sized refrigerator was plugged into one outlet, a charger for electronic devices was plugged into one outlet, and a charger for a motorized wheelchair was plugged into one of the 4-plex electrical outlet-In an interview on 7/17/25 at 9:25 AM, Staff B, Certified Nursing Assistant (CNA) reported a work order was entered in the computer when something needed repaired. She let the nurse know if maintenance had not fixed the broken item. The nurse could enter an updated work order request. In an interview 7/17/25 at 1:35 PM, Staff C, Certified Medication Aide (CMA) reported he entered a work order in the computer if someone reported something not functioning properly or needed repaired. In an interview 7/17/25 at 9:30 AM, Staff K, Maintenance, reported staff could enter a work request in the TELS system on the computer or verbally told him when something needed repaired. In an interview 7/17/25 9:35 AM, the Maintenance Director reported maintenance staff received notification about things that needed repaired or checked through the TELS system. A work order was prioritized according to urgency. The Maintenance Director reported he could run a report of the work orders completed or pending work orders. In an interview 7/17/25 at 9:45 AM, Staff A, Registered Nurse reported she entered a work request in the TELS system on the computer, or she paged maintenance to let them know if equipment or something needed repaired or wasn't working. In an interview 7/17/25 at 3:48 PM, the Administrator reported he believed the reason the windowsill in room [ROOM NUMBER] may be lying on the floor was due to the bed hit the window sill when staff raised the bed up, and the windowsill broke off. The Administrator stated they probably needed to order a board that fit the windowsill to reduce the chance of the bed hitting the windowsill when the bed got raised. The Administrator stated he planned to reopen the work order and have maintenance order the custom wood to go over the windowsill. The Administrator reported the work order for the electrical outlet in room [ROOM NUMBER] entered was created on 7/15/25. A Homelike Environment policy revised 1/3/22 and effective 5/22/25 revealed residents are provided with a safe, clean, and homelike environment.

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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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, resident and staff interviews, and policy review the facility failed to report a resident's change in condition, and failed to assess and document a skin assessments for one of three residents reviewed (Resident #5). The facility reported a census of 107 residents.Findings include: The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had diagnoses of osteomyelitis to the left ankle and foot, diabetes, and renal insufficiency. The Care Plan created on 5/14/25 revealed Resident #5 had a break in skin integrity on the left third toe due to an amputation. The Care Plan directed staff to provide treatment as ordered. The Care Plan lacked information about a wound or area of concern on her bottom. An admission assessment dated [DATE] revealed the resident had a toe amputation. Section B of the assessment revealed the resident had bruises to her hands that were present on admission. The resident had no other skin abnormalities documented. The Braden Scale assessment dated [DATE] revealed the resident had a high risk for developing a pressure ulcer. The Braden Scale assessment dated [DATE] revealed the resident had a very high risk for pressure ulcers. An Order started on 5/22/25 to apply Calmoseptine ointment to the buttocks topically two times a day for pressure reduction until the area was healed. Encounter Note dated 5/22/25 documented Menthol-Zinc Oxide, Calmoseptine External Ointment 0. 44-20.6% Apply to buttocks topically two times a day for pressure reduction until healed.The Clinical Assessments under the Assessment tab in the EHR revealed the last documented assessment on 7/14/25 for a venous wound to the left lateral lower leg and a surgical wound to the left third toe amputation. The Progress Notes documented the following: a. On 6/29/25 at 9:41 PM, a weekly skin assessment completed. A new area of concerns noted with a laceration on the left shin. Resident reported she got it during a fall yesterday (6/28/25). Treatment order in place. PCP notified. b. A Skin check documented on 7/7/25 at 12:21 AM, the skin was warm and dry, and skin turgor normal.c. On 7/14/25 at 1:00 PM, the resident had a laceration to the left shin that was acquired in-house. The skin issue to the buttocks was not evaluated. d. On 7/15/25 at 2:36 PM, resident complaining of diarrhea. e. On 7/16/25 at 9:11 PM revealed the resident had a yellow, dry scab on the right buttock measuring approximately 1 centimeter (cm) by 2 cm, possibly indicating a healing superficial skin loss. No signs or symptoms of infection were observed. Calmoseptine ointment applied to the buttocks as ordered. The Skin Assessments indicated the following: a. On 7/7/25, skin warm, dry, and within normal limits (WNL).b. On 7/14/25, skin warm, dry, and WNL. No signs or symptoms of infection noted to the left foot third digit amputation site. Several bruises present to the extremities that are resolving. The record lacked any other skin assessments about a wound or skin issue on the resident's bottom. The Treatment Administration Record dated 7/1 to 7/31/25 documented Calmoseptine applied 7/1 - 7/17/25 except on 7/7/25, 7/10/25 and 7/11/25 on the AM shifts. During observation on 7/16/25 at 4:40 PM, Staff I, Registered Nurse (RN) told Resident #5 she would look at her bottom per the surveyor's request. After the resident rolled onto her right side, Staff I removed the resident's brief and noted the resident incontinent of black liquid stool. Staff I stated needed to clean the resident up in order to view her bottom. At 4:45 PM, Staff J, Certified Medication Aide (CMA) entered the room, donned gloves, and cleansed the resident's buttocks area with disposable wipes. Staff I reported she didn't see any redness or open areas to the resident's bottom but she would look further after the resident had been cleaned up. Staff I proceeded to leave the room to find a different sling for transferring the resident. After Staff J changed gloves, he lifted the resident's left buttock up in order for the surveyor to view the buttocks area. A dime-sized reddened, raised area observed to the right inner buttock with a small open area in the middle of the wound area. Staff J changed his gloves and applied Calmoseptine to the buttock area. At 4:57 PM, Staff G, RN, brought a sling to the room. At 4:50 PM, Staff I, RN, returned to the room as staff had the resident in a sling and positioned the mechanical lift to transfer the resident from the bed into her motorized wheelchair. Resident #5 said she wanted to stay up and go to supper. Staff I was observed talking with Staff G, RN, in the hallway. In an interview 7/14/25 at 3:08 PM, Resident #5 reported she had a small slit on her bottom.In an interview 7/16/25 at 9:37 AM, Staff I, RN, reported skin assessments documented on the computer under the assessments tab. In an interview 7/16/25 at 10:39 AM, the Director of Nursing (DON) reported skin assessments documented on the computer on the Skin Evaluation V7 Assessment and the wound treatments were listed under the Orders in the computer. An Interdisciplinary Team (IDT) Review note related to any skin incidents listed in the progress notes. In a follow up interview on 7/16/25 at 4:30 PM, Resident #5 reported she

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on Resident council minutes, family interview, resident interview, and staff interview the facility failed to answer call lights in a timely manner (15 minutes or less) for 3 of 4 units (North, South and North East). The facility reported a census of 107 Residents. Findings include:Review of Resident Council Minutes for April, May and June of 2025 documented the residents in attendance each month expressed concerns regarding the length of time it takes staff to respond to call lights. During an interview on 7/14/25 at 1:53 PM, Resident #79, with a Brief Interview for Mental Status (BIMS) of 15 (indicating cognitively intact) explained it takes at least 20-30 minutes to get staff to respond to call lights. During the same interview, Resident #26 with a BIMS of 14 (indicating cognitively intact) agreed that it takes a long time to get call lights answered. During an interview on 7/14/25 at 3:08 PM, Resident #5 with a BIMS of 15, explained it takes a long time to get staff to respond to her call light. She explained she turned her call light on at 1:00 PM and no staff came in to help her as of the time off the interview. She further explained that staff will come in and turn off her call light saying they will be back but that could take another 50 minutes. During an interview on 7/15/25 at 10:29 AM, Resident #39 with a BIMS of 15 explained she watched the clock when she turned her call light on that morning. She explained she turned her call light at 7:35 AM and it was not answered until 8:15 AM. During an interview on 7/17/25 at 9:07 AM, a family member that is frequently in the facility reported it takes 30 minutes or longer for the call light to be answered. During an interview on 7/17/25 at 12:01 PM the Director of Nursing (DON) explained the standard and expectation for answering call lights is less than 15 minutes. She explained she was aware of the resident's concerns and had provided education, completed audits, hired another unit manager and adjusted staffing. She further explained there was no reason for the lights to not be answered

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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** Based on observation, staff interview, and policy review, the facility failed to follow infection control practices for a resident with a feeding tube for 1 of 3 residents reviewed for medication review (Resident #79). The facility also failed to follow infection control practices for a resident with a catheter for 1 of 1 resident reviewed for catheter care (Resident #19). The facility reported a census of 107 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE], indicated that Resident #79 had hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia following cerebral infarction, aphasia following cerebral infarction and a feeding tube. The Care Plan for Resident #79, with a target date of 7/18/25, indicated a feeding tube related to dysphagia secondary to Cerebral Vascular Accident (CVA) requiring Enhanced Barrier Precautions (EBP). During an observation on 7/15/25 at 12:34 PM, Staff A, RN gave medications to Resident #79. Staff A, RN donned gloves and gown for EBP precautions. Prior to medication administration, blood sugar, blood pressure and pulse oximetry were obtained. Equipment of glucometer, automatic blood pressure cuff and pulse oximeter were placed back into the medication cart without being sanitized and without hand hygiene or glove removal. Insulin was given and returned to the medication cart. Scopolamine patch was placed and wrapper discarded in trash on the side of the medication cart. Medications were charted with gloves still on. Then, Staff A, RN got medications out of the medication cart, opening several draws without hand hygiene or glove removal. Medications were given via gastrostomy tube, documented and returned to the medication cart. Gloves were doffed and then she adjusted resident’s clothing. Finally, Staff A, RN doffed her gown and performed hand hygiene. During an observation on 7/16/25 at 9:10 AM, Staff B, CNA and Staff C, CNA were transferring and providing hygiene for Resident #79. Both staff members donned gown and gloves. Resident #79 was transferred to her wheelchair and Staff B doffed her gloves and began combing Resident #79’s hair. New gloves were donned without hand hygiene. Staff C doffed gown and gloves and unplugged feeding pole and moved next to resident. Staff C then donned new gloves without hand hygiene but did not don a new gown. During an interview with the Director of Nursing (DON) on 7/17/25 at 11:45, she stated that EBP here is by the splash factor when germs can splash on to other surfaces. If residents have all their clothes on and the area of concern like a catheter or wound is covered, EBP is not required. If their clothes are off or they are close to the area where it could splash, EBP is required. To clarify, stated if taking off a resident’s shirt who has a suprapubic catheter, EBP would be required. However, if a vaginal catheter and taking off resident’s shirt, EBP would not be needed. Stated EBP would be required for transfer out of bed to a wheelchair with a mechanical lift. Stated combing hair would require EBP as it is part of the process of getting up. Pertaining to hand hygiene, stated that it would be required between glove changes and between dirty and soiled areas. Reviewed findings of observations with her and she stated that staff should have performed hand hygiene in both situations. Review of document titled Hand Hygiene, approved 5/22/25, indicates that the use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of document titled Enhanced Barrier Precautions has no approval date but copyright date of 2025 indicates to implement EBP with high-contact resident care activities including providing hygiene. The Center for Disease Control and Prevention (CDC) directs nursing facility staff to implement EBP for residents with wounds and/or indwelling medical devices, regardless of MDRO status, during high contact resident care activities to include providing hygiene. (https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html?CDC_AAref_Val=https:// www.cdc.gov/hai/containment/PPE-Nursing-Hom es.html) 2.The MDS assessment for Resident # 19 dated 5/3/2025, included a diagnosis of neuromuscular dysfunction of bladder and revealed the resident had an indwelling catheter. During 3 different observations on 7/14/2025 at 3:08, 7/15/25 at 9:04 AM, and 7/16/25, Resident #19 was sitting in her recliner and the catheter bag was lying on the floor, with the drain port touching the floor. Interview on 7/17/25 at 1 PM, the Director of Nursing reported the catheter bag should not be on the floor.