

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 02/18/2026
NAME OF PROVIDER OR SUPPLIER Bishop Drumm Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on direct observation, clinical record review, resident and staff interview the facility failed to provide dignified grooming for residents who requested it in 1 of 15 residents surveyed (Resident #2). The facility reported a census of 124. Findings include: The quarterly Minimum Data Set (MDS) for resident #2, dated 11/27/2025, documented the following relevant diagnoses: Coronary artery disease, Diabetes Mellitus (diabetes), anxiety disorder, depression, unspecified fracture of left hip, generalized muscle weakness. The MDS also documented that the resident required assistance with personal cares, and specified the resident required substantial or maximal assistance with personal hygiene. The Care Plan for Resident #2, last revised on 02/13/2026, documented the resident requires assistance with personal cares and discussed the resident's preference for her hair to remain long, brushed daily, and that she requested to be shaved daily. This was initiated in the care plan on 02/22/2025. In a direct observation of Resident #2 on 02/10/2026 at 11:36 AM Resident #2 was noted to have a long, substantial beard and had matted unwashed hair. On 02/10/2026 at 11:36 AM Resident #2 reported she had requested that staff members to help her shave every time they come to offer her a shower. She admitted she prefers bed baths, but the staff members tell her they cannot shave her because she is diabetic and she had to be shaved by a barber or nurse because of her diabetic status. The resident reported this had increased her feelings of depression, because she was not getting help caring for herself when she asks for it. A review of the Kardex entry for personal hygiene between the dates of 01/13/2026 and 02/11/2026 failed to document a single refusal for showers or personal cares. The Kardex included documentation that bathing had occurred on every single day during the look back period and documented the resident required extensive assistance with personal hygiene tasks on more than half of all the opportunities for personal hygiene. A review of the Kardex entry for bathing between the dates of 01/13/2026 and 02/11/2026 failed to document a single resident refused bathing opportunity. On 02/11/2026 at 02:00 PM with Staff N, facility barber reported she was told by other residents in the facility that staff members have refused to trim their beards or cut facial hair. She believed CNAs and shower aides could cut hair at a residents request but did not believe this is getting regularly done due to staffing shortages. On 02/12/2026 at 08:36 AM Staff M, Registered Nurse (RN), reportedly confirmed Resident #2 had been asking to get her facial hair removed for several days, but she worked nights, and was unable to help with the request. She was unsure if a certified nurses aide (CNA) could cut the facial hair of a resident with diabetes. In an interview on 02/12/2026 at 09:46 AM with Staff O, CNA, she stated she was familiar with Resident #2 and confirmed she preferred to be clean shaven. She stated the resident moved to a hall and she no longer worked directly with her but at her request kept her shaved. She did not believe Resident #2 had ever refused to be shaved while she was directly working with her, but noted refusals would be noted in the Kardex or Pocket Plan of Care in the electronic health record (EHR). In an interview on 02/11/2026 at 02:59 PM with the Assistant Director of Nursing (ADON), she confirmed</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 165448	Facility ID: 165448 If continuation sheet Page 1 of 17

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>shaving is provided by the facility for residents who request to be shaved and confirmed it was her expectation that staff members provide this service when requested by residents. Review of a facility provided document titled Shaving the Resident, with a last approved date of 05/22/2025, notes proper procedure for shaving a resident includes documenting any refusals with nurse supervisor and documenting it in the resident's medical record.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews, and policy review, the facility failed to provide timely physician and family notification for 1 of 1 resident (#8) who experienced a change in condition or treatment. The facility reported a census of 124 residents. Findings include: Resident #8's Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition. It included diagnoses of diabetes mellitus, partial paralysis, and non-traumatic brain dysfunction. It also revealed the resident was independent with eating, required moderate assistance with sit-to-stand and chair-to-chair and toilet transfers, and required supervision with oral and personal hygiene, moderate assistance with toileting and bathing, substantial assistance with upper body dressing, bed mobility, lying-to-sitting, sitting-to-lying, and sit-to-stand mobility, and was dependent with lower body dressing, footwear, and all other forms of mobility. The Care Plan dated 6/18/25 directed staff to involve her family with decisions and medical updates. On 2/16/26 a continuous observation starting at 11:48 AM contained the following; Staff A, Licensed Practical Nurse (LPN) attempted to wake Resident #8 while seated in her wheelchair at the dining room table. Resident #8 was lethargic and Staff A had to grab or tap Resident #8's left arm multiple times to get Resident #8 to respond. Staff A transported Resident #8 in her wheelchair to an area in the hall that provided more sunlight. Staff A asked Staff B, Certified Medication Aide (CMA) to get Resident #8's vital signs. Staff B informed Staff A that Resident #8's temperature was 100.4 degrees Fahrenheit (F). Staff A instructed Staff B to give Resident #8 Tylenol. Staff B attempted to give Resident #8 two (2) Tylenol tablets but the resident pulled her head back both times and said no! Staff A instructed Staff C, Certified Nurse Aide (CNA), to transport Resident #8 back to her room. At 12:19 PM, Staff A went to the nurses' station, got her purse, stopped to assist another resident in her room, then left the unit for lunch. She returned to the unit from lunch at 1:25 PM. A Nurse's Note progress note dated 2/16/26 at 12:05 PM documented the res <resident> is semi responsive, responds to touch and voice otherwise not. has temp of 100.4 refuses to take Tylenol. The following multiple interviews conducted on 2/16/2026 revealed; At 1:51 PM, Staff D, Registered Nurse (RN) stated a temperature of 100.4 F is significant and added if a resident, who is typically responsive, has to be touched or spoken to loudly to elicit a response, and has a temperature of 100.4 F, it is a change in condition and the provider should be notified. She stated the provider notification should be documented on the electronic change in condition form and in the nursing progress notes. At 2:01 PM, Staff E, LPN stated 100.4 F is a significant temperature. She also confirmed if a resident, who is typically responsive, has to be touched or spoken to loudly to get a response, and has a temperature of 100.4 F, it is a change in condition and the provider should be notified. She also stated the provider communication would be documented in the progress notes. At 2:30 PM, Staff A confirmed Resident #8's event constituted a change-of-condition and stated the change-of-condition form should've been completed at that time. She also admitted she contacted the resident's brother and the provider after she returned to the unit from lunch. She further stated she was not aware of a facility policy specifying a family or provider notification timeframe. An eINTERACT Change in Condition Evaluation dated 2/16/26 at 2:53 PM indicated Staff A documented a family and provider notification at 1:00 PM. On 2/17/26 at 2:30 PM, the Assistant Director of Nursing (ADON) stated anytime there is a change in condition or vital signs outside of parameters, staff should escalate it through an eINTERACT Change in Condition and notify the provider. She also stated the staff member should not have gone to lunch without communicating it to another nurse</p> <p>(continued on next page)</p>		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prior.A policy titled Notification of Changes effective 7/25/25 indicated the facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification. It identified circumstances requiring notification include a significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status.		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews, and policy review, the facility failed to provide assessment and interventions for 1 of 1 resident (#8) who experienced an elevated temperature and a change in mental condition. The facility reported a census of 124 residents. Findings include: Resident #8's Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition. It included diagnoses of diabetes mellitus, partial paralysis, and non-traumatic brain dysfunction. It also revealed the resident was independent with eating, required moderate assistance with sit-to-stand and chair-to-chair and toilet transfers, and required supervision with oral and personal hygiene, moderate assistance with toileting and bathing, substantial assistance with upper body dressing, bed mobility, lying-to-sitting, sitting-to-lying, and sit-to-stand mobility, and was dependent with lower body dressing, footwear, and all other forms of mobility. The Care Plan revised 1/20/26 indicated the resident had memory problems but did not include staff directives for a mental change in condition. On 2/16/26 a continuous observation which started at 11:48 AM revealed the following, Staff A, Licensed Practical Nurse (LPN) attempted to wake Resident #8 while seated in her wheelchair at the dining room table. Resident #8 was lethargic and Staff A had to grab or tap Resident #8's left arm multiple times to get Resident #8 to respond. Staff A transported Resident #8 in her wheelchair to an area in the hall that provided more sunlight. Staff A asked Staff B, Certified Medication Aide (CMA) to get Resident #8's vital signs. Staff B informed Staff A that Resident #8's temperature was 100.4 degrees Fahrenheit (F). Staff A instructed Staff B to give Resident #8 Tylenol. Staff B attempted to give Resident #8 two (2) Tylenol tablets but the resident pulled her head back both times and said no! Staff A instructed Staff C, Certified Nurse Aide (CNA), to transport Resident #8 back to her room. At 12:19 PM, Staff A went to the nurses' station, got her purse, stopped to assist another resident in her room, then left the unit for lunch. She returned to the unit from lunch at 1:25 PM. A Nurse's Note progress note dated 2/16/26 at 12:05 PM documented the res <resident> is semi responsive, responds to touch and voice otherwise not. has temp of 100.4 refuses to take Tylenol. Interviews conducted on 2/16/26 revealed the following: a. At 1:51 PM, Staff D, Registered Nurse (RN) stated a temperature of 100.4 F is significant and added if the resident refused Tylenol, she would take the resident's temperature at least hourly. She also stated she would notify the provider and document it in the nurse's progress notes. b. At 2:01 PM, Staff E, LPN stated 100.4 F is a significant temperature. She also confirmed if a resident, who is typically responsive, has to be touched or spoken to loudly to get a response, and has a temperature of 100.4 F, it is a change in condition and the provider should be contacted. She also stated the provider communication would be documented in the progress notes. c. At 2:30 PM, Staff A confirmed Resident #8's event constituted a change-of-condition. She admitted she did not contact the provider until she returned from lunch at 1:25 PM. She stated her assessments were documented in the Electronic Health Record (EHR) on a Change in Condition form and the nurse's progress notes. An eINTERACT Change in Condition Evaluation dated 2/16/26 at 2:53 PM indicated Staff A documented Resident #8's assessment but did not include any interventions. The Progress Notes did not include any follow-up assessments or interventions for Resident #8's change in condition. On 2/17/26 at 2:30 PM, the Assistant Director of Nursing (ADON) stated anytime there is a change in condition or vital signs outside of parameters, staff should escalate it through an eINTERACT Change in Condition and notify the provider. She also stated the staff member should not have gone to lunch without communicating it to another nurse prior. The facility did not have a policy that directly addressed assessment and</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>interventions of standard nursing practice.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interview, and policy review, the facility failed to apply foot pedals to a resident's wheelchair during transport for 1 of 1 resident (#8). The facility reported a census of 124 residents. Findings include: Resident #8's Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition. It included diagnoses of diabetes mellitus, partial paralysis, and non-traumatic brain dysfunction. It also revealed the resident was independent with eating, required moderate assistance with sit-to-stand and chair-to-chair and toilet transfers, and required supervision with oral and personal hygiene, moderate assistance with toileting and bathing, substantial assistance with upper body dressing, bed mobility, lying-to-sitting, sitting-to-lying, and sit-to-stand mobility, and was dependent with lower body dressing, footwear, and all other forms of mobility. It also indicated the resident used a wheelchair and walker in the 7-day look-back period. The Care Plan revised 1/20/26 did not indicate the resident was non-compliant with foot pedal use on her wheelchair. On 2/16/26 at 11:48 AM, Staff A, Licensed Practical Nurse (LPN) attempted to wake Resident #8 while seated in her wheelchair at the dining room table. Resident #8 was lethargic and Staff A had to grab or tap Resident #8's left arm multiple times to get Resident #8 to respond. Staff A transported Resident #8 in her wheelchair without accompanying foot pedals to an area in the hall that provided more sunlight. At 1:51 PM, Staff D, Registered Nurse (RN) stated it is never ok to transport a resident in a wheelchair without foot pedals. At 2:01 PM, Staff E, LPN stated it is never ok to transport a resident in a wheelchair without foot pedals and added the resident's feet must be on the foot pedals during transport. At 2:30 PM, Staff A confirmed staff should ensure foot pedals are applied to a resident's wheelchair during transport and admitted she should've had Resident #8's foot pedals on her wheelchair when she transported her from the dining room. On 2/17/26 at 2:30 PM, the Assistant Director of Nursing (ADON) stated staff should always have foot pedals on a wheelchair during transport unless the resident is propelling themselves. The facility did not have a policy that included staff directives for transporting residents in wheelchairs.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on direct observation, clinical record review, resident and staff interview, and facility policy review, the facility failed to maintain adequate staffing levels resulting in excessively long call-light times reported by residents, reports of staff members sleeping on the job, the North East Dining room being closed due to low staffing, and the Director of Nursing (DON) working the floor as a charge nurse when prohibited. The facility reported a census of 124. Findings include: The Minimum data sets (MDS) for the following residents documented their Brief Interview for Mental Status Scores (BIMS) scores, which indicated levels of cognition. Resident #1's MDS reported her BIMS score as 10, indicating moderate impairment. Resident #2's MDS reported her BIMS score as 00, indicating the test could not be completed. Resident #3's MDS reported her BIMS score as 15, indicating fully intact cognition. Resident #4's MDS reported her BIMS score as 15, indicating fully intact cognition. Resident #7's MDS reported her BIMS score as 15, indicating fully intact cognition. Resident #8's MDS reported her BIMS score as 12, indicating moderate impairment. Resident #9's MDS reported her BIMS score as 15, indicating fully intact cognition. Resident #10's MDS reported her BIMS score as 15, indicating fully intact cognition. A continuous direct observation on 02/09/2026 from 07:45 PM until 09:03 PM recorded the following. At 07:50 PM room [ROOM NUMBER]'s call light was turned on. At 08:01 PM room [ROOM NUMBER]'s call light was answered with staff responding for seconds before leaving the room. At 08:08 PM room [ROOM NUMBER]'s call light was turned on. At 08:17 PM room [ROOM NUMBER]'s call light was answered, with staff again responding for seconds before leaving the room. At 08:26 PM room [ROOM NUMBER]'s call light was turned on. At 08:30 PM room [ROOM NUMBER]'s call light was answered, with staff again responding for seconds before leaving the room. At 08:42 PM room [ROOM NUMBER]'s call light was turned on. At 08:43 PM room [ROOM NUMBER]'s call light was answered, with staff responding for approximately one second before leaving the room. In an interview on 02/09/2026 at 08:54 PM with Resident #10, who resided in room [ROOM NUMBER], she was asked directly if the staff members had addressed her call light request. She stated they had not, she was waiting and had been turning on her call light for approximately one hour without them answering her questions or telling her why she could not get help. She stated she was waiting to see if they would be able to do a bath or bed bath as she had not been given one tonight despite her requesting one. She reported staff members entering her room just to turn her call light off without a word. She expressed frustration. Review of staffing files dated from 01/10/2026 through 02/09/2026, revealed the Director of Nursing (DON) worked the floor on two occasions, on 01/11/2026 and 01/21/2026. The DON is prohibited from serving as a charge nurse when the average daily census exceeds 60 residents. Review of the Resident Council Minutes from 10/01/2026 through 02/04/2026 identified issues related to staff members not providing showers/baths as scheduled, not providing fresh water, staff members being on their cell phones while on the job, and long call light times as repeated issues during the lookback period. In an interview with Resident #1 on 02/09/2026 at 01:08 PM she stated call light times are terrible in the facility, frequently over 30 minutes, and she identified nights as the worst period of time to get help. In an interview on 02/10/2026 at 11:30 AM with Resident #4, she stated call light times have been long, and identified the weekends and nights as periods when call light times were the worst. When asked how long call lights can take she stated they can take over an hour recently. In an interview on 02/10/2026 at 11:36 AM with Resident #2, she reported she can expect to wait over an hour for call lights, and also identified the nights and weekends as the worst, she stated this was a frequent every day occurrence. In an interview on 02/10/2026 at 02:34 PM with Resident #3 and Resident #7,</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>who wished to speak to me together, they stated they have directly seen staff members sleeping on the job. Resident #7 reported seeing staff members sleeping as recently as the past weekend. She provided the exact time and location the Staff member was alleged to be sleeping. Resident #3 and Resident #7 both stated call light times and bad, and agreed call light times during the nights and weekends can take hours, with Resident #7 noting it took three hours for them to assist her in changing a soiled incontinence brief this past weekend. Resident #7 stated she had brought this up to the administration a number of times, both privately and through the Resident Council. Resident #3 agreed she had also brought it up a number of times to facility management. Both residents wished the surveyor to know they do not feel the facility has an adequate number of staff, and report the issues with call lights is almost daily. In an interview on 02/10/2026 at 03:39 PM with Resident #9, she stated the staffing in the facility is the biggest issue in the facility. She stated this past weekend, the weekend identified as 02/07/2026 and 02/08/2026, she waited an hour and a half for assistance changing a soiled incontinence brief. She stated they also closed the North East Dining hall due to lack of staff and forced all residents to eat in their rooms. She stated she is very vocal about this significant issue, and has reported it to a number of management staff but feels nothing has been done to improve the situation. She expressed frustration over having to wait an hour and a half or assistance in being changed after having soiled herself, and stated it made her feel terrible. In an interview on 02/10/2026 at 03:47 PM with Resident #8, she stated call lights are terrible in the facility, and identified nights and weekends as the hardest time to get help. She stated it took over two hours this past weekend, identified as 02/07-02/08, to get help getting off of the toilet. She stated they also closed the NE dining all this weekend and forced all residents to eat in their rooms. She reported catching a staff member sleeping this weekend, and identified the same location and time as another resident did. In an interview on 02/11/2026 at 11:40 AM with Staff S, Certified Nurse Aide (CNA), she stated the facility does not have enough staff to get her job done, and stated it was taking sometimes hours to get residents the assistance they requested. In an interview on 02/11/2026 at 02:00 PM with Staff N, she stated the facility doesn't have adequate staffing and she has personally seen staff members sleeping on the job about a month ago. She stated she had brought this up to the DON. In an interview on 02/12/2026 at 08:36 AM with Staff M, Registered Nurse (RN), she stated the overnight and early morning shifts struggle for staff members. She feels sometimes she has enough to do her job, but if someone calls in there might not be any relief and people call in frequently. She stated the weekends are the worst for staffing. She stated she had not seen fellow staff members sleeping, but stated she was aware of at least one staff member who had gotten in trouble for sleeping on the job. She stated the facility does not fire people if they are caught sleeping on the job. In an interview on 02/12/2026 at 09:12 AM with Staff P, RN, she stated she had not seen or heard of other staff members sleeping on the job. She stated she does know of staff members who go on break and sleep at the nurses station, but noted they had a meeting where they were told they should not do this. She stated her job can be hard due to call ins, and feels that it happens at least a few times a week when they are working short staffed. She also stated the DON had been working the floor in an attempt to cover open shifts when there was no one else available. In an interview on 02/12/2026 at 11:58 AM with Staff L, CNA, she stated she has personally seen staff members sleeping on the job before and noted she reported it to the DON. She stated her job can be hard with call ins, which can be frequent, but noted the DON had been working the floor to try and cover open shifts before she went on leave. In an interview on 02/12/2026 at 12:07 PM with Staff T, CNA, she stated she does not like picking up shifts on nights or weekends because they are always short handed and it makes the</p> <p>(continued on next page)</p>		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<p>job too hard. She stated she knows the DON has been working the floor to try and cover open shifts, usually on at night or on the weekends. She stated that while she has not directly seen staff members sleeping while on the floor, she knows it does happen at night and on the weekends, and reiterated it is why she doesn't like picking up those shifts. She stated she believes this is happening because staff members are working frequent back-to-back shifts in an attempt to cover open shifts. In an interview on 02/12/2026 at 03:16 PM with Staff U, Occupational Therapist Registered and Licensed (OTR/L), she stated that while she has not seen staff members sleeping on the job, residents have told her they have caught staff members sleeping on the job. She stated the last a resident had approached her about this issue was a week or two ago, and she encouraged the resident to report this to the DON and Long Term Care Ombudsman (LTCO). In an interview on 02/12/2026 at 03:40 PM with Staff V, Maintenance Director, he stated that while he had not directly seen staff members sleeping on the job residents had reported night shift staff sleeping on the job. He encouraged them to report this to the DON. In an interview on 02/12/2026 at 04:36 PM with Staff D, RN, she stated that while she has not directly seen staff members sleeping on the job she has had reports from residents about staff members sleeping on the job. She also noted she has seen staff members at the nursing station with their eyes closed who appeared to startle when a noise was made, but she was unsure if they were asleep. In an interview on 02/12/2026 at 04:43 PM with Staff W, RN, he stated that while he has not seen staff members sleeping on the job, he does work short handed once or twice a week on his shift. He notes it makes his job harder and slows call lights. He stated weekends are the worst for being short handed. In an interview on 02/11/2026 at 02:59 PM with the Assistant Director of Nursing (ADON), she stated staff members were prohibited from sleeping while on the job, and noted it was her expectation for call lights to be answered within 15 minutes. Review of a facility policy titled Rules of Conduct identifies Sleeping or giving the appearance of sleeping on the job during working hours as Unsatisfactory Behaviors/Terminations in the code of conduct rules. There was no policy available for the Director of Nursing working the floor.</p>		

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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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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>Based on clinical record review, resident and staff interview, and facility policy review, the facility failed to prevent the Director of Nursing (DON) from serving as a charge nurse when a facilities daily average census exceeds 60 residents. The facility reported a census of 124. Findings Include: In an interview on 02/12/2026 at 09:12 AM with Staff P, Registered Nurse (RN), she stated the facility is under staffed and the DON has been working nights and overnight shifts to help cover staffing. She confirmed the DON was serving in her role as a charge nurse. In an interview on 02/12/2026 at 9:36 AM with Staff Q, RN, she confirmed the DON has been working as a charge nurse alongside the Assistant Executive Director and other nursing leadership to cover staffing shortfalls in the facility. She stated the DON is currently on maternity leave but she knew the DON was working the floor of the facility the week she left for maternity leave. In an interview on 02/12/2026 at 11:39 AM with Staff R, Certified Nurse Aide (CNA), she confirmed the DON has been working the floor as a nurse leading up to her maternity leave due to staffing shortages. In an interview on 02/12/2026 at 11:58 AM with Staff L, CNA, she confirmed what other staff members had stated, the DON was working the floor as nurse leadership to cover staffing shortages. She stated it last happened in January. Review of the last 30 days of staffing logs documented the DON worked as a floor nurse on 01/11/2026 and 01/21/2026. In an interview on 02/12/2026 at 12:16 PM with the Assistant Executive Director, she confirmed the DON had been serving as a charge nurse on the floor and stated she was aware it was prohibited. She clarified that she was new to the role and was not aware it had been an issue until it was brought up over the course of the survey. A policy was unavailable for review.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews, and policy review, the facility failed to correctly administer insulin by failing to prime a newly attached insulin pen needle before administering it for 1 of 3 residents (#14) and verifying documented open date for 2 of 3 residents (#14, #15), and attempted to administer a medication without an order for 1 of 3 residents (#8). The facility reported a census of 124 residents. Findings include: Resident #15's Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated moderately impaired cognition. It included diagnoses of chronic kidney disease and diabetes mellitus. It indicated she required setup assistance with eating, moderate assistance with oral hygiene, was dependent with transfer mobility, and required maximal assistance with all other Activities of Daily Living (ADLs) and mobility. It also indicated she received insulin injections 7 days within the 7-day look-back period. The Electronic Health Record (EHR) included a Clinical Physician's Order dated [DATE] for fast-acting insulin with a FlexPen three (3) times per day with meals. The Care Plan revised [DATE] directed staff to administer diabetes medication as ordered by doctor. A continuous medication observation on [DATE] at 11:23 AM revealed Staff A, Licensed Practical Nurse (LPN) prepared an insulin FlexPen to administer Resident #15's insulin. She removed the insulin pen from the medication cart, placed a needle on the tip of the FlexPen, swabbed the resident's left, lower abdomen, placed the needle tip against the abdomen, and injected the insulin. She did not prime the needle to remove the air and ensure the resident received the full dose of insulin. At 11:31 AM, Staff A stated the insulin pen was good for 30 days after the date opened and confirmed there was no date opened documented date on the FlexPen. She also stated she forgot to prime the pen and should not have used the insulin pen since the date opened was not documented. She admitted she did not notice the date opened label was blank prior to administering the insulin. 2. Resident #14's Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated completely intact cognition. It included diagnoses of chronic kidney disease, diabetes mellitus, heart failure, and morbid obesity. It indicated she was independent with eating, required setup assistance with oral hygiene, and maximal assistance with all other Activities of Daily Living (ADLs) and mobility. It also indicated she received insulin injections 7 days within the 7-day look-back period. The EHR included a physician's order dated [DATE] for fast-acting insulin, with a FlexPen three (3) times per day with meals. A continuous medication observation on [DATE] at 11:40 AM revealed Staff A prepared an insulin FlexPen to administer Resident #14's insulin. She removed the insulin pen from the medication cart, placed a needle on the tip of the FlexPen, primed the needle with 2 units of insulin from the FlexPen, swabbed the resident's right, lower abdomen, placed the needle tip against the abdomen, and injected the insulin. At 11:43 AM, Staff A stated she did not know when the insulin pen was opened because it wasn't dated. She admitted she did not check the date opened label before administering the insulin. 3. Resident #8's Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition. It included diagnoses of diabetes mellitus, partial paralysis, and non-traumatic brain dysfunction. It also revealed the resident was independent with eating, required moderate assistance with sit-to-stand and chair-to-chair and toilet transfers, and required supervision with oral and personal hygiene, moderate assistance with toileting and bathing, substantial assistance with upper body dressing, bed mobility, lying-to-sitting, sitting-to-lying, and sit-to-stand mobility, and was dependent with lower body dressing, footwear, and all other forms of mobility. The Care Plan revised [DATE] included a chronic pain</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>focus area and directed staff to administer pain medication as ordered. Monitor for pain on scale 0-10. Notify MD if medication and non-medication intervention ineffective. The EHR included a Clinical Physician's Order dated [DATE] for Acetaminophen 650 mg every six (6) hours as needed for mild pain. The order was noted to be on hold status. It did not include directives for a fever. On [DATE] at 11:48 AM, Staff A attempted to wake Resident #8 while seated in her wheelchair at the dining room table. Resident #8 was lethargic and Staff A had to grab or tap Resident #8's left arm multiple times to get Resident #8 to respond. Staff A transported Resident #8 in her wheelchair to an area in the hall that provided more sunlight. Staff A asked Staff B, Certified Medication Aide (CMA) to get Resident #8's vital signs. Staff B informed Staff A that Resident #8's temperature was 100.4 degrees Fahrenheit (F). Staff A instructed Staff B to give Resident #8 acetaminophen. Staff B attempted to give Resident #8 two (2) acetaminophen tablets but the resident pulled her head back both times and said no! Staff B stopped trying to administer the medication. On [DATE] at 1:51 PM, Staff C, Registered Nurse (RN) stated the date opened should be checked prior to administering insulin and should not be used if no date opened is documented. She also stated if she had an order for acetaminophen for a resident's pain, she would use it for a resident's fever also. At 2:01 PM, Staff E, LPN, stated the date opened should be checked prior to using insulin. She also stated staff should discard the insulin if the date opened is not documented and get a new one. She further stated she would contact the provider for an order to use the acetaminophen for the resident's fever if the original order did not include provider's approval. At 2:30 PM, Staff A stated it was not ok to use a medication for a reason not included on the physician's order. She admitted she did not know the acetaminophen order did not include use for a fever. On [DATE] at 2:30 PM, the Director of Nursing (DON) stated all medications opened should have a date on it and staff should be checking for a date prior to use. She also stated staff should correctly assemble the insulin pen and prime the needle before administering insulin. She further stated staff should've made sure there was an order for acetaminophen for a fever. A policy titled Medication Administration effective [DATE] indicated medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. It also directed staff to identify the expiration date and to notify the nurse manager if the medication was expired.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews, and policy review, the facility failed to provide an accurate health record for a change in condition for 1 of 1 resident (#8). The facility reported a census of 124 residents. Findings include: Resident #8's Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition. It included diagnoses of diabetes mellitus, partial paralysis, and non-traumatic brain dysfunction. It also revealed the resident was independent with eating, required moderate assistance with sit-to-stand and chair-to-chair and toilet transfers, and required supervision with oral and personal hygiene, moderate assistance with toileting and bathing, substantial assistance with upper body dressing, bed mobility, lying-to-sitting, sitting-to-lying, and sit-to-stand mobility, and was dependent with lower body dressing, footwear, and all other forms of mobility. The Care Plan dated 6/18/25 directed staff to involve her family with decisions and medical updates. On 2/16/26 a continuous observation starting at 11:48 AM revealed the following. Staff A, Licensed Practical Nurse (LPN) attempted to wake Resident #8 while seated in her wheelchair at the dining room table. Resident #8 was lethargic and Staff A had to grab or tap Resident #8's left arm multiple times to get Resident #8 to respond. Staff A transported Resident #8 in her wheelchair to an area in the hall that provided more sunlight. Staff A asked Staff B, Certified Medication Aide (CMA) to get Resident #8's vital signs. Staff B informed Staff A that Resident #8's temperature was 100.4 degrees Fahrenheit (F). Staff A instructed Staff B to give Resident #8 Tylenol. Staff B attempted to give Resident #8 two (2) Tylenol tablets but the resident pulled her head back both times and said no! Staff A instructed Staff C, Certified Nurse Aide (CNA), to transport Resident #8 back to her room. At 12:19 PM, Staff A went to the nurses' station, got her purse, stopped to assist another resident in her room, then left the unit for lunch. She returned to the unit from lunch at 1:25 PM. A Nurse's Note progress note dated 2/16/26 at 12:05 PM documented the res <resident> is semi responsive, responds to touch and voice otherwise not. has temp of 100.4 refuses to take Tylenol. On 2/16/26 at 2:30 PM, Staff A confirmed Resident #8's event constituted a change-of-condition and stated the change-of-condition form should've been completed at that time. She attested she did not perform any work-related duties while she was at lunch and admitted she contacted the resident's brother and the provider after she returned to the unit. An eINTERACT Change in Condition Evaluation dated 2/16/26 at 2:53 PM indicated Staff A documented a family and provider notification at 1:00 PM, during the time she was at lunch. On 2/17/26 at 2:30 PM, the Assistant Director of Nursing (ADON) stated staff should not be backdating and should accurately record events to reflect the time it occurred. A policy titled Documentation in Medical Record effective 1/27/26 indicated each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>Based on review of The State Survey Agency website found at https://dia-hfd.iowa.gov/, staff interview, and review of the facility QAPI (Quality Assurance Performance Improvement) plan, the facility failed to ensure an effective process to address previously identified quality deficiencies. This resulted in the facility receiving an Insufficient Nursing Staff deficiency for the fifth time in a two-year period. The facility reported a census of 124 residents. Findings Include: Review of the State Agency's public website https://dia-hfd.iowa.gov/ contained the following certification actions during the following surveys: Ending on 09/17/2025 resulted in a deficiency cited related to staffing. Ending on 07/21/2025 resulted in a deficiency cited related to staffing. Ending on 04/03/2025 resulted in a deficiency cited related to staffing. Ending on 06/27/2024 resulted in a deficiency cited related to staffing. Review of the Quality Assurance and Performance Improvement (QAPI) Plan provided by the facility, with a creation date of 02/26/2025, identifies how the QAPI team will identify issues, and specifically identifies staff retention as a QAPI improvement focus. In an interview on 2/18/26 at 10:14 AM with the Executive Direct and Assistant Executive Director, they stated the QAPI plan did not currently have a Performance Improvement Plan (PIP) related to staffing.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, and policy review the facility failed to use infection prevention standards to secure a resident's indwelling catheter tubing (#4), failed to maintain equipment in a manner to prevent cross-contamination, and failed to don appropriate Personal Protective Equipment (PPE) when providing wound care for a resident on Enhance Barrier Precautions (EBP) (#12). The facility reported a census of 124 residents. Findings include: On 2/16/26 at 9:47 AM, Resident #4's indwelling catheter drainage bag was observed hanging on a wall hook with the tubing lying across the top of her trashcan. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of chronic kidney disease, neurogenic bladder (bladder dysfunction caused by nerve damage), and paraplegia. It revealed the resident required maximal assistance with eating, oral and personal hygiene, upper body dressing, and bed mobility and was dependent for all other Activities of Daily Living (ADLs) and other mobility. It also revealed the resident had an indwelling catheter in the 7-day look-back period. The Care Plan 1/13/26 directed staff to check the tubing for kinks as needed and keep the bag lower than the resident's bladder. A Nurse's Note progress note dated 2/14/26 at 11:17 PM indicated the resident had bilateral stent (tube used to keep the tubes leading from the kidney to the bladder open) exchange on 2/13/26. On 2/17/26 at 8:33 AM, Resident #4's indwelling catheter drainage bag was observed again hanging on a wall hook with the tubing lying across the top of her trashcan. On 2/17/26 at 8:51 AM, Staff F, Certified Nurse Aide (CNA) stated it is not ok to use a resident's trashcan to keep the indwelling catheter tubing off the floor. On 2/17/26 at 9:03 AM, Staff G, Certified Medication Aide (CMA) stated it is ok to use a resident's trashcan to keep the indwelling catheter tubing off the floor. On 2/17/26 at 9:06 AM, Staff H, CNA stated it is not ok to use a resident's trashcan to keep the indwelling catheter tubing off the floor. 2. On 2/17/26 at 8:40 AM, Staff I, Housekeeper (Hskg) was observed using a housekeeping cart with silver duct tape lining both sides of the top rolling door and the back access door. The tape was not completely affixed to the cart and had multiple areas where the adhesive was exposed and able to harbor bacteria. On 2/17/26 at 8:43 AM, Staff I stated the cart was new but broke about a month prior. On 2/17/26 at 2:15 PM, Staff J, Environmental Services Director (Evs Dir) stated housekeeping staff report repair needs to him and equipment is replaced when it is damaged. He admitted he was aware of the cart with tape but was not aware it was used for repair purposes. 3. Resident #12's Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 06 out of 15 which indicated severely impaired cognition. It included diagnoses of chronic kidney disease, non-Alzheimer's dementia, heart failure, diabetes mellitus, and a right foot chronic ulcer. It revealed the resident required setup assistance with eating and oral hygiene, maximal assistance with upper body dressing and personal hygiene, and was dependent for all other ADLs and mobility. It also revealed the resident had diabetic and surgical wounds in the 7-day look-back period. A physician's order dated 6/06/24 indicated enhanced barrier precautions: PPE required for high resident contact care activities. Indication: wounds, indwelling medical devices, infection, and/or MDRO (multidrug resistant organism) status. The Care Plan dated 6/20/24 indicated the resident had actual skin impairment and required enhanced barrier precautions (EBP) with close contact cares related to presence of wounds. On 2/17/26 at 10:19 AM, Staff K, (in-home nurse) entered Resident #12's room, removed the resident's right foot dressings, and took pictures of it. He was not wearing PPE. Staff L, CNA notified asked Staff I, who was in the resident's room entrance, to tell Staff K to put on a PPE gown. Staff K declined. Staff K was also observed holding Resident #12's cup with</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>the same gloved hands so she could have a something to drink. On 2/17/26 at 10:26 AM, Staff K confirmed he removed Resident #12's right foot wound to obtain pictures for the resident's medical record. He stated he received Infection Prevention education and noticed the resident was on EBP. He also stated he was not familiar with EBP but admitted he did not refer to the EBP sign that was posted at the resident's door. He stated he refused to wear a PPE gown when Staff I asked because he was already finished in the resident's room. The EBP sign on the resident's door titled Enhanced Barrier Precautions indicated: PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing Bathing/Showering Transferring Changing Linens Providing Hygiene Changing briefs or assisting with toileting Device care or use: central line, urinary catheter, feeding tube, tracheostomy Wound Care: any skin opening requiring a dressing On 2/17/26 at 10:35 AM, Staff M stated she asked Staff L to have Staff K put on a PPE gown because the resident was on EBP which required a gown and gloves because the resident had invasive devices and a wound that required a dressing. On 2/17/26 at 3:17 PM, the Infection Preventionist (IP) stated it was absolutely not ok to use a trash can to support any component of an indwelling catheter. She also stated duct tape is absolutely not ok to be used on equipment, especially direct resident care equipment. She further stated support and contract staff are expected to comply with EBP precautions. A policy titled Infection Prevention and Control Program effective 10/07/25 indicated the facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. A policy titled Enhanced Barrier Precautions effective 9/18/25 indicated an order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO. (Peripheral IVs, continuous glucose monitors, insulin pumps, or ostomies without an associated indwelling medical device are not an indication for EBP.)</p>		