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	06/11/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, family and staff interviews, and policy review, the facility failed to provide timely notification to the son (Durable Power-of-Attorney - DPOA) for 1 of 3 residents (#2) who repeatedly refused critical medication. The facility reported a census of 119 residents. Findings include: Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of diabetes mellitus, liver cirrhosis, irregular heartbeat, and heart failure. It indicated she required maximal assistance with toileting, lower body dressing, and footwear, moderate assistance with bathing, supervision with upper body dressing and all forms of mobility except bed repositioning, and was independent with all other Activities of Daily Living (ADLs) and bed repositioning.The Electronic Health Record (EHR) included a physician's order dated 5/15/26 for 45 milliliters (mL) of lactulose oral solution by mouth every six (6) hours.The Care Plan dated 8/10/25 included liver cirrhosis and directed staff to give medications as ordered and to monitor/document effectiveness and side effects. It also included a medication focus and directed staff to keep her family informed of her condition.A Nurse's Note Progress Note dated 5/17/26 at 11:53 AM revealed the resident stated to the nurse that she didn't want the lactulose anymore due to the diarrhea and nausea. It also indicated the son was in the facility and stated his mother would be ok once her mental status improved and instructed staff to continue to give it to her.The Medication Administration Record (MAR) revealed the resident refused the lactulose on the following dates and times:5/17/26 - 6:00 PM5/18/26 - 00:00 AM, 6:00 AM5/19/26 - 00:00 AM, 6:00 AM, and no documentation at 6:00 PM5/20/26 - 00:00 AM, 12:00 PM5/21/26 - 00:00 AM, 6:00 PM5/22/26 - 00:00 AM, 6:00 AM, 12:00 PM, 6:00 PM5/23/26 - 00:00 AM, 6:00 AM, 6:00 PM5/24/26 - 00:00 AM, 6:00 AMA Alert Note dated 5/17/26 documented no bowel movement for 3 days. resident returned from hospital on 5/15/26. Resident reports having bowel movements.A Nurse's Note Progress Note dated 5/19/26 at 5:54 AM revealed the resident refused both the midnight and 6:00 AM doses of lactulose despite nursing encouragement. The Progress Note did not include documentation the son was notified of the aforementioned refused doses.A Nurse's Note Progress Note dated 5/20/26 at 1:29 PM revealed the resident's son was present at the resident's bedside but did not include notification the resident refused the prior eight (8) doses of lactulose.A Nurse's Note Progress Note dated 5/20/26 at 3:30 PM indicated the son was present during lunchtime and attempted to wake his mother. The Progress Note did not include documentation the resident's son was notified his mother refused the prior eight (8) doses of lactulose.A MDS Note Progress Note dated 5/22/26 at 2:47 PM revealed the resident's son (DPOA) visited frequently but did not include documentation the son was notified his mother refused the prior 13 doses of lactulose.A Nurse's Note Progress Note dated 5/22/26 at 4:55 PM revealed the resident was ordered a new antianxiety medication and indicated the son was made aware of it. The Progress Note did not include documentation the son was notified the resident refused the prior 13 doses of lactulose.On 6/08/26 at 12:29 PM, the resident's son stated the facility did not notify him that Resident #2 was repeatedly refusing the medication. He stated he had always been able to (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	convince her to take it in the past and felt he would've been able to again had he been notified.Four (4) Progress Notes dated 5/22/26 at 8:19 PM, 5/23/26 at 1:58 AM, 5/24/26 at 1:06 PM, and 5/24/26 at 3:47 PM included new medication orders and revealed the son was notified of each order but did not include documentation he was notified of the previously refused lactulose doses.On 6/09/26 at 9:31 AM, Staff O, Licensed Practical Nurse (LPN) stated if a resident refused a significant medication, a progress note should be documented and the provider and family member should be notified as long as the POA was invoked.On 6/08/26 at 10:00 AM, Staff P, Registered Nurse (RN) stated if a resident refused a significant medication, a progress note should be documented and the family member and the provider, or hospice if the resident received hospice services, should be notified as long as the POA was invoked.On 6/10/26 at 1:59 PM, the Director of Nursing (DON) stated staff should've notified the DPOA after two (2) consecutive medication refusals.A policy titled Notification of Changes revised 4/29/26 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 defines circumstances requiring notification include significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status and may include clinical complications. It also included circumstances that require a need to alter treatment.On 6/15/26 at 5:04 PM, the Administrator provided a Progress Notes report which included a Late Entry Progress Note documented sometime after 6/09/26 at 12:27 PM with a 5/17/26 effective date and timed for three (3) hours prior to the first lactulose refusal dated 5/17/26 at 6:00 PM that led to the deficiency.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy review, the facility failed to provide post-fall assessments and interventions for 2 of 3 residents (#2, #5). The facility reported a census of 119.Findings include:Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of diabetes mellitus, liver cirrhosis, irregular heartbeat, and heart failure. It indicated she required maximal assistance with toileting, lower body dressing, and footwear, moderate assistance with bathing, supervision with upper body dressing and all forms of mobility except bed repositioning, and was independent with all other Activities of Daily Living (ADLs) and bed repositioning.An Interdisciplinary Note Progress Note dated 8/29/25 at 11:52 AM revealed Resident #2 was found on the floor in her room on 8/22/25 at 4:30 PM. The Progress Note also referenced neurological checks.The Neurological assessment dated [DATE] revealed the last two (2) 4-hour neurological checks and the first 12-hour neurological check were not completed.A Nurse's Note Progress Note dated 2/07/26 at 11:11 AM revealed Resident #2 was observed sitting on the floor in her bedroom and told the nurse she fell walking to her recliner. It also indicated neurological checks were initiated.The Neurological assessment dated [DATE] revealed the last 4-hour neurological check and the two (2) 12-hour neurological checks were not completed.The Care Plan revised 8/25/25 did not include a neurological check focus or interventions.2. Resident #5's MDS assessment dated [DATE] identified a BIMS score of 02 out of 15 which indicated severely impaired cognition. It included diagnoses of anemia, low blood pressure upon standing, a stroke, and non-Alzheimer's dementia. It indicated she was independent with walking 10 feet, required setup assistance with eating, oral hygiene, bed mobility, sit-to-lying, lying-to-sitting, sit-to-stand, chair-to-chair and toilet transfers, supervision with dressing, footwear, personal hygiene, and ambulating 50-feet or greater, and moderate assistance with toileting, shower transfers, and showering.A Nurse's Note Progress Note dated 2/08/26 at 12:17 PM revealed Resident #5 was found on the floor by staff. It indicated neurological checks were initiated.The Neurological assessment dated [DATE] revealed the fourth 4-hour neurological check was not completed.The Care Plan revised 4/15/26 did not include a neurological check focus or interventions.On 6/10/26 at 6:32 AM, Staff N, Registered Nurse (RN) stated neurological checks should be done every (1) hour x 4, every 4 hours x 5, and every 12 hours x 2 if a resident had an unwitnessed fall. She also stated there were no reasons neurological checks should not be completed unless the resident was sent to the hospital.On 6/10/26 at 7:34 AM, Staff O, Licensed Practical Nurse (LPN) stated neurological checks should be done every (1) hour x 4, every 4 hours x 5, and every 12 hours x 2 if a resident had an unwitnessed fall. She also stated neurological checks should resume if the resident is not admitted to the hospital.On 6/10/26 at 7:51 AM, Staff H, RN stated neurological checks should be done every (1) hour x 4, every 4 hours x 5, and every 12 hours x 2 if a resident had an unwitnessed fall. She also stated the neurological checks should be completed in their entirety unless the resident left the building.On 6/10/26 at 1:59 PM, the Director of Nursing (DON) stated neurological checks should be completed as indicated in the form directives.The facility did not have a policy specific for assessments & interventions directly related to nursing care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on photographs, family and staff interviews, and policy review, the facility failed to provide adequate nursing supervision by not preventing a Certified Nurse Aide (CNA) from sleeping while on-duty. The facility reported a census of 119 residents. Findings include: Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of diabetes mellitus, liver cirrhosis, irregular heartbeat, and heart failure. It indicated she required maximal assistance with toileting, lower body dressing, and footwear, moderate assistance with bathing, supervision with upper body dressing and all forms of mobility except bed repositioning, and was independent with all other Activities of Daily Living (ADLs) and bed repositioning.The Care Plan dated 8/10/25 included liver cirrhosis and directed staff to give medications as ordered and to monitor/document effectiveness and side effects. It also included a medication focus and directed staff to keep her family informed of her condition.On 6/08/26 at 12:29 PM, the resident's DPOA stated he was at the resident's bedside on 5/23/26 and activated the call light to get staff assistance for the resident. He stated after about an hour, he walked to the nurses' station at 11:49 PM and discovered the CNA asleep at the nurses' station. He also stated he did not want to touch the CNA because he didn't want her to misperceive his intentions so he called out to her several times but received no response. He stated she remained asleep for approximately 30 minutes before other staff arrived and woke her up.On 6/10/26 at 10:25 AM, the Director of Nursing (DON) stated the staff member was terminated for sleeping on duty.On 6/10/26 at 1:59 PM, the DON stated staff should not have slept at the nurses' station. She also stated that if the staff member was taking a break, she should've notified the nursing supervisor that she was going to take her break in the breakroom.On 6/10/26 at 8:54 AM, the Associate Executive Director revealed the facility did not have a policy specific to nursing supervision as it was part of the RN and LPN job descriptions.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, staff interviews and policy review, the facility failed to secure prescribed medications from the possibility of unauthorized access. The facility reported a census of 119 residents. Findings included:On 6/10/26 at 6:03 AM, a medication cart was discovered unlocked with staff operating from another medication cart at the end of a resident hall but not in direct line-of-sight. The medication cart contained hydralazine (a potent blood pressure medication) and ondansetron (a nausea medication that can cause heart rhythm problems). There were no residents present.At 6:04 AM, Staff N, Registered Nurse (RN) approached the medication cart and stated she thought she locked it.On 6/10/26 at 1:16 PM, Staff I, Licensed Practical Nurse (LPN) stated medication carts should be locked when staff walk away. She also stated there is no situation that justifies leaving the medication cart unlocked and unattended.On 6/10/26 at 1:28 PM, Staff O, LPN stated the medication cart should be locked when staff leaves it unattended. She stated the only scenarios that would justify not locking the medication cart is If in an emergency situation such as a resident fall or screaming for help or an actual fire.On 6/10/26 at 1:59 PM, the Director of Nursing (DON) stated staff should lock the medication cart before they walk away.A policy titled Security of Medication Cart revised 1/03/22 revealed the nurse must secure the medication care during the medication pass to prevent unauthorized entry.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observations, staff interviews, and policy review, the facility failed to properly protect resident information from unauthorized access by leaving 6 residents' information unsecured and visible when staff left a report sheet face-up on the medication cart when the staff walked away. The facility reported a census of 119 residents. Findings include: On 6/10/26 at 6:20 AM, a report sheet was observed on a medication cart with 6 residents' code statuses and functional abilities unsecured and visible. Staff N, RN stated she normally covers it but there were no residents in the hall and a resident called emergently, so she responded quickly. Her medication cart and laptop were noted to be locked and she stated she was able to lock those but not able to turn the report sheet over before responding to the resident. She stated she accepted responsibility for the report sheet being left exposed.On 6/10/26 at 1:16 PM, Staff I, LPN stated staff should put paper with someone's name or personal information on it in their pocket or position it so no one can see it.On 6/10/26 at 1:59 PM, the Director of Nursing (DON) stated resident information should be secured.A policy titled Confidentiality of Information and Personal Privacy revised 1/03/22 indicated the facility will safeguard the personal privacy and confidentiality of al resident personal and medical records.

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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 observations, staff interview, and policy review the facility failed to use infection prevention standards when staff failed to cover clean linen when transported in a resident hall and failed to don appropriate Personal Protective Equipment (PPE) when providing personal care for a resident on Enhance Barrier Precautions (EBP) (#8). The facility reported a census of 119 residents. Findings include:On 6/10/26 at 6:03 AM, Staff K, Certified Nurse Aide (CNA) transported an uncovered cart with linen down a resident hall.On 6/10/26 at 1:21 PM, Staff J, CNA stated clean linen being delivered to resident rooms should be in a bag.On 6/10/26 at 1:33 PM, Staff L, CNA stated staff should place clean linens in a bag when delivering them to multiple resident's rooms. 2. Resident #8's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated completely intact cognition. It included diagnoses of diabetes mellitus, a stroke, chronic obstructive pulmonary disease (COPD), and left-sided paralysis. It revealed the resident required setup assistance with eating and oral hygiene, moderate assistance with upper body dressing and bed repositioning, maximal assistance with personal hygiene, and was dependent for all other Activities of Daily Living (ADLs) and mobility.The Care Plan revised 11/11/25 included a break in skin integrity (wound) and indicated the resident required Enhanced Barrier Precautions with close contact cares related to presence of skin disruption.On 6/10/26 at 7:45 AM, Staff G, Certified Nurse Aide (CNA) entered Resident #8's room without putting on PPE.At 8:09 AM, Resident #8 and Staff G exited Resident #8's room. Staff G stated she dressed, toileted, groomed, and changed Resident #8's underwear with maximal assistance.At 8:16 AM, Staff H, Registered Nurse (RN) carried the trash out of the resident's bathroom. She confirmed she could not find a used PPE gown in the trash. At 8:28 AM, Staff G she was not sure if she used one but was unable to locate one in the resident's room. She stated night shift staff emptied the trash so whatever was in the trash, was what she put in it. She was unable to locate a used PPE gown in the resident's trash can.On 6/10/26 at 1:16 PM, Staff I, Licensed Practical Nurse (LPN) stated staff should wear the PPE including the gown when providing direct resident care for residents on EBP precautions.On 6/10/26 at 1:21 PM, Staff J, CNA stated staff should wear the PPE gown if the resident is on EBP and dressing, toileting, or cleaning is to occur.On 6/10/26 at 1:28 PM, Staff K, LPN stated staff should wear PPE when toileting, dressing, or cleaning a resident on EBP.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.DressingBathing/ShoweringTransferringChanging LinensProviding HygieneChanging briefs or assisting with toiletingDevice care or use:central line, urinary catheter, feeding tube, tracheostomyWound Care: any skin opening requiring a dressing3. On 6/10/26 at 6:03AM Staff pushed an uncovered linen cart down the central hallway.On 6/10/26 at 1:59 PM, the Director of Nursing (DON) stated staff should've covered the linen cart when transporting linen in the hall and staff should've worn PPE if resident contact was anticipated.A policy titled Handling Clean Linen revised 3/02/23 indicated clean linens must be transported by methods that ensure cleanliness and protect from dust and soil during intra or inter-facility loading, transport and unloading, such as: placing clean linen in a properly cleaned cart and covering the cart with disposable material or a properly cleaned reusable textile material that can be secured to the cart.A policy titled Enhanced Barrier Precautions revised 9/16/25 identified Enhanced Barrier Precautions (EBP) as an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. It defined high-contact resident care activities to include:DressingBathingTransferringProviding hygieneChanging linensChanging briefs or assisting with toiletingDevice care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline cathetersWound care: any skin opening requiring a dressing