STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165450	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Estates of Toledo	403 Grandview Drive Toledo, IA 52342

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 25858 Based on clinical record review, staff interview, and facility policy and procedure review at the time of the investigation, the facility failed to document on a resident with a change in condition for 1 of 6 residents reviewed (Resident #6). The facility identified a census of 41 residents. Findings include: 1. A Minimum Data Set (MDS) completed for Resident #6 with an assessment reference date of 7/23/24, documented diagnoses which included heart failure, hypertension, diabetes mellitus, and Non-Alzheimer's dementia. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 7 which indicated moderate impaired cognitive decisions and sometimes is understood and usually understands others. The resident required dependent to substantial assistance from staff for dressing, toilet use, and personal hygiene and dependent with transfers. The MDS also documented a wheelchair as primary mode of transportation. The Care Plan with a focus area initiated 7/23/24, the resident requires tube feeding related to dysphagia, swallowing problems, and also has an oral diet of pureed with nectar thickened liquids. Interventions include: *Listen to lung sounds per protocol. *Monitor/document/report to Medical Doctor, Aspiration- fever, shortness of breath, Abnormal breath/lung sounds, Abnormal lab values, Abdominal pain, distension, tenderness, Constipation or fecal impaction, Diarrhea, Nausea/vomiting, Dehydration. The Progress Notes dated 8/3/2024 at 6:37 a.m., Health Status Note Text: At approximately 5:55 a.m., Certified Nursing Assistant (CNA) reported resident feeling warm. During assessment, temp. 97.1, Respirations 22, Heart Rate 82, oxygen saturation at 90% on room air, resident complained of sore throat, wet cough observed, crackles audible in bilateral. upper lobes. HOB elevated at this time, writer reported to oncoming nurse who will monitor and report if symptoms worsen. The Progress Notes dated 8/3/2024 at 8:10 a.m., Health Status Note Text: New order from on call provider to start Mucinex x 5 days and for 2-3 view chest x-ray. BioTech closed in this area today and has her scheduled for 8/4-8/5. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record lacked documentation of any further assessment on the resident with a change in condition. Interview on 8/21/24 at 1:30 p.m., the facility Quality Assurance Nurse confirmed and verified that the clinical record lacked any documentation of on-going assessment with Resident #6 with the change in condition and it is the expectation of the nurses to follow the federal rules and guidelines with documentation and the facility policy and procedure. The Clinical Change in Condition Management dated 6/2015, documented The Interdisciplinary team strives to identify and manage all resident/patients that are experiencing a change in condition. Daily observation and communication is important in identifying changes in a resident/patient that requires further investigations. Daily observation includes but is not limited to changes in: *Physical assessment (cardiovascular, respiratory, mental status, neurological) *Behavior *Mobility *Comfort level *Response to medications Clinical care management includes routine assessment, evaluation, response to changes in clinical condition and communication with residents/patients and/or families/responsible parties. Procedure: 1 Assess resident/patient clinical status when a change in condition is identified. 2. Review the resident/patient medical record

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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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 25858 Based on clinical record review, staff interview, and speech therapy recommendations the facility failed to provide direction for adequate supervision to implement speech therapy recommendations for 1 of 6 resident reviewed (Resident #1). The facility identified a census of 41 residents. Findings include: The Minimum Data Set (MDS) with an assessment reference dated 7/21/24, documented Resident #1 with diagnoses which included Non-Alzheimer's Dementia, anxiety, depression, bi-polar, and weakness. The MDS documented the resident with the ability to be understood and ability to understand others, with short and long term memory problems and moderately impaired for decision making abilities, and disorganized thinking with delusions. The resident required set up assistance with eating and is edentulous (no natural teeth). The Care Plan with an initiated date of 7/16/24, identified a problem of the resident had nutritional problem or potential nutritional problem related to dementia which could impact intake as disease progresses. Interventions include: *Monitor/document/report to Medical Doctor for signs/symptoms of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. *Provide, serve diet as ordered. Monitor intake and record q (each) meal. *Registered Dietician to evaluate and make diet change recommendations. *The resident needs a calm, quiet setting at meal times with adequate eating time. The resident prefers to sit (Specify location). Encourage The resident's socialization and interaction with table mates during meals. The Speech Therapy Evaluation and Plan of Treatment dated 7/23/24-8/20/24, documented patient referred due to cognitive concerns and swallowing evaluation completed on this date. Patient was referred due to coughing during meals. Patient is currently on regular solids/thin liquid diet. Patient reports she coughs on everything and has been for a while. Oral exam revealed patient is edentulous. Patient has dentures but does not wear them because she says it is too much work to get them cleaned up, get the glue on and get them in. Cough prior to oral intake. Patient demonstrated coughing episode with thin liquids. Speech therapist would recommend a mechanical soft diet but patient refused. Speech therapist spoke with patients Power of Attorney who was educated on risk of aspiration and recommendations. Patient POA agreed with patients decision to remain on a regular solid diet at this time. Speech therapist recommends swallow study in order to determine safest and least restrictive diet. Distant supervision during oral intake, cues from staff for strategies: small bites, slow rate, alternate solids and liquids. The Clinical Record lacked documentation that these recommendations were followed or implemented. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 8/20/24 at 12:00 p.m., the facility Registered Dietician confirmed and verified that the facility staff needed to follow the Speech Therapist recommendations as written and had no knowledge of the Speech Therapist recommendations for the small bites, alternate solids/liquids. Interview on 8/20/24 at 12:15 p.m., the facility physician confirmed and verified that they were not aware of the Speech Therapist recommendations and that the facility failed to notify that the Speech Therapist recommended a video swallow study and to have Resident #1 alternate solids/liquids and small bites. Interview on 8/20/24 at 1:00 p.m., Staff A, Register Nurse (RN), confirmed and verified that the Speech Therapist recommendations were not followed and that the facility follows the federal regulations and guidelines.