

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165451	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Accura Healthcare of Marshalltown		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 South Second Street Marshalltown, IA 50158	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500</p> <p>Based on clinical record review, observation, and staff interview, the facility failed to accurately assess residents for the need of safety smoking equipment for two of three residents reviewed for smoking (Residents #22 and #56). The facility reported a census of 53 residents.</p> <p>Findings include:</p> <p>1. Resident #56's Minimum Data Set (MDS) assessment dated [DATE] indicated they had unclear speech and usually made themselves understood. The MDS identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. Resident #56 utilized a wheelchair. The MDS included diagnoses of tobacco use, non Alzheimer's dementia, stroke, other psychoactive substance abuse (uncomplicated), and unspecified disorder of psychological development.</p> <p>The Care Plan Focus dated 7/1/24 indicated that smoking is important to Resident #56. The Interventions directed the staff to assist her with proper supplies to prevent smoking related injuries.</p> <p>The Smoking Assessment completed 7/1/24 assessed Resident #56 as having no cognitive losses. The Assessment reflected Resident #56 needed adaptive equipment of supervision and a smoking apron.</p> <p>On 7/23/24 at 4:10 PM and 7/24/24 at 1:10 PM observed Resident #56 not wearing a smoking apron during the staff supervised smoking times.</p> <p>2. Resident #22's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. Resident #22 used a manual wheelchair. The MDS included diagnoses of tobacco use, cancer, anemia, end stage renal disease with dialysis, anxiety disorder, bipolar disorder, and age related physical debility.</p> <p>The Care Plan Focus dated 9/5/19 indicated Resident #22 felt being able to smoke cigarettes is extremely important. He is able to smoke as long as he followed the provided guidelines. The Interventions instructed the facility to complete smoking assessments every quarter.</p> <p>The Care Plan lacked interventions related to the use of safety smoking equipment or the level of supervision.</p> <p>The smoking assessment completed on 1/16/24 indicated Resident #22 needing supervision, smoking apron, and 1:1 assistance.</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
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The smoking assessment completed on 4/17/24 indicated Resident #22 needing a smoking apron.</p> <p>The Smoking Assessment completed 5/8/24 indicated Resident #22 needed supervision and a smoking apron.</p> <p>On 7/23/24 at 4:10 PM and 7/24/24 at 1:10 PM observed Resident #22 not wearing a smoking apron during the staff supervised smoking times.</p> <p>On 7/24/24 at 1:10 PM Staff I, Certified Nursing Assistant (CNA), denied knowing any residents requiring smoking supplies or safety equipment. Staff I didn't believe the current pocket CNA Care Plan listed any residents needing smoking safety equipment.</p> <p>On 7/24/24 at 3:00 the Assistant Director of Nursing (ADON), Staff A, Registered Nurse, and Staff H, MDS Coordinator indicated all residents who smoke receive a smoking assessment. If any safety interventions indicated, they update the Care Plan and notify the CNAs via the pocket Care Plans. When asked, all reported there were no residents in need of safety smoking equipment. They learned Residents #22 and #56's most recent smoking assessments reflected they needed smoking aprons. All staff members looked surprised at this information and expressed concern of the inaccurate assessment. All staff members indicated Resident #22 didn't ever wear a smoking safety apron. Staff H mentioned the smoking apron may have marked in error with Resident #56's assessment.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500</p> <p>Based on clinical record review, observation and staff interview, the facility failed to develop and implement a comprehensive person centered Care Plan for 1 of 16 residents reviewed (Residents #56), regarding the use and need of a wander guard due to history of exit seeking. The facility reported a census of 53 residents.</p> <p>Findings include:</p> <p>Resident #56's Minimum Data Set (MDS) assessment dated [DATE] indicated they had unclear speech and usually made themselves understood. The MDS identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. Resident #5 didn't exhibit wandering behaviors. Resident #56 utilized a wheelchair. The MDS included diagnoses of tobacco use, non Alzheimer's dementia, stroke, other psychoactive substance abuse (uncomplicated), and unspecified disorder of psychological development.</p> <p>The Care Plan with a target date of 7/7/24 lacked information related to Resident #56 wandering or the need for a wander guard.</p> <p>The clinical record review completed 7/23/24 didn't show an active order for the use of a wander guard or for staff to check placement of a wander guard.</p> <p>The Progress Note dated 6/19/24, reflected Resident #56 attempted to leave the facility building on two separate occasions. The facility placed a wander guard.</p> <p>The Progress Note dated 7/5/24, indicated staff found Resident #56's wander guard in a drawer, it looked cut off. The staff applied a new wander guard.</p> <p>The Progress Note dated 7/17/24, Resident #56 attempted to go out the front door and needed several staff members to bring her back from the door.</p> <p>On 7/23/24 and 7/24/24 witnessed Resident #56 wearing a wander guard on her lower right leg.</p> <p>On 7/23/24 at 3:15 PM Staff A, Registered Nurse, acknowledged Resident #56 had a wander guard. Staff A also recognized Resident #56's Care Plan didn't reflect the use of a wander guard. Staff A added given the fluctuation of Resident #56's exit seeking behaviors and current use of a wander guard, the Care Plan should address the intervention.</p> <p>Per email confirmation from the facility administrator, the facility does not have a policy or procedure specifically related to wander guard use or Care Plan development.</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49990</p> <p>Based on direct observation, resident interviews, staff interviews, and document review the facility failed to provide and document restorative cares for 3 of 3 residents reviewed (Residents #7, #24, and #43). The facility reported a census of 53.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident #7's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status score of 15, indicating intact cognition. Resident #7 required full assistance for toilet use and transfers, and required maximal assistance for bed mobility. The MDS recorded Resident #7 didn't have impaired range of motion (ROM) and used a manual wheelchair for mobility. The MDS included diagnoses of congestive heart failure (CHF), respiratory failure, type 2 diabetes, and obesity. Resident #7 started Occupational Therapy (OT) on 6/14/24. Resident #7 received restorative nursing program (RNP) for 0 days in the 30-day look back period. <p>The Care Plan Focus dated 2/12/24 reflected Resident #7 had an activities of daily living (ADL) deficit due to his diagnosis of obesity. The Care Plan Interventions directed the following:</p> <ol style="list-style-type: none"> a. Resident #7 required assistance with perineal care twice a day and as needed (PRN). b. Resident #7 needed 2 assist with a standing mechanical lift. Resident #7 needed staff assistance with locomotion. c. 2/12/24: Resident #7 worked with Physical Therapy (PT) and OT. <p>The OT Discharge Summary signed 7/12/24, reflected Resident #7 discharged from OT services on 7/12/24. The OT indicated they established an RNP for Resident #7. He had a good prognosis with consistent staff follow through. The OT recommendations included an RNP and ROM program. The Outcome Risk(s) reflected Resident #7 agreed with the discharge plan to start restorative services.</p> <p>The RNP dated 7/12/24 included the following:</p> <ol style="list-style-type: none"> a. Resident #7 complete upper body exercises with Red/Green TheraBand's (resistance bands) as tolerated. Elbow flexes, elbow extensions, shoulder extension and rotation for 2 3 sets of 10 repetitions. b. Resident #7 complete continuous cycling for upper and lower body for 15 minutes with level 2 3 resistance as tolerated. c. Resident #7 complete choice of catch/toss, ring toss, and/or bean bag toss. d. Noted they should encourage resident to get out of bed and participate in group activities as tolerated. <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Response History related to Active ROM to upper and lower extremities 3-5 times a week at medium level for 5 to 15 minutes reviewed on 7/24/24 at 12:29 PM for the previous 30 days reflected Resident #7 received ROM on 7/23/25 for 15 minutes. The report lacked other documentation to reflect Resident #7 received ROM outside of that day.</p> <p>The Response History related to Group Exercise Program reviewed on 7/24/24 at 12:38 PM for the previous 20 days lacked documentation to indicate Resident #7 received group exercise.</p> <p>The electronic health record (EHR) and paper chart lacked further documentation that Resident #7 performed RNP exercises.</p> <p>In an interview on 7/24/24 at 11:00 AM Staff J, Restorative Aide, stated she didn't know why Resident #7's clinical record didn't have documentation, as she believed he participated in restorative services.</p> <p>In an interview on 7/24/24 at 10:32 AM, Resident #7 stated he only participated in restorative services when someone came to get him out of bed and helped him down to the activity room. He indicated he received approximately one opportunity a week to participate in his RNP.</p> <p>On 7/24/24 at 10:42 AM Staff A, Quality Assurance (QA) Nurse, stated she expected the staff to document all participation in the RNP, including refusals. She stated Resident #7 had an RNP set up as a daily task to ensure he received at least three opportunities to participate a week. She confirmed his record didn't have documentation for the RNP outside of 7/23/24.</p> <p>In an interview on 7/25/24 at 11:27 AM the Administrator, stated the facility followed the standards of care for PT, OT, and Restorative services. He acknowledged that meant the facility needed to offer restorative services when recommended.</p> <p>34817</p> <p>2. Resident #24's MDS assessment dated [DATE] admitted to the facility on [DATE]. The MDS documented Resident #24 had impaired ROM to their upper and lower extremity on one side. Resident #24 required supervision for eating, partial to moderate assistance for bed mobility, and required total assistance from staff for transfers and toilet use. The MDS included diagnoses of cerebrovascular accident (CVA) (stroke), hemiplegia (paralysis on one side), and hemiparesis (muscle weakness) affecting the right side. The MDS reflected Resident #24 didn't have Occupational Therapy (OT), Physical Therapy (PT), or RNP activities during the 7 day look back period.</p> <p>The Quarterly Nursing assessment dated [DATE] at 1:49 PM, indicated Resident #24 had limitations in ROM to the upper and lower extremities on one side of her body. She didn't participate in an RNP. Resident #24 required extensive assistance of 2 staff for transfers, extensive assistance for dressing, and required assistance for personal hygiene.</p> <p>Resident #24's MDS assessment dated [DATE] reflected she received OT services from 7/18/23 - 7/31/23, PT services from 7/18/23 - 8/2/23, and participated in RNP activities zero (0) days during the 7 day look back period.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Care Plan Focus dated 7/17/23 identified Resident #24 had a deficit in ADLs due to weakness and a contracture. The Care Plan directed Resident #24 need 2 staff assist with transfers. The Intervention instructed to get Resident #24 up and ready for participation with OT and PT.</p> <p>The PT Discharge Summary dated on 8/2/23 reflected Resident #24 required maximum assistance from 2 staff for transfers. The therapist documented Resident #24 actively participated consistently for 15 minutes in a lower extremity exercise program to help enhance her coordination and ability to assist with functional transfers. She met the goal on 7/28/23. Resident #24 discharged from PT to a restorative program in order to prevent ADL decline. Resident #24 consistently participated in use of an exercise bicycle (a motorized movement device developed for people with movement restrictions) for her lower extremities. The PT recommended an RNP with the exercise bicycle for 15 minutes at least 2 3 times per week. The Discharge Summary reflected Resident #24 had a good prognosis and ability to maintain her current level of function with consistent staff follow through.</p> <p>Resident #24's May 2024 Documentation Survey Report lacked an RNP except for group exercises. The Documentation indicated Resident #24 refused all documented activities except on 5/9/24 of bingo and social time.</p> <p>Resident #24 June 2024 Documentation Survey Report lacked an RNP except for group exercises. The Documentation indicated Resident #24 refused all documented activities except on 6/17/24 (group exercise) and 6/21/24 (tv/movies).</p> <p>A PT Evaluation and Plan Of Treatment dated 6/25/24 revealed Resident #24 referred to PT due to increased muscle weakness. The PT documented the resident had not previously participated in an RNP. The PT functional mobility assessment revealed the resident had dependence for transfers, and required substantial to maximum assistance for bed mobility.</p> <p>Resident #24's MDS assessment dated [DATE] identified a BIMS score of 14, indicating cognition intact. The MDS indicated Resident #24 had impaired ROM to the upper and lower extremities on one side. Resident #24 required partial to moderate assistance with eating, and substantial to maximum assistance for bed mobility, transfers, and toilet use. The MDS recorded OT started on 6/21/24, PT started on 6/25/24, and she participated in the RNP activities 0 days during the 7 day look back period.</p> <p>The Quarterly Nursing assessment dated [DATE] at 11:26 AM, reflected Resident #24 had limitations in ROM to the upper and lower extremities on one side of her body. Resident #24 didn't participate in an RNP. Resident #24 required extensive assistance for transfers, and needed total assistance from staff for bathing, dressing, and personal hygiene.</p> <p>On 7/22/24 at 11:36 AM, observed Resident #24 sit in a wheelchair in the dining room with a plate of food in front of her.</p> <p>On 7/23/24 at 12:29 PM, watched the staff performed cares for Resident #24., noted a contracture to her left hand. The staff offered to place a pillow under her left arm for comfort.</p> <p>On 7/25/24 at 7:45 AM, witnessed a Certified Nurse Aide (CNA) assist Resident #24 eat breakfast.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview 7/23/24 at 12:57 PM, Staff D, CNA, reported Resident #24 sometimes went to group exercise class but she didn't usually do much exercise in the class. Staff D stated Resident #24 had a RNP with ROM exercises but she didn't know how often or how much she participated in the exercises.</p> <p>Resident #24's July 2024 Documentation Survey Report directed the following:</p> <p>a. Please assist her to all group exercises.</p> <p>- First documented on 7/23/24</p> <p>b. Transfer practice wheelchair to bed stand with 2 assist.</p> <p>- First documented 7/23/24.</p> <p>During an interview 7/23/24 at 1:06 PM, the Restorative Aide reported Staff A, QA and Restorative Nurse, notified her when a resident had a restorative program and what activities they needed her to work with Resident #24. The Restorative Aide stated they documented the restorative program and activities performed in the electronic health record (EHR) under tasks. The Restorative Aide reported Resident #24 participated in the restorative group exercise class Monday through Friday, she enjoyed playing ball.</p> <p>During an interview 7/23/24 at 1:21 PM, Staff A reported she tried to get residents on a restorative program or therapy when they first come to the facility. Therapy make recommendations for the residents' restorative program and give her the information. She entered the program into the computer. She talked to the Restorative Aide about the resident and what program of exercises to do. They develop an exercise program according to the resident's preference. Staff A added the CNA's also performed ROM with the residents. Staff A reported the staff request therapy evaluate a resident whenever they notice a change or decline in the resident's status.</p> <p>During an interview 7/25/24 at 12:56 PM, the Assistant Director of Nursing (ADON), reported Staff A as the responsible person for the restorative program. When Resident #24 arrived to the facility, she couldn't walk and had a contracture in her hand. The staff did all of her ADL's. The ADON explained the staff tried to encourage her to eat but they often had to assist her with eating.</p> <p>During an interview 7/25/24 at 1:02 PM, Staff A reported she didn't find an RNP for Resident #24 prior to July 2024. Staff A stated she added the restorative activity under the tasks in the EHR whenever she received the restorative program information for a resident. She then put the restorative program recommendations from therapy in a folder. Staff A acknowledged Resident #24's EHR didn't have the paper document scanned in, but thought that was a good idea to start doing that. She let the Restorative Aide know whenever they had a new resident for the program. Staff A reported the goal of a restorative program was to maintain the resident's level of function and potentially increase their ability to do better than what they could do. Staff A stated the Restorative Aide documented when the resident performed or refused the RNP in the EHR under tasks.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Resident #43's admission MDS assessment dated [DATE] admitted to the facility on [DATE]. Resident #43 required supervision and touch assistance with eating. In addition, Resident #43 needed extensive assistance of two staff for bed mobility and transfers. The MDS included diagnoses of CVA and a hip fracture. The MDS recorded Resident #43 started PT and OT on 3/13/23, and didn't have RNP activities during the 7 day look back period.</p> <p>Resident #43's MDS assessment dated [DATE] reflected he didn't have impaired ROM. Resident #43 required set up assistance for eating, and substantial to maximum assistance for bed mobility and transfers. The MDS recorded Resident #4 had two or more falls without injury during the look back period. The MDS documented PT and OT started on 1/23/24, and he had no RNP activities during the 7 day look back period.</p> <p>Resident #43's MDS assessment dated [DATE] reflected he didn't have impaired ROM. Resident #43 required set up assistance for eating. He needed substantial to maximum assistance for bed mobility and total assistance with transfers. The MDS recorded Resident #43 received OT services from 1/23/24 4/10/24 and PT 1/23/24 - 2/28/24. Resident #43 didn't have RNP activities during the 7 day look back period.</p> <p>The Care Plan Focuses initiated 3/9/23 described Resident #43 with:</p> <p>a. Revised 7/28/23: limited physical mobility related to neurological deficits and weakness. The Care Plan directed:</p> <p>i. Group exercise</p> <p>ii. 7/28/23: Nursing Rehab/Restorative: Exercise bike for lower body level 5 for 15 minutes.</p> <p>b. an ADL deficit due to a history of CVA, anoxic brain damage, and weakness. The Care Plan directed staff</p> <p>i. Do a stand pivot transfer.</p> <p>ii. Assist of 2 staff for bed mobility</p> <p>iii. Encourage Resident #43 to participate in group exercises, and a nursing rehabilitation restorative program with the exercise bike for the lower body for 5 to 15 minutes. The Care Plan lacked the frequency for RNP or group exercises.</p> <p>The PT Discharge Summary dated 2/28/24 reflected Resident #43 had weakness and required partial to moderate assistance for bed mobility. In addition, Resident #43 required substantial to maximum assistance of 1 2 staff for transfers. The PT recommended an RNP and assistance of 1 2 staff for transfers. PT documented they established a RNP for ROM that included a reciprocal activity for the bilateral lower extremities for 5 for 15 minutes. The note reflected the maintenance of Resident #43's current level of function as good with consistent staff follow through on the RNP.</p> <p>Resident #43's March 2024 Documentation Survey Report lacked RNP activities. The Group Exercise Program directed time to complete exercise as Night 10:00 PM - 6:00 AM. All documentation reflected not applicable.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875</p> <p>Based on clinical record review, staff interviews, observations, and policy review the facility failed to implement consistent supplement serving amounts for 1 of 3 residents reviewed (Resident #43) for nutrition and weight loss. The facility reported a census of 53 residents.</p> <p>Findings include:</p> <p>Resident #43's MDS assessment dated [DATE] listed an admitted [DATE]. The MDS identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired cognition. Resident #43 required supervision and touch assistance with eating. In addition, Resident #43 needed extensive assistance of two staff for bed mobility and transfers. The MDS included diagnoses of anemia, hypertension (high blood pressure), heart failure (heart muscle does not pump enough blood), renal disease, diabetes mellitus, cerebrovascular accident (CVA), non Alzheimer's disease, malnutrition, dysphagia (difficulty swallowing), and anoxic brain damage (lack of oxygen to the brain). The MDS reflected Resident #43 didn't have a 5% weight loss in the last month or 10% weight loss in the last 6 months. The MDS indicated Resident #43 ate a mechanically altered diet and had a therapeutic diet.</p> <p>The Care Plan Focus revised 3/9/23 indicated Resident #43 had an alteration in his nutrition due to his potential for weight loss due to the diagnosis of anoxic brain damage. The Care Plan directed staff to serve supplements as ordered.</p> <p>Resident 43's weight summary revealed the following weights from 1/10/24 to 7/1/24:</p> <ul style="list-style-type: none"> a. 1/10/24 = 155 lbs. (pounds) b. 2/2/24 = 150 lbs. c. 2/29/24 = 148 lbs. d. 3/11/24 = 148 lbs. e. 4/3/24 = 146 lbs. f. 5/3/24 = 145 lbs. g. 6/4/24 = 136 lbs. h. 7/1/24 = 131 lbs. <p>Resident #43's Physician Order dated 10/3/23 directed staff to administer a thickened house supplement one time a day for weight management. The order lacked direction on how much of the supplement to give.</p> <p>Resident #43's Physician Order dated 5/1/24 directed staff to administer a thickened house supplement two times a day for weight management. The order lacked direction on the amount to give.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Accura Healthcare of Marshalltown		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 South Second Street Marshalltown, IA 50158	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #43's February 2024 to July 2024's Medication Administration Records (MAR) reflected the house supplement documented, indicating staff administered it but lacked documentation on how much Resident #43 received or consumed of the supplement.</p> <p>A Progress Note titled Nutrition/Dietary dated 2/15/24 at 8:18 PM reflected Resident #43's annual nutritional assessment revealed a current weight of 150 lbs. with a body mass index (BMI) of 21.5%. The assessment documented a weight loss of 3.2% in 30 and 90 days and 4.5% in 180 days. Resident #43's diet order consisted of a general diet, pureed textures, and nectar thickened liquids. The note documented Resident #43 had an order for house supplement every day with good acceptance and meal intakes averaging 50% or less.</p> <p>A Progress Note titled Nutrition/Dietary dated 3/11/24 documented Resident #43 triggered a significant weight loss of 10.3% in 180 days. Resident #43 current weight of 148 lbs. with a BMI of 21.2%. Resident #43's diet order consisted of a general diet, pureed textures, and nectar thickened liquids. The note documented Resident #43 had an order for house supplement 8 ounces every day with good acceptance per the MAR and meal intakes averaging 50% or less with 240 milliliters of fluid at every meal. The note recommended starting one scoop of protein powder three times a day at meals for unintended weight loss.</p> <p>A Progress Note titled Nutrition/Dietary dated 4/29/24 documented Resident #43's quarterly assessment revealed a current weight of 146 lbs. with a BMI of 20.9%. The noted documented Resident #43 didn't have a significant weight change, but her weight did trend downward. Resident #43's diet order consisted of a general diet, pureed textures and nectar thickened liquids. The note documented Resident #43 had an order for house supplement every day with good acceptance per MAR and meal intakes averaging 50%. The note recommended increasing house supplement to twice a day related to subpar intakes and a trending down weight status.</p> <p>A Progress Note dated 5/1/24 documented the Dietitian recommended to increase house supplement from daily to twice a day due to subpar intakes and weight trending downward. The note documented the facility received a verbal order and updated the MAR.</p> <p>A Progress Note titled Nutrition/Dietary dated 7/23/24 documented Resident #43's quarterly assessment revealed a current weight of 131 lbs. with a BMI of 18.8%. The EHR reflected a significant weight loss of 10.2% in 90 days and 12.6% weight loss in 180 days. Resident #43's diet order consisted of a general diet, pureed textures and nectar thickened liquids. The note documented Resident #43 received a house supplement twice a day with meal intakes averaging 50% 75%. The note recommended increasing house supplement to 4 ounces three times a day.</p> <p>On 7/24/24 at 4 PM, the Director of Nursing (DON) reported the Dietitian directed them to have the house supplement's physician order written generically, as the facility had different types of supplement available at different times such as ensure and boost. The DON acknowledged Resident #43's house supplement orders didn't state how much of the supplement to give. The DON reported the nurses usually give a Styrofoam cup full of the house supplement.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/24/23 at 4:05 PM, Staff A, Quality Assurance (QA) Nurse, reported when she received training, her trainer directed her to give a cup full of the house supplement. Staff A stated she watched the residents take the house supplement to make sure they consumed it. Staff A stated she treated the supplement as a medication order and agreed a medication order should have the amount/dose included in the directions of the order.</p> <p>On 7/25/24 at 7:50 AM, Staff B, RN (Registered Nurse) reported she administered the house supplement according to the directions of the physician order. Staff B reviewed Resident #43's house supplement order and verified the order didn't give directions on how much of the supplement to give. Staff B confirmed the physician order should state how much to give. Staff B stated she had worked at the facility a long time and the house supplement orders always have stated how much to give.</p> <p>On 7/25/24 at 8:35 AM, Staff C, Licensed Practical Nurse (LPN), reported when she administered a house supplement she looked at the MAR to see how much to give and then measured the supplement with a medication cup. Staff C acknowledged Resident #43's house supplement order didn't state how much to give. Staff C stated she usually gave Resident #43 what the other residents got. Staff C stated she usually gave Resident #43 4 8 ounces of the house supplement depending on his mood and what he was willing to take. Staff C stated Resident #43 had thrown the cup of supplement at her before and she does not want to wear it. Staff C verified a Styrofoam cup on the medication cart held 6 ounces.</p> <p>On 7/25/24 at 9:30 AM, the DON recognized the concern with Resident #43's house supplement related to inconsistent serving amounts, lack of directions in the physician order, and weight loss. The DON reported she had a concern when the Dietitian requested to change the house supplement orders. She went through all of the resident's physicians' orders for house supplements and updated the orders to include 4 ounces.</p> <p>On 7/25/24 at 11:30 AM, the Administrator reported he expected the house supplement orders to include an amount to give. He also expected the Dietitian to know that.</p> <p>A facility policy titled Resource: Nutrition Interventions for Unintended Weight loss dated 2021 documented the following conclusions about unintended weight changes that may include, but not limited to:</p> <ul style="list-style-type: none"> *A target range for weight based on the individual's overall condition, goals, prognosis, usual body weight, etc. *Approximate calorie, protein, and other nutrient needs. *Whether and to what extent to anticipate weight stabilization or improvement. *Whether altered weight or nutritional status could be related to an underlying medical condition (e.g., fluid, and electrolyte imbalance, medication related anorexia, or an infection). *Determine if the information obtained is supporting documentation to suggest a malnutrition diagnosis. Based on analysis of relevant information, the facility should identify a clinically pertinent basis for any conclusion that an individual cannot attain or maintain acceptable parameters of nutrition status. 		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>46875</p> <p>Based on observation and staff interviews, the facility failed to post the daily nurse staffing information. The facility reported a census of 53 residents.</p> <p>Findings include:</p> <p>On 7/23/24 at 11:50 AM, observed the facility didn't have the daily nurse staffing information posted.</p> <p>On 7/23/24 at 12:00 PM, The Administrator acknowledged and confirmed the facility didn't post the daily nurse staffing information and that they didn't have the information readily accessible to residents and visitors. The Administrator reported they kept the daily nurse schedules in a binder at the nurses' station. The Regional Nurse Consultant (RNC) reported the facility would correct the issue and post the daily nurse staffing information.</p> <p>On 7/23/24 at 1:00 PM, The Administrator reported the facility didn't have a policy regarding the daily nurse staffing postings. He stated the facility follows the standard of care in which this case the facility didn't.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50500</p> <p>Based on observations, staff interviews, facility documents, and policy review, the dietary staff failed to label and store food items in order to maintain food quality and reduce the risk of contamination and food borne illness. The facility also failed to ensure resident dishes and kitchen equipment reached the appropriate sanitizing temperature when utilizing the dish machine to reduce the risk of bacteria growth and cross contamination. The facility reported a census of 53 residents.</p> <p>Findings include:</p> <p>Initial tour of the main kitchen on 7/22/24 at 10:15 AM revealed the following concerns:</p> <p>a. July 2024's dish machine temperature log lacked entries for seven days, two of the three required entries for four days, and one of the three required entries for one day.</p> <p>b. Several labels reflecting outdated food items found in the cooler:</p> <p>i. Squirt bottle of ranch dated 7/8/24</p> <p>ii. Squirt bottle of French dated 6/30/24</p> <p>iii. Bag of bacon bits dated 7/13/24</p> <p>c. Four of five plastic containers of cereal didn't have a label or had an outdated label</p> <p>d. Plastic containers under the prep table had an incomplete label or no label</p> <p>e. Undated and unlabeled bags of cereal in dry storage</p> <p>f. Two unsecured plastic bags of pasta</p> <p>g. Box labeled cocoa powder had another bag placed on top of a partial opened bag of cocoa powder</p> <p>In an interview on 7/22/25 at 10:14 AM, the Dietary Manager confirmed the lack of documented temperatures for the dish machine. They said the kitchen staff should document the temperatures three times day to correlate with meal service.</p> <p>In an interview on 7/24/25 at 9:40 AM, the Dietary Manager acknowledged the presence of the outdated food items in the cooler, the unlabeled cereal containers/bags as well as the containers under the prep table, the unsecured pasta, and cocoa powder in dry storage. The Dietary Manager reported they expected the facility shouldn't keep food in the coolers longer than three days (then discard it) and food should also have a proper label, date, and securely sealed.</p> <p>An undated policy titled Food Storage revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. Food should have a date when placed on the shelves</p> <p>b. Must use plastic containers with tight fitting covers or sealable plastic bags for storing grain products, sugar, dried vegetables, and broken lots of bulk foods, or opened packages.</p> <p>c. All containers or storage bags must be legible and accurately labeled and dated.</p> <p>d. Use or discard leftover food within 7 days.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500</p> <p>Based on observation, staff interview, the Centers for Disease Control and Prevention (CDC) and facility policy review, the facility staff failed to follow infection control practices in order to prevent and control the onset and spread of infection within the facility by not wearing the required personal protection equipment and rinsing resident equipment after use for one of one resident observed (Resident #52). The facility reported a census of 53 residents.</p> <p>Findings include:</p> <p>1. Resident #52's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 0, indicating severely impaired cognition. Resident #52 required total staff assistance for toilet use and personal hygiene. The MDS reflected Resident #52 had a urinary catheter. The MDS included diagnoses of non Alzheimer's dementia, metabolic encephalopathy (swelling on the brain due to imbalances in the body), and urinary retention. The MDS listed active infections of septicemia (blood infection) and urinary tract infection (UTI).</p> <p>The Care Plan identified Resident #52 used a catheter due to urinary retention. The Interventions directed the protocol for UTI, monitoring signs and symptoms of UTI, providing catheter cares two times daily, and use of enhanced barrier precautions (EBP).</p> <p>During observation on 7/25/24 at 1:20 PM, Staff G, certified nursing assistant (CNA), completed hand hygiene upon entering Resident #52's room to empty the urinary bag. Staff G donned only gloves, no gown, and proceed to gather the necessary supplies. Staff G placed a towel barrier on the floor, put the supplies on the towel, and used an alcohol swab to sanitize the nozzle. Staff G proceed to empty the urinary bag into Resident #52's labeled graduate without the nozzle coming in contact with the graduate. Staff G used a new alcohol swab to sanitize the nozzle afterwards. Staff H gathered the used supplies and threw away disposable items. Staff G emptied the graduate into the toilet and verbalized they couldn't find a cup or another graduate to rinse out the used one. Staff G didn't prefer to rinse out the graduate under the bathroom sink and would get a cup to rinse it out. Without rinsing the graduate, Staff G placed the used graduate by the toilet. Approximately ten minutes after watching Staff G complete the urinary bag cares, observed the used graduate with a small amount of urine present, indicating no one rinsed it out after using.</p> <p>In an interview 7/25/24 at 1:50 PM, the Assistant Director of Nursing (ADON) reported Staff G self reported not wearing a gown during emptying of the urinary bag, signifying non adherence with the EBP standards. The ADON acknowledged Staff G's preference for using a cup to rinse out the used graduate, but didn't know if they did it that time.</p> <p>The Enhanced Barrier Precaution policy, dated 5/6/24, instructed the staff to initiate the use of EBP for residents with an indwelling medical device (urinary catheters). Personal protective equipment (PPE) included gowns and gloves. In addition, observed EBP signage on Resident #52's door which summarizes when staff is to implement EBP and required PPE.</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 - Few</p>	<p>The CDC website related to the Guideline for Prevention of Catheter-Associated Urinary Tract Infections (2009) dated 3/25/24 directed to empty the collecting bag regularly using a separate, clean collection container for each patient.</p>

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875</p> <p>Based on clinical record review, staff interviews, Centers for Disease Control and Prevention (CDC) guidelines and facility policy review, the facility failed to screen for eligibility, offer, provide education and document vaccine consent or refusal for the COVID 19 (coronavirus disease) immunization for 3 of 5 resident reviewed (Resident #23, #43, #22). The facility reported a census of 53 residents.</p> <p>Findings include:</p> <p>1. Resident #23's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.</p> <p>Review of the clinical record revealed Resident #23 had received a COVID vaccination on 8/11/22. The clinical record lacked documentation of education with a consent or refusal provided to Resident #23 for an additional COVID-19 vaccination after 8/11/22.</p> <p>Review of the CDC recommendations for adults aged [AGE] years and older recommended individuals to get one updated COVID 19 vaccine followed by one additional dose of an updated COVID 19 vaccine at least 4 months after the previous updated dose. The CDC and NHSN (National Healthcare Safety Network) documented adults aged [AGE] years or older are up to date when the individual had received 2 doses of the updated 2023 2024 COVID 19 vaccine, or received 1 dose of the updated 2023 2024 COVID-19 vaccine within the past 4 months.</p> <p>2. Resident #43's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired cognition.</p> <p>Review of the clinical record revealed Resident #43 had received a COVID vaccination on 8/10/22. The clinical record lacked documentation of education with a consent or refusal provided to Resident #43 of an additional COVID-19 vaccination after 8/10/22.</p> <p>The CDC's Website related to Use of an Additional Updated 2023-2024 COVID-19 Vaccine Dose for Adults Aged [AGE] years and older: Recommendations of the Advisory Committee on Immunization Practices - United States, 2024 dated 4/25/24 indicated the CDC's Advisory Committee on Immunization Practices (ACIP) recommended that all persons aged [AGE] years and older receive 1 additional dose of any updated COVID-19 vaccine. The CDC recommended the additional dose given at least 4 months after the previous updated dose. The CDC and NHSN documented adults aged [AGE] years or older are up to date when the individual had received 2 doses of the updated 2023 2024 COVID 19 vaccine, or received 1 dose of the updated 2023 2024 COVID 19 vaccine within the past 4 months.</p> <p>3. Resident #22's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.</p> <p>(continued on next page)</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the clinical record revealed Resident #22 had received a COVID vaccination on 8/11/22. The clinical record lacked documentation of education with a consent or refusal provided to Resident #8 of an additional COVID 19 vaccination after 8/11/22.</p> <p>The CDC website related to Stay Up to Date with COVID-19 Vaccines last reviewed 5/14/24 recommended people aged [AGE] years and older who got COVID-19 vaccines before September 12, 2023, should get 1 updated COVID-19 vaccine.</p> <p>On 7/24/24 at 9:00 AM, The Administrator reported the facility didn't have any COVID-19 vaccination clinics to offer the 2023 2024 COVID vaccine.</p> <p>On 7/24/24 at 9:29 AM, the ADON (Assistant Director of Nursing) reported August 2022 as the last COVID 19 vaccination clinic the facility had.</p> <p>On 7/24/24 at 12:35 PM, Staff A, QA (Quality Assurance) Nurse, reported March 2023 as the last documented conversation she had with the Pharmacy to set up a vaccination clinic for the COVID 19 vaccine.</p> <p>On 7/24/24 at 1:10 PM, the Administrator stated he expected the staff offer the residents a COVID 19 vaccination any time a new vaccine comes out.</p> <p>On 7/25/24 at 8:25 AM, the ADON verified the facility didn't offer Residents #23, #22, and #43 the updated COVID 19 vaccine.</p> <p>The facility policy titled COVID 19 Vaccination updated 5/6/24 reflected the facility would provide all residents with the opportunity and encouragement to receive the COVID 19 vaccinations. The policy further documented that if the resident would like to be up to date on the COVID 19 vaccine but is not, the facility would contact the primary physician to get an order, if not contraindicated.</p>		