STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Boulevard Council Bluffs, IA 51503

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on electronic health record review (EHR), resident interviews, staff interviews and policy review the facility failed to provide dignity and respect during personal cares to 2 of 22 residents reviewed (Resident #8 and #175). The facility reported a census of 22 residents. Finding include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #8 documented a Brief Interview of Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. On 1/8/25 at 9:30 AM Staff G Certified Nurse Assistant (CNA) stated residents at the facility had told her about negative statements and care that Staff H had given. Staff G stated Resident #8 told her a couple days ago she was having a hard time standing up off the toilet. Staff G stated Resident #8 told her Staff H said she could not sit here and babysit you guys. Staff G stated Resident #8 was talking about the incident in the dining room. Staff G stated another resident that sat at the dining room table stated they could hear Staff H telling her that in Resident #8's room as well. Staff G stated Resident #8 sat with Resident #175. Staff G stated she told Staff I, Licensed Practical Nurse (LPN), the nurse that was working that morning. Staff G stated she did not know if it was passed on further from Staff I. On 1/9/25 at 10:01 AM Staff I, LPN stated she had not had any staff report that another staff treated a resident undignified. Staff I stated if the staff reported that a staff was treating a resident without dignity she would report it to a nurse manager or the administrator. 2. The MDS dated [DATE] for Resident #175 documented a BIMS of 15 indicating no cognitive impairment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Boulevard Council Bluffs, IA 51503

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/6/25 at 3:08 PM Resident #175 stated Staff H, CNA told her if she went to the bathroom before she went to bed she would not have to go now. Resident #175 stated Staff H told her to hurry up when in the bathroom. Resident #175 stated when she was talked to like that it made her sad and hurt her feelings. Resident #175 stated that she wanted to tell Staff H that her income is paying Staff H's wages and it is not Resident #175 fault she was at the facility because she wouldn't have been there if she didn't have to. Resident #175 stated Staff H doesn't treat her with enough dignity. Resident #175 stated Staff H was mean and short when talking to Resident #175. Resident #175 stated she was not reluctant to talk to Staff H when she completed care but did. Resident #175 stated she did not feel abused but felt like Staff H could treat her with a little more dignity. Resident #175 stated she did not inform any staff at the facility. On 1/9/25 at 7:41 AM the Administrator stated she was not aware of the incident with Resident #8 and the incident had not been reported to her. The Administrator stated if the report was passed on to the nurse by a CNA the expectation was the incident would be passed on to the management team. The Administrator stated Resident #175 had not voiced any concerns with the care or treatment by staff. The Administrator stated the facility's expectation was the residents at the facility would be provided dignity and respect from all employees. The Administrator stated the incident would be investigated. On 1/9/25 at 7:50 AM Staff J, Registered Nurse (RN)/Nurse Manager stated she was not aware of the incident with Resident #8 and Staff H and the incident had not been reported to her. Staff J stated usually if a staff makes a negative comment the management is made aware of the incident. Staff J stated if the incident was reported to her it would have been investigated and passed on to the DON and/or the Administrator. On 1/9/25 at 8:48 AM the DON stated she was not aware of the incident with Resident #8 and Staff H and it had not been reported to her. The DON stated usually if a staff makes a negative comment the management is made aware of the incident. The DON stated if the nurse was informed the nurse should have taken the incident to some sort of management team. The DON stated Resident #175 had not voiced any concerns with the care or treatment by staff. On 1/9/25 at 8:55 AM Resident #8 stated she did not remember names well. Resident #8 stated some staff are short with her about the need to have them clean her up after going to the bathroom. Resident #8 stated some staff have told her that they had been in the room [ROOM NUMBER] or 4 times already. Resident #8 stated Staff H had been short with her a couple of times, once or twice when she was not able to get up off the toilet on her own. Resident #8 stated she did not feel abused. Resident #8 stated most of the time staff are really good to her. Resident #8 stated staff were short with her at times and felt during those times she felt like the staff should have provided her with more dignity. On 1/09/25 at 9:12 AM Staff B, LPN/Infection Preventionist (IP) nurse manager/Staff Development Coordinator stated the chain of command for a CNA to report was to report to the nurse, then the nurse should report it to the nurse manager and then the nurse manager would report that to the DON. Staff B stated she was not aware of an incident between Resident #8 and Staff H and the incident had not been reported to her. Staff B stated usually if a staff makes a negative comment the management is made aware of the incident. Staff B stated if a nurse was notified the nurse should have taken any concerns to some sort of management team. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Boulevard Council Bluffs, IA 51503

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy dated 10/21/22 documented abuse, neglect and exploitation of residents and misappropriation of resident property is prohibited. Such allegations will be investigated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Boulevard Council Bluffs, IA 51503

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on clinical record review, staff interviews and policy review the facility failed to follow professional standards of quality for 2 of 4 residents reviewed. Resident #172 had a low blood glucose reading, staff failed to document the reading and failed to follow up with a second check. Resident #9 had low blood pressure readings and staff failed to establish parameters to determine when to hold his hypertension medication. The facility reported a census of 22 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #172 had a Brief Interview for Mental Status score of 14 (intact cognitive ability). She was totally dependent on staff for toileting hygiene, showers, and partial assistance with sit to stand and transfers. She was on pain medications, the MDS showed that she was not assessed for frequency or intensity. A Baseline Care Plan Summary, dated 12/3/24, showed that Resident #172 was admitted for skilled care after a hospitalization for extradural and subdural abscess drainage and sepsis with intravenous antibiotics. She had diagnosis that included: diabetes mellitus, neuropathy and osteomyelitis. Nursing was to manage vital signs, pain, blood sugars, cardiac and respiratory status and antibiotic for epidural abscess. According to the Medication Administration Record (MAR) Resident #172 had an order dated 12/2/24 at 5:16 PM, for Humalog insulin 8 units in the morning for diabetes. The MAR showed that the medication was held that morning with a note see nurse notes. The Progress Note dated 12/5/24 at 8:10 AM showed that the morning insulin was not given because the blood sugar reading was too low, OJ (orange juice) given. The chart lacked documentation of what that number was or that there was a follow up blood glucose check. The Progress Note showed that at 10:04 AM on 12/5/24, the resident was given pain medication, and at 12:00 PM the resident left the facility Against Medical Advice (AMA). On 1/8/24 at 12:40 PM, Staff B, Licensed Practical Nurse (LPN) said that she remembered that the insulin for Resident #172 had been held on the day that she was discharged but she didn't remember exactly what the number was. She said that it would have been documented. Staff B said that the Certified Medication Aide (CMA) that was working that day would have been the one that took it and followed up. Staff B looked at the resident's chart and verified that this information was missing. On 1/9/25 at 10:00 AM, the Director of Nursing (DON) said if a resident had a low blood sugar reading, staff should have checked it again, documented, given the resident some glucose and then followed up with another check in 15 minutes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Boulevard Council Bluffs, IA 51503

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled: Hypoglycemia (low blood glucose) last reviewed on 9/28/2011 showed that hypoglycemia should be treated promptly, with fast acting carbohydrates, then repeat finger stick in 15 minutes after the first item was given. Repeat the accu-check every 15 minutes times one hour. If the blood sugar remained less than 70mg/dl (milligrams per deciliter) the physician must be called. 2) According to the MDS dated [DATE], Resident #9 had a BIMS score of 15 (intact cognitive ability). He was totally dependent on staff for toileting hygiene, and required some assistance with sit to standing, transfers and walking. His diagnosis included heart failure, orthostatic hypotension, hypertension and atrial fibrillation. The Care Plan reviewed on 12/8/24, showed that Resident #9 had diabetes mellitus and was at risk for falls. Staff were to increase assistance if the resident appeared weak. The resident was on analgesic medication related to chronic pain and anti-anxiety medication related to anxiety, staff were to monitor for effectiveness and side effects. The Care Plan lacked a focus area for hypertension or monitoring for side effects of hypertensive medication. According to the American Medical Association New BP (Blood Pressure) guidelines, published [DATE] retrieved on 1/9/25 at 12:23 PM from: New BP guideline: 5 things physicians should know | American Medical Association, Normal BP systolic (top number) less than 120 and diastolic (bottom number) less than 80. Elevated 120-129 and less than 80 The following blood pressures were documented in the Vitals Tab and the MAR showed that hypertension medication was given to Resident #9 without having taken a follow up BP: a. 12/7/24; 98/53 b. 12/11/24; 94/34 c. 12/20/24; 98/45 d. 12/21/24; 98/38 e. 12/25/24; 99/41 f. 12/30/24; 92/31 g. 1/1/25; 114/50 h. 1/3/25; 118/59 i. 1/4/25; 112/57 j. 1/5/25; 117/47 k. 1/6/25; 114/53 l. 1/7/25; 120/48 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Boulevard Council Bluffs, IA 51503

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	m. 1/8/25; 111/53 On 1/07/25 at 8:03 AM, Staff C, Certified Medication Aide (CMA) said that there would be parameters entered in the computer to hold the medication for abnormal blood pressures, and that the blood pressure machine would alert them if it was extremely low. She said that if the blood pressure was less than 90/40 she would notify the nurse. On 1/7/25 at 8:20 AM, Staff D, Registered Nurse (RN) said that she would want to be notified if/when a blood pressure was below 90/50. Staff D said that Resident #9 frequently had low blood pressures but did not have parameters set to hold the hypertension medication. On 1/8/24 at 12:40 PM, Staff B agreed that 38 was a low diastolic number. She was not aware of specific facility policy on BP parameters and when to hold the medication, they just use nursing judgement. On 1/08/25 at 1:22 PM, the Medical Director said that he uses standard parameters to hold the hypertension medication if the systolic number was less than 100 and the diastolic was less than 60. On 1/9/25 at 10:00 AM, the DON agreed that Resident #9 has had some very low blood pressures and some of the nurses would hold the medication while others would go ahead and give it without parameters established. She said that when the BP medication was changed for Resident #9, there were parameters established, but it didn't get transferred over onto the MAR. On 1/09/25 at 12:16 PM, the Administrator said they did not have a policy on BP parameters and they follow professional standards.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Boulevard Council Bluffs, IA 51503

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on interviews with facility staff and healthcare services, policy and record review the facility failed to ensure that follow up services and appointments were established before discharge for 1 of 3 residents reviewed. Resident #173 was discharged to a hotel without securing home health services or follow up appointments with the doctor. The facility reported a census of 22 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE] Resident #173 had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive ability). He required partial assistance with showers or bath, supervision or touch assistance with toileting hygiene, dressing and applying footwear and transfers. The diagnosis for Resident #173 included orthostatic hypotension, type 2 diabetes mellitus and chronic kidney disease. The Admission Note dated 12/3/24 at 12:32 PM, showed that Resident #173 was admitted to the facility for Physical Therapy and Occupational Therapy (PT/OT), and orthostatic hypotension (low blood pressure). He did not have any personal items upon admission. He was in need for assistance with planning regular task, such as shopping or remembering to take his medications. The Social Services (SS) Note dated 12/3/24 at 2:26 PM, showed that the discharge plan would be for the resident to return home with Home Health services. The Nursing Note dated 12/11/24 at 4:04 PM, showed that Resident #173 had 2+ to 3+ edema (severity of edema is graded on a scale of 1 to 4 based on how deep the pits are and how long they last after you press the swollen area. The grade of 3+ is deep pitting) to the Bilateral Lower extremities. The orders tab showed that the resident had an order for Ace wraps (elastic bandage used to control swelling) to his feet and legs daily for edema. The Discharge Plan (DP), dated 12/16/24 at 8:33 AM, Section A showed that Resident #173 had met goals and the physician agreed that his needs could be safely met in a lower health setting. Section B of the DP indicated that the resident used a walker for ambulation and the resident stated that he felt scared and nervous about the discharge. Section C titled: Community Services, included the name and phone number of the Primary Care Physician (PCP) and Home Health (HH) service. Section E; Follow up Appointments, lacked documentation of appointments arranged by the facility. On 1/6/25 at 12:33 PM, the PCP for Resident #173 said that the resident had contacted her office on 12/27/24 and said that he had been locked out of his house so he couldn't get the supplies that he needed to manage his diabetes. He told her that he was discharged from the nursing home to a hotel and he was concerned because his legs and feet were very swollen. He didn't know what to do and he had been waiting for her office to call him for an appointment. Resident #173 said that he didn't have the compression devices for his legs and he was having trouble programming the pump for his diabetes management. The PC followed up and called the facility to get his discharge paperwork, but as of 1/6/25, it hadn't been sent to her office. On 1/6/25 at 12:40PM, the cell phone number for Resident #173 was not in service. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Boulevard Council Bluffs, IA 51503

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/07/25 at 2:12 PM, the Social Worker (SW) said that Resident #173 had been locked out of his mom's home, where he had been living before his admission to the hospital. She said that he did not have any other family support and he wasn't appropriate for a homeless shelter so she arranged for him to go to a hotel. She said that a homeless shelter would not have accepted him because of his health needs related to his edema and diabetes. The SW said that she tried to call the resident after discharge to follow up, but he did not answer the call. SW said that she called the PCP office to get him an appointment but she was told that they couldn't set up an appointment because they didn't accept his insurance. She said that she didn't have an alternative for a doctor appointment for him. The SW said that she had called three different home health agencies and two out of the three would not take his insurance so she arranged for the third (HH3) to provide services. She thought that they would have made contact with the resident at this point and were working with him. On 1/7/24 at 2:21 PM, a representative with HH3 said that she had just gotten a phone call from SW this morning. She said that the facility had sent a referral to them back in December, but they were not able to accept him at that time. The SW told her today that HH service had been set up with another agency but they dropped the ball so she was wondering if HH3 could accept the resident. The representative told her that they could work with Resident #173 and they did accept his insurance, but it would take some time to do the paper work before they could actually go out to see him. Back in December, they had only received a face sheet. On 1/7/24 at 2:31 PM, a representative at the clinic of the PCP checked and verified that they did accept the insurance for Resident #173. She could not find any notation that the facility had tried to arrange for a follow up appointment for the resident at discharge. She said that there was a note that Resident #173 had called the clinic yesterday to let them know that he was out of the hospital now. And he wanted to set up an appointment. On 1/9/24 at 10:00 AM, the Director of Nursing (DON) said that she had gotten the medication list to the pharmacy for Resident #173 on the day that he was discharged and a friend of the resident picked them up at the pharmacy. She said that she was only involved in that portion of the discharge and the SW would have taken care of the follow up appointments and services for the residents. On 1/09/25 at 11:02 AM, the Administrator said that it was her understanding that HH had been set up for Resident #173 before he was discharged . She thought that there was probably just a misunderstanding with the appointment with the PCP. The Discharge plan/Recapitulation of Stay dated 12/16/24 at 8:33 AM, showed that after documents had been signed and dated, staff were to make a copy and fax copy to resident's community physician, Home Care referral. A facility policy titled: Discharge Summary and Plan of Care, revised on 2/13/17, showed that appropriate discharge planning and communication of necessary information would be provided to the continuing care provider. A post discharge plan of care would be developed with the resident and representative, which would assist the resident to adjust to his new living environment. The plan would indicate where the individual planned to reside and any follow up care and post discharge medical and non-medical services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Boulevard Council Bluffs, IA 51503

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on staff interviews, clinical record review and policy review the facility failed to assess pain and failed to complete vitals and complete a comprehensive assessment prior to transfer out for 1 of 4 residents reviewed. Resident #171 experienced severe pain related to a fracture and staff failed to assess pain levels, administer pain medication and notify the physician per the plan of care. The facility reported a census of 22 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #171 documented a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment. The MDS documented the resident received scheduled and PRN (as needed) pain medications and experienced pain frequently. The MDS documented the resident limited participation in therapy and day to day activities frequently. She rated her pain at an 8 on a scale of 0-10 with 10 being the worse. The MDS listed diagnosis of lumbar vertebrae fractures and other multiple trauma, and arthritis. The Care Plan for Resident #171 documented the resident is on analgesic medication therapy for pain and has pain in her back and legs. The Care Plan documented a goal the resident will verbalize adequate pain control. The Care Plan directed staff as follows: -Administer pain medications as ordered. -Monitor effectiveness of medication. -Ask the resident what non-medication pain relief methods have helped in the past and attempt to utilize these strategies. -Notify physician if pain management interventions are unsuccessful. Review of Resident #171's Medication Administration Record (MAR) for November 2024 documented the following physician's order for pain: -Lidocaine external patch 4% apply to the back in the morning and at bedtime for pain. -Meloxicam 15mg 1 tablet by mouth in the morning for arthritis. -Acetaminophen 500mg give 2 tablets by mouth 3 times a day for pain at 8am, 2pm and 8pm. -Tylenol 325mg give 2 tablets by mouth every 4 hours as needed for pain or fever. -Cyclobenzaprine Hcl 10mg give 1 tablet by mouth every 8 hours as needed for muscle spasms. -Oxycodone 5mg give 1 tablet by mouth every 24 hours as needed. The MAR for November 2024 revealed the following tapering dose of Oxycodone for Resident #171: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Boulevard Council Bluffs, IA 51503

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	-Oxycodone 10 mg every 4 hours 11/5/24 to 11/12/24 then to, -Oxycodone 5 mg every 6 hours as needed for pain 11/12/24 to 11/14/24 then to, -Oxycodone 5 mg every 24 hours as needed for pain for 3 days 11/14/24 to 11/17/24. The MAR revealed the resident took Oxycodone 2-3 times per day through 11/13/24 and then utilized it once a day through 11/16/24. She rated her pain at an 8 with the last dose and it was documented as effective at 7:41 PM. Oxycodone was not utilized on 11/17/24 despite having an order for it. The MAR for November 2024 revealed the resident received Tylenol 650mg on 11/18/24 and it was documented as effective at 4:15 AM but lacked a rating of pain. The resident did not receive any PRN pain medication on 11/17/24. The MAR revealed the resident received Cyclobenzaprine 10mg one tablet on 11/18/24 and it was documented as effective at 4::15 AM but lacked a rating of pain. Review of Resident #171's EHR documented no assessment on 11/18/24 completed by Staff I Licensed Practical Nurse (LPN) for pain. The Progress Notes for Resident #171's documented the following: -On 11/5/24 at 3:58 PM the resident admitted from the hospital following lumbar surgery. She rated her pain at 9 on a scale of 0-10 with 10 being the worst. -On 11/14/24 at 11:54 AM returned from appointment with physician with new orders to decrease frequency of oxycodone to 1 tablet as bedtime PRN. -The Progress Notes revealed several entries daily to include the resident receiving pain medication several times per day from admission thru 11/16/24 at 8:14 PM. -On 11/17/24 at 11:10 AM the record revealed a skilled note documented. The resident pain assessed at a 0 but the note documented the resident alert and confused. Not able to make needs known. Tolerating medications appropriately. Resident screaming out in pain throughout day but was managed through pharmacological techniques. -The Progress Notes lacked any other documentation on 11/17/24 including a lack of pain assessments, and a lack of vitals. -On 11/18/24 the Progress Notes revealed the resident received Tylenol and Cyclobenzaprine at 4:15 AM for right hip pain. The note lacked a rating of pain or any other assessment. -On 11/18/24 at 9:38 AM per request of doctor since pain is not under control being sent to the emergency department. The husband and son at facility and agreed. The InterAct Hospital Transfer Form dated 11/18/24 documented a pain scale level of 9 at 6:43 AM. On 1/7/25 at 3:10 PM Staff I, Licensed Practical Nurse (LPN) stated she contacted the doctor and he stated if Resident #171's family wanted her transferred to the ER then she should be sent. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Boulevard Council Bluffs, IA 51503

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	On 1/7/25 at 4:16 PM the DON stated Resident #171 was sent to theER on [DATE] related to uncontrollable pain. The DON stated Resident #171 was complaining of pain and the staff were changing Resident #171 when the family arrived at the facility. The DON stated she did not speak to the family she thought it was the Administrator or Staff J. The DON stated she was not present and could not speak to what occurred. On 1/7/25 at 4:33 PM Staff J Registered Nurse (RN) stated Resident #171 was sent to the ER for uncontrolled pain. On 1/8/25 at 9:30 AM Staff G Certified Nurse Assistant (CNA) stated she was familiar with Resident #171. Staff G stated she cared for Resident #171 while she was at the facility and cared for her on 11/18/24. The aide stated getting Resident #171 out of bed and assisting getting legs off the side of the bed would cause her pain. Staff G stated she reported the pain to the nurse when Resident #171 was in pain. Staff G stated the nurse would complete an assessment and pain medication would be administered. Staff G stated Resident #171's was better after pain medication was given. Staff G stated Resident #171 was sent out 11/18/24 related to the pain. Staff G stated Resident #171 had complaints of pain first thing in the morning on 11/18/24. Staff G stated 11/18/24 Resident #171 was very confused and was tearing her briefs off. Staff G stated she tried to get Resident #171 up and she was screaming so she laid her back down. Staff G stated Resident #171 continued to pull her briefs off and changed her sheets 2 or 3 times. On 1/9/25 at 8:35 AM the DON acknowledged no assessment was completed related to the Resident #171's pain on 11/18/24. The DON stated she would have called the doctor prior or given her as needed (PRN) medication. The DON stated she would have expected an assessment to have been completed on Resident #171 related to the reported pain. The DON stated on the transfer document in the EHR that pain was documented at a 9. The DON stated the pain level of 9 was determined 6:43 on 11/18/24. The DON stated her expectation was a PRN pain medication would have been given or a physician would have been called when staff and therapy were unable to get Resident 171 out of bed that morning. On 1/9/25 at 10:01 AM Staff I, LPN stated she did not recall if she completed an assessment. Staff I stated the standard was to obtain vitals and a morning assessment each morning. Staff I stated she believed it was passed on to her that Resident #171 was in pain by the CNA and the therapy department. Staff I stated if she remembered right Resident #171 was in pain in some moments and at times was not. Staff I stated she was not sure if Resident #171 was having actual pain this day or it was a behavior. Staff I stated she was at the facility at 6:00 AM and received a nursing report until 6:30 AM. Staff I stated both the therapy department and the CNA reported at the same time that Resident #171 had pain. Staff I stated she walked by and asked Resident #171 if she was in pain and Resident #171 said she felt fine. Staff I stated she remembered Staff G reporting to her again that Resident #171 was in pain or wanted out of the facility after Resident #171 said she felt fine. Staff I stated she was not told prior to entering the room that Resident #171 was in pain. Staff I stated she would have assessed immediately if she was told. Staff I stated she tried to complete an assessment and Resident #171 was not allowing her to complete the assessment. Staff I stated earlier she had helped Staff G move Resident #171 up in bed and asked her if that caused pain. Staff I stated Resident #171 said no it did not cause any pain. Staff I stated she did not remember if she offered Resident #171 a PRN pain medication. Staff I stated if she had the time and opportunity she would have charted the assessment. Staff I stated she did not remember if she completed an assessment on Resident #171 that day or not. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Boulevard Council Bluffs, IA 51503

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	Review of the policy revised 6/19/19 titled, Pain Management documented the purpose is to accomplish an effective pain assessment and management program; providing residents the means to receive necessary comfort. Physician involvement is to notify the physician with new onset, worsening intensity and absence of effective pain and/or side effect interventions. Nursing responsibilities are when pain is identified, the nurse will implement the resident plan of care appropriate management using pharmacological and/or non-pharmacological interventions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Boulevard Council Bluffs, IA 51503

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 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** 47673 Based on clinical record review, observations, policy review, and staff interviews the facility failed to provide appropriate infection prevention practices when providing personal care and providing catheter care to a resident that was on Enhanced Barrier Precautions (EBP) for 2 of 3 residents reviewed (Resident #2 and #180). The facility reported a census of 22 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #2 documented a Brief Interview for Mental Status (BIMS) score of 00 indicating severe cognitive impairment. The MDS documented the utilization of an indwelling catheter. Review of Resident #2's Medication Administration Record revealed a physician's order to change 16 FR 10cc monthly and change drainage bag at bedtime every 30 days for infection control. Review of Resident #2's MDS dated [DATE] documented utilization of indwelling catheter. On 1/7/25 at 10:09 AM Staff K, Certified Nurse Assistant (CNA) entered Resident #2's room applied gown, rolled sleeves up on gown, completed hand hygiene and applied gloves. Staff K completed catheter care on Resident #2. Staff K removed the gown, removed gloves and completed hand hygiene. Staff K stated anytime she completed catheter care a gown must be worn with gloves. On 1/7/25 at 1:51 PM the Director of Nursing (DON) stated the facility's expectation was the gown would have been worn with the sleeves down over the wrist during catheter cares On 1/7/25 at 1:00 PM the Administrator stated the facility's expectation was the sleeve of the gown would be down over the wrist during catheter care. Review of undated procedure titled, Sequence for putting on Personal Protective Equipment (PPE) Gown should fully cover torso from neck to knees, arms to end of wrists, and wrap around the back. Fasten the back of neck and waist. Centers for Disease Control and Prevention website titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), visited 7/11/24 and updated 7/12/22 revealed recent changes included, additional rationale for the use of Enhanced Barrier Precautions (EBP) in nursing homes, including the high prevalence of multidrug-resistant organism (MDRO) colonization among residents in this setting. Expanded residents for whom EBP applies to include any resident with an indwelling medical device or wound (regardless of MDRO colonization or infection status). Expanded MDROs for which EBP applies. Clarified that, in the majority of situations, EBP are to be continued for the duration of a resident's admission. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status and Infection or colonization with an MDRO. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Boulevard Council Bluffs, IA 51503

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The MDS dated for completion 1/10/25 for Resident #180 documented a BIMS score of 10 indicating moderate cognitive impairment. Review or Resident 180's Care Plan documented Resident #180 had an infection of the lungs and to use droplet precautions developed 1/5/25. Review of Resident #180's Progress Notes documented by Staff M, Licensed Practical Nurse (LPN) on 1-5-24 revealed reason for admission to hospital Positive for influenza A with infection present during admission to the facility. On 1/6/25 at 3:03 PM observation of drawers outside of Resident #180's room revealed no eye protection and no signs documenting contact precautions. On 1/6/25 at 3:43 PM Staff L, Registered Nurse (RN) stated Resident #180 was in contact and droplet precautions. The RN stated does not use N95. On 1/7/25 at 12:41 PM Staff B, Licensed Practical Nurse LPN IP / Long term care manager and Staff Development Coordinator stated Resident #180 should have been in droplet and contact precautions. Staff B stated staff are notified of the need to wear Personal Protective Equipment (PPE) by drawers and signs outside the door of the resident's room. Staff B stated staff should have had face shields or goggles for droplet precautions when entering Resident #180 ' s room. Staff B stated the charge nurse should have hung the signs and obtained the appropriate PPE for staff to wear. On 1/7/25 at 1:55 PM the DON stated Staff B determined when Resident #180 would come out of precautions. The DON stated Resident #180 was on droplet and contact precautions. The DON stated a mask, gloves, gown and eye wear should have been worn when in Resident #180's room. On 1/7/25 at 2:10 PM Staff L, Registered Nurse (RN) stated she cared for Resident #180 on 1/6/25. Staff L stated Resident #180 was on droplet precautions on 1/6/25. Staff L stated she spoke to Staff J about Resident #180 1/6/25 and was told Resident #180 was in isolation. Staff L stated she did not wear a face shield, only wore a mask, gloves and a gown during interactions with Resident #180 on 1/6/25. Staff L stated Resident #180 continued to have s/s of infection on 1/8/25. Staff L stated Resident #180 had an occasional cough present when she entered the room. Staff L acknowledged there was no signage on the door revealing isolation precautions. Staff L stated with a resident on droplet precautions eye protection should have been worn. On 1/7/25 at 2:30 PM Staff C, Certified Medication Assistant (CMA) acknowledged she cared for Resident #180 on 1/6/25. Staff C stated on 1/6/25 Resident #180 was in contact precautions. Staff C acknowledged she was supposed to wear gloves, facemask and gown because Resident #180 had the drawers outside of her room. Staff C stated she was told in the report Resident 180 was in isolation. Staff C stated it was not reported to her that Resident #180 was in droplet precautions. Staff C stated she did not wear eye protection when caring for Resident #180 on 1/7/25. Staff C stated there was not eye protection available in the drawer outside of Resident #180's room. Review of Droplet Precautions sign documented everyone must make sure their eyes, nose, mouth are fully covered before entering the room and to remove face protection before room exit.