

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165466	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2025
NAME OF PROVIDER OR SUPPLIER  Chapters Living of Council Bluffs		STREET ADDRESS, CITY, STATE, ZIP CODE  3000 Risen Son Blvd 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, family and staff interviews, the facility failed to maintain a clean environment for residents. The facility reported a census of 26 residents.</p> <p>Findings include:</p> <p>Observations on 6/3/2025 at 10:30 AM the area between the set of exit doors by room [ROOM NUMBER], revealed multiple dead June bugs on the floor. Continued observations on 6/4/2025, 6/5/2025, and 6/10/2025 revealed the area to still have multiple dead June bugs on the floor.</p> <p>On 6/4/2025 at 10:15 AM a family member of Resident #4, stated housekeeping has not been in her room since she has been admitted . One family member stated she has been picking up the debris on the floor in her mother's room and bathroom.</p> <p>On 6/4/25 at 10:45 AM the Director of Nursing was made aware of Resident #4's concern about the lack of cleaning to her room.</p> <p>On 6/5/2025 during a follow-up interview with Resident #4 and her family, they were informed the DON was made aware of their housekeeping concerns. The family indicated housekeeping still had not been in the room. The family pointed out white debris by the resident's recliner and observed a white spot on the floor under a set of chairs across from the resident's bed. In the bathroom the toilet had a textured, brown stain at the toilet bowl down to the base of the toilet. At 12:51 PM the DON was made aware of the condition of the toilet, and the room remaining to need housekeeping's attention. During a follow up observation at 1:40 PM Resident #4's was still in need of housekeeping's attention. The floor continued to contain white debris by her recliner and the white spot remained present under the set of chairs across from the resident's bed.</p> <p>On 6/10/2025 at 1:09 PM the Skilled Unit Manager/Assistant Director of Nursing stated housekeeping is to clean resident's rooms and bathrooms every day. She added they usually have two housekeepers in the building but at times they will work with one housekeeper. She denied receiving concerns from residents about the cleanliness of their rooms and bathrooms.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review, facility investigative file review, staff and family interviews the facility failed to report to the State Agency, when Resident #3 reported staff were rude to her and threw her call light out of reach. The investigation included three resident reviews. The facility reported a census of 26 residents.</p> <p>Findings include:</p> <p>According to an admission Minimum Data Set (MDS) reference tool with an assessment date of 3/14/2025 Resident #3 had a Brief Interview of Mental Status score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented Resident #3 required substantial/maximal assistance of staff for toileting hygiene and was dependent on staff for transfers to the toilet. The MDS indicated she was occasionally incontinent of urine and frequently incontinent of bowel. The following diagnoses were listed for Resident #3: stroke, atrial fibrillation, coronary artery disease, heart failure, thyroid disorder, and sleep apnea.</p> <p>The Care Plan focus area with an initiation date of 3/10/2025 documented Resident #3 needed assistance with Activities of Daily Living (ADLs). Resident #3 required the assistance of 1 staff for bed mobility and the assistance of two staff for toilet transfers.</p> <p>The Director of Nursing (DON) provided a folder with the following report:</p> <p>-On 4/9/2025 the DON was asked to speak with Resident #3 regarding a complaint that she had regarding a night shift Certified Nursing Assistant (CNA). She went and spoke with the resident; her son was present. When asked what happened, Resident #3 stated Staff F came in to her room during the night to take her off the bedpan. In doing so she spilled the bedpan on the bed. Resident #3 went on to say that she asked Staff F if she spilled the bedpan and she stated she did not, but had wet washcloths lying there. Resident #3 stated Staff F was rude to her and stated she was on her call light too much, then tossed the call light over the chair. The resident stated Staff F left the room but did come back to change her sheets, and put the call light back on the bed at that time. Resident #3 requested that Staff F not be allowed back in her room. Resident #3 denied wanting to put in a formal complaint or grievance, she stated she just did not want Staff F in her room. The DON reassured Resident #3 that Staff F would not be allowed to be in her room, and if Staff F was working the nurse on duty would be the one to come and assist her with her needs. Resident #3 was happy with this.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The DON messaged Staff F and asked her to call. She had a phone conversation with Staff F regarding resident rights, expectations of care, and communication with residents. Staff F stated that yes she did move the call light but it was to change the sheets. The DON educated her that even though she left the room to gather more supplies that the resident is to always have the call light within reach; she stated she understood. When asked about the spilled the bedpan, Staff F stated she had wet washcloths lying on the bed. She was educated about infection control, the proper way of handling bedding and cleansing cloths are to be in a bag or barrier in place. Staff F stated she understood. She was also educated on communication with residents as well as the expectations of providing care to them. She stated she understood and she believed it was a misunderstanding between her and Resident #3. Staff F was education that it is the staff's job to ensure that the residents are being provided the proper care and that she would need to remain out of Resident #3's room. The nurse will go provide the necessary care. Staff F stated she understood. Staff G, Previous Administrator was informed of the incident; she was in agreement with the education provided to Staff F and asked her to remain out of the room allowing nurses to provide cares.</p> <p>-On 5/9/2025 the DON went and spoke with Resident #3 regarding her concerns a month ago about Staff F. The resident stated everything has been going well, that staff have been doing a good job. She had no concerns at this time and has been happy with the cares she is being provided here. There have been no further complaints regarding Staff F from any residents regarding cares.</p> <p>On 6/4/2025 at 12:35 PM the DON was asked if there were any concerns reported to her about Staff F. She indicated there was one concern from Resident #3. She completed an investigation and found that there was a miscommunication between Staff F and Resident #3. Staff F acknowledged she put Resident #3's call light out of reach but not purposely or intentional. She followed up with Resident #3; she was happy with the response and had no further complaints.</p> <p>On 6/4/2025 at 1:26 PM Resident #3's Son (emergency contact #1) stated his mom had a stroke and was admitted to the facility for rehabilitation services. She told him she had to go to the bathroom and Staff F assisted her on to the bedpan. When she removed the bedpan, Resident #3 reported, Staff F dumped the bedpan on the bed. When she questioned Staff F about it, she told Resident #3 that it was her imagination and it was nothing. His mom told him her bed was wet and she told Staff F this as well. His mom reported Staff F took her call light away that night; through it over the chair in her room. Staff F then went on to say she was crazy and was not wet. A nurse came in and took care of her the rest of the night. His mom had requested that Staff F no longer take care of her. His mom reported to him that Staff F was rude to her and told her she was on her call light too much.</p> <p>On 6/4/2025 at 1:39 PM Staff G, Previous Administrator stated she remembered the DON had written Staff F up, or investigated her not too long before she left the facility. She was unsure exactly what it was about. The investigation summary as read to her and reported the DON did not inform her about the entirety of the situation. She indicated Resident #3's son was here every day, would bring her in lunch and dinner. When asked if this should have been reported, she stated she would have reported this to the State Agency had she known the entire story.</p> <p>On 6/5/2025 at 10:19 AM during a follow-up interview, the DON was asked if this should have been reported to the State Agency. She stated Staff G was the Abuse Coordinator at that time. The DON was informed that Staff G indicated she was not made fully aware of the situation and she would have reported the allegation had she known. The DON stated that is disheartening because she was aware of the concerns from Resident #3.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/10/2025 at 1:09 PM the Skilled Unit Manager/Assistant Director of Nursing (ADON) stated she was not aware this alleged incident was not reported to the State Agency, she was not involved in the investigation and assumed they had reported it. She added since the new company has taken over, Corporate has been directing them to report everything. She acknowledged this should have been reported. At 3:25 PM she indicated she was unable to get into the program the previous owners used to obtain policies. She went through the binders they have and could not find a policy the facility would follow in regards to the concerns identified during the survey.</p> <p>On 6/10/2025 at 3:58 PM corporate staff were asked to provide policies they would be implementing at the facility since taking over the facility. A list of policies was sent to the corporate staff at 5:00 PM. As of 6/13/2025, corporate staff had not emailed the requested policies.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, facility investigative file review, staff and family interviews the facility failed to thoroughly investigate when Resident #3 reported staff was rude to her and removed her call light out of reach. The facility also failed to complete a thorough investigation when Resident #4 reported staff were mean to her. Three residents were reviewed related to this investigation. The facility reported a census of 26 residents.</p> <p>Findings include:</p> <p>1. According to an admission Minimum Data Set (MDS) reference tool with an assessment date of 3/14/2025 Resident #3 had a Brief Interview of Mental Status score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented Resident #3 required substantial/maximal assistance of staff for toileting hygiene and was dependent on staff for transfers to the toilet. The MDS indicated she was occasionally incontinent of urine and frequently incontinent of bowel. The following diagnoses were listed for Resident #3: stroke, atrial fibrillation, coronary artery disease, heart failure, thyroid disorder, and sleep apnea.</p> <p>The Care Plan focus area with an initiation date of 3/10/2025 documented Resident #3 needed assistance with Activities of Daily Living (ADLs). Resident #3 required the assistance of 1 staff for bed mobility and the assistance of two staff for toilet transfers.</p> <p>The Director of Nursing (DON) provided a folder with the following report:</p> <p>-On 4/9/2025 the DON was asked to speak with Resident #3 regarding a complaint that she had regarding a night shift Certified Nursing Assistant (CNA). She went and spoke with the resident; her song was present. When asked what happened, Resident #3 stated Staff F came in to her room during the night to take her off the bedpan. In doing so she spilled the bedpan on the bed. Resident #3 went on to say that she asked Staff F, CNA if she spilled the bedpan and Staff F said she did not, but had wet washcloths lying there. Resident #3 stated Staff F was rude to her and stated she was on her call light too much, then tossed the call light over the chair. The resident stated Staff F left the room but did come back to change her sheets, and placed the call light back on the bed at that time. Resident #3 requested that Staff F not be allowed back in her room. Resident #3 denied wanting to put in a formal complaint or grievance, she stated no she just did not want Staff F in her room. The DON reassured Resident #3 that Staff F would not be allowed to be in her room and if Staff F was working the nurse on duty would be the one to come and assist her with her needs. Resident #3 was happy with this.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/5/2025 at 10:23 PM Staff I Previous Scheduler/Certified Medication Aide (CMA) stated when she went in to give Resident #3 her medication that morning of the alleged incident, the resident was acting off and that's when she reported to her the CNA the worked overnights did not need to be in her room anymore. She was very upset but this was not the first time it had happened with Staff F. Staff I went to the DON and Staff G about what Resident #3 had said. Resident #3 reported to the DON that Staff F told her to stop using her call light, she was not the only person she was taking care of, then moved her call light. The DON told Staff I that Staff F was not allowed to be in Resident #3's room and that's all she was told and that's all that happened. No one asked her to make a statement.</p> <p>On 6/5/2025 at 12:57 PM Staff H CNA stated it was not just Resident #3 that had issues with Staff F. There have been issues with Resident #3 and cognitively impairment residents. The nurse's on duty have been made aware. Resident #3 told her Staff F took her call light away. She does not see Resident #3 just saying something like that. The resident told her she was on the bedpan and it dumped in her bed. When she told Staff F about this, she told her it was nothing but Resident #3 was sure it was wet from her urine. Staff F told her she was not going to change her bed, because she was just on her call light at 5:30 AM and Staff F gets off at 6:00 AM. Staff F is good when other staff are around but does not do her job when no one is around. Staff H indicated no one has talked to her about these concerns.</p> <p>On 6/5/2025 at 2:58 PM Staff F, CNA stated the night in question she was working with a nurse that would not help her. They were in the middle of sending someone out to the hospital, Resident #3 had her call light on, wanted to be changed, she put her on the bedpan and left the room. Resident #3 used her call again, she assisted with taking her off the bed pan, and changed her bedding. As she was about to go to another room to assist with transferring a resident to the stretcher, Resident #3 used her call light again, she went and said she will be with her as she was in the middle of sending someone out to the hospital or something like that. That's when Resident #3 threw water at her. It was reported Resident #3 told the DON she hid the resident's call light. The resident stated her pad was wet, it wasn't so she changed it anyway's. Staff F stated she always pinned Resident #3's call light to her blanket. She indicated she got a text from the DON on 4/9/2025 asking about what happened. She could not remember what was said. The summary provided by the DON was read to her and she stated she moved the call light while she was assisting the resident with using the bedpan, but gave it back to her after that. When asked why the resident's bed was wet, she stated it was from the wipes, not wet from urine like the resident thought it was. She was not asked to write a statement but was asked to not go in Resident #3's room.</p> <p>2. The Kardex Report for Resident #4 documented the resident had been admitted to the facility on [DATE].</p> <p>The Care Plan focus area with an initiation date of 5/30/2025 documented Resident #4 required the assistance of two staff and gait belt for a stand pivot transfer.</p> <p>The facility provided the following report, completed by the DON, dated 5/31/2025:</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-At 2:00 PM the DON was asked to speak with Resident #4's children/family regarding some statements that their mother had made. In talking with them they informed me that she stated that she didn't sleep very well and had stated that the night shift staff were not very nice to her per Resident #4. They went on to say that they apologized to all the staff for their mothers' statements and being difficult to take care of since she was admitted yesterday on the 30th. They asked me questions about her medications that she was prescribed from the hospital and the Urinary Tract Infection that she had if that could be a possible reason she is acting this way or having behaviors. I did explain to them that yes sometimes in the elderly a Urinary Tract Infection can at times make them act out of their normal cognitive baseline. They also asked about her narcotic pain medications and if there was something different that she could take because they believe that all she received in the hospital was Tylenol. I did reassure them that yes, I would reach out to either the physician or her Nurse Practitioner (NP) and ask them to please review her medications and advise any changes. They were all appreciative of that. Resident #4's family continued to say that she is very opinionated and can be extremely difficult to deal with, that she has not believed things that they have been telling her and has been acting out of her normal. They again apologized for their mother stating things such as the staff were mean to her because they fully believe that it never happened. I asked them why they don't believe it happened, they stated that it's because she just wants to go home and doesn't want to be in rehab so she is coming up with all kinds of reasons to leave. She has made numerous statements that she was leaving and going to walk home to her son's house. They stated that they have explained it to her numerous times why she needs to be in rehab after her fall and broken arm so that she can get strong again, get back to her normal once she is able to go home. They had said their mother has argued with them all the way about leaving. I did let them know that we would place a wander guard on their mother for safety and that I would have two staff members present at all times when caring for their mother; they agreed and were happy with this.</p> <p>-The DON went into Resident #4's room along with her 4 children and asked how she was doing. She stated well, not very well. I asked her why she wasn't doing very well and she stated that she was leaving and going home and getting the hell out of here. I asked her how her night went and she stated that she hasn't been sleeping well, she thought she was going to be able to go home and they brought her here. I reassured her that she was here for therapy, to get strong again so that when she returns home she will be at her previous functioning and be able to take care of herself again. Her daughter then stated that she said the same thing to her mother but her mother refuses to acknowledge any of this. Resident #4 then looked at her daughter and stated that her daughter was ridiculous. I asked her why her night was so bad and she said that the people out in the hallway are up past their bedtimes and they refused to go to bed. I educated her that those people are staff members and that when they are here they do not go to bed, that they are here to take care of all the residents throughout the night. She stated well that black man came in here, changed my pants and they were mean to me, I was scared for my life. I asked her how they were mean to her and she couldn't give me a reason. I asked her how she felt scared for her life, she shrugged her shoulders and shook her head then looked over at her daughter. I then educated Resident #4 that I do not have a black man that works here on nights and she shrugged her shoulders at me. She then stated, Well it doesn't matter because I'm going home even if I have to walk home. Then her daughter stated well mom that's the only way you're going home because all of us are not taking you because the doctor has to ok you to go home safely. The resident sat there and shook her head. I reassured the family that I would investigate things, I would reach out to the doctor or nurse practitioner regarding her medications, and they were thankful for that.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The DON reached out to Resident #4's provider and asked her to please review her medications, in addition to the concerns that were brought forward. Changes were made to her medications, changed her antibiotic as well as discontinuing her Oxycodone and continued with her Tylenol. Family is aware of the medications changes and were thankful that they were made. Resident #4 has been having paranoia about her medications and believing that the staff have been poisoning her. The nursing staff have started to take the medications from the pharmacy into her room and popping them out in front of her so that she can see that they are coming directly from the pharmacy and this has been successful for her to take her medications.</p> <p>-The DON, reached out to Staff J Certified Nursing Assistant (CNA) and spoke with her about her care that she provided the night of the 30th when Resident #4 was admitted , asked her how the night went. Staff J stated that the night went well and she didn't have any issues with her. She went on to say that she assisted her to get ready for bed and to the restroom and that the resident was kind throughout the process of getting ready for bed. I asked her if there were any issues or complaints from Resident #4 throughout the night and she stated that no she didn't have any issues. I asked her if the resident had any complaints of pain or discomfort or behaviors and she stated no, everything had been good and she didn't have any problems.</p> <p>-On Sunday June 1st, 2025, I &amp; name redacted RN DON, received a phone call from Resident #4's son stating that in talking to his mother again that she is adamant that a black male came into her room that night and was talking with the black male's mother. I again reassured him that I do not have any black males working the floor and he stated that he knows that it wasn't true but he just wanted me to know. I thanked him for his call.</p> <p>-The facilities findings were determined that no abuse had taken place, and the facility will continue to follow physician orders and update care plan as necessary.</p> <p>The report lacked other resident interviews, staff interviews that cared for the resident after the alleged incident and a follow up interview with Resident #4.</p> <p>The following Progress Notes were documented in Resident #4's record:</p> <p>a) On 5/31/2025 at 6:23 AM: Resident was not cooperative with staff. She was incontinent of bowel bladder and kicked staff as they provided care. Resident is on fall charting and during rounds resident was attempting to get of bed. When nurse asked what she wanted to do at 3:00 AM she just screamed at staff. Staff got her up, once she was up she began to yell she wanted to get back in bed. Resident will not keep sling on right upper extremity, she was not easily directed.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Chapters Living of Council Bluffs		STREET ADDRESS, CITY, STATE, ZIP CODE  3000 Risen Son Blvd Council Bluffs, IA 51503	
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b) On 5/31/2025 at 1:50 PM: at 8:20 AM Resident #4's family notified this morning about fall and resident's noncompliance with medications, going in and out of other resident's room; requiring 1:1. She was refusing to eat breakfast and/or take in fluids. Family states resident has never been like this before. Family was made aware that with a urinary tract infection (UTI) and new environment that may be the cause. Her family arrived at 9:30 AM and made this writer aware that resident is stating that a big black man came in her room during the night, ripped her brief off and was really rough with her. The family was informed that there was not a male CNA that took care of her and that the UTI may be causing confusion; family was understanding. The family requested to call the DON and report this themselves, DON notified. The DON spoke to her family and had a planned meeting at 2:00 PM per the family. Resident #4 sat with family most of the morning trying to give medications that she would not take from staff. Resident stated she didn't trust us. Family was unable to give her medications that was in the medication cup already. Although resident did agree to take some of her medications while watching family pop medications out of bubble packs. Family stated they were leaving and would be back at two to have a meeting with the DON about the above concerns. They wanted the resident laid down and family didn't want her to be bothered while they were gone. Resident #4 rested with eyes closed after being laid down, no attempts to get out of bed.</p> <p>On 6/4/2025 at 10:15 AM Resident #4 sat in a wheelchair in her room with three family members present. Resident #4 stated the first night she was in the building she was all alone. She was in bed, in the process of getting ready. One man in the facility. There were 3-4 young staff at night. The 1st time they came in there was a man with the girls. They went and got the head of the department. They took her up to the room by the office outside of her room (she is located close to the nurse's station where there's a room for staff to chart in). They did things that she was afraid of. When asked what happened she stated one staff member really upset her. That staff member came in said you are wet, took her clothes off then left. The staff got new clothes. There was a black lady in the room too, she looked at her as this staff member pulled her clothes off but she did not do anything. It's like what that staff was doing did not bother her. The person that took her clothes off and redressed her was a black man that wore street clothes. Family says no one at the facility wore a name badge so they don't know who they are. She indicated she had a cell phone in her drawer in the night stand. When she got scared she told the slim, black male she was going to call her daughter. The male took her phone and said she could not have it. They took it away until the next day. She is discharging from the facility because she does not feel safe here. The family stated they want her to feel safe, which is why they want to move her. They are hoping this will calm her behaviors while she goes through therapy.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/4/2025 at 3:30 PM Staff J, CNA stated the first night of Resident #4's stay she was very confused and focused on going home. She was very adamant about going home and not following safety concerns. Staff J denied being rough with Resident #4 during her interaction with her. Staff J stated the resident thought she was a man, she kept calling her a man or he (her voice did sound like a man's voice). Resident #4 would say she did not want him taking care of her. When she went in to Resident #4's room her bed was soaked and she needed to be changed, she became combative. Staff J had asked the nurse to come in; Staff K, Licensed Practical Nurse (LPN). Through distraction they were about to get the resident cleaned up and changed. After she was cleaned up, she would not stay still; she kept trying to get up so they brought her out to the sitting area by the nurse's station. Before Staff J left for the morning, she assisted Resident #4 back to bed, gave report and left. During a follow up interview on 6/5/2025 at 2:03 PM Staff J stated Resident #4 would not keep the sling on her arm that night. When she let the resident know her brief had stool in it, she started kicking, saying no no. The nurse heard her yelling and she came in. When asked what was going on with the cell phone at the nurse's station, Staff J stated the resident was going to call 911, so she removed it from her room and brought it to the nurse's station.</p> <p>On 6/5/2025 at 1:18 PM Staff K, LPN stated the first night of Resident #4's stay she indicated she heard Resident #4 yelling in her room. When asked what she was yelling, Staff K stated the resident was just yelling. She went down the hall to see what was going on. She asked Resident #4 what was wrong and she continued to yelling and saying ow. Resident #4 then stated you are hurting me in which Staff K informed the resident that she needed changed because she had poop on her. Her brief was opened and could see the stool. She let Resident #4 know that no one is trying to hurt her, you just need changed. Staff K stayed with the resident while Staff J went to get supplies to assist the resident. Once Staff J, CNA returned, Staff K left the room so cares could be completed. Resident #4 fell shortly after Staff J got her cleaned up. She kept trying to stand up on her own so they put her in her wheelchair and brought her to the nurse's station/TV area. When asked about a cell phone that night, she stated she saw one at the nurse's station on the desk. Staff J said something about someone calling 911. Staff K told her that's fine, let them come.</p> <p>On 6/4/2025 at 1:39 PM Staff G Previous Administrator stated she would have interviewed 5 residents about the concerns being investigated, their safety and if they had any concerns at all. She would have had the staff members sign and date their statements, then the Administrator would have signed and dated the statements as well. When abuse is questioned, a thorough investigation is to be completed.</p> <p>On 6/10/2025 at 3:25 PM the Skilled Unit Manager/Assistant Director of Nursing (ADON) indicated she was unable to get in to the program the previous owners used to obtain policies. She went through the binders they had and could not find a policy the facility would follow in regards to investigating abuse allegations.</p> <p>On 6/10/2025 at 3:58 PM corporate staff were asked to provide policies they would be implementing at the facility since taking over the facility. A list of policies was sent to the corporate staff at 5:00 PM. As of 6/13/2025, corporate staff had not emailed the requested policies.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review, resident and staff interview the facility failed to complete a comprehensive Care Plan for 2 of 7 residents (Residents #5 and #9) after their admission. The facility reported a census of 26 residents.</p> <p>Findings include</p> <p>1. According the 5-day Minimum Data Set (MDS) assessment tool with a reference date of 4/15/2025 documented Resident #5 had a BIMS score of 14. A BIMS score of 14 suggested no cognitive impairment. The MDS documented she was admitted to the facility on [DATE]. The MDS documented she was at risk for developing pressure ulcers/pressure injuries and had 3 unhealed stage 4 pressure ulcers, present upon admission. The following treatments were listed for Resident #5: pressure reducing device for chair and bed, and pressure ulcer/injury care. The MDS listed the following diagnoses for Resident #5: pressure ulcer of sacral region stage 4, anemia, renal failure, stroke, sepsis, atrial fibrillation, pressure ulcer of right and left buttock stage 4, adult failure to thrive.</p> <p>The Care Plan focus area with an initiation date of 4/9/2025 documented the resident had a pressure injury (specify: type and location) related to with no further information. The Care Plan lacked the type and location of the pressure ulcer.</p> <p>On 6/10/2025 at 11:37 AM Resident #5 stated she had a pressure ulcer on her right heel and her bottom.</p> <p>2. According the admission MDS assessment tool with a reference date of 5/12/2025 documented Resident #9 had a BIMS score of 7. A BIMS score of 7 suggested mild cognitive impairment. The MDS documented he was admitted to the facility on [DATE]. Resident #9 was at risk for developing pressure ulcers and had 1 stage 2 pressure ulcer present upon admission. The following treatments were listed for Resident #9: utilized a pressure reducing device for his chair and bed, applications of ointments/medications other than to his feet, and was not on a turning and repositioning program.</p> <p>The Care Plan focus area with an initiation date of 5/7/2025 documented the resident had a pressure injury (specify: type and location) relate to, with no further information. The Care Plan lacked the type and location of the pressure ulcer. The following interventions were listed on the Care Plan:</p> <p>a) Initiation date of 5/7/2025 administer treatments as ordered, maintain clean and dry skin, monitor nutritional status, weekly skin checks</p> <p>b) Initiation date of 5/8/2025 enhanced barrier precautions (EBP) related to wounds: EBP sign outside resident's room. Gown and glove for high contract resident care activities. Face shield should be used for any tasks that have a high potential of splash or spray.</p> <p>The Care Plan lacked interventions to prevent new pressure ulcers from developing.</p> <p>(continued on next page)</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>Review of skin assessments revealed the following assessments:</p> <p>a) On 5/15/2025 stage 2 pressure ulcer to Resident #5's left gluteus was acquired in house. Treatments were listed as cushion and nutrition/dietary supplements.</p> <p>b) On 5/15/2025 stage 2 pressure ulcer to Resident #5's right gluteus was acquired in house. Treatments were listed as frequent position changes, supplement as ordered, and cushion provided.</p> <p>On 6/4/2025 at 10:10 AM Resident #9 stated he is able to move himself in bed, staff are the ones that do his treatments to his sores.</p> <p>On 6/10/2025 at 9:52 AM Staff N Certified Nursing Assistant (CNA) stated that she will look at a resident's Care Plan when caring for residents with pressure ulcers. She stated if a resident had a pressure ulcer she would make sure they are turned every 2 hours and the resident is kept clean and dry. When asked if they had care sheets to use, she denied having that option.</p> <p>On 6/10/2025 at 9:54 AM Staff M, Licensed Practical Nurse (LPN) was asked what interventions are in place for Resident #5 to prevent the development of new pressure ulcers. Staff M stated repositioning, treatments, supplements, encouraging him to get out of bed and she believed he had a cushion in his chair. She will look on the Care Plans of individualized interventions.</p> <p>On 6/10/2025 at 11:49 AM Staff O, CNA stated interventions used to help prevent Resident #5 from developing a pressure ulcer or the worsening of a pressure ulcer she would reposition him, ensure he is up for meals. She added he is compliant with these things. She will go to the charting system to look in resident's Care Plans for interventions.</p> <p>On 6/10/2025 at 1:09 PM the Skilled Unit Manager/Assistant Director of Nursing was asked what kind of information should be on the Care Plan if a resident had a pressure ulcer. She indicated the fact the resident had one and interventions. She indicated the MDS Coordinator/Infection Preventionist updates the Care Plans, but if something comes up anyone can update them. If a resident is admitted with a pressure ulcer the Care Plan should include that they have it, the monitoring of it, the use of enhanced barrier precautions, treatment and location of the pressure ulcer.</p> <p>On 6/10/2025 at 1:52 PM the MDS Coordinator/Infection Preventionist stated anyone can work on the Care Plans. The baseline Care Plan is developed then they build off of that. When asked what information should be on a Care Plan for a resident that has/had a pressure ulcer she stated nutritional interventions, keeping the resident off the area, monitoring and assessments, and treatments.</p> <p>On 6/10/2025 at 3:25 PM the Skilled Unit Manager/Assistant Director of Nursing (ADON) indicated she was unable to get in to the program the previous owners used to obtain policies. She went through the binders they have and could not find a policy the facility would follow in regards to comprehensive Care Plans.</p> <p>On 6/10/2025 at 3:58 PM corporate staff were asked to provide policies they would be implementing at the facility since taking over the facility. A list of policies was sent to the corporate staff at 5:00 PM. As of 6/13/2025, corporate staff had not emailed the requested policies.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review, resident and staff interview the facility failed to update 3 of 3 resident's Care Plans (Resident #1, #9 and #10) after they experienced a fall. The facility also failed to update 1 of 3 resident's (Resident #9) Care Plan when he developed a new pressure ulcer. The facility reported a census of 26 residents.</p> <p>Findings include:</p> <p>1. According to the admission Minimum Data Set (MDS) assessment tool with a reference date of 12/22/2024 Resident #1 had a Brief Interview of Mental Status (BIMS) score of 2. A BIMS score of 2 suggested severe cognitive impairment. Resident #1 utilized a walker and wheelchair for mobility. He required partial/moderate assistance for sitting to lying, lying to sitting, sitting to standing, chair/bed to chair transfer, and toilet transfer. The MDS documented he had a fall in the last month prior to admission/entry, in the last 2-6 months prior to admission/entry, and had a fall since admission/entry with no injuries.</p> <p>The Care Plan focus area with an initiation date of 12/16/2024 documented Resident #1 was at risk for falls. Resident had a fall on 2/10/2025 staff were instructed to monitor for decline in Activities of Daily Living (ADLs).</p> <p>The following Progress Notes were documented:</p> <p>a) 2/9/2025 at 11:37 AM around 10:00 AM the resident was heard falling in his room. The aide was around the corner and came in, saw him on his knees by the bathroom door. He said he fell after going to the bathroom and landed on his knees.</p> <p>b) 2/9/2025 at 5:00 PM staff answered resident's bathroom light, found resident on the floor in front of the toilet.</p> <p>c) 2/10/2025 at 9:30 AM resident was noted to be sitting on the floor in front of his wheelchair.</p> <p>2. According to the admission MDS assessment tool with a reference date of 5/12/2025 documented Resident #9 had a BIMS score of 7. A BIMS score of 7 suggested mild cognitive impairment. The MDS documented he was admitted to the facility on [DATE]. Resident #9 was at risk for developing pressure ulcers and had 1 stage 2 pressure ulcer present upon admission. The following treatments were listed for Resident #9: utilized a pressure reducing device for his chair and bed, applications of ointments/medications other than to his feet, and was not on a turning and repositioning program. The following diagnoses were listed for Resident #9: stroke, cancer, atrial fibrillation, coronary artery disease, septicemia, urinary tract infection, diabetes mellitus, weakness, fall on same level.</p> <p>The Care Plan focus area with an initiation date of 5/7/2025 documented the resident had a pressure injury (specify: type and location) relate to, with no further information. The Care Plan lacked the type and location of the pressure ulcer. The following interventions were listed on the Care Plan:</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a) Initiation date of 5/7/2025 administer treatments as ordered, maintain clean and dry skin, monitor nutritional status, weekly skin checks</p> <p>b) Initiation date of 5/8/2025 enhanced barrier precautions (EBP) related to wounds: EBP sign outside resident's room. Gown and glove for high contract resident care activities. Face shield should be used for any tasks that have a high potential of splash or spray.</p> <p>The Care Plan lacked interventions to prevent new pressure ulcers from developing.</p> <p>Review of skin assessments revealed the following assessments:</p> <p>a) On 5/15/2025 stage 2 pressure ulcer to Resident #5's left gluteus was acquired in house. Treatments were listed as cushion and nutrition/dietary supplements.</p> <p>b) On 5/15/2025 stage 2 pressure ulcer to Resident #5's right gluteus was acquired in house. Treatments were listed as frequent position changes, supplement as ordered, and cushion provided.</p> <p>On 6/4/2025 at 10:10 AM Resident #9 stated he is able to move himself in bed, staff are the ones that do his treatments to his sores.</p> <p>Observation on 6/4/2025 at 10:10 AM revealed Resident #9 lying in bed watching television. A fall mat was folded up resting against the wall across from the foot of the resident's bed. A walker was resting by the door of the room, close to the bathroom, across the room from the bed. On 6/5/2025 at 8:58 AM resident lying in bed sleeping, fall mat placed on the floor to the right of his bed.</p> <p>The Care Plan focus area with an initiation date of 5/7/2025, documented the resident was at risk for falls. The Care Plan listed the following interventions with an initiation date of 5/7/2025:</p> <p>a) Keep needed items, water, etc within reach</p> <p>b) Maintain a clear pathway in the room, free of obstacles</p> <p>The following Progress Notes were documented for Resident #9:</p> <p>a) On 5/20/2025 at 7:00 AM: at 5:15 AM resident was observed sitting on the floor, beside his bed with his back against the bed. Resident was unable to state what happened,</p> <p>b) On 6/5/2025 at 1:15 AM the CNA found resident sitting on the floor by the doorway to his room. Resident stated he had gotten up to go to the restroom and fell on the way back from the restroom. It appears he slid out of bed then scooted himself to the doorway. Resident encouraged to use his call light if he needs anything and not get up without staff assistance, bed is in lowest position with the safety mat by his bed.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. According to the quarterly MDS assessment tool with a reference date of 5/9/2025, Resident #10 had a BIMS score of 3. A BIMS score of 3 suggested severe cognitive impairment. The MDS documented she required partial/moderate assistance for lying to sitting on the side of her bed, sitting to standing, chair/bed, to chair transfer, and toileting transfer. Resident #10 had two or more falls since her admission/entry, one fall resulted in an injury. The following diagnoses were listed for Resident #10: Alzheimer's Disease, diabetes mellitus, hip fracture, anxiety, depression, and muscle weakness.</p> <p>The Care Plan focus area with an initiation date of 2/7/2025 documented she was at risk for falls. The Care Plan focus area had interventions that were last revised on 5/6/2025 with the following interventions: fall on 5/6/2025 neurological checks per facility protocol and consider increasing activities during waking hours.</p> <p>The following progress notes were documented:</p> <p>a) On 5/1/2025 at 5:22 PM this nurse was notified Resident #10 had a witnessed fall in the common area. Resident attempted to stand up and walk form her wheelchair.</p> <p>b) On 5/12/2025 at 4:27 PM Resident #10 was in the commons area by the nurse's station when she attempted to stand up out of her wheelchair and fell backwards hitting her head on the floor. Resident#10 was lethargic and started to mumble words. Resident was sent to the hospital for evaluation.</p> <p>c) On 5/20/2025 at 7:38 PM Resident #10 seen sitting on the floor, alert and oriented to self. No injuries.</p> <p>On 6/10/2025 at 9:52 AM Staff N Certified Nursing Assistant (CNA) stated that she will look at a resident's Care Plan when caring for residents with pressure ulcers. She stated if a resident had a pressure ulcer she would make sure they are turned every 2 hours and the resident is kept clean and dry. If a resident is at risk for fall she will make frequent rounds and put eyes on the resident. When asked if they had care sheets to use, she denied having that option.</p> <p>On 6/10/2025 at 9:54 AM Staff M Licensed Practical Nurse (LPN) was asked what interventions are in place for Resident #5 to prevent the development of new pressure ulcers. Staff M stated repositioning, treatments, supplements, encouraging him to get out of bed and she believed he had a cushion in his chair. She will look on the care plans of individualized interventions for residents with pressure ulcers and if they are at risk for falls.</p> <p>On 6/10/2025 at 11:49 AM Staff O CNA stated interventions used to help prevent Resident #5 from developing a pressure ulcer or the worsening of a pressure ulcer she would reposition him, ensure he is up for meals. She added he is compliant with these things. She will go to the charting system to look in resident's Care Plans for interventions, this included interventions for residents at risk for falls.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/10/2025 at 1:09 PM the Skilled Unit Manager/Assistant Director of Nursing was asked what kind of information should be on the Care Plan if a resident has a pressure ulcer. She indicated the fact the resident has one and interventions. She indicated the MDS Coordinator/Infection Preventionist updates the call lights but if something comes up anyone can update them. If a resident is admitted with a pressure ulcer the care plan should include that they have it, the monitoring of it, the use of enhanced barrier precautions, treatment and location of the pressure ulcer. When asked what kind of information should be on the care plan if a resident was at risk for falls, she stated the fact they are a fall risk, possible triggers for the falls and interventions that are put in place. When asked how soon the care plan should be updated she stated immediately so the CNAs can implement them. After a fall happens the call plan could include keeping them in line of sight, not left unattended in their wheelchair. She added it just depends on what the situation was when the time happened. They can put a reminder sign up to use the call light or their walker when needed to ambulate.</p> <p>On 6/10/2025 at 1:52 PM the MDS Coordinator/Infection Preventionist stated anyone can work on the care plans. The baseline care plan is developed then they build off of that. When asked what information should be on a care plan for a resident that has/had a pressure ulcer she stated nutritional interventions, keeping the resident off the area, monitoring and assessments, and treatments.</p> <p>On 6/10/2025 at 3:25 PM the Skilled Unit Manager/Assistant Director of Nursing (ADON) indicated she was unable to get in to the program the previous owners used to obtain policies. She went through the binders they have and could not find a policy the facility would follow in regards to care plan revision.</p> <p>On 6/10/2025 at 3:58 PM corporate staff were asked to provide policies they would be implementing at the facility since taking over the facility. A list of policies was sent to the corporate staff at 5:00 PM. As of 6/13/2025, corporate staff had not emailed the requested policies.</p>		

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NAME OF PROVIDER OR SUPPLIER  Chapters Living of Council Bluffs		STREET ADDRESS, CITY, STATE, ZIP CODE  3000 Risen Son Blvd Council Bluffs, IA 51503	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review, resident and staff interview, and facility policy review the facility failed to provide the appropriate interventions to prevent falls for 2 or 3 residents (Resident #1, #9, and #10). The facility also failed to complete neurological assessments after 2 of 4 residents (Resident #4 and #10) after they experienced an unwitnessed fall. The facility reported a census of 26 residents.</p> <p>Findings include:</p> <p>1. According to the admission Minimum Data Set (MDS) assessment tool with a reference date of 12/22/2024 Resident #1 had a Brief Interview of Mental Status (BIMS) score of 2. A BIMS score of 2 suggested severe cognitive impairment. Resident #1 utilized a walker and wheelchair for mobility. He required partial/moderate assistance for sitting to lying, lying to sitting, sitting to standing, chair/bed to chair transfer, and toilet transfer. The MDS documented he had a fall in the last month prior to admission/entry, in the last 2-6 months prior to admission/entry, and has had a fall since admission/entry with no injuries.</p> <p>The Care Plan focus area with an initiation date of 12/16/2024 documented Resident #1 was at risk for falls. Resident had a fall on 2/10/2025 staff were instructed to monitor for decline in Activities of Daily Living (ADLs).</p> <p>The following progress notes were documented:</p> <p>a) on 2/9/2025 at 11:37 AM around 10:00 AM the resident was heard falling in his room. The aide was around the corner and came in, saw him on his knees by the bathroom door. He said he fell after going to the bathroom and landed on his knees.</p> <p>b) on 2/9/2025 at 5:00 PM staff answered resident's bathroom light, found resident on the floor in front of the toilet.</p> <p>c) on 2/10/2025 at 9:30 AM resident was noted to be sitting on the floor in front of his wheelchair.</p> <p>The Care Plan lacked interventions after Resident #1 had falls on 2/9/2025 and 2/10/2025.</p> <p>2. Resident #4 was admitted to the facility on [DATE].</p> <p>Record review revealed the following progress notes:</p> <p>a) On 5/30/2025 at 8:39 PM resident heard yelling from help in her room, resident was on the floor supine just beside her recliner,</p> <p>b) On 6/6/2025 at 6:50 AM notified by staff that resident was yelling and was on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review revealed a document titled Neurological Assessment Flow Sheet. On 5/31/2025 at 6:20 AM, 6:35 AM, 6:50 AM, 7:05 AM, 7:35 AM, 8:05 AM, 8:35 AM level of consciousness, pupil response, motor functions, and pain response was not documented as being assessed. On 5/31/2025 at 9:05 AM, 10:05 AM, 11:05 AM, 1:05 PM vitals were not documented as being obtained, level of consciousness, pupil response, motor functions, and pain response was not documented as being assessed. On 6/1/2025 at 7:05 PM , 6/2/2025 at 5:05 PM, 6/3/2025 at 1:05 PM and 7:05 PM vitals were not documented as being obtained, level of consciousness, pupil response, motor functions, and pain response was not documented as being assessed. 6/6/2025 at 1:35 PM and 3:35 PM vitals were not documented as being obtained, level of consciousness, pupil response, motor functions, and pain response was not documented as being assessed.</p> <p>3. According to the admission MDS assessment tool with a reference date of 5/12/2025 documented Resident #9 had a BIMS score of 7. A BIMS score of 7 suggested mild cognitive impairment. The MDS documented he was admitted to the facility on [DATE]. Resident #9 was at risk for developing pressure ulcers and had 1 stage 2 pressure ulcer present upon admission. The following treatments were listed for Resident #9: utilized a pressure reducing device for his chair and bed, applications of ointments/medications other than to his feet, and was not on a turning and repositioning program. The following diagnoses were listed for Resident #9: stroke, cancer, atrial fibrillation, coronary artery disease, septicemia, urinary tract infection, diabetes mellitus, weakness, fall on same level.</p> <p>Observation on 6/4/2025 at 10:10 AM revealed Resident #9 lying in bed watching television. A fall mat was folded up resting against the wall across from the foot of the resident's bed. A walker was resting by the door of the room, close to the bathroom, across the room from the bed. On 6/5/2025 at 8:58 AM resident lying in bed sleeping, fall mat placed on the floor to the right of his bed.</p> <p>The Care Plan focus area with an initiation date of 5/7/2025, documented the resident was at risk for falls. The care plan listed the following interventions with an initiation date of 5/7/2025:</p> <p>a) Keep needed items, water, etc within reach</p> <p>b) Maintain a clear pathway in the room, free of obstacles</p> <p>The following progress notes were documented for Resident #9:</p> <p>a) 5/20/2025 at 7:00 AM: at 5:15 AM resident was observed sitting on the floor, beside his bed with his back against the bed. Resident was unable to state what happened,</p> <p>b) 6/5/2025 at 1:15 AM the CNA found resident sitting on the floor by the doorway to his room. Resident stated he had gotten up to go to the restroom and fell on the way back from the restroom. It appears he slid out of bed then scooted himself to the doorway. Resident encouraged to use his call light if he needs anything and not get up without staff assistance, bed is in lowest position with safety mat by his bed.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. According to the quarterly MDS assessment tool with a reference date of 5/9/2025, Resident #10 had a BIMS score of 3. A BIMS score of 3 suggested severe cognitive impairment. The MDS documented she required partial/moderate assistance for lying to sitting on the side of her bed, sitting to standing, chair/bed, to chair transfer, and toileting transfer. Resident #10 had two or more falls since her admission/entry, one fall resulted in an injury. The following diagnoses were listed for Resident #10: Alzheimer's Disease, diabetes mellitus, hip fracture, anxiety, depression, and muscle weakness.</p> <p>The Care Plan focus area with an initiation date of 2/7/2025 documented she was at risk for falls. The Care Plan focus area had interventions that were last revised on 5/6/2025 with the following interventions: fall on 5/6/2025 neurological checks per facility protocol and consider increasing activities during waking hours.</p> <p>The facility provided incident reports for Resident #10's unwitnessed falls on: 2/10/2025 at 10:30 PM, 2/15/2025 at 2:35 PM, 3/4/2025 at 6:55 PM.</p> <p>The following Progress Notes were documented:</p> <p>a) On 5/12/2025 at 4:27 PM Resident #10 was in the commons area by the nurse's station when she attempted to stand up out of her wheelchair and fell backwards hitting her head on the floor. Resident was lethargic and started to mumble words. Resident was sent to the hospital for evaluation.</p> <p>b) On 5/20/2025 at 7:38 PM Resident #10 seen sitting on the floor, alert and oriented to self. No injuries.</p> <p>Record review revealed a document titled Neurological Assessment Flow Sheet. On 2/12/2025 at 7:15 AM, 11:15 AM vitals were not documented as being obtained and 2/13/2025 at 7:15 AM vitals were not documented as being obtained, level of consciousness, pupil response, motor functions, and pain response was not assessed. On 2/18/2025 at 7:30 AM and 11:30 AM vitals were not documented as being obtained, level of consciousness, pupil response, motor functions, and pain response was not assessed. On 3/5/2025 at 7:35 AM, 9:35 AM, 11:35 AM, 1:35 PM vitals were not documented as being obtained, level of consciousness, pupil response, motor functions, and pain response was not assessed. On 5/9/2025 at 8:30 AM vitals were not documented as being obtained, level of consciousness, pupil response, motor functions, and pain response was not documented as being assessed. On 5/12/2025 at 7:00 PM, 8:00 PM, 9:00 PM vitals were not documented as being obtained, level of consciousness, pupil response, motor functions, and pain response was not assessed. At 11:00 PM pupil response, motor functions, pain response not documented as being assessed. On 5/13/2025 at 3:00 AM vitals were not documented as being obtained, level of consciousness, pupil response, motor functions, and pain response was not documented as being assessed.</p> <p>On 6/4/2025 at 11:20 AM Staff M Licensed Practical Nurse (LPN) stated if a resident has a witnessed fall and they do not hit their head, neurological checks are not required. If a resident has an unwitnessed fall not able to tell if they hit their head or not, neurological checks are started. Neurological checks are completed every 15 minutes x 4 times, every 1-hour x 4 hours, every 2 hours x 8 times, and every 4 hours x 72 hours. She indicated this includes obtaining vital signs and completing the flowsheet that is started after a resident falls. During a follow up interview on 6/10/2025 at 9:54 AM Staff M stated she will look on the care plans of individualized interventions for residents with pressure ulcers and if they are at risk for falls.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/10/2025 at 9:52 AM Staff N Certified Nursing Assistant (CNA) stated that she will look at a resident's care plan when caring for residents with pressure ulcers. She stated if a resident had a pressure ulcer she would make sure they are turned every 2 hours and the resident is kept clean and dry. If a resident is at risk for fall she will make frequent rounds and put eyes on the resident. When asked if they had care sheets to use, she denied having that option.</p> <p>On 6/10/2025 at 11:49 AM Staff O CNA stated she will go to the charting system to look in resident's care plans for interventions, this included interventions for residents at risk for falls.</p> <p>On 6/10/2025 at 1:09 PM the Skilled Unit Manager/Assistant Director of Nursing indicated the MDS Coordinator/Infection Preventionist updates the call plans but if something comes up anyone can update them. When asked what kind of information should be on the care plan if a resident was at risk for falls, she stated the fact they are a fall risk, possible triggers for the falls and interventions that are put in place. When asked how soon the care plan should be updated she stated immediately so the CNAs can implement them. After a fall happens the call plan could include keeping them in line of sight, not left unattended in their wheelchair. She added it just depends on what the situation was when the time happened. They can put a reminder sign up to use the call light or their walker when needed to ambulate. She stated while completing the neurological checks after an unwitnessed fall staff are to check the resident's vital signs, mental status and grips. After the fall, an initial head to toe is to be completed.</p> <p>On 6/10/2025 at 1:52 PM the MDS Coordinator/Infection Preventionist stated anyone can work on the care plans. The baseline care plan is developed then they build off of that.</p> <p>On 6/10/2025 at 3:25 PM the Skilled Unit Manager/Assistant Director of Nursing (ADON) indicated she was unable to get in to the program the previous owners used to obtain policies. She went through the binders they have and could not find a policy the facility would follow in regards fall interventions after a fall is sustained.</p> <p>On 6/10/2025 at 3:58 PM corporate staff were asked to provide policies they would be implementing at the facility since taking over the facility. A list of policies was sent to the corporate staff at 5:00 PM. As of 6/13/2025, corporate staff had not emailed the requested policies.</p> <p>The facility provided a documented titled Neurological Assessment with an revision date of 12/7/2011, indicated it is the policy of the facility that neurological assessments will be performed by a licensed nurse when resident status warrants such as an unwitnessed fall. Neurological assessments should be performed as follows for a 72 hour period, unless otherwise ordered by the attending physician: every 15 minutes x 4, every 1 x 4, every 2 hours x 8 and every 4 hours until 72 hour period complete.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on record review, resident and staff interviews the facility failed to ensure 2 of 3 resident's (Resident #2 and #5) treatment orders were signed out as being completed. The facility reported a census of 26 residents.</p> <p>Findings include:</p> <p>1. According to the Significant Change Minimum Data Set (MDS) assessment tool with a reference date of 2/25/2025 Resident #2 had a Brief Interview of Mental Status (BIMS) score of 8. A BIMS score of 8 suggested no mild cognitive impairment. The MDS documented he was at risk for developing pressure ulcers/pressure injuries and had one unhealed stage 1 pressure ulcer/pressure injury. The MDS documented the following treatments: pressure reducing device for his chair and bed, and applications of ointments/medications other than to his feet. The MDS listed the following diagnoses for Resident #5: stroke, renal insufficiency, depression and obesity.</p> <p>The Care Plan focus area with an initiation date of 2/11/2025 documented Resident #2 had a pressure injury to his right and left lateral malleolus related to immobility. The care plan directed staff to administer medications and treatments and ordered.</p> <p>Review of Resident #2's February 2025 Treatment Administration Record (TAR) revealed the following orders were not signed out as being completed:</p> <p>a) Apply dressing to right lateral malleolus daily until healed was not signed out as being completed on 2/25/2025,</p> <p>b) Apply skin prep to left lateral malleolus twice a day (BID) until healed was not signed out as being completed on 2/12/2025 AM shift, 2/18/2025 AM shift, and 2/19/2025 AM shift,</p> <p>c) Apply skin prep to right lateral malleolus twice a day (BID) until healed was not signed out as being completed on 2/12/2025 AM shift, 2/18/2025 AM shift, and 2/19/2025 AM shift,</p> <p>d) Calmoseptine external ointment, apply to buttocks topically BID was not signed out as being completed on 2/12/2025 AM shift, 2/18/2025 AM shift, and 2/19/2025 AM shift,</p> <p>e) Evaluate left lateral malleolus stage 1 pressure ulcer for complications including symptoms of infection was not signed out as being completed on 2/12/2025 AM shift, 2/18/2025 AM shift, and 2/19/2025 AM shift,</p> <p>f) Evaluate right lateral malleolus stage 1 pressure ulcer for complications including symptoms of infection was not signed out as being completed on 2/12/2025 AM shift, 2/18/2025 AM shift, and 2/19/2025 AM shift,</p> <p>Review of Resident #2's March 2025 TAR revealed the following orders were not signed out as being completed:</p> <p>a) Cleanse left outer arm skin tear with wound cleanser, pat dry and apply band-aid daily and as needed (PRN) until healed was not signed out as being completed on 3/3/2025, 3/5/2025, 3/12/2025,</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b) Cleanse stage 1 PU to right lateral malleolus with wound cleanser, pat dry and apply foam dressing daily until healed was not signed out as being completed on 3/3/2025, 3/5/2025, 3/12/2025,</p> <p>c) Apply skin prep to left lateral malleolus twice a day (BID) until healed was not signed out as being completed on 3/3/2025 AM shift, 3/5/2025 AM shift, 3/12/2025 AM shift,</p> <p>d) Calmoseptine external ointment, apply to buttocks topically BID was not signed out as being completed on 3/3/2025 AM shift, 3/5/2025 AM shift, 3/12/2025 AM shift,</p> <p>e) Evaluate left lateral malleolus stage 1 pressure ulcer for complications including symptoms of infection was not signed out as being completed on 3/3/2025 AM shift, 3/5/2025 AM shift, 3/12/2025 AM shift,</p> <p>f) Evaluate left outer arm skin tear for complications including symptoms of infection was not signed out as being completed on 3/3/2025 AM shift, 3/5/2025 AM shift, 3/12/2025 AM shift,</p> <p>g) Evaluate right lateral malleolus stage 1 pressure ulcer for complications including symptoms of infection was not signed out as being completed on 3/3/2025 AM shift, 3/5/2025 AM shift, 3/12/2025 AM shift,</p> <p>h) House barrier cream to protect skin every shift was not signed out as being completed on 3/3/2025 AM shift, 3/5/2025 AM shift, 3/12/2025 AM shift.</p> <p>2. According the 5-day MDS assessment tool with a reference date of 4/15/2025 Resident #5 had a BIMS score of 14. A BIMS score of 14 suggested no cognitive impairment. The MDS documented she was at risk for developing pressure ulcers/pressure injuries and had 3 unhealed stage 4 pressure ulcers. The following treatments were listed for Resident #5: pressure reducing device for chair and bed, and pressure ulcer/injury care.</p> <p>The Care Plan focus area with an initiation date of 4/9/2025 documented the resident had a pressure injury and directed staff to administer medications as ordered, and administer treatments as ordered.</p> <p>Review of Resident #5's April 2025 TAR revealed the following orders not signed out as being completed:</p> <p>a) Evaluate stage 4 sacral wound/peri-wound for complications including symptoms of infection was not signed out as being completed on 4/16/2025 on the AM shift, 4/21/2025 on the AM shift, 4/22/2025 on the AM shift, 4/24/2025 on the AM shift, 4/28/2025 on the AM shift, and 4/29/2025 on the AM shift,</p> <p>b) Evaluate stage 4 left buttocks wound/peri-wound for complications including symptoms of infection was not signed out as being completed on 4/16/2025 on the AM shift, 4/21/2025 on the AM shift, 4/22/2025 on the AM shift, 4/24/2025 on the AM shift, 4/28/2025 on the AM shift, and 4/29/2025 on the AM shift,</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>c) Evaluate stage 4 right buttocks wound/peri-wound for complications including symptoms of infection was not signed out as being completed on 4/16/2025 on the AM shift, 4/21/2025 on the AM shift, 4/22/2025 on the AM shift, 4/24/2025 on the AM shift, 4/28/2025 on the AM shift, and 4/29/2025 on the AM shift,</p> <p>d) Left buttocks stage 4 pressure ulcer: cleanse with wound cleanser, apply Xerofoam to wound base, cover with ABD pad, secure with tape. Change daily and PRN was no signed out as being completed on 4/21/2025 on the AM shift, 4/22/2025 on the AM shift, 4/24/2025 on the AM shift, 4/28/2025 on the AM shift, and 4/29/2025 on the AM shift,</p> <p>e) Left buttocks stage 4 pressure ulcer cleanse with wound cleanser, apply triad to wound edges, apply 2 layer Xerofoam to wound base, cover with ABD pad, secure with tape, change daily and PRN not signed out as being completed on 4/14/2025 and 4/18/2025,</p> <p>f) Right upper (inner) arm puncture wound-cleanse daily with wound cleanser and leave open to air was not signed out as being completed on 4/16/2025,</p> <p>g) Right buttocks stage 4 pressure ulcer, cleanse with wound cleanser, apply triad to wound edges, apply 2 layer Xerofoam to wound base, cover with ABD pad, secure with tape, change daily and PRN not signed out as being completed on 4/11/2025,</p> <p>h) Right buttocks stage 4 pressure ulcer cleanse with wound cleanser, apply triad to wound edges apply prisma and xeroform to wound base cover with ABD pad, secure with tape change daily and PRN not signed out as being completed on 4/14/2025, 4/16/2025, and 4/18/2025,</p> <p>i) Right buttocks stage 4 pressure ulcer cleanse with wound cleanser, apply prisma and Xerofoam to wound base cover with ABD pad, secure with tape change daily and PRN not signed out as being completed on 4/21/2025, 4/22/2025, 4/24/2025, 4/28/2025, and 4/29/2025,</p> <p>j) Sacral stage 4 pressure ulcer cleanse with wound cleanser, apply Santyl and adaptic to wound base apply black foam apply wound vacuum 125 mm/hg continuous suction change 2 times weekly and prn dysfunction in the morning every Tuesday and Friday not signed out as being completed on 4/18/2025 (Friday).</p> <p>Review of Resident #5's May 2025 TAR revealed the following orders as not being signed out as completed:</p> <p>a) Evaluate stage 4 sacral wound/peri-wound for complications including symptoms of infection was not signed out as being completed on: 5/5/2025, 5/8/2025,</p> <p>b) Evaluate stage 4 left buttocks wound/peri-wound for complications including symptoms of infection was not signed out as being completed on: 5/5/2025, 5/8/2025,</p> <p>c) Evaluate stage 4 right buttocks wound/peri-wound for complications including symptoms of infection was not signed out as being completed: 5/5/2025, 5/8/2025,</p> <p>d) Left buttocks stage 4 pressure ulcer: cleanse with wound cleanser, apply Xerofoam to wound base, cover with ABD pad, secure with tape. Change daily and PRN was no signed out as being completed on</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5/5/2025, 5/8/2025,</p> <p>e) Per Wound Care Clinic: hold wound vac to sacrum until next wound care appointment. Apply Santyl, gauze, ABD, skin friendly tape daily and PRN to sacrum in the morning for wound care was not signed out as being completed on 5/5/2025, 5/8/2025,</p> <p>f) Right buttocks stage 4 pressure ulcer cleanse with wound cleanser, apply triad to wound edges apply prisma and Xerofoam to wound base cover with ABD pad, secure with tape change daily and PRN not signed out as being completed on 5/5/2025, 5/8/2025.</p> <p>On 6/10/2025 at 11:37 AM Resident #5 stated she had a pressure ulcer on her right heel and her bottom. She added they do the dressings and treatments every day.</p> <p>On 6/4/2025 at 11:20 AM Staff M Licensed Practical Nurse (LPN) stated if an order is not signed out on a resident's TAR it was not done.</p> <p>On 6/10/2025 at 1:09 PM the Skilled Unit Manager/Assistant Director of Nursing (ADON) stated when staff complete a treatment order staff should sign out the order. When asked what it meant if the order was not signed out she stated the staff member either did not sign it out or it was not completed.</p> <p>On 6/10/2025 at 3:25 PM the Skilled Unit Manager/Assistant Director of Nursing (ADON) indicated she was unable to get in to the program the previous owners used to obtain policies. She went through the binders they have and could not find a policy the facility would follow in regards to treatment orders and the administration process.</p> <p>On 6/10/2025 at 3:58 PM corporate staff were asked to provide policies they would be implementing at the facility since taking over the facility. A list of policies was sent to the corporate staff at 5:00 PM. As of 6/13/2025, corporate staff had not emailed the requested policies.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165466	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2025
NAME OF PROVIDER OR SUPPLIER  Chapters Living of Council Bluffs		STREET ADDRESS, CITY, STATE, ZIP CODE  3000 Risen Son Blvd Council Bluffs, IA 51503	

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on resident council notes, facility assessment review, resident and staff interview the facility failed to provide sufficient staff for safe transfers and assisting residents timely when needed. The facility reported a census of 26 residents.</p> <p>Findings include:</p> <p>Review of April 2025 Resident Council Notes revealed a resident indicated it would be nice if they could have more Certified Nursing Assistants (CNAs) on the overnight shift.</p> <p>Review of the facility assessment dated 7/2023 through 6/2024 documented 1 Licensed Practical Nurse (LPN)/Registered Nurse (RN) to 15 residents ratio on the day shift, 1 LPN to 30 residents on the overnight shift, 1 Certified Nursing Assistant (CNA) to 10 residents ratio on the day and evening shifts, and 1 CNA to 15 residents ration on the overnight shift. If the census is 30 or above, 1 Certified Medication Aide (CMA) works day shift, 8 hours.</p> <p>On 6/4/2025 at 10:00 AM Resident #7 stated staffing can be iffy at times. She reported she has had to weight for 40 minutes for help. She has been fighting a Urinary Tract Infection (UTI) and can't hold her bladder that long. When staff come in to see what she needs, she's had an accident they get aggravated, others will come in a change her without issues. When asked how this made her feel she stated humiliated. When asked what shift this usually happened on, she stated it varied on all shifts.</p> <p>On 6/5/2025 at 12:57 PM Staff L CNA stated they would run with two CNAs on the morning and evening shift, then one on the overnight shift. They have one resident that is the assistance of two staff on the skilled side but a lot of residents on the long term side are the assistance of two staff. She acknowledged the use of a mechanical lift has been used with just one staff member because of staffing. She indicated she has used the lift by herself because it's hard to do repositions with only two staff.</p> <p>On 6/5/2025 at 2:56 PM Staff F CNA stated she worked at the facility full time until May then she went as needed (PRN) because she was always on the floor by herself with a nurse. She indicated when it was just her and another nurse call lights would take a while because she was with another resident.</p> <p>On 6/10/2025 at 3:25 PM the Skilled Unit Manager/Assistant Director of Nursing (ADON) indicated she was unable to get in to the program the previous owners used to obtain policies. She went through the binders they have and could not find a policy the facility would follow in regards to call light response time and the use of a mechanical lift.</p> <p>On 6/10/2025 at 3:58 PM corporate staff were asked to provide policies they would be implementing at the facility since taking over the facility. A list of policies was sent to the corporate staff at 5:00 PM. As of 6/13/2025, corporate staff had not emailed the requested policies.</p>

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

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>Based on review of the facility's assessment and staff interview the facility failed to update the Facility Assessment. The facility reported a census of 26 residents.</p> <p>Findings include:</p> <p>On 6/5/2025 at 12:48 PM the Administrator provided the Facility Assessment. The document was dated 7/2023 through 6/2024 with the previous facility name attached to it.</p> <p>On 6/10/2025 at 2:08 PM the CEO currently working as the Administrator stated the Executive Director or Administrator usually updates the Facility Assessment. He indicated they could not find and updated assessment and they have not updated once since they took over in February.</p> <p>On 6/10/2025 at 3:25 PM the Skilled Unit Manager/Assistant Director of Nursing (ADON) indicated she was unable to get in to the program the previous owners used to obtain policies. She went through the binders they have and could not find a policy the facility would follow in regards to the Facility Assistant.</p> <p>On 6/10/2025 at 3:58 PM corporate staff were asked to provide policies they would be implementing at the facility since taking over the facility. A list of policies was sent to the corporate staff at 5:00 PM. As of 6/13/2025, corporate staff had not emailed the requested policies.</p>

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NAME OF PROVIDER OR SUPPLIER  Chapters Living of Council Bluffs		STREET ADDRESS, CITY, STATE, ZIP CODE  3000 Risen Son Blvd Council Bluffs, IA 51503	
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on record view, resident and staff interviews the facility failed to ensure 3 of 10 resident's (Resident #7, #8, and #10) records were complete and accurate. The facility reported a census of 26 residents.</p> <p>Findings include:</p> <p>1. According to the 5-day Minimum Data Set (MDS) assessment tool with a reference date of 5/16/2025, Resident #7 had a Brief Interview of Mental Status (BIMS) score of 10. A BIMS score of 10 suggested no cognitive impairment. The MDS documented she was dependent on staff to shower or bathe self. The following diagnoses were listed for Resident #7: urinary tract infection (UTI), hypertension, anxiety, depression, and obesity.</p> <p>The Care Plan focus area with an initiation date of 5/12/2025 documented Resident #7 required assistance with Activities of Daily Living (ADLs). The care plan documented she required the assistance of one staff for bathing and tub/shower transfers.</p> <p>Record review of Resident #7's bathing record, revealed only two showers were documented as being completed in the last 30 days. A shower was documented as being given on 5/24/2025 and 5/27/2025. The record lacked documentation to reflect Resident #7's showers twice a week.</p> <p>On 6/4/2025 at 10:00 AM Resident #7 stated she received a bath or shower twice a week since she has been in the facility. She had no issues with not receiving a bath or shower.</p> <p>2. According to the 5-day MDS assessment tool with a reference date of 5/7/2025, Resident #8 had a BIMS score of 7. A BIMS score of 7 suggested Resident #8 had mild cognitive impairment. The MDS documented she required substantial/maximal assistance with shower/bathing herself. The MDS documented the following diagnoses for Resident #8: UTI, septicemia, morbid obesity, and dysphagia.</p> <p>The Care Plan focus area with an initiation date of 5/1/2025 documented she required assistance with ADLs.</p> <p>Record review of Resident #8's bathing record, revealed only two showers were documented as being completed in the last 30 days. A shower was documented as being given on 5/24/2025 and 5/28/2025. A shower was documented as refused on 5/27/2025. The record lacked documentation to reflect Resident #8's showers twice a week.</p> <p>On 6/4/2025 at 10:07 AM Resident #8 stated she receives a shower on Tuesdays and Sundays unless she does not feel well. She had no concerns with no receiving a bath/shower regularly.</p> <p>3. According to the quarterly MDS assessment tool with a reference date of 5/9/2025 documented Resident #10 had a BIMS score of 3. A BIMS score of 3 suggested she had severe cognitive impairment. The MDS documented she had utilized a walker and wheelchair for mobility. Resident #10 required partial/moderate assistance for lying to sitting on the side of her bed, sitting to standing, chair/bed to chair transfer and toilet transfers. The MDS listed the following diagnoses: Alzheimer's Disease, diabetes mellitus, hip fracture, anxiety, depression, and muscle weakness.</p> <p>(continued on next page)</p>		

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

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Care Plan focus area with an initiation date of 2/7/2025 documented Resident #10 was at risk for falls.</p> <p>Record review revealed the following progress notes:</p> <p>a) On 5/1/2025 at 5:22 PM nurse was summoned to the common area because the resident had a witnessed fall. Resident #10 attempted to stand up and walk from her walker.</p> <p>b) On 5/12/2025 at 4:27 PM Resident #10 was in the commons area by the nurse's station when she attempted to stand up out of her wheelchair. She fell backwards hitting her head on the floor. Neurological checks were started, resident was lethargic and started to mumble words. Resident was sent to the emergency room for evaluation.</p> <p>On 6/6/2025 at 12:43 PM the Director of Nursing (DON) provided incident reports for Resident #10. Incident reports for the falls on 5/1/2025 and 5/12/2025 were not provided.</p> <p>On 6/10/2025 at 1:09 PM the Skilled Unit Manager/Assistant Director of Nursing (ADON) stated staff have been good about giving resident's their baths but not good about documenting it. She indicated some staff can't get in to the resident's chart to document or do not have access to their charting system. When asked who completes the incident reports after a fall, she stated at one time they had incident reports that no one had access to. They would do a post incident evaluation, do the report by hand, then the Director of Nursing (DON) would do the incident report in the charting system. Since the company change over they will be doing the incident reports in the charting system.</p> <p>On 6/10/2025 at 3:25 PM the Skilled Unit Manager/Assistant Director of Nursing (ADON) indicated she was unable to get in to the program the previous owners used to obtain policies. She went through the binders they have and could not find a policy the facility would follow in regards to documentation of baths and incident reports.</p> <p>On 6/10/2025 at 3:58 PM corporate staff were asked to provide policies they would be implementing at the facility since taking over the facility. A list of policies was sent to the corporate staff at 5:00 PM. As of 6/13/2025, corporate staff had not emailed the requested policies.</p>

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>Based on document reviews, staff interviews, and policy review the facility failed to employ a qualified person to serve as the Infection Preventionist (IP) for the facility. The facility reported a census of 26 residents.</p> <p>Findings include:</p> <p>The facility provided a document from their previous owners, titled Infection Preventionist that documented the facility will employ one or more individuals with responsibility for implementing the facility's infection prevention and control program. The facility will designate a qualified individual as Infection Preventionist (IP) whose primary role is to coordinate and be actively accountable for the facility's infection prevention and control program and antibiotic stewardship program. The facility will ensure the IP works at least part-time at the facility, is adequately qualified and completed a specialized training in infection prevention and control through accredited continuing education.</p> <p>On 6/5/2025 at 11:50 PM the Minimum Data Set (MDS) Coordinator stated she is the facility's IP. When asked if she is certified she stated she is going through the training and has gone through some of the modules. She started these in April. The Director of Nursing (DON) is going through them as well so she has someone to bounce ideas off of. She indicated someone from Corporate helps with the IP responsibilities and handles the resident infection tracking and trending.</p> <p>On 6/5/2025 at 12:51 PM the DON stated the MDS Coordinator is the IP and finishing up her classes. She herself is taking the course too so she can bounce ideas off of her. She was unsure of any prior training the MDS Coordinator may have had for the IP role. When asked how was responsible for the antibiotic stewardship program she stated the MDS Coordinator.</p> <p>On 6/5/2025 at 1:40 PM in the MDS Coordinator's office the facility's antibiotic stewardship binder sat on a chair. When reviewed the binder with her, it was noted it had not been completed for 2025. The MDS Coordinator stated the previous IP did not keep up with it prior to her leaving the facility.</p> <p>On 6/10/2025 at 1:09 PM the Skilled Unit Manager/Assistant Director of Nursing (ADON) stated the MDS Coordinator is their IP. When asked if she was certified, she indicated she knew she had don't some modules. She added the Corporate Nurse has been to the facility since the new company took over, she last visited about 2-3 weeks ago and was always available by phone if they need anything.</p> <p>On 6/10/2025 at 3:58 PM corporate staff were asked to provide policies they would be implementing at the facility since taking over the facility. A list of policies was sent to the corporate staff at 5:00 PM. As of 6/13/2025, corporate staff had not emailed the requested policies.</p>