STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165468	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastern Star Masonic Home	715 West Mamie Eisenhower Boone, IA 50036

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 Based on observations, staff interview, resident interview and family interview the facility failed to maintain a comfortable environment and safe functional equipment in the facility and resident rooms (Resident #4 , and #74) . The facility reported a census of 74. Findings include: 1. During an observation on 07/15/24 at 12:48 PM the thermostat in the conference room that leads into the memory care unit was 83.2 Fahrenheit. During an observation on 07/15/24 at 12:55 PM the thermostat in the hallways outside of room [ROOM NUMBER] E revealed the temperature of 82.1 Fahrenheit. In an interview on 07/15/24 at 12:50 PM Staff B, the Assistant Director of Nursing (ADON) relayed a company is returning to work on the air conditioner today, relayed it had just went down and a part had been ordered. In an Interview on 07/16/24 at 2:30 PM with family members, relayed had complained about the air conditioners not working in the memory care unit, referred to a phone text message to another family member alerted residents' room in memory care unit was 79 degrees and something must be done. Relayed a text in her phone on 07/5/2024 to a family member alerted the temperature was 76 degrees in resident family member room and felt this was not comfortable. Relayed staff had been running a hose to get water onto an outside air conditioning unit perhaps to get it to work better. In an Interview on 07/18/24 at 9:02 AM with Staff A relayed the memory care air conditioning had been out all summer and temperatures got up to 85 at the beginning of the summer, had heard they are working on bids. Relayed different companies looked at the system, fans were brought in along with the styrofoam coolers, and it helped some. Staff A relayed the start of the air conditioner issues began last summer in the unit and believed it was fixed then broke again. Residents are overall comfortable during the day, are out in the common area with the portable devices. Observation revealed temperatures in the common area at 77 degrees Fahrenheit. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/17/24 at 5:45 PM the Director of Compliance relayed had been working with different vendors on quotes for a new air conditioning units and parts were on order for the main unit. Relayed is aware of the issue and had brought in fans, portable units throughout and is hopeful with the new bids to correct the issue. Was relayed no actual policy on temperature, followed the Iowa code. In an interview on 07/18/24 at 2:00 PM the Administrator relayed the memory care section had two air conditioning units, one is working at half capacity and one is down. Relayed the general population unit had been fixed this week when a part arrived and was only down a few days. Relayed bids were received to replace the memory care units. 48886 2. The Minimum Data Set (MDS) assessment dated [DATE], documented Resident #75 had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS further documented an admitted to the facility 7/2/24. During an observation on 7/15/24 at 1:18 PM, Resident #75's room temperature was 87.3 degrees Fahrenheit. During an interview on 7/15/24 at 1:20 PM, Resident #75 advised her room temperature is warm, stating it was at 91 degrees Fahrenheit earlier on this date. Resident #75 stated her room temperature has been warm since she admitted to the facility on [DATE], stating she would like for her room temperature to be around 72 degrees Fahrenheit and the room is uncomfortable. 3. The MDS assessment for Resident #4, dated 4/30/24, documented a BIMS score of 15, indicating intact cognition. The MDS further documented an admitted to the facility 9/28/23. During an observation on 7/15/24 at 1:42 PM, Resident #4's room temperature was 86.2 degrees Fahrenheit. During an interview on 7/15/24 at 1:45 PM, Resident #4 advised it has been this warm in her room all day today and last night. Resident #4 stated her room is always warm, but today is exceptionally warm. Resident advised her room is usually around 80 degrees, stating it is uncomfortable in her room. During an interview on 7/16/24 at 12:52 PM, Resident #75 stated her room is still a little too warm, she would like for it to be cooler, especially when she is trying to sleep. Resident #75 stated it is hard for her to sleep when the room is this warm. Resident stated the room is a little cooler today than yesterday, but it has not gone below 80 degrees yet. Observation of the thermostat in the resident's room revealed the room temperature to be 80 degrees Fahrenheit. During an observation on 7/17/24 at 10:57 AM, Resident #75's room temperature was 83.1 degrees Fahrenheit. During an interview on 7/17/24 at 10:57 AM, Resident #75 stated it is uncomfortable in her room, stating it has been uncomfortably warm in her room since she admitted on the 2nd of June. It makes it difficult to sleep. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/17/24 at10:59 AM, Resident #4 stated her room is never really cool, she always has a fan going. Resident #4 stated her room is usually in the 80's, today it is 77.7 degrees Fahrenheit. The resident said her room got into the 90's on 7/15/24.

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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** 50500 Based on clinical record review and staff interviews, the facility failed to follow a physician's order for 1 of 1 residents reviewed to notify the physician or complete further assessments of daily weight changes within the established parameters (Resident #37). The facility reported a census of 74 residents. Findings Include: The MDS (Minimal Data Set) assessment dated [DATE] documented Resident #37 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS further documented the resident had diagnoses to include coronary artery disease, hypertension, diabetes, arthritis, and chronic ischemic heart disease. Review of the Electronic Health Record (EHR) for Resident #37 showed a physician order with a start date 8/16/23 with an order for daily weights. If weight changes more than 3 pounds in one day or 5 pounds in one week, staff is to assess and re-weigh; notify the provider, family, and document in the nurse's notes. Review of the EHR for Resident #37 revealed the following weight discrepancies: Weight gain of 6.6 pounds on 7/9/24; Weight gain of 4.5 pounds on 6/15/24; Weight gain of 4.2 pounds on 6/7/24; Weight gain of 4.3 pounds on 5/27/24; Weight gain of 5.9 pounds on 5/8/24; Weight gain of 5 pounds on 5/2/24 (resident refused to be weighed on 5/1/24; Weight gain noted between 4/30/24 and 5/2/24); Weight gain of 4.7 pounds on 3/19/24 (resident refused to be weighed on 3/18/24; Gain noted between 3/17/24 and 3/19/24); Weight gain of 11.1 pounds on 3/10/24. In each of the above cases, staff failed to obtain a reweigh, document acknowledgement of the weight change, further assess the resident, or notify the physician. Review of the monthly Treatment Administration Record (TAR), acknowledged the presence of bilateral lower extremity (BLE) edema. EHR progress note review between February 2024 thru July 2024 indicated an increase in BLE edema from a 2+ on 2/1/24 to 4+ pitting on 7/18/24. Staff E, Registered Nurse (RN), interviewed on 7/17/24. Staff E, RN, acknowledged Resident #37's daily weight order. Staff E, RN, explained certified nursing assistants (CNA) will obtain the daily weight and nursing staff on duty will enter the weight in the EHR. At this time, nursing has the ability to assess the weight for any changes. During an interview on 7/18/24, the Director of Nursing (DON) acknowledged Resident's #37 order for daily weights and the process staff should follow if a gain of 3 pounds in a day documented. The DON recognized the lack of assessments or acknowledgment from nursing staff regarding the weight discrepancies, regardless if the weight documentation was in error or correct. The DON unable to provide an explanation as to the lack of follow-up.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48886 Based on observations, clinical record review, and staff interviews, the facility failed to ensure safe transport of a resident in a wheelchair for 1 of 1 residents reviewed. (Resident #17). The facility reported a census of 74. Findings include: The Minimum Data Set (MDS) assessment for Resident #17, dated 5/21/24, documented a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. The MDS further documented diagnoses to include non-traumatic brain function, heart failure, renal insufficiency, arthritis, and non-Alzheimer's dementia. The Daily Pocket Care Plan for Resident #17, dated 7/15/24, under the section titled ambulate-transfer/chair, documented resident assist of 2 with Hoyer for transfer and wheelchair for distance. During an observation on 7/15/24 at 2:12 PM, Resident #17 was in the hallway, propelling himself independently in his wheelchair with both feet, using both feet on the ground to propel forward. Staff C, CNA, redirected the resident when the resident began entering another resident's room. Staff C asked the resident if he wanted help to his room, then asked the resident to pick his feet up off the floor a little, and began to push him to his room. Staff C did not engage the foot pedals, the resident's feet were loose and hanging approximately one inch off the floor. Staff C pushed the resident to his room, which was located down the hallway and turning into another hallway. During an interview on 7/17/24 at 2:53 PM, Staff D, CNA, advised having knowledge of Resident #17's care plan and history of working on the unit where the resident resides. Staff D advised the resident is mostly independent with propelling himself in his wheelchair Only on occasion staff assist with pushing resident in his wheelchair. If they do assist the resident, staff should put the foot pedals down and have him put his feet on the pedals. Sometimes the resident takes the pedals off his wheelchair, he does not like having them on. Staff D stated staff should retrieve the foot pedals before pushing him for safety reasons, to prevent his feet from dragging and getting caught under the wheelchair. Staff D stated she has observed the resident being pushed in his wheelchair by staff without the pedals down and with just being told to hold his feet up off the floor. During an interview on 7/17/24 at 3:25 PM, the DON advised Resident #17 can propel himself in his wheelchair independently. If staff need to assist the resident, they should ensure the foot pedals are engaged and his feet are placed securely on the foot pedals before pushing him. The DON stated an expectation staff ensure the foot pedals are on the wheelchair and the resident's feet are placed on the foot pedals before pushing the resident in his wheelchair. The DON stated staff should not push the resident in his wheelchair without the foot pedals and should not ask the resident to hold his feet up on his own. The DON advised the cover sheet to the pocket care plan has an alert printed in red at the bottom which reads when pushing a resident in a wheelchair the foot pedals must be on. The DON advised the facility does not have a policy on wheelchair assistance, they follow state regulations and the Master Care Plan cover sheet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated facility Master Pocket Care Plan cover sheet documented at the bottom of page 1; when pushing a resident in a wheelchair the foot pedals must be on.