STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on observation, clinical record review, policy review, resident, guardian, and staff interviews, the facility failed to notify the legal guardian of laboratory refusals and resident change in condition for 1 of 5 resident reviewed for medication use (Resident #7). The facility reported a census of 50 residents. Findings include: The Minimum Data Set (MDS) assessment, dated 7/04/24, for Resident #7 listed diagnoses included schizophrenia, diabetes mellitus, stroke, aphasia (a disorder that affects a person's ability to understand and express language, including reading and writing), hemiplegia (paralysis or weakness on side of the body), and anxiety disorder. A Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicated a moderate cognitive impairment. The MDS listed medications taken seven days a week which included insulin, antipsychotic, and an antidepressant. The MDS identified Resident #7 as not exhibiting rejection of care during the review period. A clinical record review revealed an Iowa District Court Letter of Appointment, issued on 6/10/24, that ordered [agency name redacted] to serve as guardian for Resident #7. The order included full power and authority to exercise any and all of the duties, powers, and responsibilities granted to guardians under Iowa Law. An Order Summary Report, signed by the Provider on 8/15/24, listed the following orders: a. BMP (basic metabolic panel - a test that measures eight different substances in the blood) laboratory draw every 6 months related to hypertensive (high blood pressure) heart disease. b. Psychological services and Medication Management. c. Use a Freestyle Libre for blood sugar checks (continuous blood glucose monitoring system) d. Basaglar Kwik Pen Subcutaneous (SQ) Solutions (insulin) 100 units/milliliter (ML). Inject 10 units SQ in the evening related to type 2 diabetes mellitus with hyperglycemia. e. Fiasp Flex Touch SQ Solution (insulin) Pen-injector 100 units/ML. Inject 8 units SQ before meals related to type 2 diabetes mellitus with hyperglycemia. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. Fiasp Flex Touch SQ Solution (insulin) Pen-injector 100 units/ML (insulin). Inject as per sliding scale insulin. g. Furosemide Tablet 40 milligrams (MG) (diuretic medication or often called a water pill). Give 1 tablet by mouth one time for swelling related to essential high blood pressure. h. A1C (hemoglobin A1C - a test that measures average blood sugar levels over the past three months) laboratory draw every 3 months. The Care Plan, Date Initiated: 3/10/23, Revision on 10/10/24 included a Focus area to address [Name redacted] has a history of/potential for resistance to care: Repositioning, pericare/check and change and outside appointments. Interventions did not include refusals to have blood drawn for lab work, and notifying the legal guardian of such refusals. During an observation on 11/12/24 at 11:15 AM, Resident #7 in bed, with the head of the bed elevated. Resident #7 stated she is fine and wanted more cookies. Cookies present on the residents bedside table, and within her reach. A review of Resident #7 clinical record revealed: a. An ear-Medication Administration Note on 9/01/24 at 1:10 PM, Note Text: BMP (Basic Metabolic Profile) one time a day every 6 month(S) starting on the 1st for 1 day(S) related to HYPERTENSIVE HEART DISEASE WITHOUT HEART FAILURE. Resident Refused to have blood draw. Educated resident about purpose of blood draw. Resident continues to refuse. The record did not include documentation that the residents legal guardian notified of the refusal. b. An INTERACT BAR (acronym for Situation, Background, Assessment, and Recommendation, communication tool) on 9/5/2024 at 5:26 PM, Note Text: The Change in Condition/S reported on this CIC (change in condition) Evaluation are/were: Other Change in condition at the tome of evaluation resident/patient vital signs, in part; Blood Glucose: BS: 501.0 9/5/24 R 5:08 PM .Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: Give 18 U (units) short acting insulin, and recheck 30-45 minutes. The record did not include documentation that the residents legal guardian notified of the change in condition and provider recommendation. c. An ear-Medication Administration Note on 11/4/2024 at 9:54 AM, Note Text: A1C every shift every 3 month(s) starting on the 1st for 1 day(s) Resident refused Blood Draw. ARNP (Advanced Registered Nurse Practioner) Aware. The record did not include documentation that the residents legal guardian notified of the refusal. d. A Nurses Note on 11/8/2024 at 9:02 AM, Note Text: Left great toe bumped on the hoyer during transfer after her shower. Scratch noted on cuticle that is bleeding a small amount. Bandage applied. Shower chair caused a superficial open area on gluteal [NAME] that measures 2x1x0 cm (centimeter). Barrier cream applied per order. The record did not include documentation that the residents legal guardian notified of the injury. During an interview on 11/13/24 at 5:00 PM , the Assistant Director of Nursing reported Resident #7 had refused her last BMP draw and it was documented in the progress notes on 9/01/24. The ADON voiced Resident #7 refuses her blood draws all the time. She really hates them. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Arbor Court		STREET ADDRESS, CITY, STATE, ZIP CODE 701 East Mapleleaf Drive Mount Pleasant, IA 52641	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/24 at 7:33 AM, Staff F, Licensed Practical Nurse (LPN) verbalized Resident #7 is confused at times. She has whole conversations with other people in her head, so you never know what you're going to get when you walk in her room. She was in and out of psychiatric wards long before she was at the facility. She has been this way a long time. Staff F had to ask the Director of Nursing (DON) who they notify of Resident #7 new orders. Staff F could not answer if it was appropriate for Resident #7 to be making her own decisions and asked the DON. During an interview on 11/14/24 at 7:34 AM, the DON responded to Staff F Resident #7 guardian should be notified of new orders. The DON voiced she knew Resident #7 had refused her last laboratory draw on 9/01/24. She would have to look further into Resident #7 to see if the guardian or the physician had been notified of the refused laboratory draws. During an interview on 11/14/24 8:51 AM, the court appointed legal guardian representative for Resident #7 reported she did not know anything about the resident refusing a lab draws or that the resident had a history of refusing laboratory draws. She has not been notified of any changes in the residents health condition. The only time she finds things out is when she goes to the facility. She comes to the facility monthly. She checks in with whoever is at the desk and then she goes to see the resident and looks her over. She wants to be involved in Resident #7 care and would have wanted to be informed that Resident #7 refused her laboratory draw as something like that at Resident #7 age is not good. During an interview on 11/14/24 at 9:45 AM, Resident #7 Physician reported residents have rights and he is aware of Resident #7's condition and refused labs. He feels the facility does the best they can. He voiced his next visit at the facility is 11/22/24 and he had planned to talk with Resident #7 about the missed lab draws and encourage her to have her labs drawn. During an interview on 11/14/24 at 10:14 AM, the DON reported Resident #7 had also refused her A1C lab (measures the average level of glucose (sugar) in your blood over a period of about three months; a test used to monitor diabetes) on 11/04/24 and the Advanced Registered Nurse Practitioner (ARNP) was notified at that time, but the ARNP and guardian had not been notified of the laboratory draw refusal on 9/01/24. The facility also had not notified the guardian of the laboratory refusal on 11/04/24. The DON verbalized the nurses would normally contact the guardian on something like that. During an interview on 11/14/24 a 10:16 AM, the Administrator reported she thought the facility originally had been the one to start the guardianship process. She voiced there was a temporary guardianship in place in June 2024. There was a progress note on 10/07/24 that the facility received the final permanent guardianship. She voiced the facility should have notified the guardian of any changes to the resident from the time of the temporary guardianship. The facility policy, dated 4/26/23, titled Notification of a Change in Condition Policy statement declared the Attending Physician/Physician Extender (Nurse Practitonioner, Physician Assistant, or Clinical Nurse Specialist) and the Resident Representative will be notified of a Change in a Resident's Condition per Standards of Practice and Federal and/or State Regulations. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The section titled Procedure 1. Guideline for Notification of Physician/Resident Representative (not all inclusive); in part, Significant Change or Unstable Vital Signs, Accident/Incident, Abnormal Laboratory Results, Repeated refusal to take prescribed medications, Glucometer reading below 70 or above 200 (unless specific parameters were given by the Physician for reporting.). 2. Document in the Interdisciplinary Team (IDT) Notes, included, in part; Notification of Resident Representative.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on clinical record review, Center for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, resident and staff interviews, the facility failed to complete the Minimum Data Set to accurately reflect the tobacco status for 2 of 2 residents reviewed for smoking (Resident #49 and #18). The facility identified a census of 50 residents. Findings include: 1. A Minimum Data Set (MDS) assessment, dated 9/30/24, for Resident #49 included a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. MDS Section J Health Conditions indicated Resident #49 did not utilize tobacco. MDS Section V Assessment Administration documented I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf. Staff A signed she completed Section J Health Conditions on 10/01/24. A 9/24/24 Smoke Safety Evaluation identified Resident #49 utilized tobacco and did not exhibit any safety concerns with smoking. A Progress Note dated 9/24/24 at 10:43 AM, completed by the Director of Nursing (DON) documented Resident #49 goes out to smoke and is safe to smoke. A Progress Note dated 9/25/2024 at 5:11 PM, completed by the Assistant Director of Nursing (ADON) documented Resident #49 adjusting well to the facility and went out to smoke on all three smoke breaks today. During an interview on 11/12/24 at 11:09 AM, Resident #49 reported he goes out three times a day to smoke and his smoking supplies are kept at the nurses station. A staff member always goes out to smoke with him During an interview on 11/13/24 at 1:45 PM, Staff B, Certified Nursing Assistant (CNA) reported Resident #49 has smoked since he admitted to the facility. During an interview on 11/13/24 02:05 PM Staff C, CNA reported Resident #49 has always gone out to smoke since he was admitted . 50874 (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	2.The MDS, dated [DATE], for Resident #18 included a BIMS score of 12 out of 5 indicating moderate cognitive impairment. MDS Section J Health Conditions documented Resident #18 did not utilize tobacco. Staff A, MDS Coordinator signed she completed Section J Health Conditions for accuracy on 8/14/24. During an interview on 11/13/24 at 11:49 AM, Resident #18 stated she is a current smoker. Resident #18 stated she smokes in the designated smoking area at the allowed times with supervision. Resident #18 verbalized she smokes 2-3 times per day. During an interview on 11/13/2024 at 12:13 PM, with Staff C, CNA revealed Resident #18 has smoked since she was admitted to the facility. During an interview on 11/13/24 at 4:49 PM, the DON acknowledged that Resident #49 and Resident #18 currently smoked at the facility. The DON verbalized she did not understand why it was coded wrong on the MDS and she needed to check with the MDS Coordinator. During an interview on 11/13/24 at 4:52 PM, Staff A, MDS Coordinator acknowledged both Resident #49 and #18 were coded wrong and she would be submitting (MDS) corrections. Staff A stated they have a policy for MDS accuracy. During an interview on 11/13/24 at 5:18 PM, the Administrator reported she audited the MDS for smoking not that long ago and it should been coded correctly. She voiced they do not have an MDS policy, they utilize the RAI for MDS coding. The LTC RAI 3.0 User's Manual Version 1.19.1 October 2024 page 1-4 documents the RAI process has multiple regulatory requirements. Federal regulations at 42 CFR (Code of Federal Regulations) 483.20 (b)(1)(xviii), (g), and (h) require that the assessment accurately reflects the resident's status. Page J-26 for Section J Health Condition instructs to code yes if the resident or any other source indicates that the resident used tobacco in some form during the look-back period.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 48452 Based on observation, clinical record review, and staff interviews the facility failed to ensure resubmission of the a Preadmission Screening and Resident Review (PASRR) after a change in mental health diagnoses for 1 of 1 residents reviewed (Resident #21). The facility reported a census of 50 residents. Findings include: The Minimum Data Set (MDS) for Resident #21, dated 9/26/24, included the following diagnoses: anxiety disorder; major depressive disorder, moderate, recurrent; pervasive developmental disorder; adjustment disorder; and psychotic disorder. The Brief Interview for Mental Status (BIMS) score of 15 out of 15, included intact cognition. The clinical record revealed Resident #21's diagnoses list with date added to the record. The list reflected Major Depressive Disorder, single episode, unspecified 5/28/19; Anxiety Disorder unspecified 5/28/19; Pervasive Developmental Disorder 5/28/19; Generalized Anxiety Disorder 5/28/19; Adjustment Disorder unspecified 5/28/19; Major Depressive Disorder, recurrent, moderate 7/1/24; and Unspecified Psychosis not due to a substance or known physiological condition 7/1/24. A document titled PASRR Notice of Exemption From PASRR, dated 5/27/19, recorded the resident did not meet the criteria for serious mental illness or a developmental condition and was not subject to PASRR requirements at that time. Page 2 further noted the resident was diagnosed with Depressive Disorder, Generalized Anxiety Disorder, and Rule Out Agoraphobia with symptoms of tearfulness, anxiety, and worry. A Psychiatric Initial Assessment, dated 2/1/24, revealed the resident was experiencing symptoms of depression, anxiety, psychosis, and insomnia. The Assessment/Plan section documented diagnoses of generalized anxiety disorder, major depressive disorder, and unspecified psychosis not due to a substance or known physiological condition. A Psychiatric Subsequent Assessment, dated 11/11/24, diagnoses list included Generalized Anxiety Disorder, Major Depressive Disorder (recurrent, moderate), Insomnia, and Unspecified psychosis not due to a substance or known physiological condition. During an observation on 11/13/24 at 10:59 AM, Resident #21 returned to her room. The resident stated she has mental health services via telehealth. She stated she could not remember if staff discussed her mental health with her recently and thought she would report concerns to the nurse. During an interview on 11/13/24 at 04:47 PM, the Director of Nursing reported the Social Services Director (SSD) was responsible for completing PASRR when diagnoses changed. She stated nursing got the orders and social services did the therapies because they had a closer relationship with the providers. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/13/24 at 5:02 PM, the SSD stated an updated PASRR would be submitted if there was a new diagnosis or change in status. Diagnoses for Resident #21 and the exemption were reviewed with the SSD who said she would have to look into it. On 11/14/24 at 10:10 AM, the SSD confirmed a new PASRR needed to be submitted. She was not sure why it had not been done at the time of the new diagnosis in February and indicated she was not aware the diagnoses had been added to the resident's diagnosis list in July. During an interview on 11/14/24 07:32 AM, the Administrator stated after review she determined the actual change in diagnoses happened in January. The prior SSD left in December, and she herself had been responsible for helping with PASRRs during those staff transitions. They missed adding the new diagnoses to the list in January and therefore did not submit a new PASRR. A staff member only working at the facility for a month added the diagnoses in July, and did not communicate it to the team which was why there was not a new submission then either. The facility did not have steps in place to audit for missing PASRRs. On 11/14/24 at 11:17 AM, the Administrator stated the facility did not have a policy related to PASRR submission, and followed federal guidelines established for the contracted company completing the assessments.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 42133 Based on clinical record review, resident and staff interviews, the facility failed to complete post dialysis assessments for 1 of 1 residents sampled (Resident #12). The facility identified a census of 50 residents. Findings include: The Minimum Data Set (MDS) assessment, dated 11/01/24, for Resident #12 documented a Brief Interview for Mental Status (BIMS) score of 9 out of 15 indicating moderate cognitive loss. The MDS identified Resident #12 received dialysis for a diagnosis of end stage renal disease. The Care Plan, Date Initiated: 9/8/24 included a Focus area to address Dialysis at [provider name redacted] on M-W-F (Monday-Wednesday-Friday) at 10 AM and transportation via [provider name redacted] transport. A review of the October 2024 Electronic Registered Nurse/Licensed Practical Nurse Medication Administration Record (RN/LPN MAR) revealed an order, dated 9/6/24, Vital Signs prior to sending and returning from dialysis two times a day every Mon, Wed, and Fri. The vital signs documented at 0700 (7:00 AM) and 1500 (3:00 PM) included: BP (blood pressure), Temp (temperature), Pulse, Resp (respirations). Vitals signs were not documented at 1500 on 10/7/24, and 10/28/24. A review of the November 2024 RN/LPN MAR revealed a continued order, dated 9/6/24, Vital Signs prior to sending and returning from dialysis two times a day every Mon, Wed, and Fri. Vital signs were not documented at 1500 on 11/4/24, and 11/11/24. During an interview on 11/13/24 at 12:22 PM, Staff D, Registered Nurse (RN) reported the nurses do vital signs as part of the pre and post dialysis assessment. They have a dialysis communication form they fill out, place in a binder and the binder goes to and from dialysis with Resident #12. They also record the fistula assessment on the MAR. A 11/13/24 3:30 PM review of Resident #12 dialysis binder revealed the following: a. The Dialysis Communication Record, undated, with the 10/07/24 local dialysis center documentation lacked documentation of any post dialysis assessment for vital signs. b. The Dialysis Communication Record, undated, with the 10/28/24 local dialysis center documentation lacked documentation of any post dialysis assessment for vital signs. c. The Dialysis Communication Record, undated, with the 11/04/24 local dialysis center documentation of a post dialysis assessment for vital signs. c. The Dialysis Communication Record 11/11/24 lacked documentation of a post dialysis assessment of Resident #12 vital signs. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the electronic health record sections for vital signs, progress notes and assessments revealed no documentation for vital signs or assessments post dialysis (1500) for Resident #12 on October 7, 28 and November 4 and 11. During an interview on 11/13/24 at 4:33 PM, Staff D RN reported the post dialysis assessment if it was done should be documented on the dialysis communication sheet or in the electronic health care record. She is aware they are to do a post dialysis assessment to ensure a resident is stable. She verbalized the assessment may have gotten written on a piece of paper and never made it to the resident's chart. During an interview on 11/13/24 at 4:38 PM, the Director of Nursing reported if the post dialysis assessment was not on the (dialysis communication) paper or in the computer, most likely it got done, but did not get documented. If it wasn't documented, it wasn't done. The DON verbalized she would check to see if the facility had a procedure for completing post dialysis assessments. During an interview on 11/13/24 at 6:12 PM, the Administrator responded the facility follows dialysis professional standards of practice. The facility did not have a dialysis assessment policy.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 42133 Based on Centers for Medicare and Medicaid Services (CMS) Certification and Survey Provider Enhanced Reports Reporting (CASPER) system, review of the facility Quality Assurance Performance Improvement (QAPI) Policy, and staff interview the facility failed to ensure effective measures had been taken to correct deficiencies that continue. The facility reported a census of 50 residents. Findings include: A review of the facility CASPER report revealed the facility cited for F641 (Accuracy of Assessments) in February 2024 and will be cited during the current recertificaton survey. A review of Resident #49 and #18 Minimum Data Set (MDS) Comprehensive Assessments showed both coded as no, for use of tobacco in Section J Health Conditions. On 11/13/24 at 4:49 PM, the Director of Nursing acknowledged that Resident #49 and Resident #18 currently smoked at the facility. On 11/13/24 at 4:52 PM Staff A, MDS Coordinator acknowledged both Resident #49 and #18 were coded wrong and she would be submitting (MDS) corrections. Staff A stated they have a policy for MDS accuracy. During an interview on 11/13/24 at 5:18 PM the Administrator reported she had just audited the MDS for smoking not that long ago and everything should have been coded correctly. She couldn't believe there was an issue with the MDS coding. She voiced they do not have an MDS policy, the facility utilizes the CMS Resident Assessment Instrument (User's Manual) for MDS coding. Interview on 11/14/24 at 10:10 AM the Administrator, with the Regional Director of Operations and DON present stated regarding the F641 Citation, the new MDS Coordinator was aware of the plan of correction from the last survey for the F641 MDS accuracy tag. They had audited through the Quality Assurance (QA) program the medication section of the MDS for accuracy and they looked at the MDS as a whole for accuracy. She reported they had looked at the smoking issue as a whole more in regard to care plan verses the MDS, but had looked at MDS as part of the process. A review of the facility Quality Assurance & Process Improvement (QAPI) Policy, dated 8/20/20, directed the QAPI Plan will describe how the facility will ensure care & services are delivered, meet accepted standards of quality, identify problems and opportunities for improvement, and ensure progress towards improvement is achieved and sustained. The QA Committee will meet monthly to assess and monitor the quality of services provided to residents and identify potential problems or areas of opportunity for improvement. The QA Committee will implement and systematically evaluate programs and processes to identified problems in order to proactively improve health care delivery. The QAPI Policy Procedure included: a. Performance improvement is a proactive and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and implementing new approaches to resolve systemic problems. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165478	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Utilize data obtained from a variety of sources to identify quality problems or opportunities for improvement and set priorities for resolution. c. Perform root cause analysis, identify trends/patterns, set targets, & implement action items to improve the process.