

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 04/09/2025
NAME OF PROVIDER OR SUPPLIER Arbor Court		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0578</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 request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888</p> <p>Based on clinical record review, facility policy review, and staff interview, the facility failed to accurately obtain and implement advanced directives per resident and family directives upon admission for 1 of 1 residents (Resident #202) reviewed. The facility reported a census of 51 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS), dated [DATE], revealed Resident #202 had been admitted to the facility on [DATE] from a short term general hospital.</p> <p>Review of Resident #202's Order Summary Report, dated [DATE], revealed a verbal order for CPR, effective [DATE].</p> <p>Review of Resident #202's electronic health record (EHR) revealed a lack of a signed document, by Resident #202, Resident Representative, or physician, to confirm Resident #202's wishes for life sustaining measures.</p> <p>During an interview on [DATE] at 11:28 AM, the Director of Nursing (DON) retrieved a binder which included the resident's Iowa Physician Orders for Scope of Treatment (IPOST). An IPOST is a document that allows a person to communicate their preferences for key life-sustaining treatments such as CPR, full treatment verses comfort measures only, and artificial nutrition administration. The DON stated Resident #202's IPOST was not present in the binder.</p> <p>During an interview on [DATE] at 3:18 PM, the DON stated Resident #202's family was called on [DATE] and identified Resident #202's wished for DNR. DON stated an IPOST was completed indicating a DNR on [DATE] and faxed to the physician to be signed.</p> <p>During an interview on [DATE] at 3:25 PM, the Social Services Director (SSD) explained that a call was placed to Resident #202's family on [DATE], but she was unable to leave a voicemail. The SSD acknowledged she did not document the attempt to contact Resident #202's family on [DATE].</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy, titled Advanced Directives, dated [DATE], revealed upon resident admission, the facility would provide a resident who is medically deemed competent, or resident representative, who does not have an existing Advance Directive with written information and instructions regarding the right to make Advanced Directives prior to the initiation of care or at any requested time. The Policy revealed all facility employees are responsible for implementation of Advanced Directive Policy. The Policy listed Social Services Director and Facility Administrator as responsible for monitoring this Policy.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336</p> <p>Based on observations, clinical record review, and staff interviews, the facility failed to ensure 2 foot pedals used when a staff pushed a resident in their wheelchair for 1 of 7 (Resident #17) reviewed for accidents. The facility reported a census of 51 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 scored a 00 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition severely impaired. The MDS indicated resident impaired on one lower extremity. The MDS indicated resident used a manual wheelchair and walker. The MDS revealed medical diagnoses for non-Alzheimer's dementia; hemiplegia or hemiparesis; arthritis; and hip fracture.</p> <p>The Care Plan revealed a focus area dated 10/10/24 for anytime ambulation program- increased risk for impaired physical mobility related to decreased strength, endurance, and chronic illness, as evidenced by generalized weakness ADL (Activities of Daily Living) self performance level and support level required to complete ADL task.</p> <p>During an observation on 4/06/25 at 2:39 PM, Resident #17 pushed in her wheelchair by staff. The resident had no foot pedal for the left foot while resident's wheelchair was pushed by staff.</p> <p>Observation on 4/06/25 at approximately 3:31PM, Staff C, Certified Nursing Assistant (CNA) pushed Resident #17 in her wheelchair, while the wheelchair had a foot pedal applied for one foot only.</p> <p>During an observation on 4/7/25 at 12:45 PM, Staff D, CNA assisted Resident #17 to out of a recliner and into a wheelchair. Staff D placed one foot pedal on the right side of the wheelchair and made a comment about the other foot pedal by the recliner. Staff D then asked Resident #17 to cross her legs on the one foot pedal. Resident #17's foot fell off the other foot and hung down as Staff D pushed the wheelchair out of the common area.</p> <p>During an interview on 4/8/25 at 2:03 PM, Staff A, CNA queried on how Staff A transported Resident #17 in her wheelchair, and stated Resident #17 self propelled. Staff A queried how they pushed Resident #17 in a wheelchair, and stated they put foot pedals on and pushed her. Staff A queried if they could push Resident #17 with one foot pedal, and stated no, not to her knowledge.</p> <p>During an interview on 4/8/25 at 2:44 PM, Staff B, CNA queried if she could push Resident #17 in her wheelchair with one pedal. Staff B stated she wouldn't push her from behind with one foot pedal because Resident #17 always dragged her feet.</p> <p>During an interview on 4/8/25 at 2:53 PM, Staff D, CNA queried if Resident #17 could be pushed in her wheelchair, stated yes, and acknowledged the resident needed two foot pedals. Staff D stated she got Resident #17 up and pushed her with one foot pedal to the bathroom. Staff D stated she tried to put the other foot pedal on the wheelchair but it didn't connect because a piece was broken.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/9/25 2:01 PM Staff C, CNA explained she worked Sunday from 6:00 AM to 6:00 PM. Staff C explained depended on the day whether Resident #17 used foot pedals, explained resident sometimes used, and sometimes didn't. Staff C further explained the second foot pedal peg that connected pedal to the chair was broken off. When queried if the connection piece broken when Staff C came in on Sunday, Staff C responded yes, and explained she was not sure if anyone else was aware. When queried if had been like that Saturday, Staff C could not recall. When queried how many pedals to have on if pushed in wheelchair, Staff C acknowledged two.</p> <p>During an interview on 4/9/25 at 2:41 PM, the DON (Director of Nursing) informed of the situations with one foot pedal used during wheelchair transport for Resident #17 and the DON stated Resident #17 needed 2 foot pedals when pushed if she was not able to keep her feet on one foot pedal.</p> <p>Per mail from the Administrator on 4/9/25 at 3:43 PM, no policy for wheelchair transports.</p> <p>45338</p>		