STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165482	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
United Presbyterian Home	1203 E Washington Street Washington, IA 52353

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 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** Based on observation, clinical record review, policy review, and staff interviews, the facility failed to notify the provider when a resident with a pressure ulcer did not wear his ordered orthotic (referring to externally applied devices, primarily custom-made shoe inserts, designed to support the feet and correct structural and functional issues) shoes for 1 of 2 residents reviewed for pressure ulcers (Resident #10) and failed to notify the provider in a timely manner of a significant weight loss for 1 of 3 residents reviewed for nutrition (Resident #33). The facility reported a census of 49.Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 3/24/25, listed diagnoses for Resident #10 which included cellulitis (inflammation of the tissues) of the right lower limb, pain in the right foot, and non-Alzheimer's dementia. The MDS stated the resident had an infection of the foot and one unhealed pressure ulcer. The MDS did not state the stage of the ulcer. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 8 out of 15, indicating moderately impaired cognition. Review of the a 4/6/25 Care Plan entry revealed the resident had a Stage 3 pressure ulcer (characterized by full-thickness tissue loss, where the damage extended through the dermis (second layer of skin) into the fat layer on the right foot due to a foot deformity and directed staff to administer treatments as ordered and monitor for effectiveness. An Order Note, dated 5/6/25 entered by Staff K, Wound Doctor of Nursing Practice(DNP) directed staff to consult with occupational therapy (OT) for off-loading footwear recommendations to promote wound healing. Review of Wound Treatment Plans, written by Staff K revealed the following: a. A 5/27/25 note stated therapy worked on getting a custom shoe. b. A 6/10/25 note stated therapy worked on getting a custom shoe and it had not yet arrived. c. A 6/24/25 note stated the shoes had not arrived and the date of arrival was unknown. d. A 7/1/25 note stated the resident had custom boots. e. A 7/8/25 note stated the resident had custom boots. f. A 7/15/25 note stated the resident had custom boots. (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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 7/14/25 at 12:47 p.m., Resident #10 was in his room and wore black slip on shoes. Next to the resident's bed, there was a pair of brown work boots. The boots did not contain any special inserts. No other boots were present in the resident's room During an observation on 7/17/25 at 10:22 a.m., Staff C, Licensed Practical Nurse (LPN) measured a wound on Resident #10's right inner ankle, with the following results: 1.6 centimeters (cm) x 1.3 cm x 0.2 cm (length x width x depth). The wound appeared to have a light yellow wound base and white edges. The work boots sat next to the bed. No other boots were present in the resident's room. Review of the facility policy titled Managing Condition Changes/Physician Notification, reviewed 5/2025, directed staff to report changes to the resident's physician. Review of the facility document titled Pressure Ulcers/Skin Breakdown-Clinical Protocol revealed the physician would order pertinent wound treatments including pressure reduction surfaces. During an interview on 7/17/25 at 11:37 AM, Staff L, Physical Therapy Assistant (PTA) stated the facility received an order for a custom shoe but the resident and his friend decided they would go to a shoe store themselves and figure out what the resident wanted. Staff L stated they went to a shoe store and purchased a regular work boot. Staff L stated he thought Staff K was aware of this as it was communicated through nursing. During an interview on 7/17/25 at 11:48 AM, the Director of Nursing (DON) stated she would want orthotic orders carried out. She stated she would want Staff K to know if the resident did not wear the boots. During a phone interview on 7/17/25 at 2:01 PM, Staff K, Wound DNP stated the resident wore orthotic shoes. She stated she conducted her visits virtually but Staff B, LPN stated the work boots were actually the orthotics. She stated there were orthotic inserts in his boots. During an interview on 7/17/25 at 2:09 PM, Staff B LPN confirmed the boots in the resident's room were just regular boots off the shelf. He stated Staff K interpreted the boots as orthotics but they were not and did not have inserts. Staff B stated he would relate to Staff K that they were not custom shoes. The facility lacked documentation as of 7/17/25 that they notified Staff K the resident did not wear custom boots. 2. The MDS assessment dated [DATE] revealed Resident #33 scored a 6 out of 15 on the BIMS, which indicated cognition severely impaired. The MDS indicated the resident required setup or clean-up assistance with eating. The MDS revealed no known weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months. The MDS indicated medical diagnoses for non-Alzheimer's dementia and Parkinson's disease. The MDS indicated the resident prescribed an diuretic. Review of the Care Plan revealed a Focus area dated 2/26/25 for altered nutritional status related to pneumonia, cardiovascular accident (CVA), Parkinson disease, dementia, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF). The interventions dated 2/26/25 directed daily weights unless otherwise noted by physician or dietician and resident's physician would be notified of significant weight changes. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Weight Summary, dated 7/17/25 revealed: a. On 02/21/2025, the resident weighed 175 Lbs. (pounds). On 03/23/2025, the resident weighed 165.5 Lbs. -5.0% change [Comparison Weight 2/21/25 175.0 Lbs, -5.1% (loss), -9.0 Lbs.] b. On 03/09/2025, the resident weighed 173 Lbs. On 04/12/2025, the resident weighed 163.5 Lbs. -5.0% change [Comparison Weight 3/9/25 173.0 Lbs, -5.5% (loss), -9.5 Lbs.]. c. On 02/21/2025, the resident weighed 175 lbs. On 04/28/2025, the resident weighed 158.5 Lbs. -5.0% change [Comparison Weight 3/29/25, 167.0, -5.1%, -8.5LBS]; -7.5% change [Comparison Weight 2/21/25, 175 Lbs, -9.4% (loss), -16.5 Lbs] Review of the electronic health record (EHR) revealed a lack of documentation of provider notified of the significant weight losses. Review of Provider notes dated 3/24/25 and 4/21/25 revealed a lack of documentation of the weight loss reviewed. During an observation on 7/15/25 at 11:50 AM, Resident #33 sat in the dining room and ate his lunch independently. During an interview on 7/16/25 at 3:07 PM, Staff A, LPN queried on who monitored significant weight losses and Staff A stated the Dietician did. Staff A queried if she knew anything about Resident #33 weight loss and Staff A stated no. Staff A explained she had notified the doctor for another resident who had a significant weight loss. During an interview on 7/17/25 at 10:22 AM, Staff B, LPN queried on who monitored weights and Staff B stated the nurses documented in the chart. Staff B stated he was not sure who reviewed the weights for significant weight losses, and confirmed the floor nurses did not review the resident's chart for significant weight losses. Staff B asked if he knew of Resident #33 weight loss and he stated no. Staff B reviewed the computer, and explained he noticed a steady decline in weights. Staff B queried if the provider needed notified with a weight loss of 5% in 30 days and Staff B stated he would notify. During an interview on 7/17/25 at 12:24 PM, the Dietician stated she reviewed Resident #33 notes and the Dietician didn't note a significant weight loss until May. The Dietician stated she didn't look in the EHR at the weights, and stated she went from exactly 30 days and seen if the residents showed a weight loss. The Dietician stated the provider needed to be notified of significant weight changes and in May the provider was notified. During an interview on 7/17/25 at 1:03 PM, the DON queried on Resident #33 weight loss and the DON stated she didn't know of any with him recently. The DON stated the Dietician reviewed the weights weekly and made notes in a binder. The DON reviewed the binder and stated she didn't see any notes concerning Resident #33 in April or May. The DON queried if the provider needed notified for significant weight losses and the DON stated yes, but she wanted to speak to the Assistant Director of Nursing (ADON) to see if the provider expected weight loss. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/17/25 at 2:02 PM, the Assistant Director of Nursing (ADON) queried on Resident #33 weight loss and the ADON stated the Dietician alerted them of weight losses. The ADON reviewed Resident #33 weights and then asked if the provider should be notified of weight loss and the ADON stated yes, but the provider might of wanted the weight loss and would look through the provider notes. During an interview on 7/17/25 at 3:09 PM, the Advanced Registered Nurse (ARNP) queried on who reviewed the significant weight changes and the ARNP stated usually the Dietician worked with the facility and when the ARNP came in, the facility gave her a stack of papers for resident's weights to review. The ARNP stated she signed a paper when notified of weight losses. The ARNP stated when she reviewed the resident's weights she looked at the previous note and compared to the current weight. The ARNP stated if she received a paper with weights for a resident, she reviewed the weights further. The ARNP reviewed Resident #33 weights and confirmed she would of expected notification of a 5% weight loss in 30 days.

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of unwitnessed fall reports, facility policy review, family and staff interviews, the facility failed to assess the appropriateness and effectiveness of a cushioned bolster used for fall prevention for 1 of 2 residents (Resident #31) using bolsters. The facility reported a census of 49 residents.Findings include: Review of the the Minimum Data Set (MDS) Assessment for Resident #31, dated 4/18/25, revealed the list of diagnoses included Parkinson's disease and end stage renal disease. The Brief Interview Mental Status (BIMS) score of 5 out of 15, which indicated a severe cognitive impairment. The MDS assessed Resident #31 dependent on staff for activities of daily living which included personal hygiene, mobility, transfers, dressing, toileting and rolling in bed from side to side.A review of the Care Plan, revised on 6/25/25 revealed a Focus area to address I am at risk for falls per Fall Risk Assessment. Fall on 01/29/25; no injury. Fall on 5/22/25; No injury. Fall on 05/30/25; No injury. Fall on 06/03/25; No injury. Fall on 06/23/25; Forehead Abrasion. Interventions included, in part: a. Anticipate and meet my needs. Date initiated: 3/2/23.b. Educate me/my family/caregivers about safety reminders and what to do if a fall occurs. Date initiated: 3/2/23.c. Encourage my participation in activities that promote exercise, physical activity for strengthening and improved mobility such as Restorative Program and/or group exercises. Date initiate: 3/2/23. d. Fall intervention for fall on 05/22/25; Offer resident to use the toilet after each meal. Date initiated: 5/23/25.b. Fall Intervention for fall on 05/30/25; Fall mat provided to be placed on the floor when lying down. Date initiated: 5/30/25.c. Fall Intervention for fall on 06/03/25; Bilateral bolsters placed on the bed. Date initiated: 6/3/25.d. Fall Intervention for fall on 06/23/25; Staff to ensure bolsters are tightly secured as they become loose over time. Date initiated: 6/23/25e. Please make sure my bed bolster is tight after laying me down. Date initiated: 6/23/25Review of documents titled, Unwitnessed Fall, revealed, in part: a. On 5/22/25 at 2:10 PM: Nursing Description: resident was found sitting position resting against the side of the bed as if the resident had slipped out of the bed upon inspection it seemed as though the resident was trying to go to the restroom. Resident is uninjured and acting her normal baseline.Resident Description: Resident unable to give description. Immediate Action Taken: resident assessed for injury, vitals taken all stable, neuro-check completed no deficit from baseline, resident assisted to restroom with 2 assist and hoyer lift. Offer the resident the toilet after each meal. Entered by Staff C, Licensed Practical Nurse (LPN). b. On 5/30/25 at 2:37 PM: Nursing Description: Called to resident room by therapy to observe resident lying on the floor next to her bed on her right side. Resident Description: noneImmediate Action Taken: Resident assessed for injury Resident was noted to be incontinent of urine, changed and assisted off the floor with hoyer and 4 staff.fall mat placed beside bed. Entered by Staff D, Registered Nurse (RN)c. On 6/3/25 at 3:50 AM: Nurse Description: CNA (Certified Nursing Aide) heard res calling out went into room, found res sitting on fall mat legs under bed, near foot of bed. CNA came to this nurse in charting room, reported fall to nurse. When this nurse arrived in res room res lying on R side parallel to bed, head at the HOB (head of bed) on fall mat. Denies pain, stated I slid down. [NAME] (move all extremities) per usual, oriented to self and cite.Hoyer used w/3 staff to get res back in bed, inc (incontinent) of small hard BM (Bowel movement) .Resident Description: see above [referred to Nursing Description]Immediate Action Taken: Place bilat (bilateral) to bedEntered by Staff E, RNd. On 6/23/25 at 1:40 PM: Nursing Description: Nurse was alerted by activities staff that resident was found on the floor. upon entering resident's room nurse found resident lying on her right side directly next to fall mat, upon assessment abrasion found on residents left forehead and Right side of the nasal bridge. resident reported that her face was a little sore. Bed bolster had slid down to the side of the bed. Resident Description: When asked resident reported she was trying to get up to void, and brief was wet. resident stated that her face was a little sore.Immediate Action Taken: residents VS (vital signs) taken, resident assessed for injury and pain, resident assisted back into bed with the CNA staff members.Bed bolster adjusted and tightened.Make sure Bed Bolster is tight after laying resident down. Entered by Staff C, LPNDuring an observation on 7/14/2025 at 1:00 PM, Resident #31 in bed, eyes closed, lying on her back. A Hoyer mechanical lift and reclining, high-backed wheelchair were located in the bathroom. The resident positioned with a large wedge-shaped bolster placed on the left and right side of the bed. The bolsters held in place by a strap fastened to the bed. On the left side, a body pillow positioned between the resident and the bolster. The body pillow went from the residents shoulder to knee in length. During an observation on 7/15/2025 at 8:30 AM, Resident #31 in bed, lying on her back with the bolster placed on the left and right