

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165486	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Ruthven Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2701 Mitchell Street Box 0 Ruthven, IA 51358	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875</p> <p>Based on clinical record review, staff interviews, pharmacy interviews and policy review, the facility failed to provide care and services according to accepted standards of clinical practice for 1 of 12 residents reviewed (Residents #6). The facility failed to implement a physician order for a new treatment of Epsom salt foot soaks. The facility reported a census of 29 residents.</p> <p>Findings include:</p> <p>Resident #6's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS identified Resident #6 was independent with bed mobility transfers and ambulation. Resident #6's MDS included diagnoses of hypertension (high blood pressure), cerebral palsy, pain in the right foot, and localized edema.</p> <p>A Progress Note dated 7/10/24 documented Resident #6 saw the Podiatrist, received a new order to apply TAO (triple antibiotic ointment) to the right great toe daily and to call the clinic the following morning to schedule an appointment to have the right great toenail removed.</p> <p>A Progress Note dated 7/15/24 documented Resident #6 returned with post procedure instructions directing staff to soak the right great toe two times daily and then cover with TAO and bandaid.</p> <p>A Progress Note dated 7/29/24 documented Resident #6 returned to the facility from appointment and the right great toenail removal progressing as expected. New orders received to discontinue soaks and twice a day bandaid changes to the right great toe. Apply bandaid and TAO to the right great toe nail bed once daily until healed.</p> <p>A Progress Note dated 9/5/24 at 8:17 AM documented a note text to the Physician reporting Resident #6 had an appointment on Monday to be seen for the right great toe. The note revealed Resident #6's right great toe was red, inflamed and causing resident pain and discomfort. The note requested an order to soak the right great toe in Epsom salt twice a day for 1 week.</p> <p>A Progress Note dated 9/5/24 at 5:07 PM documented the Physician responded yes to the Epsom salt soaks and okay to set up telehealth if an antibiotic needed to be started. The clinical record lacked documentation the Pharmacy was notified of the order for the Epsom salts and lacked follow up documentation regarding the need for the telehealth visit.</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Progress Note dated 9/5/24 at 9:29 PM documented Resident #6 had complaints of pain and discomfort to the right big toe. The toe appeared edematous and reddened. The note documented the toe was being dressed twice daily with a bandaid.</p> <p>Review of the September Treatment Administration Record (TAR) 2024 starting on 9/6/24 directed staff to soak Resident #6's right foot in a warm Epsom salt bath twice a day for 7 days for inflammation and pain.</p> <p>A Progress Note dated 9/6/24 at 5:53 AM documented Epsom salt had not been delivered by Pharmacy.</p> <p>A Progress Note dated 9/7/24 at 8:55 PM documented Epsom salt unavailable at this time.</p> <p>A Progress Note dated 9/8/24 at 9:42 AM documented no Epsom salt on hand.</p> <p>A Progress Note dated 9/8/24 at 9:31 PM documented awaiting on Epsom salts.</p> <p>A Progress Note dated 9/9/24 at 5:13 AM documented awaiting on Epsom salts.</p> <p>A Progress Note dated 9/9/24 at 1:16 PM documented Resident #6 returned from appointment with new orders for right great toe infection. The new orders directed staff to soak the right great toe in Epsom salt, apply TAO and cover with bandaid dressing twice a day for 10 days and start Cephalexin (oral antibiotic) 500 mg (milligrams) three times a day for 10 days.</p> <p>A Progress Note dated 9/9/24 at 11:35 PM documented Resident #6's right great toe was reddened and tender.</p> <p>A Progress Note dated 9/9/24 at 11:37 PM documented Epsom salt not available this evening.</p> <p>A Progress Note dated 9/10/24 at 11:35 AM documented Resident #6 continued to complain of soreness to the right great toe and the area remained pink. The note documented a call to the pharmacy to follow up on delivery of the Epsom salt for ordered treatment with delivery planned for that evening.</p> <p>Review of the clinical record from 9/5/24 to the morning of 9/10/24 lacked documentation regarding the follow up on the delivery of the Epsom salt.</p> <p>On 9/19/24 at 9:00 AM, the Director of Nursing (DON) reported the facility had waited on the pharmacy to deliver the Epsom salt. She stated she was not aware of what the hold up was. She stated she had called the pharmacy herself regarding the Epsom salts. The DON acknowledged the clinical record did not reflect the follow up call. The DON reported she was not responsible for ordering the supplies. She verified she would expect the facility to look at other options or ways of obtaining the treatment supply.</p> <p>On 9/19/24 at 9:40 AM, the DON reported she had talked to the Pharmacy. The DON stated the pharmacy did not have the Epsom salts in stock when it was ordered and had to wait for it to come in. When asked if she expected the staff to follow Physician orders, she stated Absolutely.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/19/24 at 9:53 AM, a Pharmacy employee reported the facility was billed for Epsom salt on 9/9/24 and it was delivered on 9/10/24. She stated the Epsom Salt was sent out as a stock item and was not on the resident profile. The Pharmacy employee reported she had gone through the refill requests and hard copies and could not locate an order for Epsom salt for Resident #6 on 9/5/24.</p> <p>On 9/19/24 at 10:07 AM, the Pharmacy Manager reported she had gone through faxes, emails, hard copies, deleted emails/faxes for 9/5/24 and 9/6/24 and could not locate an order for Epsom salt for Resident #6. She stated the pharmacy received an order for Epsom salt on 9/9/24. She stated if the facility had called with a verbal request/order, those orders would be written down and scanned in.</p> <p>An undated facility policy titled Physician orders for Medications and Treatments documented all medications would be administered as ordered by a healthcare professional authorized by the state to order medications.</p>

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>46875</p> <p>Based on personnel file reviews, facility policy review and staff interview, the facility failed to provide dependent adult abuse recertification training within 3 years for 1 of 5 employees reviewed (Staff A). The facility identified a census of 29 residents.</p> <p>Findings include:</p> <p>The personnel file for Staff A, LPN (Licensed Practical Nurse) documented a hired date of 1/12/24 . Review of the Dependent Adult Abuse Mandatory Reporter Training Certificate documented Staff A completed the 2 hour dependent adult abuse training on 8/17/21.</p> <p>Review of facility policy titled Abuse Policy dated 2023 revealed each employee shall be required to take a 1 hour recertification training within 3 years of the initial 2 hour training and every three years thereafter.</p> <p>On 9/17/24 at 1:33 PM, the Director of Nursing (DON) acknowledged and verified Staff A's Dependent Adult Abuse Mandatory Training was overdue. The DON stated Staff A would be taking the recertification training on 9/17/24.</p>