

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Tripoli Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 604 Third Street SW Tripoli, IA 50676	

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 0550</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 a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858</p> <p>Based on clinical record review, policy/procedure review, and staff interview the facility failed to treat residents with respect and dignity in a manner that promotes maintenance or enhancement of his or her quality of life for 2 out of 6 residents reviewed (Resident #5 and Resident #6). The facility identified a census of 24 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) for Resident #5, with an assessment reference dated 8/12/24, documented diagnoses which included heart failure, hypertension, Non-Alzheimer's Dementia, and depression. The MDS revealed the resident with short and long term memory impairments, severely impaired decision making abilities, hallucinations, delusions, physical behaviors directed toward others, and behavioral symptoms not directed toward others, and dependent with activity of daily living.</p> <p>The Plan of Care with an initiated date 8/31/21, had a focus area of, The resident is dependent on staff for meeting emotional, intellectual, physical, and social needs related to Cognitive deficits. Interventions include:</p> <p>*All staff to converse with resident while providing care.</p> <p>*The resident requires assistance by staff to turn and reposition in bed</p> <p>*The resident is totally dependent on staff for personal hygiene and oral care.</p> <p>*Encourage the resident to participate to the fullest extent possible with each interaction.</p> <p>*Consistency helps to decrease behaviors , can become grabby and combative with assist.</p> <p>*Decreasing communication, staff frequently reporting blank stares without response to interactions.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress. *Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later.</p> <p>The Progress Note dated 10/28/24 at 4:01 p.m., documented, Psychosocial Note Text: This writer initiated a conversation on resident safety with the following inquiries: Do you feel safe living here at the facility? resident nodded, Yes.Upon questioning whether he had observed any abuse, he shook his head no.</p> <p>A Summary Report dated 11/12/24, documented, Resident #5 is a [AGE] year old male with short and long term memory due to dementia. Was admitted to the facility on [DATE] with the following diagnoses: Type 2 Diabetes, major depressive disorder, unspecified mood disorder, congestive heart failure, hyperlipidemia, benign prostatic hyperplasia, hypertension. Resident scores a 0 on the BIMS assessment from the quarterly MDS on 11/12/24. Resident did not answer any questions when asked about the situation being investigated.</p> <p>Other residents reported that they fell safe. No one has approached them sexually or have they seen anyone approach another sexually. Residents responded that they feel safe. Assessment on residents behaviors indicated no changes. Skin assessments do no show any unknown bruises or marking.</p> <p>Staff interviews found no other improper conversations from Staff A, Certified Nursing Assistant (CNA), During nursing staff interviews each staff was re-educated on the abuse policy; focusing on what verbal abuse is and how to identify it. Conversation on what is a proper conversation verses what is not. Staff have additional education placed on their portal or in-person re-educations on abuse, when to report, how to report, and proper conversations.</p> <p>In regards to the reporting side of this: staff did not report to charge nurse because felt was able to stop the conversation from continuing. Only one sexual comment was made to the resident and it was stopped after that.</p> <p>2. The MDS for Resident #6, with an assessment reference dated 8/7/24, documented diagnoses which included anemia, hypertension, Non-Alzheimer's Dementia, depression and neurocognitive disorder, and history of traumatic brain injury. The MDS revealed the resident with a Brief Interview for Mental Status (BIMS) score of 9 which indicated moderately impaired decision making ability, no behaviors, and required partial/ moderate assistance with activity of daily living.</p> <p>The Plan of Care with an initiated date 3/26/21 had focus area of, the resident is dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits, and physical Limitations. Interventions include:</p> <p>*All staff to converse with resident while providing care.</p> <p>*The resident is able to turn in bed with minimum staff assist x 1, by holding on to side rails.</p> <p>*Occasionally uses foul/inappropriate language.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Will joke with staff et call them names.</p> <p>*Usually easily redirected when asked to correct self.</p> <p>The Progress Notes dated 10/28/24 at 9:27 a.m., documented, Psychosocial Note Text: This writer initiated a conversation about resident safety asking resident if he felt safe here at the facility, in which he confirmed that he did indeed feel safe living here because this is the only place he has ever felt like he was truly at home. When asked if he has witnessed abuse or had been abused while living here, he stated, No and doesn't think they would be so stupid to.</p> <p>A Summary report dated 11/4/24, documented Resident #6 is a [AGE] year old male with impaired short term memory due to a traumatic brain injury. admitted to the facility on [DATE] with the following diagnoses: frontal temporal neurocognitive disorder, major depressive disorder, other amnesia, contracture of muscle, hypertension, and peripheral vascular disease. Resident scores a 9 on the BIMS assessment from the quarterly MDS on 8/7/24. Resident and other residents were asked questions. Resident response when asked if he was approached in a sexual manner here at the facility, resident said not that I can remember.</p> <p>Other residents responded in the same manor. No on has approached them sexually or have they seen anyone approach another sexually. Residents responded that they felt safe. Assessment on residents behaviors indicated no changes. Skin assessments do no show any unknown bruises or markings.</p> <p>Staff interview found another improper conversation instance with Staff A, CNA, that triggered another self-report. During nursing staff interviews each staff was re-educated on the abuse policy; focusing on what verbal abuse is and how to identify it. Conversations on what is proper conversations verses what is not. Staff will have additional training placed on their portals or in-person re-education on abuse, when to report, how to report, and proper conversations.</p> <p>Interview on 12/3/24 at 3:40 p.m., the facility Administrator confirmed and verified that the expectation of the staff are to treat residents with dignity and respect at all times.</p> <p>The Resident [NAME] of Rights dated 7/2/24, documented that the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident individuality. The facility must protect and promote the rights of the resident.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858</p> <p>Based on clinical record review, resident and staff interview the facility failed to complete a two person transfer by giving the resident a one person bear hug transfer for 1 of 3 residents reviewed (Resident #9). The facility census was 24 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #9 had diagnoses which included</p> <p>seizure disorder, epilepsy, unspecified injury of the head, and limitations of activities due to disability. The MDS documented the resident with the ability to hear and understand what is heard and a Brief Interview for Mental Status (BIMS) score of 13 which indicated no impaired decision making abilities. The MDS assessment documented the resident required substantial/maximal assistance with transfer and wheelchair used for mobility. The MDS documented the resident had two falls with no injury and one fall with injury (except major).</p> <p>The Plan of Care with an initiated date 7/5/24, documented a focus area of the resident has an activity of daily living self-care performance deficit related to musculoskeletal impairment. Interventions include:</p> <p>*TOILET USE: The resident requires maximum assistance by 2 staff for toileting.</p> <p>*TRANSFER: The resident requires maximum assistance by 2 staff (stand/pivot transfer) to move between surfaces every 2 hours and as necessary.</p> <p>The Home Therapy Program dated 7/29/24, documented, functional mobility: stand pivot transfer between surfaces with gait belt and assist of two staff.</p> <p>Interview on 12/4/24 at 1:15 p.m., Resident #9, confirmed and verified that Staff B transferred him alone by a bear hug, gait belt was around the waist but not used during the transfer.</p> <p>Interview on 12/4/24 at 1:30 p.m., Staff B, Certified Nursing Assistant (CNA), confirmed and verified that Resident #9 was transferred by a bear hug and a gait belt was around the waist but not utilized and that the plan of care states to use two assist with a transfer.</p> <p>Interview on 12/4/24 at 1:45 p.m., the facility administrator confirmed and verified that doing a bear hug during a transfer is not the proper way to transfer Resident #9.</p>