STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165495	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarksville Skilled Nursing & Rehab Center	115 North Hilton St Clarksville, IA 50619

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, record and policy review, after the facility identified a change in a resident's condition, the facility failed to notify a resident's family or responsible party for 1 of 3 residents reviewed (Resident #1). After staff heard the door alarm sound, they found Resident #1 attempted to exit the building, opened a door and was outside on the sidewalk. The facility didn't notify Resident #3's wife of the incident until days later. The facility reported a census of 34 residents.Findings include: Resident #1's Minimum Data Set, dated [DATE], identified a Brief Interview for Mental Status documented a score of 11 out of 15, indicating moderately impaired cognition. Resident #1 used a wheelchair for mobility. The MDS included diagnoses of unspecified dementia and depression.A Doctor's Order dated 5/28/25, directed to apply a wander management device to the right side of Resident #1's wheelchair every day, evening, and night shift. A Care Plan Problem dated 5/28/25, documented Resident #1 had a risk for elopement. The approaches directed the staff the following:a. Check battery life on wander-management device every week.b. Check location of wander-management each shift.c. A wander-management device applied to the right side of his wheelchair. A Progress Note dated 5/17/25 at 5:42 AM recorded as a late entry on 5/18/25 at 5:42 AM, authored by Staff E, Registered Nurse (RN). After the employee door alarm sounded, a Certified Nurse Aide (CNA) went to investigate and found Resident #1 pushed open the door. When the CNA asked Resident #1 what he was doing, he replied I'm trying to get out of here. The CNA returned Resident #1 to the 200-hallway. A Progress Note dated 5/28/25 at 12:30 PM, documented the staff applied a wander management device to Resident #1's wheelchair. A Progress Note dated 5/28/25 at 2:41 PM, documented the staff notified the Primary Care Provider of Resident #1's wander management and potential elopement. In the Internal Investigation Notes, the Director of Nursing (DON), documented on 5/19/25 she received report from Staff E. Staff E reported Resident #1 pushed open the door to the employee entrance. The DON asked Staff E if they put on wander device on Resident #1. Staff E replied no, because he didn't exit the building. On 5/27/25 another nurse reported to the DON they found Resident #1 outside on 5/17/25. The DON started an internal investigation and notified the Administrator. On 5/25/25 at 12:00 PM, the DON notified Resident #1's Spouse in person of the incident. On 7/7/25 at 3:55 PM, when asked if he remembered going out a door in the building, Resident #1 responded he didn't actually live at the facility. He encouraged to ask his roommate, (the guy over there and pointed at the curtain), as he actually lived at the facility. Resident #1 responded pleasant as he sat in his recliner in his room. On 7/8/25 at 10:43 AM, witnessed Resident #1's spouse sitting on his bed in his room. Resident #1 sat in his wheelchair using an electric razor to shave. The wife stated she really didn't believe Resident #1 opened the door. She acknowledged he had memory issues but said that just isn't something he would do. She said the facility didn't have video or anything showing him trying to go out the door. She said she felt he is absolutely safe, and she had no concerns about his safety. She stated they put a wander device on him after they said he tried to go out the door. She pointed to the wander device on his wheelchair. He never tried anything like that before, she said, so's why it's so hard to believe it. She stated she didn't get notified until days after the incident happened.On 7/8/25 at 3:14 PM, Staff D, CNA, stated when she came into work the night of the incident and when everybody finished up after supper. She started her shift at 6 PM. At that time, she saw Resident #1 and he wheeled himself back to his room using his hands and his feet to propel himself in the wheelchair. At that time, the door alarm went off and it sounded the same as a call light. The door alarms didn't go off very often at all. Staff D stated she didn't see it come across her pager, as she assisted another resident transfer to a chair. Then when she walked to the nurses' station to see the computer panel, it showed the employee door alarmed and 6 minutes passed since the alarm went off. At the time, Staff D asked other staff member through her walkie talkie if anyone went out the door or checked the door. Staff D thought one person may have answered it, but added they were with another resident. Staff D went to the employee door immediately after and found Resident #1 with the right rear wheel of his wheelchair propping the door open. Staff D stated he had his left front wheel off of the sidewalk. The sky was still light outside it without rain or anything. It was probably close to the temperature inside, probably around 70 degrees. Staff D stated after she wheeled him back, probably a minute or two later, Staff E came out and she told her what happened. Staff E only asked Staff D what Resident #1 said. When Staff D him where he was going, he replied he was going home. Staff D didn't believe Staff E asked any further questions. Staff D remembered telling Staff E about Resident #1

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F 0805 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. (continued on next page)

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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 0805 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to follow Doctor's Orders for 2 out of 3 residents reviewed (Resident #2 and Resident #3). Resident #2 had an order for a mechanical soft diet with ground meat. Resident #2 received cut up sausage links instead of ground up sausage for breakfast. Resident #2 had a coughing/choking spell and five days later they admitted to the hospital with aspiration pneumonia. Resident #3 had an order for cut up meat. The kitchen staff prepared to serve Resident #3 a cheeseburger without cutting the meat cut up, as ordered by the Doctor. The facility reported a census of 34 residents.Findings include:1. Resident #2's Minimum Date Sheet (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS), score of 7, indicating severely impaired cognition. Resident #2 ate independently. The MDS included a diagnosis of heart failure. The MDS reflected Resident #2 had a mechanically altered diet (required change in texture of food or liquids). The Care Plan Problem reviewed 7/7/25 indicated Resident #2 had difficulty chewing and swallowing related to dysphagia (swallowing difficulties), having 2 teeth pulled, and unable to wear his lower denture. The Care Plan included the following approaches:a. 3/25/25: Mechanical soft diet with ground meats. b. 6/26/25: Nectar thickened liquids. A Progress Note authored by Staff A, Licensed Practical Nurse (LPN), dated 6/12/25 at 8:55 AM, documented Staff A in the dining room giving a resident their medication at approximately 7:55 AM and overheard a kitchen aide ask Resident #2 if he was okay. Staff A turned and noted he had a red face, he couldn't speak, he didn't make the universal choking signal with his hands but attempted to cough up food. Resident #2 had some air exchange and continued to attempt to cough. He had a small emesis (vomit) of undigested food and liquid into the garbage at table. The staff assisted Resident #2 back to his room. While in his room, noted redness left his face, and he became pale. Once in his room Resident #2 had a more effective cough and had a moderate emesis of undigested food and liquid. He continued to cough and threw up 2 cut chunks of sausage. Resident #2 spit up phlegm but could talk to the nurse and to the Assistant Director of Nursing (ADON) with clear and appropriate speech. No staff intervention beyond forward positioning and patting on his back to promote coughing required. Resident #2 stated that never happened before and reported being fine. The nurse obtained the following vital signs (VS):a. Blood Pressure (BP) 170/72 (Measuring standard 120/80)b. Temperature (T) 97.1 Fahrenheit (F) (Measuring standard 98.6)c. Oxygen saturation (PO2) 96% on room air (RA) (Measuring standard greater than 90%)d. Pulse (P) 64 (Measuring standard 60 - 100)e. Respirations (R) 18 (Measuring standard 12 - 20)Resident #2 told the nurse as he winked, they are reason his blood pressure is up. The assessment revealed lung sounds (LS) with course crackles (short popping noises in the lungs) and wheezes (high pitched lung sounds) throughout all anterior (front) et posterior (back) lung fields. The nurse provided him with an as needed (PRN) nebulizer (delivers medicine through a mist to the lungs) was given at this time. At 8:15 AM, this writer returned to resident's room following the nebulizer treatment et noted resident had some audible wheezes (could hear without a stethoscope), LS assessed and noted no course crackles, but he did have occasional expiratory (breathe out) wheezes to posterior bases (bottom of the lungs). His VS measured the following:a. BP 132/62, b. P 55c. R 18d. T 97.5 F e. PO2 94% RA. At 8:25 AM, the nurse placed a telephone call (TC) to the Primary Care Provider (PCP)'s office, spoke with receptionist and reported they needed to speak with the PCP's nurse. The receptionist transferred the facility nurse to the PCP nurse's voicemail. The facility nurse left a message regarding the incident that morning and Resident #2's condition since the incident. The nurse asked about a new order from the PCP for emergency room (ER) evaluation or STAT (without delay) portable x-ray. The nurse requested a TC back as soon as possible. The facility expected the PCP for rounds that afternoon. At 8:50 AM, the nurse made a TC to Resident #2's son and updated him on the incident that morning and his condition since. The nurse reported she waited for a TC back from PCP and they expected the PCP to come to the facility for rounds that afternoon. He asked how Resident #2 did the previous night and noted he didn't have notes in the nurses' notes. He reported his brother got a phone call from Resident #2 and told him This is the end. The nurse reported Resident #2 didn't make any no statements like that that morning, and other than the incident he appeared in a pleasant mood. The nurse reported she would continue to assess Resident #2 and notify his son of any new orders from the PCP or if he had any change in condition. He verbalized understanding and satisfaction with the plan of care.A Progress Note dated 6/17/25 at 6:44 PM, documented that at 5:10 PM a CNA called the nurse into Resident