STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165500	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rotary Senior Living	500 South Blaine Avenue Eagle Grove, IA 50533

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858 Based on clinical record review, staff interview, policy and procedure review, the facility failed to treat a resident with respect and dignity in a manner that promotes maintenance or enhancement of his or her quality of life for 1 out of 3 resident reviewed (Resident #2). The facility identified a census of 31 residents. Findings include: Resident #2's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 1, indicating severe memory impairments. Resident #2 displayed physical behaviors (hitting, kicking, scratching and grabbing) towards others. Resident #2 required substantial to maximal assistance with all activities of daily living (ADL) including ambulation. The MDS included diagnoses of Alzheimer's disease and non Alzheimer's dementia. The Care Plan Focus initiated 1/7/25 reflected Resident #2 required help with cares. The Interventions directed the following: a. He can become aggressive and combative with staff during care. He resists changing, toileting, bathing. Approach him calmly and have assistance present during his care. b. Resident #2 did better with peri care if someone held his hands while the other person assisted with washing him. It also helped if they talk to him to help keep him distracted. The Care Plan Focus initiated 1/9/25 indicated Resident #2 had a potential to be physically aggressive. The Interventions directed the following: a. Give Resident #2 as many choices as possible about care and activities. b. When he becomes agitated: Intervene before agitation escalates; guide away from the source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An undated, untitled, and unsigned form provided by the facility reflected Staff A, Certified Nurse Aide (CNA), reported on 1/22/25 they assisted Staff B, CNA, provide evening care to Resident #2. Upon entering the room, the staff found Resident #2 with his eye closed resting in his recliner. Staff B told Staff A to Resident #2's hands as she had the other hands, then she yanked him and acted very rough during the process of undressing and completing peri-cares. As Resident #2 received help, he became physically aggressive towards the staff. Staff A explained he attempted to comfort Resident #2 during his care by placing his hand lightly and gently on Resident #2's shoulder. Resident #2 continued to have physical aggression, as common behavior with dementia. The facility corrected the action by suspending Staff B pending the internal investigation. The facility initiated the investigation while including resident and staff interviews. The facility educated staff on timely reporting. The Summary of Findings dated 1/23/25 written by the Director of Nursing (DON), documented on 1/22/25, Staff A reported a concern regarding the cares provided by Staff B during the evening of 1/16/25. Subsequent interviews with residents indicated they felt safe and treated with respect and dignity, with no concerns about their care. Staff members who work closely with Staff B described them as helpful and attentive, with no concerns about the quality of care provided. Resident #2 had a history of physical and aggressive behaviors and mood related to his dementia. He is Care Planned to have staff assist times two with all cares to protect him and staff. The Nursing note dated 1/14/25 at 5:38 AM described Resident #2 as more cooperative with cares assist times 3. After the last rounds Resident #2 got up two times wandering around in the hallway in a T shirt and brief. Staff able to redirect with minimal difficulty. Resident #2 sat in the lounge chair at that time, as he enjoyed a Pepsi. Resident #2 remained calm. The Nursing note dated 1/22/25 at 12:45 PM indicated the staff attempted multiple times to get Resident #2 up for the day. Resident #2 refused to allow staff to assist him out of bed. The staff changed Resident #2's incontinent briefs, he continued to lay in bed at that time. The Nursing note dated 1/22/25 at 1:53 PM Resident got out of bed and sat at the table eating lunch. No behaviors noted. The Clinical Record lacked documentation of the 1/16/25 incident. Interview on 2/17/25 at 10:00 AM, the Facility Administrator confirmed all resident are to be treated with respect and dignity from staff at all times. Interview on 2/17/25 at 3:00 PM, the facility Director of Nursing (DON), verified all staff are expected to treat residents with dignity and respect per the policy/procedure. An Education form dated 1/31/25, given to surveyor by the Administrator on 2/19/25 at 4:15 PM, documented: Handling a combative resident requires a careful and compassionate approach. a. Stay calm and professional, maintain a calm demeanor, your body language and tone can influence the resident's behavior. b. Assess the situation: determine the cause of the combative behavior. It could be due to pain, confusion, fear or frustration. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Use De escalation Techniques, speak softly and use simple language, offer reassurances, avoid physical confrontation, give the resident space to reduce feeling of being trapped. d. Redirect Attention, change the focus of the conversation or activity, introduce a calming activity or a favorite topic. e. Involve other staff, if the situation escalates, seek help from other staff members, teamwork can provide additional support and safety, ensure that the care plan identifies these behaviors and interventions. f. Implement safety measures: ensure the environment is safe for both the resident and staff, remove any potential hazards, if necessary, follow protocols for managing aggressive behavior, including calling for additional help. The Resident Rights policy updated 12/16/22, defined its purpose as that all resident have their rights guaranteed to them under Federal and State laws and regulations. This policy is intended to outline resident rights requirements in long term care communities. a. All resident have the right to be cared for with respect, enhancing self esteem and self worth while incorporating the resident unique goals, preferences, and choices. Staff will value a resident's preferences and honor their input during altercations. b. Care for all residents will be done with respect and dignity in an environment that promotes quality care coupled with recognition of each resident's individuality. c. All resident will be treated with dignity and respect. d. All staff will engage in activities with residents with respect, enhancing self esteem and self worth while incorporating and honoring the resident's unique goals, preferences, and choices.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858 Based on clinical record review, the Resident [NAME] of Rights, facility investigation, staff interview, and review of policy and procedures, the facility failed to ensure all alleged violations involving mistreatment, neglect, or abuse of a resident and/or residents (Resident #2) were reported to the Department of Inspection and Appeals and Licensing (DIAL) within 2 hours. See F550 for additional information regarding Resident #2. The facility reported a census of 31 residents. Findings include: Resident #2's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 1, indicating severe memory impairments. Resident #2 displayed physical behaviors (hitting, kicking, scratching and grabbing) towards others. Resident #2 required substantial to maximal assistance with all activities of daily living (ADL) including ambulation. The MDS included diagnoses of Alzheimer's disease and non Alzheimer's dementia. The Care Plan Focus initiated 1/9/25 indicated Resident #2 had a potential to be physically aggressive. The Interventions directed the following: a. Give Resident #2 as many choices as possible about care and activities. b. When he becomes agitated: Intervene before agitation escalates; guide away from the source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later. An undated, untitled, and unsigned form provided by the facility reflected Staff A, Certified Nurse Aide (CNA), reported on 1/22/25 they assisted Staff B, CNA, provide evening care to Resident #2. Upon entering the room, the staff found Resident #2 with his eye closed resting in his recliner. Staff B told Staff A to Resident #2's hands as she had the other hands, then she yanked him and acted very rough during the process of undressing and completing peri-cares. As Resident #2 received help, he became physically aggressive towards the staff. Staff A explained he attempted to comfort Resident #2 during his care by placing his hand lightly and gently on Resident #2's shoulder. Resident #2 continued to have physical aggression, as common behavior with dementia. The facility corrected the action by suspending Staff B pending the internal investigation. The facility initiated the investigation while including resident and staff interviews. The facility educated staff on timely reporting. The Summary of Findings dated 1/23/25 by the Director of Nursing (DON), documented on 1/22/25, Staff A, CNA, reported a concern regarding the cares provided by Staff B, CNA, during the evening of 1/16/25. Subsequent interviews with residents indicated that they feel safe and treated with respect and dignity, with no concerns about their care. Staff members who work closely with Staff B described as helpful and attentive, with no concerns about the quality of care provided. Resident #2 has a history of physical and aggressive behaviors and mood related to his dementia. He is care planned to have staff assist times two with all cares to protect him and staff. Resident #2's Clinical Record lacked documentation of the 1/16/25 incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/17/25 at 10:00 AM, the facility's Administrator confirmed the facility failed to notify DIAL of the incident between Resident #2 and Staff B within the 2-hour time frame. The Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated May 2023, instructed all allegations of resident abuse shall be reported to the Iowa Department of Inspections and Appeals no later than 2 hours after the allegation is made.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858 Based on observation, clinical record review, policy review, resident, family, and staff interviews, the facility failed to provide needed services in accordance with professional standards by not assessing, intervening and documenting for a resident with a wound for 1 of 3 resident reviewed (Resident #1). In addition, the facility failed to assess his lower legs when applying or removing his ankle, foot brace (AFO) as ordered by the physician. Resident #1 had a wound on their right shin, that went unidentified until dermatology observed while at his appointment for a different situation. The clinic took a sample of the wound while at the dermatology appointment and ordered an antibiotic along with a culture of the drainage of the wound. The lab results grew Methicillin resistant Staphylococcus aureus (MRSA a type of staph bacteria that is resistant to many antibiotics use to treat infections). The facility identified a census of 31 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #1 required dependent assistance for activity of daily living (ADL) and no skin issues. The MDS included diagnoses of hypertension (high blood pressure), cerebrovascular accident (stroke), hemiplegia (inability to control one side of the body), hemiparesis (weakness of one entire side of the body), anxiety and depression. The Care Plan Need revised 12/27/24 indicated Resident #1 had an ADL self-care performance deficit related to hemiplegia, impaired balance, limited mobility, limited range of motion (ROM), and stroke. The Interventions directed: a. Revised 10/31/24: Resident #1 wore an ankle, foot brace (AFO) on his right foot, staff to inspect his skin before and after applying the AFO. b. Revised 4/26/23: Resident #1 required skin inspection once a week. Observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse. The Care Plan Need revised 2/7/25 indicated Resident #1 had an infection of infected skin area on his right lower extremity, mid shin. He received antibiotics for treatment of the infection. The Interventions directed to give antibiotics as ordered and report any signs of adverse reactions to the nurse and physician. Interview on 2/18/25 at 2:45 PM, Resident #1, stated the staff come in the morning and put on his AFO and then at night they take off the AFO to his right lower extremity, but has no knowledge if they check his skin. Resident #1 stated that during a routine dermatology appointment, the dermatologists looked at his skin underneath his pant leg and found the wound on his right shin, pushed on the wound and a white substance started to drain out from underneath a dark scab. The Dermatologists suggested to get a culture of the wound and started him on an antibiotic until the results of the wound culture came back. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on 2/19/25 at 10:00 AM, Resident #1 family, stated that during a routine dermatology appointment, the dermatologists wanted to take a look at Resident #1 legs. The dermatologists proceeded to pull up the right pant leg and noticed a blackened area underneath the Velcro strap, the dermatologist saw a white substance oozing out of the scab and started to squeeze and more white substance started to drain. The dermatologists decided to order a culture of the white substance and put Resident #1 on an antibiotic until the results came back from the culture. The Certified Nursing Assistant (CNA) Shower Skin Report dated 2/4/25, included a section regarding skin issues observed. The section of the form remained blank. The instructions indicated if no skin concerns noted please indicated no skin concerns. The Nursing Communication form dated 2/6/25, signed by the physician, directed to get a culture of the sore on Resident #1's right shin, add Mupirocin (antibiotic) ointment twice daily for 10 days and leave open to air, no bandages. Can apply to all open areas on lower extremities. Add cephalexin (antibiotic) 500 milligrams three times a day for 10 days. The Skin and Wound Evaluation V7.0 form dated 2/6/25 at 3:14 PM, documented a skin tear to Resident #1's front right lateral (side) lower leg, in house acquired. The area measured 2.2 centimeters (cm) area, 2.0 cm length by 1.5 cm width. The form described the wound as a scab (a hard-dried crust that forms over a cut or wound) with erythema (redness that may be intense bright red to dark red or purple) of the area around the skin. Resident #1's February 2025 Treatment Administration Record (TAR) listed an order dated 12/7/21 to complete a head to toe skin audit weekly on Tuesdays. The order included instruction to please take photos and measurements as directed by the skin and wound application. The order lacked documentation for the date of 2/4/25. The Nursing note dated 2/6/25 at 3:04 PM indicated Resident #1 returned from his dermatologist appointment with new orders for cephalexin 500 milligrams three times a day for 10 days due to the infected skin area on his right lower extremity, mid shin. The orders directed to leave open to air and no bandages. Apply topical Mupirocin ointment (to treat skin infections) twice daily for 10 days to all 3 areas. Resident #1 had 2 areas on the right lower extremity and one on the left knee. The provider cultured the wound on the right shin. The Nursing note dated 2/7/25 at 2:38 AM, indicated Resident #1 began an antibiotic for his skin. The note reflected Resident #1's areas to his shin and legs remained open to air, without drainage noted. The wound had redness observed on his right shin. The Nursing Note dated 2/7/25 at 11:28 AM reflected Resident #1 received cephalexin as ordered for skin infection. The facility waited for culture of the fluid to return. The nurse cleaned the area on the right lower extremity well and top softened to remove the scabbed area, no drainage observed at the time. Peri wound (skin surrounding a wound) is red and warm. Some discomfort noted with pressure and treatment of topical antibiotic ointment applied to all areas in need of treatment. No adverse issues noted with oral antibiotic. The Order Note dated 2/10/25 at 5:34 PM documented cephalexin as discontinued by Dermatologist/prescriber. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Nursing Note dated 2/11/25 at 3:18 PM reflected Resident #1 continued to take doxycycline (oral antibiotic to treat infections caused by bacteria) for skin infection to right lower leg. Resident tolerated medication well with no adverse reactions noted. Resident #1's lower legs had scabs present with the surrounding skin pink to all areas. The areas appeared improved and healing. They would continue to observe. The Nursing Note dated 2/12/25 at 12:38 AM, identified Resident #1 took doxycycline for MRSA (infection that doesn't respond to certain antibiotics) leg wounds. He denied pain in his wounds and had areas on his legs left open to air. The Infection Note dated 2/12/25 at 10:13 AM indicated Resident #1 continued to take an antibiotic, but specific antibiotic changed due to culture and sensitivity. His wounds didn't show erythema or discharge. He denied pain and no adverse effects observed due to change in antibiotic at the time. The clinical record lacked documentation of completed skin assessments after removing or applying Resident #1's AFO before and after the identification of the infection in his lower legs. Interview on 2/17/25 at 4:45 PM, Staff C, Certified Nursing Assistant (CNA), stated the staff removed Resident #1's AFO from his right lower extremity at night. Staff C confirmed his clinical record didn't have documentation of completed skin checks after removing the AFO at night or when put on in the morning. Interview on 2/18/25 at 9:03 AM, Staff D, Licensed Practical Nurse (LPN), verified Resident #1's clinical record didn't have documentation of the completed skin after they removed Resident #1's AFO at night or put on in the morning. Interview on 2/18/25 at 10:15 AM, Staff E, LPN, confirmed Resident #1's clinical record didn't have documentation of completed skin checks when removing the AFO at night or put on in the morning. Interview on 2/19/25 at 1:00 PM, the Director of Nursing verified Resident #1's clinical record lacked documentation of the completed skin checks before or after removing the AFO or putting it on him. The facility failed to check Resident #1's skin per his Care Plan. The undated Weekly Skin Assessment Policy listed the purpose as to ensure timely identification, prevention, and management of skin conditions, including pressure ulcers, in residents at the facility. a. Frequency: i. A comprehensive skin assessment must be conducted weekly for all residents. ii. Additional assessments may be required based on changes in the resident's condition, such as new wounds, health decline or hospitalization . b. Assessment Components: i. Visual inspection of the entire body, focusing on high risk areas (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	ii. Palpations to assess for skin temperature, moisture and texture. iii. Documentation of the findings including: A. any areas of concern, redness, open area, moisture related skin damage B. any signs of pressure ulcer or wounds C. Interventions provided for existing wounds, such as dressings or treatments D. Changes in skin condition compared to the previous assessment. c. Communication and Reporting: i. Weekly skin assessment findings must be communicated to the interdisciplinary team for care planning and coordination. ii. Any notable changes in the resident's skin condition should be promptly escalated to the appropriate healthcare provided for further evaluation.