

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165504	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/08/2024
NAME OF PROVIDER OR SUPPLIER  Algona Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2221 East McGregor Street Algona, IA 50511	

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 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>25854</p> <p>Based on observation, clinical record review, staff interview and a nursing assistant checklist form the facility failed to provide appropriate perineal cares for 1 of 3 residents reviewed, (Res #1). The facility reported a census of 31 residents.</p> <p>Findings include:</p> <p>A Minimum Data Set (MDS) assessment form dated 9/24/24 indicated Resident #1 had diagnosis that included Non-Alzheimer's Dementia. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 (cognitively impaired), dependent on staff with toilet transfers and toileting and frequently incontinent of her bowels and bladder.</p> <p>A Care Plan indicated the resident had a Focus area of a requirement of assistance with activities of daily living (ADL's), revised 7/17/24. The Interventions/Tasks included the following as dated.</p> <p>a. Please assist me with toileting upon rising in the morning, before or after activities and at my hour of sleep (HS). Assist me with any incontinent cares as needed. I utilize adult incontinent pull ups.(revised 4.18.24)</p> <p>An observation on 10/8/24 at 12:55 p.m. revealed Staff A, Certified Nursing Assistant (CNA) and Staff B, CNA as they toileted the resident whom Staff A confirmed as incontinent. Staff A removed the resident's soiled brief as the resident voided. Upon completion staff stood the resident as Staff A positioned herself behind the resident and cleansed her mid gluteal region times (x) 3 wipes and bilateral buttocks but failed to cleanse the resident anteriorly. During an interview at the same time Staff A confirmed she failed to cleanse the resident anteriorly.</p> <p>A Nurse Aide Skills Checklist form dated 2012 included the following directive:</p> <p>a. Wash and rinse the abdomen and anterior thighs (all areas in contact with urine/feces). Women - gently separate the labia and wash down one side then the other from front to back.</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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