STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165508	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Health Center, Inc	410 East 10th Street Cedar Falls, IA 50613

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on observation, clinical record review, policy review and staff interview, the facility failed to check gastronomy tube (g-tube, a tube inserted through the belly that brings nutrition directly to the stomach and is sometimes referred to as a feeding-tube) placement prior to flushing water and administering medications down the g-tube for 1 of 1 resident observed (Resident #21). The facility identified a census of 48 residents. Findings include: Resident #21's Minimum Data Set (MDS) assessment dated [DATE] identified he rarely/never understood, he had no memory recall of current season, location of room, staff names and/or faces, or that he lived in a nursing home. The MDS reflected he had severely impaired daily decision making skills. Resident #21 had upper and lower extremity impairments on both sides of the body. The MDS listed him as dependent for care (oral care, toileting, dressing, bathing, turning in bed). The MDS included diagnoses of Parkinson's, unspecified, end stage renal disease, non Alzheimer's Dementia, and dysphagia (difficulty swallowing). The MDS documented Resident #21 received 51% or more of nutrition and 501 cubic centimeters (CC's, unit of measure) per day or more through a feeding-tube. A Nursing Facility Physician Visit Note dated 4/15/25 documented Resident #21 had diagnoses of dementia, gastrointestinal hemorrhage (excessive bleeding in the stomach) associated with peptic ulcer (an injury inside the body usually caused by increased acid production), colon ulcer of the large intestine and utilizing a feeding-tube. An Order Review History Report electronically signed by the Provider on 5/14/25 documented the following orders: a. Jevity 1.2 Calorie Oral Liquid give 105 milliliters (ML) via g-tube two times a day for tube feeding. Run the feeding for 14 hours. b. Flush g-tube with 60 ML water before and after medication administration. c. Measure g-tube from insertion site to the end of g-tube daily to check the tube placement. Notify the primary care provider if the measurements are off. d. Flush the g-tube with 150 ML water before and after the feeding two times a day. (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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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Medications may be crushed and cocktailed per g-tube (administration) every shift. f. Change piston syringe, graduate, feeding bag, and tubing every 24 hours. Document date and resident initials one time a day. On 5/14/25 at approximately 8:10 AM Staff A, Licensed Practical Nurse (LPN), reported Resident #21 tube feeding as not done and she would check it again soon. Around 8:20 AM Staff A reported Resident #21 feeding as almost done and she would disconnect his feeding soon. On 5/14/25 at 9:02 AM observed Staff A donned (put on) gloves and an isolation gown, then entered Resident #21's room to administer his morning medications. Staff A obtained a syringe dated 5/14/25 with a graduate (container used to collect fluid usually with measurements) dated 5/12/25 and proceeded to fill the graduate with water to perform the post feeding and medication flush prior to medication administration. Staff A opened the g-tube, attached the syringe and poured water into the syringe without checking for g-tube placement by aspirating (using the syringe to suck out contents) gastric (stomach) contents or measuring from the insertion site to the end of the g-tube. In addition, witnessed Staff A couldn't get the water to flow in the syringe and pushed the water with resistance into the g-tube to complete the remaining water flush, administer Resident #21's medications, and complete the final water flush. During an interview on 5/14/25 at 9:14 AM Staff A explained they aspirate for gastric contents but she didn't do that prior to administering his medication; or she could have used a stethoscope and listened to the resident's abdomen. Interview on 5/14/25 at 3:34 PM Staff B, LPN, reported the nurses are required to check placement of a g-tube by auscultating (listen to) the abdomen with a stethoscope and measuring the length on the g-tube. Staff B explained the nurse should check g-tube placement before administering medications down the feeding-tube. Staff B stated Resident #21 couldn't communicate if he had any issues with his feeding-tube. During an interview on 5/15/25 at 8:05 AM the Director of Nursing (DON) reported she needed to check the facility policy. After reviewing the policy, the DON stated the nurses check the g-tube placement by measuring the insertion site to the end of the tube daily. After reviewing the medication policy with the DON, she verbalized she expected the nurses to measure the g-tube placement to ensure the placement of the tube prior to medication administration. The Medication Administration Policy, revised October 2024 directed the nurse to check for tube placement per policy before administering medications down the g-tube. The Feeding-tube Placement Check Policy, revised October 2024 under Procedure directed the following: a. Feeding-tubes will have placement checks at least daily. b. Measure from insertion site to end of tube and document on the Medication Administration Record.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on observation, clinical record review, policy review and staff interview the facility failed to serve the physician ordered diet for 1 of 3 residents on a carbohydrate-controlled diet (Resident #47). The facility identified a census of 48 residents. Findings include: Resident #47's Minimum Data Set (MDS) assessment dated [DATE] identified she had short/long term memory impairment with moderate impaired daily decision making. The MDS included a diagnosis of type two diabetes mellitus (DM) with diabetic polyneuropathy (a condition where multiple peripheral nerves in the body are damaged from high blood sugar levels). The MDS reflected Resident #47 received insulin injections seven days a week and hypoglycemic (blood sugar lowering) medications while a resident. An Order Review History Report electronically signed by the Provider on 4/29/25 documented the following physician orders: a. Toujeo Solostar (insulin) subcutaneous solution pen injector 300 Units (U)/Milliliter (ML) inject 16 units subcutaneously one time a day related to DM with diabetic neuropathy. b. Metformin hydrochloride oral tablet 500 MG give 2 tablets by mouth two times a day related to DM with diabetic neuropathy. c. Humalog KwikPen (insulin) Subcutaneous Solution Pen Injector 100 U/ML. Inject per sliding scale: i. if 150 - 200 = 1; 201 - 250 = 2; 251 - 300 = 3; 301 - 350 = 4; 351 - 400 = 5, and above 400 call Provider. d. Free Style Libre 3 Reader Device (continuous glucose monitor) inject 1 applicator subcutaneously every day shift, every 15 days. e. Provide a consistent carbohydrate diet (CCHO, a diet that focuses on consuming the same amount of carbohydrate at each meal to enhance blood sugar control), 60 - 75 grams of carbohydrates per meal. Resident #47's May 2025 Electronic Medication Administration Record (EMAR) showed indicated her Toujeo Solostar insulin increased to 20 Units subcutaneously in the morning of 5/2/25. The Care Plan Focus dated 5/2/25 identified Resident #47 had a nutritional problem related to type two DM with diabetic chronic kidney disease. The Care Plan directed to provide the diet per physician orders. The Week 1 Tuesday Noon 2/11/25 Dietician approved menu directed the following CCHO diet: (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. 3 ounces of boneless barbeque ribs b. A #16 scoop (2 ounces) mashed sweet potatoes c. 4 ounces green beans with bacon and red onions d. One flakey biscuit e. One teaspoon margarine f. 4 ounces vine ripened watermelon g. 6 fluid ounces of milk On 5/13/25 at 12:07 PM watched Staff C, Dining Hospitality Coordinator, review Resident #47's meal ticket which listed her diet as a CCHO diet. Staff C plated 3 ounces of ribs, 4 ounces of sauteed green beans with bacon and red onion, 4 ounces of sweet potato, one flakey biscuit with margarine and a 4 ounce bowl of watermelon. On 5/13/25 at 12:40 PM Staff C reviewed Resident #47's meal ticket with the Surveyor and verbalized she had served the 4 ounce serving of sweet potatoes to Resident #47 and it should have been the #16 (2 ounce) scoop of sweet potatoes as listed on the meal ticket. She voiced she checked the menu extensions prior to meal service and she served Resident #47 the regular diet, not the CCHO diet. During an interview 5/14/25 at 1:00 PM the Certified Dietary Manager explained staff are to follow the diet as posted on the approved Menus as the serving sizes are on the menus to eliminate serving mistakes. The extensions are printed onto the daily menu, so the actual serving sizes are posted on the meal ticket. She expected the staff to follow the menus. During an interview on 5/14/25 at 1:37 PM the Dietitian reported Staff C made an honest mistake and she expected staff to serve the approved dietary menu. The Food Production and Service Policy, revised December 2023, directed the Registered Dietitian Nutritionist Supervisor of Dining Services and/or the Lead Hospitality Coordinator are responsible for seeing the menu is followed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42133 Based on observation, clinical record review, policy review and staff interview the facility failed to properly store food according to manufacturer's directions, ensure staff contain hair in hairnets when in the kitchen, and failed to ensure hot food is held at 135 degrees Fahrenheit (F) for safety. The facility reported a census of 48 residents. Findings include: The initial kitchen observation completed on 5/12/25 at 9:48 AM on the second floor kitchen revealed the following: a. One 3/4 full carton of Ready Care thickened orange juice dated 4/18/25. The Manufacturer Directions on the side of the carton directed to discard 7 days after opening. b. One 1/4 full bottle of Thick It Clear Advantage Thickened Water, level 2, mildly thick, dated 4/15/25. The Manufacturer Label on the bottle directed to use within 14 days after opening. During a follow up inspection of the second floor kitchen on 5/13/25 at 10:54 AM the following observations were made: a. One 3/4 full carton of Ready Care thickened orange juice dated 4/18/25. The Manufacturer Directions on the side of the carton directed to discard 7 days after opening. b. One 1/4 full bottle of Thick It Clear Advantage Thickened Water, level 2, mildly thick, dated 4/15/25. The Manufacturer Label on the bottle directed to use within 14 days after opening. Interview on 5/13/25 at 11:00 AM Staff A, Dining Hospitality Coordinator, reported she was trained juices could only be used for three days, then they were to dispose of them. During an interview on 5/13/25 at 11:01 AM the Dietitian reported they follow the label directions from the manufacturer for discarding fluids. She couldn't answer if the date on the bottle was the delivery stock date or the open date as they date all food items when they come in for delivery. She expected the staff to date food and fluid items when opening and follow the label instructions. On 5/13/25 at 11:35 AM witnessed Staff D and Staff E, Certified Nursing Assistants (CNAs), prepare drinks in the kitchen with approximately 4-5 inches of side tendrils of hair hanging out of the sides of their hairnets. On 5/13/25 at 12:13 PM saw Staff D come out of the back kitchen with 4-5 inches of side hair hanging out of the sides of the hairnet, they opened a bag of Doritos and put it on the counter top for the cook to serve out to a resident. On 5/13/25 at 12:18 PM saw Staff D entered the kitchen with approximately 4-5 inches of side hair hanging out of her hairnet to get a resident pop from the pop machine. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/13/25 at 12:32 PM witnessed Staff D in the kitchen with 4-5 inches of hair hanging out the sides of her hair net as she obtained butter from the kitchen for a resident's sweet potato. The post meal temperatures completed on 5/13/25 at 12:37 PM revealed the temperature of the green beans at 123.1 degrees Fahrenheit. The green beans sat in a steam pan throughout the entire meals service from 12:04 PM to 12:37 PM with the stove burner in the off position. Staff C turned the oven down to 300 degrees Fahrenheit at 11:59 AM, then down to 250 degrees at 12:02 PM and finally turned the oven to the warm position at 12:04 PM. Interview on 5/13/25 at 12:41 Staff C verbalized hot food should be held at 135 degrees or higher. During an interview 5/14/25 at 1:00 PM the Certified Dietary Manager voiced staff are to have all hair contained in a hairnet when in the kitchens. The staff are trained to keep hot food temperatures above 140 degrees, but the staff know the actual requirement is to keep at a minimum of 135 degrees. If there is a lull in the meal service, the steam pans of food should be put back in the over to keep the food hot. During an interview on 5/14/25 at 1:37 PM the Dietitian reported she expected the hot food to be held at 135 degrees Fahrenheit or higher. In addition, she expected the staff to ensure all hair is covered with a hairnet before entering the kitchens. The Food Storage Policy, reviewed December 2023, under Procedure directed foods held in the refrigerator shall be appropriately covered, labeled and dated. The Food Temperature/Food Safety Policy, reviewed December 2023, directed to maintain all foods served at proper temperatures including during food preparation and service. The Policy directed food temperatures should be taken periodically to assure hot foods stay above 135 degrees Fahrenheit during the holding and plating process. The Infection Control Staff Related Preventive Measures Policy, revised October 2024, directed dietary staff will wear hair restraints while in the kitchen areas to prevent hair from contacting exposed food.