STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165516	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jackson Ridge Healthcare Center	1015 Wesley Drive Maquoketa, IA 52060

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review, family and staff interview, the facility failed to document the physician and family were notified of 2 of 2 changes in condition (Residents #23 after a fall with skull fracture and #49 after a significant amount of bloody urine returned after an indwelling catheter was inserted). The facility reported a census of 47 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] identified Resident #23 as cognitively impaired with a BIMS (Brief Interview for Mental Status) of 03 and had the following diagnoses: Coronary Artery Disease, Heart Failure, and Non-Alzheimer's Dementia. The MDS identified Resident #23 was dependent on staff for assistance with oral hygiene and personal hygiene and required substantial/maximal assistance with toileting and dressing. The MDS also identified Resident #23 had 2 falls with no injury and one fall with minor injury. On 11/3/23, the Care Plan identified Resident #23 at risk for falls related to Alzheimer's Disease and psychotropic medication use. Interventions included: a. Bed alarm in place to alert staff to resident movement for safety due to recent cognitive changes resulting in poor safety awareness b. If fall occurs, follow facility fall protocol A review of the Incident Report dated 7/14/24 at 7:00 AM had documentation of the following: Nursing description: Called to room by staff as heard bed alarm going off and witnessed resident fall hitting head on wall on back upper head and landing on left side of hip. Resident Description: I was walking A review of the Nurse's Progress Notes had documentation of the following: 7/14/24 at 7:00 AM (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff heard alarm going off and saw Resident #23 fall, hit his head on wall and landed on his left side. Assessed head to toe. No new skin areas noted. A slightly reddened area 2 cm (centimeters) by 1 cm on the back of his upper head. ROM (range of motion) as usual. Pupils equal and reactive. Denies any pain or discomfort no nausea or vomiting, alert and responsive. Vital signs table Assisted up per Hoyer lift and two staff to standing. The note did not have documentation to show the physician or family had been notified of the fall. 7/14/24 12:01 PM Telephone call to Resident #23's Family Member and she requested Resident #23 be sent to ER (emergency room) to be evaluated. Physician called and received a new order received to send to ER to be evaluated. Sent to ER. 7/14/24 4:42 PM Received call from the hospital. Resident #23 will be coming back to facility. No new orders. CT scan showed a fracture of the temple area. In an interview on 7/31/24 at 1:08 PM, Staff I, LPN reported the following: a. When a resident has a fall and hits their head, the nurse should complete a head to toe assessment, do neuro checks, contact the doctor and family, neuro assessments every 15 minutes for 1 hour, every 30 minutes for 1 hour and every 8 hours until 72 hours has passed. b. The doctor and family should be notified before the shift ends. c. Assessments should be charted on the neuro flow sheet, condition report for the doctor and in the progress notes d. When a resident is sent to the ER, the nurse should document vitals, condition, a head to toe assessment, that she contacted the doctor and family, and whoever is on call, call the ambulance, give a report and how they were transported to the ER. e. When Resident #23 fell on [DATE], she reported she did not witness the fall. It had been reported to her by Staff H, CMA who said she witnessed the fall. Staff H reported he fell against the wall and hit his head. Staff I assessed Resident #23 and found a little reddened area to the right posterior part of his head. The area was not raised or open and was about 2 centimeters in size. This was the second fall Resident #23 had that day. Staff I was in Unit 1 when the fall occurred. She would usually stay on Unit 1 and a CMA would oversee Unit 2. f. The only fall precaution that she could recall that Resident #23 had was a pad alarm underneath him which goes off when he gets up. In an interview on 8/5/24 at 10:55 AM, Staff G, CNA reported the following: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When Resident #23 fell on [DATE], she worked on East hall and when she arrived to Unit 2, Resident #23 was on the floor. His alarm was going off and by the time they got there, he was already on the floor. Staff C, CMA was in the room and Staff I, LPN came to assess him. After that fall, they started having a nurse stay back in Unit 2, the men's unit. Before that it was just one nurse between Unit 1 and 2 and that nurse usually stayed on Unit 1. After Resident #23 was supposed to be transferred with assist of one with gait belt and standby assist. Resident #23 did not go to the hospital until later that afternoon around 2:00 PM. The family was upset that he had hit is head and they were not called. 2. The Minimum Data Set (MDS) dated [DATE] identified Resident #49 as severely cognitively impaired without a BIMS score conducted. The MDS also identified Resident #49 had the following diagnoses: Non-Traumatic Brain Dysfunction, Non-Alzheimer's Dementia, and Renal Insufficiency (Kidney Failure). The MDS also identified Resident #49 required partial/moderate assistance with oral hygiene, toileting, dressing, and personal hygiene and required substantial/maximal assistance with showers. The MDS also identified Resident #49 to be incontinent of urine and stool. A review of the Nurse's Progress Notes had documentation of the following: 7/2/24 5:24 AM Resident #49 had 4 moderate amounts of red drainage from penis ranging from red to reddish/brown. Lower abdomen firm and tender to touch, slightly distended. There was no documentation to show the physician was notified. 7/3/24 1:24 AM Foley catheter inserted with an immediate return of 600 cc red drainage. There was no documentation to show the physician was notified. On 4/22/24, the Care Plan identified Resident #49 with the problem of recurrent prostatitis and directed staff to monitor/document for signs and symptoms of Prostatitis: need to urinate often, burning/stinging and/or pain with urination, decreased amount of urine with each urination, rectal pain/pressure, pain low back and/or pelvis, discharge from urethra during BMs (bowel movements). In an interview on 8/5/24 at 3:36 PM, the DON (Director of Nursing) reported the following: a. When a resident has an unwitnessed fall and hits their head, she would expect the nurse to notify the physician and family as soon as possible. b. She would expect them to complete an assessment right away for a baseline and document this in the risk management or nurse's notes. c. The family and physician should have bee notified immediately after Resident #23 fell , she had no explanation as to why there was a 5 hour gap between the fall and the initial call to the family and physician. A review of the Facility Policy titled: Change of Condition Resident Physician dated as last revised 12/23/16 had documentation of the following: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Between the hours of 8:00 AM and 10:00 PM seven days a week, the attending Physician or Nurse Practitioner shall be notified of all conditions or health status changes. b. Between the hours of 10:00 PM and 8:00 AM, the attending physician or physician on call should be notified of any change in condition, health status or incident that: aa. Resulted in an injury that has the potential for physician intervention bb. Abnormal diagnostic values that fall out of the normal range cc. Acute symptoms, ie: unusual bleeding or other conditions as deemed necessary. A review of the Facility Policy titled: Change in Resident's Condition or Status, dated as last revised February 2021 had documentation of the following: Policy Statement: Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). The nurse will notify the resident's attending physician or physician on call when there has been a(an): a. accident or incident involving the resident; b. discovery of injuries of an unknown source; c. adverse reaction to medication; d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; f. refusal of treatment or medications two (2) or more consecutive times); g. need to transfer the resident to a hospital/treatment center; h. discharge without proper medical authority; and/or i. specific instruction to notify the physician of changes in the resident's condition. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. the resident is involved in any accident or incident that results in an injury including injuries of an unknown source; b. there is a significant change in the resident's physical, mental, or psychosocial status; c. there is a need to change the resident's room assignment; d. a decision has been made to discharge the resident from the facility; and/or e. it is necessary to transfer the resident to a hospital/treatment center.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review, and staff interviews, the facility failed to repair a bathroom light in one room (Resident #23) and door casings to 6 other rooms in Unit 2. The facility reported a census of 47 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] identified Resident #23 as cognitively impaired with a BIMS (Brief Interview for Mental Status) of 03 and had the following diagnoses: Coronary Artery Disease, Heart Failure, and Non-Alzheimer's Dementia. The MDS also identified Resident #23 was dependent on staff for assistance with oral hygiene and personal hygiene and required substantial/maximal assistance with toileting and dressing. The MDS also identified Resident #23 had 2 falls with no injury and one fall with minor injury. In an observation on 7/30/24 6:12 AM, Staff E, CNA and Staff O, CMA/CNA assisted resident to stand in his bathroom. Staff E tried to turn on the light switch, the light would not turn on. Both aides stood in the dark bathroom with the resident as he voided into the toilet. Resident #23 said turn the light on. however, the light still would not turn on. At 6:26 AM after both staff assisted Resident #23 back to his bed they went to the bathroom to wash their hands and the light then lit up. 2. In an observation on 7/30/24 11:06 AM, the door casing to left side of entrance to room [ROOM NUMBER] had a piece approximately 2.5 feet long missing with sharp edges exposed. On 7/31/24 at 8:28 AM, the door casing remains unchanged. 3. During a review of Unit 2 on 8/1/24 at 8:53 AM, observations revealed the following: room [ROOM NUMBER]- 1.5 feet portion missing from the trim with sharp edges exposed. room [ROOM NUMBER]- 3 inch area of rough exposed wood in door casing. room [ROOM NUMBER]- 2 feet portion missing from the casing with sharp edges exposed. room [ROOM NUMBER]- 1 inch gouge noted with sharp edges exposed. room [ROOM NUMBER]- 3 gouges from 1/2 inch to 2 inches wide, with sharp edges exposed. In an interview on 8/5/24 at 10:55 AM, Staff G, CNA reported a. Usually first thing in the morning Resident #23's light doesn't work, but after things get warmed up, they turn on without problems. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. If she sees door casings are missing pieces and have sharp edges, she would write it in the maintenance book. When the maintenance supervisor completes the work orders, he initials them and it stays in the book. In an interview on 8/5/24 at 11:12 AM, Staff E, CNA reported the other day in Resident #23's room was the first time the bathroom light wouldn't work. It has happened in another room. When things like that happen or when we see rough sharp edges around the door frame, the staff are supposed to tell the Maintenance Supervisor about it, fill out a work order and put it in the Maintenance Supervisor's door. In an interview on 8/5/24 at 3:03 PM, the Maintenance Supervisor reported the following: a. He was not made aware of the problems with light bulbs not working in the bathrooms in the residents' rooms. He had not received any work orders to address that issue. b. If staff find problems that he needs to repair, there is a notebook with work orders outside his office door. The other notebook is behind the East nurse's desk. He checks this book every day. After he completes the task, he documents it on the work order on paper. c. He was only made aware of two resident room doors that needed repair. He was waiting on parts to arrive. Some of the staff could not find pieces that were broken off the door. d. He was unsure of how long the door casings were in need of repair. The previous corporation would not allow him to buy anything to repair things. The new corporation is better about allowing him to purchase what he needs. In an interview on 8/5/24 at 3:36 PM, the DON (Director of Nursing) reported the following: a. When staff sees that door casings are broken with sharp edges exposed, she would expect them to write in the maintenance book. There is one on East by med refrigerator and there should be another one in Unit 2. b. The work orders for maintenance are kept in the notebook. c. When the work order is completed, the Maintenance Supervisor will sign each off as they are completed. d. She was not aware that there were lights in Unit 2 that were not working properly. Staff should have completed a work order and put it in the Maintenance Notebook. A review of the policy titled: Work Orders dated as last revised December 2004 had documentation of the following: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. In order to establish a priority of maintenance service, work orders must be filled out and forwarded to the maintenance director. b. It shall be the responsibility of the department directors to fill out and forward such work orders to the maintenance director. c. A supply of work orders is maintained at each nurses' station. d. Work order requests should be placed in the appropriate file basket at the nurses' station. Work orders are picked up daily. e. Emergency requests will be given priority in making necessary repair.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37072 Based on record review and staff interviews the facility failed to update a Care Plan to indicate the residents correct transfer status for one out of one Care Plan reviewed (Resident #22). The facility identified a census of 47 residents. Findings include: The MDS for Resident #22 dated 6/10/24, listed diagnoses of atrial fibrillation (irregular heartbeat), hypertension (high blood pressure), and diabetes mellitus (DM). The Brief interview for Mental Status (BIMS) reflected a score of 3, severely impaired cognition. The MDS reflected Resident #22 dependent on staff for transfers. Review of the Care Plan with intervention dated 6/4/24 revealed Resident #22 is dependent on 2 staff for Sara lift or Hoyer (mechanical lift) for transfers. The therapy recommendations dated 6/13/24 revealed assist times 2 staff with front wheeled walker. Staff to use assist times 2 with front wheeled walker wheelchair to follow for distance. The notes from weekly medicare meeting minutes dated 6/14/24 reflected to change Resident #22 to assist with two with front wheeled walker wheelchair to follow. The occupational therapy notes dated 8/1/24 revealed discharge recommendations for assist times two with front wheeled walker. On 08/01/24 at 10:13 AM Staff J, Certified Nursing Assistant (CNA) stated staff need to look on the kardex and the Care Plan for how much assist to provide with a transfer for residents. She looked at the the kardex/Care Plan in the electronic health record (EHR) for Resident #22 and stated it does say Sara lift or Hoyer. She stated this was changed when she completed therapy. On 08/01/24 at 10:19 AM Staff I, Licensed Practical Nurse (LPN) stated when physical or occupational therapy changes transfer status it should be updated on the Care Plan. Staff go to the Care Plan to know what amount of assist to provide a resident for transfers. On 08/01/24 at 10:22 AM the Director of Nursing (DON) stated everything should be updated on the Care Plan. The MDS coordinator should update during the medicare meeting if a residents transfer status changed. She stated if Resident #22 Care Plan says a mechanical lift [NAME] or Hoyer lift that is wrong she has been upgraded to a transfer with one. On 08/01/24 at 10:26 AM Staff K, Occupational Therapy stated Resident #22, she should be a 2 person assist for transfers the communication form was provided to the MDS Coordinator to update the Care Plan. The facility provided an untitled policy with a revision date of 11/17 which directed staff the comprehensive Care Plan will at a minimum identify the following: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Services that will be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review, and staff interview, the facility failed to document 3 of 3 residents had been given showers twice a week. (Residents #6, #34, and #38). The facility reported a census of 47 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] identified Resident #6 as severely cognitively impaired with a BIMS (Brief Interview for Mental Status) of 03 and had the following diagnoses: Stroke, Coronary Artery Disease, and Hemiplegia (paralysis of one side of the body). The MDS also identified Resident #6 was dependent on staff for all activities of daily living and had a feeding tube. Observations of Resident #6 include the following: 7/30/24 at 7:08 AM Resident #6 sat up in her wheelchair wearing clean clothing and gripper socks, however, her hair stuck straight up and appeared greasy as if it had not been shampooed for a few days. 7/31/24 at 8:16 AM Resident #6 was asleep in bed without any clothing on, had a [NAME] Strap across her abdomen and covered with a sheet from her lower abdomen to her feet. Her hair stuck straight up and appeared greasy, with a slight odor noted. 7/31/24 at 9:24 AM assessment unchanged A review of Resident #6's shower records for May, June, and July 2024 revealed the following: May 2024 Scheduled Wednesday and Saturday nights No documentation of showers for 7 days from May 2 through 8, June 2024 No documentation of showers for 6 days from June 3 through 8, for 7 days from June 20 through 26 July 2024 No documentation of showers for 7 days from 7 through 13, 6 days from July 21 through 26 On 4/17/23, the Care Plan identified Resident #6 with the problem of having an ADL (activities of daily living) self-care performance deficit related to a stroke and dementia. The Care Plan directed staff to provide assistance with showering 2 times per week and PRN (as needed). If she is being combative with cares, assist of two is recommended to ensure safety. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The Minimum Data Set (MDS) dated [DATE] identified Resident #34 as severely cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 03 out of 15. The MDS also identified Resident #34 with the following diagnoses: Non-Traumatic Brain Dysfunction, Alzheimer's Disease, and Atrial Fibrillation. The MDS also identified Resident #34 as dependent on staff for assistance with oral hygiene, required substantial/maximal assistance with toileting, showers, and personal hygiene. A review of Resident #34's shower records for May, June, and July 2024 revealed the following: May 2024 Scheduled Wednesday and Sunday nights No showers documented for 10 days from May 10 through 19, for 4 days from 23 through 26 June 2024 No showers documented for 6 days from June 7 through 12, 6 days from 21 through 26 July 2024 No showers documented for 6 days from July 12 through 17 On 4/7/23, the Care Plan identified Resident #34 with the problem of having an ADL (activities of daily living) self-care performance deficit related to Alzheimer's Disease and Dementia with Behavioral Disturbances. The Care Plan directed staff to provide assistance of one with showers twice a week and PRN. 3. The Minimum Data Set (MDS) dated [DATE] identified Resident #38 as severely cognitively impaired with a BIMS (Brief Interview for Mental Status) of 03 and had the following diagnoses: Non-Traumatic Brain Dysfunction, Non-Alzheimer's Dementia, and COPD (Chronic Obstructive Pulmonary Disease). The MDS also identified Resident #38 required substantial/maximal assistance with personal hygiene, showers, and toileting and required only set up assist with other activities of daily living. A review of Resident #38's shower records for May, June and July 2024 revealed the following: May 2024 Documentation showed showers given for all scheduled days. June 2024 No documentation of showers given for 6 days from June 19 through 24. July 2024 No documentation of showers given for 6 days from July 6 through 11 and for 6 days from July 24 through 29. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/12/24, the Care Plan identified Resident #38 with the problem of having an ADL (activities of daily living) self-care performance deficit related to impaired mobility and dementia with behavioral disturbances. The Care Plan directed staff to provide assistance with showering. Assist of two recommended when resistive behaviors are noted. In an interview on 8/5/24 at 3:36 PM, the DON (Director of Nursing) reported the following: a. Thee majority of residents are scheduled to have showers twice a week, there is one resident that wants it daily. b. When the resident refuses, she would expect the aide to re-approach and try again. The CNA will document in the electronic medical record that the resident refused, but they cannot document a narrative note. She would expect the nurse to document the reason why in Progress Notes. A review of the undated facility policy titled: Shower did not direct staff to attempt to provide at least 2 showers a week, the need to report if the resident refuses to shower, despite re-approaching the resident later and the need for the nurse to document why the resident refused and interventions taken.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review, family and staff interview, the facility failed to utilize proper transfer techniques for 1 of 3 residents observed for transfers (Resident #22) and failed to utilize the proper technique to push 2 of 2 residents observed in wheelchairs (Residents #23 and #27). The facility reported a census of 47 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] identified Resident #23 as cognitively impaired with a BIMS (Brief Interview for Mental Status) of 03 out of 15 and had the following diagnoses: Coronary Artery Disease, Heart Failure, and Non-Alzheimer's Dementia. The MDS also identified Resident #23 was dependent on staff for assistance with oral hygiene and personal hygiene and required substantial/maximal assistance with toileting and dressing. The MDS also identified Resident #23 had 2 falls with no injury and one fall with minor injury. On 11/3/23, the Care Plan identified Resident #23 at risk for falls related to Alzheimer's Disease and psychotropic medication use. In an observation of cares on 7/30/24 at 6:17 AM, Staff O, CMA/CNA pushed Resident #23 in his wheelchair without the foot pedals on and his feet skimming the floor from his bathroom to beside his bed. (approximately 15 to 20 feet). 2. The Minimum Data Set (MDS) dated [DATE] identified Resident #27 as moderately cognitively impaired with a BIMS (Brief Interview for Mental Status) of 07 and had the following diagnoses: Non-Traumatic Brain Dysfunction, Atrial Fibrillation (an abnormal heart rhythm), and Coronary Artery Disease. The MDS also identified Resident #27 was dependent on staff for assistance with toileting, showers, dressing, personal hygiene, and transfers. The MDS also identified Resident #27 had a history of one fall without injury. A review of the Care Plan revealed no interventions placed to address the need to place foot pedals on the wheelchair prior to transporting Resident #27. Observations of the staff transporting Resident #27 in his wheelchair revealed the following: 7/30/24 8:10 AM after Staff I, LPN administered insulin in the shower room, she pushed Resident #27 in his wheelchair without foot pedals on and with his feet skimming the floor. Staff I pushed Resident #27 from the shower room to the main dining room (approximately 50 feet). 7/31/24 8:47 AM Staff E, CNA pushed Resident #27 in his wheelchair with his left foot on one foot pedal, and the right foot without foot pedal and skimming the floor. In an interview on 8/5/24 at 3:36 PM, the DON (Director of Nursing) reported the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Before staff are ready to transport a resident in a wheelchair, she would expect them to make sure there are foot pedals on the wheelchair and that the resident's feet are on the foot pedals. 37072 3. The MDS for Resident #22 dated 6/10/24, listed diagnoses of atrial fibrillation (irregular heartbeat), hypertension (high blood pressure) and diabetes mellitus (DM). The Brief interview for mental status (BIMS) reflected a score of 3, severely impaired cognition. The MDS reflected Resident #22 dependent on staff for transfers. During an observation on 07/29/24 at 2:04 PM surveyor heard screaming coming from Resident #22 room. The surveyor knocked on the door and entered room, Staff J, Certified Nursing Assistant (CNA) in room completed a transfer of Resident #22 with one person and gait belt. Staff J completed the transfer from residents wheelchair to her recliner. Resident #22 stated that is not the way the transfer is supposed to be completed. Staff J stated she did a pivot transfer with her and she will not be doing that again because it did not go well. Review of the Care Plan with intervention dated 6/4/24 revealed Resident #22 is dependent on 2 staff for Sara lift or Hoyer (mechanical lift) for transfers. The therapy recommendations dated 6/13/24 revealed assist times 2 staff with front wheeled walker. Staff to use assist times 2 with front wheeled walker wheelchair to follow for distance. The notes from weekly medicare meeting minutes dated 6/14/24 reflected to change Resident #22 to assist with two with front wheeled walker wheelchair to follow. The occupational therapy notes dated 8/1/24 revealed discharge recommendations for assist times two with front wheeled walker. On 08/01/24 at 10:13 AM Staff J, Certified Nursing Assistant (CNA) stated staff need to look on the kardex and the Care Plan for how much assist to provide with a transfer for residents. She looked at the the kardex/Care Plan in the electronic health record (EHR) for Resident #22 and stated it does say Sara lift or Hoyer. She stated this was changed when she completed therapy. On 08/01/24 at 10:19 AM Staff I, Licensed Practical Nurse (LPN) stated when physical or occupational therapy changes transfer status it should be updated on the Care Plan. Staff go to the Care Plan to know what amount of assist to provide a resident for transfers. On 08/01/24 at 10:22 AM the Director of Nursing (DON) stated everything should be updated on the Care Plan. The MDS coordinator should update during the medicare meeting if a residents transfer status changed. She stated if Resident #22's Care Plan says a mechanical lift [NAME] or Hoyer lift that is wrong she has been upgraded to a transfer with one. On 08/01/24 at 10:26 AM Staff K, Occupational Therapy stated Resident #22, she should be a 2 person assist for transfers the communication form was provided to the MDS Coordinator to update the Care Plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/01/24 at 10:27 AM the DON stated if Resident #22 is a 2 person assist I would expect the staff to be using 2 people to transfer her and a gait belt. They should follow the Care Plan for transfer status. The facility provided an undated policy titled Transfer Techniques which directed staff to obtain help when necessary, or as identified on the care plan/care card.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review, and staff interview, the facility failed to ensure narcotics were properly secured for one of two medication carts reviewed and failed to properly dispose of an undated insulin pen for Resident #27. The facility reported a census of 47 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] identified Resident #27 as moderately cognitively impaired with a BIMS (Brief Interview for Mental Status) of 07 and had the following diagnoses: Non-Traumatic Brain Dysfunction, Atrial Fibrillation (an abnormal heart rhythm), and Coronary Artery Disease. The MDS also identified Resident #27 was dependent on staff for assistance with toileting, showers, dressing, personal hygiene, and transfers. The MDS also identified Resident #27 had a history of one fall without injury. In an observation on 7/30/24 7:40 AM, Staff I, LPN removed a Lantus insulin pen from the medication cart and verified the Lantus pen was not dated when opened. Staff I obtained two new pens of Lantus and Humalog. Staff I then left the undated Lantus pen on top of the medication cart in the dining room where multiple residents sat waiting to be served breakfast. No other staff were noted in the dining room when Staff I failed to dispose of the undated Lantus pen before she pushed Resident #27 into the shower room. In an interview on 7/31/24 at 1:08 PM, Staff I, LPN reported the following: When she has an insulin pen that was not dated and replaces it, she would need to throw the undated pen away right away. She admitted she forgot to do that the other day. 2. On 7/30/24 at 4:27 AM, during a review of the medication cart on Unit 1 with Staff N, RN verified the narcotic drawer was not locked. Staff N immediately locked the drawer. In an interview on 8/5/24 at 3:36 PM, the DON (Director of Nursing) reported the following: a. If a nurse realizes one of the insulin pens is not dated and she gets a new one, she would expect the nurse to throw the undated pen away immediately. b. The drawer where narcotics are kept should be locked at all times. A review of the facility policy titled: Medication Storage dated as last revised April 2007 had documentation of the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Compartments containing drugs and biologicals shall be locked when not in use and trays or carts used to transport such items shall not be left unattended if left open or otherwise potentially available to others.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50874 Based on observation, policy review, resident and staff interviews the facility failed to serve foods that was warm and palatable for 1 of 1 meal services observed. The facility reported a census of 47 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #32 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS listed diagnoses of anemia, hypertension, hyperlipidemia, thyroid disorder, and dysphagia. During an interview on 7/29/24 at 10:52 AM Resident #32 reported the food is terrible and is not hot enough when the meal is served. Observation 07/30/24 at 11:35 AM dietary Staff A, cook wheeled the steam table to Unit I/Unit II dining area. Staff A, cook recorded food temperatures held in the warming pans of the steam table. The dietary supervisor and consultant dietitian were approximately 5 feet away from the steam table observing. The food temperatures revealed the following: a. Pureed fried rice - 127 degrees Fahrenheit (F) b. Pureed egg roll - 134 degrees F c. Pureed broccoli - 131 degrees F Staff A, cook proceeded to plate 10 meals for Unit 1. The plated meals were covered and placed on a meal tray rack and delivered to the unit. A sample plate was requested. After the last resident meal tray was served, the consultant dietitian tested the food temperatures of the sample plate with the surveyor. The food temperatures revealed the following: d. Broccoli - 116 degrees F e. Orange Chicken - 132.5 degrees F f. Egg roll - 110 degrees F g. Fried rice - 114.1 degrees F At 12:35 PM the steam table was wheeled back to the kitchen to serve residents in the main dining room. A second sample plate was requested to taste the meal. The dietitian again tested the food temperature with the surveyor. The food temperatures revealed the following: a. Broccoli 125 degrees F and tasted cold. b. Fried rice 110 degrees F and tasted cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Staff A, cook on 07/30/24 at 1:22 PM, revealed that she received training on proper food temperatures for serving and was instructed to not serve foods at improper temperature. During an interview with Staff B, dietary supervisor on 7/30/24 at 2:14 PM, reported training is provided at monthly meetings and the expectations are food will not be served at improper temperatures. Staff B, dietary supervisor stated she tries to monitor the food temperatures daily. A record review of the food temperature logs revealed the following: a. 7/8/24 Breakfast protein puree - 132 degrees F b. 7/8/24 Lunch protein puree - 129 degrees F c. 7/8/24 Lunch vegetable puree - 128 degrees F d. 7/9/24 Breakfast protein mechanical soft - 132 degrees F e. 7/9/24 Breakfast protein puree - 124 degrees F f. 7/17/24 Breakfast protein mechanical soft -132 degrees F g. 7/17/24 Breakfast protein puree - 126 degrees F h. 7/18/24 Breakfast protein puree - 124 degrees F i. 7/22/24 Breakfast protein puree - 132 degrees F j. 7/22/24 Lunch protein puree - 132 degrees F k. 7/22/24 Vegetable puree - 128 degrees F l. 7/23/24 Breakfast protein puree - 128 degrees F m. 7/23/24 Lunch protein regular - 128 degrees F An undated facility policy for General Food Preparation and Handling revealed all meats need to be heated throughout to a minimum temperature of 145 degrees F for fish or beef roasts for 15 seconds; 155 degrees F for ground beef and pork for a minimum of 15 seconds, 165 degrees F for poultry and any leftovers.

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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. 50874 Based on observation, policy review, and staff interviews the facility failed to demonstrate proper food handling of utensils when serving, allowing dishes, steam table pans, and storage containers to air dry completely, and storing wet wiping cloths in an approved sanitizing solution. The facility reported a census of 47 residents. Findings include: During initial kitchen observation on 7/29/24 at 10:30 AM, observed Staff A, cook removing items from the clean dish rack and did not allow the items to air dry. An 8-inch plastic plate was stacked in a plastic tub near the steam table and 2 clear plastic storage containers (one approximately 6 inches in diameter and one approximately 8 inches in diameter) were stacked on top of other storage containers while still wet. During observation on 7/30/24 at approximately 11:20 AM, Staff A, cook was in the process of preparing pureed items. Staff A, cook had pureed broccoli and rinsed the equipment and placed in the dish rack and slid the dish rack into the dish machine. Staff A went to the hand washing sink, washed her hands, turned the faucet off with her wet hand, turned the dial to dispense a paper towel, dried her hands with the paper towel and went to a drawer where she pulled out 2 towels. She used one of the dry towels to wipe off the stainless-steel prep table. Staff A tossed the 2 towels on the middle shelf of a stainless-steel cart located behind her to her left when standing at the food prep table. She pulled the robot coupe container, blade, measuring container, and spatula from the clean dish rack and carried them to the prep table. Staff A proceeded to puree 6 egg rolls. While the robot coupe was operating she picked up the used towel from the stainless-steel cart and wiped the robot coupe off while it was running. Towel again placed on the middle shelf of the stainless-steel cart next to the unused towel. Staff A, cook scraped the pureed egg roll into a steam table warming pan, covered it and placed it in the steam table. Staff A rinsed the robot coupe canister, measuring cup, and spatula and placed items in a dish rack for washing in the dishwasher. Staff A picked up the same towels, walked over to the sink and used the spray nozzle to wet the towel down. Staff A returned to the prep table and wiped the table down. The towel was then tossed into a 5-gallon bucket of towels under the sink with the spray nozzle. No sanitizing solution bucket was observed in the area during this time. The dietary supervisor and the consultant dietitian were both present during this observation. During observation on 7/30/24 at 12:48 PM, Staff A, cook had scooped fried rice and tossed the scoop into the steam table pan causing the scoop to land entirely in the pan. The scoop was a gray handled #8 size 4-ounce scoop. The handle of the scoop laid in the fried rice. Staff A grabbed the scoop with her bare hand and continued to plate food up for residents in the main dining room. An undated facility policy for General Food Preparation and Handling revealed that staff are to handle utensils, cups, glasses and dishes in such a way as to avoid touching surfaces with which food or drink will come in contact. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/01/24 08:27 AM with Staff B, dietary supervisor revealed there were sanitation buckets available but the staff member did not have one in her area during the observation on 7/30/24. The expectation is for staff members to use the sanitizing solution and towels when wiping off a food prep area. During an interview on 08/01/24 at 8:37 AM with Staff A reported her process for sanitizing the food prep area are to grab a dry towel, wet it down with the spray nozzle at the sink and use it a couple of times before getting a new towel. She was unaware of the sanitizing solution buckets until recently. During a record review on 08/01/24 at 11:37 AM, the facility Sanitation of Dietary Equipment policy lacked direction in sanitizing the food prep area.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50874 Based on observation, resident, family and staff interviews the facility failed to demonstrate proper hand washing technique while preparing and handling food. The facility also failed to utilize proper infection control techniques during an observation of one of two residents during incontinence care. (Resident #46) The facility census was 47. Findings include: 1. During continuous observation of the puree process on 7/30/24 from 11:06 AM to 11:40 AM, Staff A, cook washed her hands 6 times. Each time she would turn on the water, wash her hands, turn off the faucet with her wet left hand and use her right hand to turn the dial on the right side of the paper towel dispenser. When the paper towel was dispensed she would then dry her hands and toss the used paper towel in the trash. Staff A failed to follow facility Hand Washing Technique to shut the water off with a dry paper towel. During an interview on 7/30/24 with Staff B, dietary supervisor hand washing audits are completed. The last audit was completed on 7/11/24. During an interview on 08/01/24 Staff A stated when she washes her hands she turns on the hot water and lets it warm up for about 20 seconds, washes her hands, and had been informed that she is to use a paper towel to shut the faucet off. She stated she previously was not using a paper towel to shut the faucet off. An undated facility policy for Hand Washing Technique revealed that faucets are considered contaminated. When turning off the faucets, use a dry paper towel to prevent re-infecting hands and fixtures. Staff should always wash hands before eating, drinking, or handling food. 25855 2. The Minimum Data Set (MDS) identified Resident #46 as severely cognitively impaired with a BIMS (Brief Interview for Mental Status) of 03 and had the following diagnoses: Non-Traumatic Brain Dysfunction, Benign Prostatic Hyperplasia (a condition which causes the prostate gland to grow), and Non-Alzheimer's Dementia. The MDS also identified Resident #46 was dependent on staff for assistance with oral hygiene, toileting, showers, dressing, personal hygiene, and transfers. The MDS also identified Resident #46 was always incontinent of urine and stool. On 1/12/24, the Care Plan identified Resident #46 with the problem of having an ADL (Activities of Daily Living) self-care performance deficit related to Dementia. The Care Plan directed staff to follow the intervention of encouraging regular toileting to help prevent incontinent episodes. Staff of one to assist with toilet hygiene and incontinence care. The Care Plan did not address the need to empty the washbasins used for incontinence care into the toilet. During an observation of incontinence care on 7/29/24 at (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:52 AM Staff P, CMA and Staff E, CNA held on to each side of the gait belt and assisted Resident #46 to stand in front of the toilet, his pants were noted to be saturated with urine to cover an area of approximately 6 inches wide. Staff E used the correct technique to cleanse his rectal crease after he had been incontinent of a bowel movement, using a washbasin to dip the cloths into. 12:00 PM after cares were completed, Staff E emptied the washbasin into the sink instead of the toilet. In an interview on 8/5/24 at 10:55 AM, Staff G, CNA reported after peri cares, she should empty the basin of water into the toilet. In an interview on 8/5/24 at 11:12 AM, Staff E, CNA reported after she gives peri cares to a resident who was incontinent of stool, she should have emptied the wash basin into the toilet when she gave Resident #46 incontinent cares the other day. In an interview on 8/5/24 at 3:36 PM, the DON (Director of Nursing) reported the following: a. When CNAs are giving peri cares after a resident has a bowel movement, she would expect the CNA to empty out the wash basin into the toilet. b. When a nurse is getting ready to give a capsule medication via the GT, she would expect the nurse to put on gloves before she opens up the medication capsule. A review of the undated facility policy titled: Incontinence Care did not have documentation to instruct staff to empty the wash basin (after providing incontinence care after a BM) into the toilet.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37072 Based on observations, policy review, and staff interview the facility call light system failed to alert staff of call light initiated to a central staff work area or directly to a staff member. The facility identified a census of 47 residents. Findings include: On 07/29/24 at 12:36 PM Resident #40 observed in her bathroom, room [ROOM NUMBER], on the toilet by herself, stated she put her call light on but no one came to answer it. The call light has a white and red bulb outside the door to notify the staff the resident had pushed the button. The light outside the room failed to light up even after the surveyor pushed the button in the bathroom. On 07/29/24 at 12:38 PM Staff J, Certified Nursing Assistant (CNA), assisted Resident #40 out of the bathroom she stated the call light is supposed to make a ringing noise at nurses station. This one does not make ringing noise and one other one so we have to make visual checks just for the bathroom due to the call light does not work. On 07/31/24 at 3:37 PM Staff D, Registered Nurse (RN), stated I am primarily in the South Unit (men's unit) so there is no buzzing and we have to watch for them. I am not able to tell you what the East hall has for call lights not all of them buzz. On 07/31/24 at 3:54 PM Staff L, housekeeping supervisor, stated some of them buzz to the nurses station and some of them don't buzz. I don't know why they don't buzz some work and some don't, there are a bunch of boxes on the wall and not sure which ones should be the call lights. The bathroom lights all turn red. She verified room [ROOM NUMBER] bathroom call light does not work. On 07/31/24 at 3:49 PM Staff M, CNA stated the call lights don't all ring to the nurses station or anywhere but they do light up. On 07/31/24 at 3:53 PM Staff G, CNA stated the call lights on East hall only the lower half ring to the nurses station. The rest for East hall do not ring at the nurses station. The South or unit 2 don't ring to central area just light up. There is not a central panel over in the memory care unit that light up. On 07/31/24 at 3:56 PM the Maintenance Supervisor replaced bulb in room [ROOM NUMBER] it worked and then did not, replaced 3 x and it kept burning out. He stated he has a bad batch of bulbs. On 08/01/24 at 12:46 PM Staff L, housekeeping supervisor stated the room that light rings to main nurses station are only rooms 26, 28, 29, 30, 31, 32, & 33 and I am not sure why the sound does not work on any of the rest of them. The South unit has a main panel that lights up but the North unit does not have a panel that lights up or rings to any nurses station. I am not sure when the call lights quit working but they must have at one time because some of them still do work. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165516	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jackson Ridge Healthcare Center	1015 Wesley Drive Maquoketa, IA 52060

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/01/24 at 1:48 PM the Director of Nursing (DON) stated, I am not aware they were not correctly working I knew a couple did not make noise I was not aware of room [ROOM NUMBER] bathroom not working I would expect staff to let us know as soon as possible if they are not working so we can replace the light. On 08/01/24 at 2:07 PM the Administrator stated the call light system is two bulbs, bathroom and bed side, so they can be pulled both sides East there is a panel that shows the lights outside the door and their is a panel that lights up for the men's unit wing, she confirmed there is no central location for the memory unit and the lower half of the East hall. We looked at the panel and only the one on the lower half of the East hall lit up or alarmed at the nurses station. The facility provided an dated policy titled Call Lights which directed staff to monitor call lights for malfunction and report any problems immediately. Until the necessary repairs are completed, check on resident frequently.