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	06/26/2025

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews the facility failed to follow a Care Plan intervention for 1 out of 3 residents reviewed with weight loss. (Resident #1) The facility identified a census of 59 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #1 indicated a Brief Interview for Mental Status (BIMS) score of 2 which indicates severe cognitive impairment. It further indicated diagnoses including: hypertension, non - Alzheimer's Dementia, and cerebrovascular accident. The MDS indicated Resident #1 required extensive assist from staff for transfers, bathing, dressing, and personal hygiene. Resident #1 was independent with eating. The MDS indicated Resident #1 had a weight loss. On 06/23/25 at 12:28 PM to 1:15 PM during a continuous observation Resident #1 ate her dessert and then got up per self and staff assisted back to her recliner in the main lounge area next to the dining area. The regular lunch had not been served yet. Resident drank a glass of milk per self but did not drink the orange drink in front of her. During the meal service no one offered her a plate of food or assisted her back to the table to eat the main part of the meal. On 06/24/25 at 08:08 AM observed Resident #1 at the table in the main dining room with a water glass and 3 cups with liquids in them drinking them independently. Resident attempted to get up per self and staff assisted her to the recliner in the main lounge area. Dietary started serving food at 8:15 AM no one ever offered her a plate of food or attempted to redirect her back to the table for the breakfast meal or brought a tray to the recliner. Review of the Care Plan revealed an intervention dated 12/14/24 which directed staff Resident #1 is independent with intakes of foods/fluid after set-up from the staff. She likes to eat in the recliner in the main lobby of the facility. Resident #1 needs cueing from the staff as she often refuses meals. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/26/25 at 09:57 AM Staff H, Certified Nursing Assistant (CNA) regarding Resident #1 when she walks away she goes over to her recliner and we try to redirect and she refuses but then we will give her the drink in her recliner. Then when the food comes out we try to redirect her back to table. We have not tried to set up a tray at the recliner. At least while I have been working, dietary has never brought out the food and put it on an over-bed table. We know what the Care Plan instructs us to do by the kardex in our charting or on the computer in the electronic health record. If there are changes to the Care Plan there is a binder with communication sheets which entails any changes like their transfers or diets. 06/26/25 10:04 AM Staff D, Registered Nurse (RN) stated Resident #1 has supplements we give her at meal times and we give her snacks throughout the day. When she walks away from the table we do try to redirect her. It's kind of hit and miss and they should redirect her back to the table. She has ate some meals at the recliner, we definitely have tried to get her to eat but she will refuse there also. It's more redirection and attempt to give her what she wants to eat. You can look at the kardex or look at it on the electronic health record for her Care Plan. On 06/26/25 at 10:20 AM the Director of Nursing stated she would expect staff to follow the Care Plan. She states Resident #1 refuses the meals we offer and the staff will offer snacks all day long. The facility provided an untitled policy dated 11/17 which directed responsible staff will be informed of the interventions that are identified in the care plan. They will receive notification initially and when changes are made.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, document review, clinical record review, policy review, and staff interview, the facility failed to serve the Dietician approved menu for 5 of 5 residents receiving a pureed diet. (Residents #1, #8, #19, #43, #46). The facility identified a census of 59 residents. Findings include: An untitled document provided by the facility on 6/23/25 documented Residents #1, #8, #19, #43, and #46 on pureed diets. A 6/24/25 Week Two Dietician approved Menu for Tuesday documented the following puree menu: a. Beef cube pepper steak, 1 serving (4 ounces (Oz.) b. French onion rice, 1 serving (4 Oz) c. Buttered peas, #12 scoop d. Seasonal fresh fruit, 1 serving Observation on 6/24/25 at 10:42 AM Staff A, [NAME] reported the facility had five residents on pureed diets and she planned to puree five servings of each item. Staff A placed five, 4 Oz. servings of peas into the Avamix blender, adding 1 ¼ cups milk to blend the mixture. She poured the mixture into a large measuring cup and reported the total volume as 2.5 cups. Staff A utilized the Pureed Diet Portion Sizes/Scoop Chart and stated the serving size was a #8 scoop. Staff A covered the steam pan with two servings of peas with foil and wrote peas #8 on top. During an observation on 6/24/25 at 10:52 AM Staff A placed 5 servings of beef cube pepper steak into the Avamix blender, added 1 cup milk and blended. She reported the total volume of the mixture as 3.5 cups. Staff A utilized the Pureed Diet Portion Sizes/Scoop Chart and voiced the serving size as #6 slightly heaping (SH) scoop. Staff A covered both steam pans with foil and label one steam pan unit, meat #6 SH and the other pan East, meat #6 SH. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 6/24/25 at 11:04 AM Staff A placed five, #8 (4 Oz.) servings of French onion rice into the Avamix blender, added 1 ½ cups milk for volume and blended. Staff A reported the total volume of the mixture as 4 cups. She utilized the Pureed Diet Portion Sizes/Scoop Chart and verbalized the serving size as two #10 scoops. Staff A covered both steam pans with foil and wrote, unit, rice, #10 x 2 on one pan and East, rice, #10 x 2 on the second steam pan. Observation on 6/24/25 at 11:52 AM revealed Staff A served a #6 scoop of beef cube pepper steak, portion under the rim of the #6 scoop (not heaped) and one #10 scoop of the French onion rice to Residents #8, #19, and #43. At 12:31 PM Staff A served Resident #46 a #6 non-heaped scoop of beef cube pepper steak and one #10 scoop of French onion rice. At 12:33 PM Staff A plated a #6 non-heaped scoop of beef cube pepper steak with bits of blacked, burned pieces on top after scraping the steam pan; placed a half of a #10 scoop of French onion rice with dark blackened pieces on the plate and ¼ of a #8 scoop of peas on Resident #1 plate. The plate was served out to Resident #1. A 6/24/25 review of Resident #1 Minimum Data Set (MDS) assessment dated [DATE] documented Resident #1 with a significant weight loss (5% or more in the last month or loss of 10% or more in last 6 months) and not on a physician prescribed weight loss regimen. The Electronic Healthcare Record (EHR) revealed Resident #1 went from 129 pounds to 102.5 pounds in six months. On 6/24/25 at 12:50 PM Staff A voiced it was 'her bad.' They had run out of pureed food and that happens a lot. The scoops are weird. She further verbalized she hadn't prepared an extra serving and that was the problem. She got nervous and didn't prepare an extra portion today. Interview on 6/24/25 at 3:05 PM Staff B, [NAME] reported there are five residents on puree diets and she always prepares an extra serving and corrects the pureed total volume to a lower measured level so when she uses the chart it will ensure a larger serving size. She doesn't run out of pureed food. She writes down the puree serving sizes in a notebook and places the correct scoop into each steam pan to ensure she serves out the correct serving size. During an interview on 6/24/25 at 3:15 PM the Certified Dietary Manager (CDM) voiced she expects staff to use heaping measurements for each serving during the puree preparation and to prepare an extra serving to ensure there is plenty of pureed food. Interview completed on 6/25/25 at 4:35 PM, the Consulting Dietician explained the facility prepares the exact number of puree diet portions to the number of residents on pureed diets. She expects the dietary staff to put in a little extra food to accommodate for the loss of food when the food is transferred from container to container during the preparation process. If food runs out during the meal, she would expect the staff to prepare another pureed portion of the menu item. The staff are to follow the approved menu as written. The undated Pureed Process Procedure directed to measure the total volume of the food after it is pureed and divide the total volume of the pureed food by the original number of the portions. See the Puree Scoop Chart. The undated Menu Policy lacked direction to the staff to follow and serve the Dietician approved menu.

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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. Based on observation, policy review, and staff interview, the facility failed to minimize the risk of foodborne pathogens by storing dishes wet; failed to cover food during transport, and failed to maintain proper food temperatures. The facility identified a census of 59 residents. Findings include: Observation on 6/24/25 at 11:08 AM revealed Staff C, Dietary Aide (DA) continually taking wet dishes from the dish rack and placing back in storage. Finally, Staff C removed a glass 8-cup measuring cup and two white spatulas from a dish rack on the clean side of the dishwasher. Staff C hung the measuring cup and two spatulas above the preparation table where Staff A, [NAME] prepared the puree food items for the noon meal. The 8-cup measuring cup observed with water droplets all along the top rim of the cup and the two spatulas had water droplets on the backside of the spatulas which hung touching each other on the rack. Observation on 6/24/25 at 12:44 PM Staff B pushed a cart with Resident #10 and #17 room trays out of the kitchen and down the hallway without covering the fruit bowls. Staff C transported the uncovered fruit approximately 45 feet to Resident #10 room and approximately 90 feet to Resident #17 room. During an interview on 6/24/25 at 12:45 PM Staff A reported all food items are to be covered when transporting food down the hallways to resident rooms. Final food temperatures taken 6/24/25 at 12:46 PM at the completion of meal service revealed the following: a. Mechanical soft beef cube pepper steak 133 degrees Fahrenheit (F) b. Pureed French onion rice 110.2 degrees F A palatability test at 12:50 PM revealed the French onion rice tasted warm at best. Interview completed on 6/24/25 at 12:49 PM, Staff A reported they are required to hold hot foods on the steam table at 135 degrees. An interview conducted on 6/24/25 at 3:05 PM Staff B verbalized hot foods are to be held at 135 degrees on the steam table. All food items have to be covered when transported out of the kitchen. They have plate and lid covers of all sizes to cover glasses and bowls. (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 6/24/25 at 3:16 PM the Certified Dietary Manager explained she has trained the staff to ensure equipment is dry before storing to prevent bacteria from growing on dishes/equipment. She expects all food items to be covered when food is transported back to resident rooms. They have lids to cover all food items for transport. Staff are trained to hold hot food at 135 degrees or higher on the steam table. No food shall be served out to residents if less than 135 degrees. Interview completed on 6/25/25 at 4:35 PM the Consulting Dietician explained she had been with the facility for around two years. She audits the kitchen for sanitation, food preparation, and food temperatures. She couldn't recall if the facility had issues with dish storage on the prior survey, but dishes should always be put away once dry. All food is to be covered when being transported out of the kitchen. The undated Room Tray Policy directed all food and drink would be covered for transport and served at the proper temperatures. The undated Food Temperatures Policy directed all hot food must be served to the resident at the temperature of at least 135 degrees at the time of the resident receiving it.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on observation, document review, policy review, and staff interview, the facility failed to ensure an effective Quality Assurance Performance Improvement (QAPI) process to address a previously identified quality deficiency, resulting in a repeated deficiency identified on two consecutive recertification surveys within 10 months. The facility reported a census of 59 residents. Findings include: The Center for Medicare and Medicaid (CMS) 2567 Form from the recertification survey dated 7/29/24 - 8/07/24 documented the facility failed to ensure dishes were dry before storing. The facility Plan of Correction (POC) dated 8/08/24 documented a stop and dry sign was created and hung above the clean storage side of the dishwasher. The Registered Dietician or designee would complete weekly audits for sanitation and drying of equipment. An audit would be conducted for 12 weeks and then reviewed by the QAPI committee for compliance. The facility's current survey 6/23/25 to 6/26/25 resulted in deficient practices regarding the storage of wet dishes in the kitchen. Observation on 6/24/25 at 11:08 AM revealed Staff C, Dietary Aide (DA) continually taking wet dishes from the dish rack and placing back in storage. Finally, Staff C removed an 8-cup measuring cup and two white spatulas from a dish rack on the clean side of the dishwasher. Staff C hung the measuring cup and two spatulas above the preparation table where Staff A, [NAME] prepared the puree food items for the noon meal. The 8-cup measuring cup observed with water droplets all along the top rim of the cup and the two spatulas had water droplets on the backside of the spatulas which hung touching on the rack. During an interview on 6/24/25 at 3:16 PM the Certified Dietary Manager explained she has trained the staff to ensure equipment is dry before storing to prevent bacteria from growing on dishes/equipment. A 6/25/25 8:38 AM observation of the kitchen dishwasher revealed no stop and dry sign on the clean side of the dishwasher. Staff F, Dietary Aide reported she thought there had been a stop and dry sign on the clean side of the dishwasher, but it hadn't been there for some time. Interview completed on 6/25/25 at 4:35 PM the Consulting Dietician explained she had been with the facility for around two years. She audits the kitchen for sanitation. She couldn't recall if the facility had issues with dish storage on the prior survey, but dishes should always be put away once dry. During an Interview on 6/26/25 at 10:10 AM the Administrator reported she oversees the QAPI program. She thought the sign reminding to put dishes away when dry was still hanging by the dishwasher on the dirty side of the dishwasher. Observation 6/26/25 at 10:15 AM with the Administrator revealed a Low Temp Dish Machine Guideline Poster hanging on the dirty side of the dishwasher. Under Daily Warewash Procedures the poster directed staff to allow dishes to drain and air dry in small print. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further interview with the Administrator on 6/26/25 at 10:21 AM revealed, the Administrator, Consulting Dietician, and Staff G, Consultant all assist with doing random kitchen audits which included observation for storage of dry dishes. The process had been run through the QAPI program and the random audits continued. They all work on kitchen audits. Staff C is a newer employee within the past three months and was not involved in the prior kitchen survey. On 2/26/25 at 10:52 AM the Administrator provided Huddle Meeting documentation dated 2/27/25 for Staff C. The Huddle Team Meeting Notes, 2/27/25, Topic Machine Dishwashing directed to never overload the dish racks and to air dry all items. The Huddle Team Meeting notes directed to use the Low Temp Dishmachine Guidelines Poster as a resource. The undated QAPI Plan Policy outlined goals are specific, measurable, actionable, relevant and have a timeline for completion. Methods used to monitor care and services include survey results (2567). The Administrator and QAPI team will analyze the information. The QAPI team will be responsible to monitor and ensure that interventions or actions are implemented and effective in making improvements.

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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. Based on observation, policy review, manufacturer's directions for cleaning and disinfection, and staff interview, the facility failed to properly sanitize a blood glucose meter used for multiple residents (Residents #5, #7, and #21). The facility identified a census of 59 residents. Findings include: Observation of the 6/25/25 morning medication administration revealed the following: On 6/25/25 at 7:20 AM Staff D, Registered Nurse (RN) reported there is one blood glucose machine (Assurance Platinum meter) on each medication cart that is used for multiple residents. She voiced there are two residents that share the machine on the East hallway, Residents #5 and #21. Observation on 6/25/25 at 7:22 AM revealed Staff D entered Resident #5 room to perform a blood glucose check. She placed the blood glucose meter, cotton balls, lancet, and alcohol prep pads at the foot end of Resident #5 unmade bed. After applying gloves, she moved the blood glucose machine, alcohol pads, lancet, and cotton balls to the Resident's bedside table without a clean barrier underneath. Staff D pulled a container of blood glucose strips out of her right uniform pocket, opened and placed a strip in the machine. At 7:26 AM Staff D completed the blood glucose check, walked out to the medication cart and placed the blood glucose meter and bottle of strip on top of the medication cart without a clean barrier or disinfecting the items. Staff D wiped down the blood glucose machine with a Sani Cloth in a back and forth motion on each side of the machine, less than 10 seconds, threw the Sani Cloth in the garbage and placed the meter in the medication cart. Interview completed 6/25/25 at 1:34 PM Staff E, Licensed Practical Nurse (LPN) explained they clean the blood glucose meter after each use. They wipe down the machine with a Sani Wipe, throw away the wipe and let the meter air dry on its own. Staff E first stated she didn't think there was a required time to keep the meter wet, then Staff E went to the medication cart, checked the container, and said it is two minutes. On 6/25/25 at 1:50 PM the Infection Preventionist provided a list documenting Resident #5 utilized the blood glucose meter before meals and at hour of sleep; Resident #21 utilized the blood glucose meter twice a day and Resident #7 utilized the blood glucose meter as needed. A 6/25/26 review of Resident #5, #7, and #21 June 2025 Electronic Treatment Administration Record (ETAR) revealed all the resident's had utilized the blood glucose meter. During an interview on 6/26/25 at 8:04 AM the Infection Preventionist explained she expects the nurses to sanitize the blood glucose meter with a Sani Cloth and let it sit in the Sani Cloth for the required wet time, then air dry the meter on a paper towel. The nurses are all required to place blood glucose supplies on a clean barrier in the resident rooms. The Policy for Care of Multi Use Glucometer (Blood Sugar Meter) and Blood Sugar Sampling directed the nurses to cleanse the machine with a manufacturer recommended wipe product and follow the product specifications for use. The Policy failed to address the use of a clean barrier under supplies when completing a blood glucose check. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Super Sani-Cloth Germicidal Disposable Wipe General Guides for Use documented to use a wipe to remove visible soil prior to disinfecting, unfold a clean wipe and thoroughly wet surface, allow treated surface to remain wet for two minutes, let air dry. The Arkray Technical Brief, Cleaning and Disinfecting the Assure Platinum Blood Glucose Monitoring System (BGMS) documented the meter should be cleaned and disinfected after use on each patient. The Brief directed the Cleaning Procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfecting procedure. The Disinfecting Procedure is needed to prevent the transmission of blood-borne, pathogens. The Brief Cleaning and Disinfecting FAQ included the cleaning and disinfecting cannot be accomplished with one wipe. Each time the cleaning and disinfecting procedure is preformed, two wipes are needed. One wipe to clean the meter and a second wipe to disinfect the meter. The Brief further documented Cleaning and Disinfecting the blood glucose meter is a high priority as meters are at a high risk of becoming contaminated with blood-borne pathogens such as Hepatitis (inflammation of the liver) B Virus, Hepatitis C Virus, and Human Immunodeficiency Virus (HIV, a virus that attacks the body's immune system). Transmission of these viruses from resident to resident has been documented due to contaminated blood glucose devices. According to the Center for Disease Control and Prevention, cleaning and disinfecting the meters between resident use can prevent the transmission of these viruses through indirect contact.