STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165530	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Haven Village	133 Indian Hills Drive Glenwood, IA 51534

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 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** Based on observations, family interview, staff interviews, clinical record review, and policy review the facility failed to review and revise the Care Plans for 2 of 16 residents reviewed (Resident #15 and Resident #24). The facility failed to revise the interventions for a resident who sustained a burn and a resident who had a pressure area develop. The facility reported a census of 65 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #15 scored 10/15 on the Brief Interview for Mental Status (BIMS) score indicating moderate cognitive impairment. The document revealed diagnoses of cerebrovascular accident/transient ischemic attack/stroke, Non-Alzheimer's dementia, coronary artery disease, and asthma/chronic obstructive pulmonary disease (COPD)/chronic lung disease. The assessment disclosed the resident required partial/moderate assistance for transfers, and independence with rolling left/right, and lying to/from sitting. The document revealed the resident was at risk for pressure ulcers/injury, did not have a pressure ulcer/injury, and no other skin problems or wounds. The document indicated the resident utilized skin and ulcer/injury treatments including pressure reducing devices for chair and bed. The resident did not receive hospice services. Observed on 6/2/2025 at 12:27 PM Resident #15 seated in her recliner with a blanket cradle tent at the foot of the bed. Observed on 6/3/25 at 12:28 PM Resident #15 was seated in her recliner when Staff I, Registered Nurse (RN), provided Betadine treatment for a pressure area on the left great toe. The blanket cradle was observed at the foot of the bed. Observed on 6/4/25 at 7:15 AM Resident #15 in bed with a blanket cradle in place at the foot of the bed. On 6/2/25 at 12:27 PM Resident #15's daughter stated the resident had pressure areas on her toes that were now healing. The family member stated the resident has a preference for having several blankets, and believed the blankets were applying pressure to her toes. The daughter stated the staff were now getting the resident up into her recliner more and the resident has a tent that keeps the blankets off of her toes. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #15's Medication/Treatment Administration Record for 6/25 revealed an order for a blanket tent to keep blankets off the feet with start date of 5/21/25, and wound care to left great toe with start date of 6/2/25. Resident #15's Pocket Care Plan, provided 6/4/25, identified skin interventions of barrier cream to intergluteal cleft and buttocks BID, air mattress with blanket cradle, and reposition frequently as the resident allows. Resident #15's Care Plan dated 6/3/25 revealed a problem area, risk for pressure injury related to impaired mobility, poor nutrition and need for staff assistance with a start date of 9/11/24 and revision on 6/3/25. The approaches for staff intervention included nursing to complete weekly skin assessments with wound details and measurements. The primary care physician (PCP) notified of new and worsening wounds. The document disclosed the resident to be assisted with repositioning at least every 2-3 hours. The Care Team to monitor for signs of skin breakdown and notify nursing of any concerns. The document revealed the start dates for the approaches at 9/21/24. The resident's Care Plan further revealed a problem area of risk for falls edited on 6/3/25. The problem area revealed an approach start date of 4/24/25 with a 4/23/25 unwitnessed fall out of bed without major injury with the air mattress removed from bed for safety with a creation date of 4/28/25. The Electronic Medical Record (EMR) Progress Notes revealed on 3/6/25 during a Care Conference discussion of the use of an air mattress and blanket cradle due to new wounds on the resident's toes. The document with an entry on 3/8/25 revealed the air mattress was delivered. The Progress Note dated 4/24/25 revealed Hospice exchanged the air mattress for a foam mattress. The facility failed to update the Pocket Care Plan and Care Plan to reflect Resident #15's current needs. The Pocket Care Plan reflected the use of an air mattress that was removed on 4/24/25. The Care Plan failed to identify interventions put into place for treatment of pressure injuries to the resident's toes. On 6/4/25 at 2:50 PM Staff J, RN/Care Coordinator (CC), stated the blanket cradle is reflected on the Pocket Care Plan and on the nurses orders. The blanket cradle should be reflected on the Care Plan. On 6/4/25 at 3:32 PM Staff B, Director of Nursing (DON), stated he expected the Care Plan to reflect the interventions needed to provide care to the resident. On 6/5/25 at 9:49 AM a Hospice representative stated the blanket cradle was delivered on 3/12/25. 2. According to the MDS assessment dated [DATE] Resident #24 could not complete the BIMS. The staff assessment revealed the resident had short term and long term memory problems, and moderately impaired cognitive skills for daily decision making. The resident had diagnoses of coronary artery disease, hypertension, and chronic pain. The resident required setup for eating. Observed Resident #24 on 6/2/25 at 12:10 PM drinking coffee with a noon meal. Observed Resident #24 on 6/4/25 at 9:00 AM have a cup of coffee on the dining table. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #24's Progress Note dated 12/22/24 revealed the resident spilled a cup of coffee and sustained red blistering areas on bilateral inner upper thighs that were approximately the size of a soft ball. Resident #24's Pocket Care Plan, provided 6/5/25, revealed the resident loved coffee and to place 3-4 ice cubes in it before serving. Resident #24's Care Plan dated 6/3/25 revealed a problem area with a start date of 4/17/20 for a nutrition risk that was edited on 6/3/25. An approach for the problem area revealed thin liquids and enjoyed coffee throughout the day created on 9/16/24. The facility failed to update the Care Plan to reflect the burn on 12/22/24 and the interventions put into place. The Care Plan further failed to identify interventions that had been trialed and refused by the resident, and responses made by the family regarding the burn. On 6/4/25 at 3:08 PM Staff J stated was on vacation at the time of the incident and the Pocket Care Plan should have the recommendation following the burn. On 6/4/25 at 4:34 PM the Administrator stated the facility has a priority to update the Pocket Care Plan as it is what the direct care staff utilize to keep the residents safe and to provide care. The Administrator stated the Care Plan should have more information and they should be updated timely. The Administrator stated the Care Plans should be updated maybe in a week or 2 following the update to a Pocket Care Plan. The Administrator stated the facility is in the process of moving from MatrixCare to PointClickCare electronic documentation platform and with that the Care Plan will revise and change. The facility Skin Integrity and Wound/Pressure Injury Prevention/Treatment/Observation and Documentation Policy, dated 6/20, revealed the nurses would monitor for change in condition and implement interventions, and update the Care Plan as needed to prevent skin breakdown. The facility Hot Liquids Safety Policy, dated 5/15/24, revealed interventions related to hot liquids would be individualized and noted on the resident's Care Plan. The facility Comprehensive Care Plans Policy, dated 6/6/25, revealed all services are identified in the resident's comprehensive assessment and meet professional standards of quality. The document disclosed it would be reviewed and revised by the interdisciplinary team after each comprehensive review and quarterly MDS assessment, and alternative interventions will be documented as needed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews, and policy review the facility failed to provide the needed services in accordance with professional standards by not completing assessments for 1 of 16 residents (Resident #24) reviewed. The facility reported a census of 65 residents. Findings include: According to the MDS assessment dated [DATE] Resident #24 could not complete the BIMS. The staff assessment revealed the resident had short term and long term memory problems, and moderately impaired cognitive skills for daily decision making. The resident had diagnoses of coronary artery disease, hypertension, and chronic pain. The resident required setup for eating. The Progress Note dated 12/22/24 revealed Resident #24 spilled a cup of coffee and sustained red blistering areas on bilateral inner upper thighs that were approximately the size of a soft ball. Review of Assessments completed from 1/1/24 to 6/5/25 revealed the facility failed to complete a Hot Liquids Risk Assessment for Resident #24. Observed Resident #24 on 6/2/25 at 12:10 PM drinking coffee with a noon meal. Observed Resident #24 on 6/4/25 at 9:00 AM have a cup of coffee on the dining table. On 6/4/25 at 10:28 AM Staff E, Registered Dietitian, stated she was unaware of any resident having a burn related to coffee spillage. The staff stated she was unaware of the facility policy/procedure regarding serving of coffee and temperatures. On 6/4/25 at 3:08 PM Staff J stated she was on vacation at the time of the incident. The staff was unable to produce a Hot Liquids Risk Assessment for the resident. On 6/4/25 at 3:24 PM Staff B stated Hot Liquids Risk Assessment should be completed upon admission and quarterly. The DON stated he could not locate a Hot Liquids Risk Assessment for Resident #24. On 6/4/25 at 9:00 AM the Administrator stated there should have been a Hot Liquids Risk Assessment completed for Resident #24. The facility Hot Liquid Safety Policy reviewed/revised 5/15/24 disclosed all residents were assessed for their ability to handle containers and consume hot liquids as part of their. It was noted this sentence was incomplete and no further details on assessment were provided in the policy.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and clinical record review the facility failed to provide adequate treatment and interventions to prevent the worsening of pressure ulcers for 1 resident (Resident #23) and failed to implement interventions timely for 2 of 4 residents reviewed (Resident #23, #15). Staff failed to apply the pressure-reducing boots for Resident #23 and failed to document or follow up on a new area for Resident #23 and #15. The facility reported a census of 65 residents. Findings include: The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. 1. According to the Minimum Data Set (MDS) dated [DATE], Resident #23 was unable to participate in a Brief Interview for Mental Status (BIMS) assessment. He had severe memory problems, and impaired cognitive skills. The resident was totally dependent on staff for eating, toileting, dressing, rolling over, and transfers. Resident #23 was at risk for pressure injury and did not have any ulcers at the time of the assessment. His diagnoses included; deep venous thrombosis, neurogenic bladder, secondary Parkinsons, chronic embolism and thrombosis of deep veins of lower extremities, chronic kidney disease. The Care Plan for Resident #23, last revised on 8/7/24, showed that the resident was at risk for fluid volume depletion/excess edema, and was on diuretic therapy. Nursing was to monitor for edema. He had chronic pain related to arthritis and neuropathy in the bilateral lower extremities, nursing was to encourage and assist to position for comfort. The resident was at risk for skin breakdown related to impaired mobility, pain and use of compression stockings. Nursing was to assist with wearing heel protectors at all times and floating heels while in bed to prevent pressure sores. Staff were to observe skin and any wounds for changes such as redness, tenderness, drainage and to notify the physician. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Braden assessment dated [DATE] for Resident #23 documented he was at moderate risk for pressure related skin breakdown. On 6/2/25 at 12:44 PM, a Hospice Nurse Aide (HNA) attended to the resident and removed his stockings. The resident was not wearing edema-wear hose, the skin on his feet was tight and his lower extremities were swollen. On his left distal foot/heel area, there was an undated wound dressing patch. Medial to the patch was an uncovered, open red ulcer on his heel. On the 2nd and 3rd toes of the left foot there were small open blisters. The medial side of his right ankle contained an unblanchable red area. The HNA was not aware if any of these sores were new or if they were being treated. The documents titled: Skin Integrity Events revealed the following: a. On 3/18/25 at 1:39 PM, the resident had red moist area to bilateral groin and tips of toes dry and cracked. No other areas documented. b. On 5/6/25 at 6:55 PM, the resident had a new wound measuring 2 centimeter (cm) x 2 cm. It was intact, not open. The intervention implemented was skin prep and heel protectors. c. On 5/17/25 heels and toes not checked, no measurements. d. On 5/24/25 left heel 5 cm x 3.3 cm. brown center the medial aspect of skin injury tissue was black in color and 2 cm x 2 cm. the second and third toes 0.2 cm x 0.2 cm. A review of the clinical record revealed an order dated 4/14/23 that Resident #23 would wear bilateral heel protectors at all times. An on-going observation on 6/3/25 revealed the following: a. At 11:20, Staff pushed the resident to the lunch table. He was wearing gripper socks, no edema wear and no protective boots. b. At 1:30 PM, the resident was still in the wheel chair. It was tipped back slightly, he was sleeping. His feet were unsupported, dangling, not on the foot rest. c. At 3:30 PM, the resident was in the same position in front of the television in the dining area. His feet were dangling, not on foot pedals. His legs were swollen. d. At 4:20 PM, the resident was still in the wheel chair, in front of the television. His legs dangling. He was leaning forward in the chair with his head hanging down and reaching into the air for unseen items. A Nursing Note dated 6/4/25 at 2:25 PM, showed two new areas distal to the larger wound on the left heel that measured 0.5 cm x 0.5 cm. The area was pink surrounding the wound where the dressing tape maybe tearing the skin. The chart lacked mention of the new area on the right heel, and lacked documentation that the doctor or Hospice had been contacted regarding the new open wounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/5/25 at 8:02 AM, Staff O, Care Coordinator, provided wound treatment changes for Resident #23. The patch on his left heel was not dated and it was soaked with serosanguinous fluid. Staff O acknowledged that it was macerated. She said that the nurse on the previous day, had noticed that the wound was getting worse and they would contact hospice. The area on the left heel measured 2 cm. x 1.8 cm. in the center with two smaller areas nearby measuring 0.7 cm. x 0.6 and 0.5 cm. x 0.5 cm. When directed to the right heel, Staff O look at it and agreed that it was unblanchable, and it measured 2.6 cm x 1.4 cm. Staff O acknowledged that the protective boots must be on at all times. On 6/5/25 at 10:26 AM, Staff O CC said that she ordered a support board for the wheel chair for Resident #23. She said that his feet should not be dangling, and this was concerning for his chronic edema. Staff O said that the resident needed to be repositioned more often. According to a facility policy titled; Skin Integrity and Wound/Pressure Injury Prevention/Treatment/Observation and Documentation, dated June of 2020; preventative measures encourage repositioning, heel protectors. All nurses would be responsible for ensuring the Care Plan and interventions were updated and monitor to ensure interventions were carried out as planned. 2. According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #15 scored 10/15 on the Brief Interview for Mental Status (BIMS) score indicating moderate cognitive impairment. The document revealed diagnoses of cerebrovascular accident/transient ischemic attack/stroke, Non-Alzheimer's dementia, coronary artery disease, and asthma/chronic obstructive pulmonary disease (COPD)/chronic lung disease. The assessment disclosed the resident required partial/moderate assistance for transfers, and independence with rolling left/right, and lying to/from sitting. The document revealed the resident was at risk for pressure ulcers/injury, did not have a pressure ulcer/injury, and no other skin problems or wounds. The document indicated the resident utilized skin and ulcer/injury treatments including pressure reducing devices for chair and bed. The resident did not receive Hospice services. The Electronic Medical Record (EMR) Skin Assessments for Resident #15 revealed the following: -On 1/19/25 red areas noted to the top of bilateral feet 1st digits. The resident denied pain. -On 1/23/25 tips of bilateral feet, 1st digits noted to have red areas. -On 1/30/25 tips of bilateral feet, 1st digits noted to have red areas. -On 2/6/25 red areas noted to bilateral feet 1st digits, the tip of them. -On 2/14/25 no concerns with feet. -On 2/20/25 red areas noted to bilateral feet, 1st digits. -On 2/28/25 no concerns with toes. -On 3/5/25 left foot, 1st digit noted to have a black area that measures approximately 1.2 cm in diameter. Right foot, 1st digit noted to have a scabbed area that measures approximately 0.5 cm in diameter. No drainage noted from either digit. Requested that the resident be seen by the wound nurse during rounds. Also a request had already been sent for a podiatry appointment. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-On 3/6/25 left foot, 1st digit noted to have a black area that measures approximately 1.2 cm in diameter. Right foot, 1st digit noted to have a scabbed area that measures approximately 0.5 cm in diameter. No drainage noted from either digit. The Braden Scale, dated 1/11/25, revealed the resident was not at risk. The Progress Notes revealed on 2/24/25 a referral was generated for podiatry for the right foot; the 5th digit was long, loose, and fungal. The Progress Notes revealed notification to the physician with new orders on 3/6/25 for painting Betadine to scabbed areas on bilateral great toes twice daily until healed. Note on 3/6/25 also revealed referral to hospice services. Observed on 6/2/2025 at 12:27 PM Resident #15 seated in her recliner with a blanket cradle tent at the foot of the bed. On 6/2/25 at 12:27 PM Resident #15's daughter stated the resident had pressure areas on her toes that were now healing. The family member stated the resident has a preference for having several blankets, and believed the blankets were applying pressure to her toes. The daughter stated the staff were now getting the resident up into her recliner more and the resident has a tent that keeps the blankets off of her toes. On 6/4/25 at 2:50 PM Staff J, Registered Nurse (RN)/Care Coordinator (CC) revealed she was not aware of the resident's skin condition until 3/5/25. Staff J stated when there was a change in skin condition the Care Coordinator and/or the physician should be notified. The staff stated it would have been acceptable to use a fax notification as it was not an emergency. Staff J stated she did not know what stage the wound was when she was notified as she did not stage the wound. On 6/4/25 at 3:32 PM Staff B, Director of Nursing (DON) stated the Care Coordinator should have been aware of the reddened toes either by reviewing the Skin Assessments or by notification from the nurse completing the assessment. On 6/5/25 at 9:35 AM the Administrator stated she expected if toes were reddened there would have been some intervention(s) put into place. The facility Skin Integrity and Wound/Pressure Injury Prevention/Treatment/Observation and Documentation Policy, dated 6/20, revealed all team members were responsible for preventing, caring and providing treatment for skin integrity issues. The document disclosed all impaired skin integrity concerns/skin care the physician should be notified immediately and documented. The document further revealed all nurses were responsible for monitoring for changes in condition, implementing interventions, and updating the Care Plan to prevent skin breakdown.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interviews, staff interviews and policy review the facility failed to provide food at an appetizing temperature to 2 of 20 residents reviewed (Resident #6 and #30). The facility reported a census of 65 residents. Findings include: 1. The Minimum Data Set MDS dated [DATE] revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. On 6/2/25 at 12:31 PM Resident #6 stated the meat, vegetable, and potatoes will be served cold. Resident #6 stated the food had been served cold in the last week. 2. The MDS dated [DATE] revealed Resident #30 had a BIMS score of 13 indicating no cognitive impairment. On 6/2/25 at 12:33 PM Resident #30 stated the food that should be warm is served cool or cold at least once a week. Resident #30 stated the staff would warm it up but she did not ask. On 6/3/25 at 11:35 AM an observation of lunch service with Staff C, [NAME] revealed all food removed from the oven and placed on the stove top. Staff C did not turn the stove top on. On 6/3/25 at 11:36 AM Staff C obtained temperatures of the food. The temperature of the beef stroganoff was 165 degrees, mashed potatoes 203 degrees, chuckwagon corn 197 degrees, low sodium beef for 2 mg sodium diet 166 degrees and cream corn for mechanical diet 166.2 degrees. A continuous observation of lunch service on 6/3/25 from 11:35 AM - 11:55 AM revealed Staff C plated the lunch meal and the CNA staff took the plates to the residents. Staff C placed the last plate in the microwave, turned the microwave on, removed the plate from the microwave and gave the plate to a CNA to take to Resident #30. The temperature of the food placed in the microwave was not checked. On 6/3/25 at 11:55 AM post service temperatures were obtained by Staff C. The temperatures revealed the corn had a temperature of 158 degrees, mashed potatoes 121 and beef stroganoff 130 degrees. On 6/3/25 at 11:56 AM Staff C stated she placed the plate in the microwave because she thought the food might be cold. Staff C acknowledged that she did not obtain a temperature of the food removed from the microwave prior to sending the food out to the resident. Staff C explained she should have obtained the temperature of the food placed in the microwave prior to sending the food to the resident. Staff C stated the food in the microwave should have been at least 165 degrees after being microwaved. Staff C stated her expectation was a minimum of 135 for holding temperatures of the food on the stove. Staff C acknowledged the stove top was not on and the back burner did not work because the knob was broken off. Staff C stated she was not sure if anyone was aware the back burner did not work. Staff C stated it had been broken for a while and she did not tell anyone. Staff [NAME] stated Resident #30 will complain when the food is served cold and frequently does. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/25 at 2:28 PM Staff D, Certified Dietary Manager (CDM) stated Staff C stated his expectation was 150 degrees or above for holding temperature of food during meal service. Staff D stated his expectation was the temperatures would have held and the stove top would have been on to ensure the temperature would maintain an appropriate holding temperature. Staff D stated residents did complain about the food being cold. Staff D stated it was usually the same 2 residents in house 138. On 6/4/25 at 10:21 AM Staff E, Registered Dietitian stated Staff C reheated the plate and served it and did not recheck the temp prior to serving the plate. Staff E stated the facility policy stated the temperature should be checked to ensure the temp is 165 degrees or above. Staff E stated temperatures should be held at 135 or above during meal service. Staff E stated the temperature of the meat at the end of service concerned her. Review of undated document titled, Food Temperatures documented all hot food items would be served to the resident at the temperature of at least 120 degrees at the time the resident received the food. Hot food items may not fall below 140 after cooking unless it is an item which is to be rapidly cooled to below 40 degrees and reheated to at least 165 degrees prior to serving. Normally hot foods will be 165 - 180 degrees or higher when removed from the cooking heat source. If held at 160 - 180 degrees this would ensure serving to the residents at 140 degrees or above. Cooking temperatures must be reached and maintained according to regulations, laws and standardized recipes while cooking.

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	165530	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Haven Village	133 Indian Hills Drive Glenwood, IA 51534

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. According to the MDS dated [DATE], Resident #3 had a BIMS score of 15 (intact cognitive ability). He was independent with eating and required supervision and touch assistance with transfers. He had highly impaired hearing ability. His diagnoses included neurogenic bladder, diabetes mellitus, aphasia, anxiety communication deficit. The Care Plan updated on 4/24/25, showed that Resident #3 was at risk for choking related to dysphagia staff would offer a regular, mechanical soft diet. The resident had significant anxiety and wanted to know what to expect throughout the day. He was deaf, and it was important for him to be involved in his cares. Writing material was provided to the resident, he was able to write and understand short phrases. On 6/4/25 at 6:00 AM, with the use of writing materials kept in the back pocket of his wheel chair, Resident #3 communicated that he was not aware that there were meal options if he preferred something other than what was being served. Resident #3 wrote that he didn't like corn or peas but he did not know what substitutes he could have for a vegetable. 3. According to the MDS dated [DATE], Resident #7 had a BIMs score of 15 (intact cognitive ability). He was independent with eating, toileting, dressing and hygiene. His diagnoses included diabetes mellitus and anxiety disorder, The Care Plan updated on 6/3/25, showed that he had anxiety and did not like disruptions in scheduled. Staff were to encourage him to participate in care his cares by asking questions. The resident had autism and had difficulty in social interactions. On 6/2/25 at 2:30 PM, Resident #7 said that he was not aware of food substitute options at meals. He added: I don't know what would happen if I didn't eat what they served me. On 6/4/25 at 6:00 AM, Staff P, CNA said that she was not sure of food options that residents had for meals if they didn't like what was being served. She did not know where the options were listed. On 6/3/25 at 2:00 PM, Staff Q, Cottage Cook, said the options for residents included: hamburger patty, peanut butter or deli meat sandwich or soups. She acknowledged that these options were not posted anywhere for the residents to see daily. On 6/3/25 at 2:30 PM, the Dietary Manager provided a list of alternatives that included sandwiches, soups and cereal. He said this list was not posted or given to the residents but kept in a binder in the kitchen areas. He said there were some items that residents could request other foods, but it would be limited related to availability. He said that the residents didn't have a menu to fill out, they know to look at the black board where the meals are posted and that the kitchen knows their likes and dislikes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/3/25 at 3:00 PM, the Administrator said that the staff carry pocket care plan that included the residents' preferences. Staff were expected to check those to see if there was anything on the menu that they didn't like. She said they don't post the optional menu because the residents would then think that these were their only options and they can have whatever they would like to eat. The Administrator said that in the small cottage environment, the staff know the residents well, that included their foods preferences. An undated document included in the admission packet showed that resident food preferences would be considered and staff would assist the residents to exercise their choice in what they eat and drink. Based on observation, resident interview, staff interview and policy review the facility failed to provide food that accommodates the resident preferences and provide an appealing option for residents who chose not to eat food that was initially served to them or requested a different meal choice for 2 of 20 residents reviewed (Resident #3, #7 and #56). The facility reported a census of 65 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] revealed Resident #56 had a Brief Interview for Mental Status (BIMS) score of 0 indicating Resident #56 was rarely/never understood. The MDS also indicated Resident #56 was deaf. On 6/3/25 at 11:35 AM an observation of lunch service with Staff C, Hostess/Cook revealed all food removed from the oven and placed on the stove top. Observation revealed no alternative food prepared for lunch at that time. Review of undated document titled, Substitutes for Meals hanging on the refrigerator facing the interior of the kitchen unable to be seen by staff or residents outside of the interior of the kitchen. On 6/4/25 at 11:52 AM observation of Staff F, Certified Nursing Assistant (CNA) presented a lunch meal to Resident #56. Resident #56 picked up the corn and shook his head left to right that indicated no. Staff F asked Resident #56 if he didn't like the corn and Resident #56 shook his head no again. Staff F returned the corn to the kitchen and told Staff C Resident #56 refused the corn. On 6/4/25 at 12:25 PM Staff C acknowledged corn was not on Resident #56's pocket care plan for a dislike but he did not want corn for lunch on 6/4/25. Staff C stated she would usually offer the resident something if they refuse the vegetable. Staff C acknowledged she did not offer Resident #56 an alternative. Staff C explained the CNA did not say she asked Resident #56 if he wanted an alternative either. Staff C acknowledged she should have asked Resident #56 if he wanted an alternative and she did not. On 6/4/25 at 12:40 PM Staff F acknowledged that she did not offer Resident #56 anything else when he refused the corn on 6/5/25. Staff F stated she would typically offer the resident an alternative but did not offer an alternative vegetable on 6/4/25 to Resident #56. Staff F stated she thought the alternative was usually a vegetable medley that also contained corn. Staff F stated she did not know what would be offered if the resident did not want corn because the medley would also contain corn. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/3/25 at 12:06 PM Staff A Certified Nursing Assistant/Certified Medication Assistant (CNA/CMA) stated helps with lunch service when at the facility. Staff A stated the residents knew what the meal was by reading the menu board. Staff A stated no staff ask the residents what they want for the meals or if they want an alternate. Staff A stated if it is set in front of them and they don't like it the cook will find an alternative. Staff A stated there was not an alternative menu that the residents are aware of if they do not like what they are having. On 6/3/25 at 12:11 PM Staff G, CNA stated sometimes the residents say they do not like what was served as the meal. Staff G stated she would offer a sandwich or something else. Staff G stated there were only sandwiches provided as an alternative. Staff G stated there was not a list of alternatives for the resident to choose from. Staff G stated if the cook was busy she would make the sandwich or the cook would make it. On 6/3/25 at 12:15 PM Staff H, Registered Nurse (RN) the menu is listed on the wall and if the resident asks they will get them something different. On 6/3/25 at 2:28 PM Staff D, Certified Dietary Manager (CDM) stated since the facility changed to the new menu there has not been as many substitutions. Staff D stated just the meal on the board was usually prepared. On 6/4/25 at 10:21 AM Staff E, Registered Dietitian stated the alternate food items were not posted anywhere but the hostess is supposed to know and to use a pocket care plan for likes and dislikes.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, Electronic Health Record (EHR) review, policy review, and staff interview the facility failed to provide appropriate infection prevention practices when providing care to a resident with an indwelling catheter, that was on Enhanced Barrier Precautions (EBP) for 1 of 2 residents reviewed (Resident #30). The facility reported a census of 65 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #30 documented a Brief Interview for Mental Status (BIMS) score of 13 indicating moderate cognitive impairment. The MDS also indicated use of an indwelling catheter. Review of the EHR titled, Care Plan, dated 4/19/24 documented Resident #30 had an indwelling catheter and required EBP precautions. Resident #30's team will follow EBP precautions. EBP supplies would be available in Resident #30's room for staff to utilize when providing care. Review of the EHR titled, Orders, dated 8/7/23 documented physician orders for catheter cares each shift, change catheter bag weekly and change 18 Fr all silicone catheter monthly. An observation on 6/3/25 at 2:10 PM of Resident #30's catheter bag emptied revealed Staff A, Certified Nursing Assistant / Certified Medication Assistant CNA/CMA completed hand hygiene, applied gloves, did not apply a gown, obtained a barrier, applied barrier to the ground, placed graduated cylinder on the barrier, cleansed catheter tip with alcohol wipe, emptied urine into graduated cylinder, cleansed catheter tip with alcohol wipe, closed the catheter tip, graduate taken into the bathroom, graduate emptied into the toilet, 650mL removed from graduate, gloves removed, and hand hygiene completed. On 6/4/25 at 5:04 PM the Director of Nursing (DON) stated the facility's expectation was that a gown would be donned during catheter care or contact with a catheter at all. The DON acknowledged that Resident #30 was on EBP. The DON acknowledged Resident #30 utilized a catheter. The DON acknowledged that a gown should have been worn during catheter care for Resident #30. Review of policy implemented 4/1/24 titled, Enhanced Barrier Precautions Policy and Procedure documented EBP are used in conjunction with standard precautions and expand the use of personal Protective Equipment (PPE) to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Residents will be placed on EBP with indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Indwelling medical devices include but are not limited to central lines, urinary catheters, feeding tubes and tracheostomies.