

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165579	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/05/2024
NAME OF PROVIDER OR SUPPLIER  Maquoketa Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1202 German Street 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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>48452</p> <p>Based on observation, record review, staff interview, resident interview, and policy review the facility failed to treat residents with dignity and respect throughout cares provided for 1 of 3 residents reviewed (Resident #1). Staff and other residents entered a shower room without the bathing resident's permission and without effective privacy barriers in place. The facility reported a census of 31 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) for Resident #1 dated 9/2/24 documented a Brief Interview for Mental Status (BIMS) assessment score of 15 which indicated intact cognition. Diagnoses included spinal stenosis (narrowing of the spinal canal that compresses the spinal cord and nerves), stress incontinence, and other abnormalities of gait and mobility. The MDS further documented Resident #1 required supervision or touch assistance with tub/shower transfers and partial to moderate assistance with bathing.</p> <p>During an observation of the shower room across from resident room on 12/2/24 at 11:11 AM a shower curtain pushed against the wall hung from a ceiling track that ran the length of the front of the shower. 11 metal bead strips connected the track to the shower curtain. 10 of them were tangled together and could not be separated. The curtain did not cover the shower stall for privacy. The interior side of the stall contained a large opening into the rest of the room. There was no curtain on the track to cover that opening, and the track did not extend to cover the whole opening. The facility's wheelchair scale sat angled in the corner on the same half of the room as the exposed opening. A linen bin against the wall contained used towels, which indicated the room was in use for bathing.</p> <p>During an interview at 11:52 AM on 12/2/24 Resident #1 reported dignity and privacy concerns related to cares and bathing in the facility. She stated some staff did not knock before entering her room. That was part of the reason she posted a sign on the outside of her door to direct visitors. She stated some staff did not shut the doors to her room or bathroom when they assisted her with cares. She reported she heard staff share private information over the walkie talkies. Her biggest concerns were infection control in the shower room and aides who brought residents into the shower room during her shower to weigh them on the wheelchair scale. She stated it was not uncommon and questioned why staff couldn't just wait for her to be done.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 165579
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a follow up interview on 12/5/24 at 8:52 AM, Resident #1 reported the shower room incidents happened more than once, most recently last week. She stated she told the aides to wrap the shower curtain around the door handle when she was in the room to try to prevent anyone else from coming in during her shower.</p> <p>On 12/4/24 at 1:10 PM Staff B, Certified Nursing Assistant (CNA), stated there was a shower curtain in the bathroom but it wouldn't do anything to cover the stall. A resident who entered would still be able to see inside of the stall.</p> <p>On 12/5/24 at 11:14 AM Staff E, CNA confirmed Resident #1 had asked her to wrap the shower curtain around the shower room door. She reported if a resident was bathing and staff needed a towel or something, staff did go into the room to get them. She wasn't aware of a resident being brought in.</p> <p>During an interview at 8:55 AM on 12/5/24 the Director of Nursing denied knowing aides brought other residents in for weights during showers.</p> <p>At 9:33 AM on 12/5/24 the Administrator stated she was not aware aides brought residents in for weights during showers and that was not acceptable in any way, shape, or form.</p> <p>A policy titled Residents' Rights Policy dated 10/2023 documented residents have the right to a dignified existence as well as personal privacy and confidentiality.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>49976</p> <p>Based on record review, Facility Assessment review, resident and staff interviews, and policy review the facility failed to employ sufficient numbers of staff to meet resident needs, and failed to answer call lights in a timely manner for 3 of 4 residents reviewed (Resident #1, Resident #3, and Anonymous). The facility reported a census of 31 residents.</p> <p>Findings include:</p> <p>1. A review of the facility staff schedules from November 2nd through December 7th, 2024 revealed Certified Nursing Aides (CNAs) were not present in the required ratios during the day shifts as follows:</p> <ul style="list-style-type: none"> <li>~ Missing one CNA- 14 days</li> <li>~ Missing two CNAs- 3 days</li> </ul> <p>In an interview on 12/02/24 at 1:12 PM a resident who wished to remain anonymous explained staff were not coming in often enough to toilet them. They were short staffed in the facility. On 12/05/24 at 8:12 AM the same resident noted the previous evening they put the call light on at 7:00 PM and watched the clock on the wall- it was almost exactly two hours before staff came to assist them to bed for the evening.</p> <p>In an interview on 12/05/24 at 9:02 AM the Director of Nursing (DON) explained she would love to have 3-4 aides per day shift but did not think the facility was understaffed with just 3. She acknowledged the fourth person would be helpful. She noted the Administrator decided how many staff were needed based on the census but she did the scheduling and they talked about it with every new admission.</p> <p>In an interview on 12/05/24 at 10:33 AM the Administrator explained the staffing ratios were a group effort- the team looked at the Patient Per Day (PPD) numbers as well as the acuity of the residents. They staffed 3-4 CNA's during each day shift and 2 at night. She noted they had the facility assessment but mostly decide based on the PPD and acuity. She updated the Facility Assessment in the fall when they had a higher census, but acknowledged the required ratio was based on the average and that was 33 residents. On 12/04/24 the census was 34 and they still ran with only 6 CNAs. She acknowledged there was no reason a resident should have to wait almost two hours for assistance.</p> <p>The Facility Assessment Tool, updated 7/2024 expressed the following:</p> <p>Staffing plans are based on resident volume. The average daily census is 33 residents. Special consideration is taken when residents with special needs or care requirements are present on admission or develop during the stay at the facility. The staffing mix is flexible to accommodate increased acuity based on Interdisciplinary Team assessment.</p> <p>It instructed staff ratios to be the following:</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>~ Days- Certified Nursing Aides (CNA's) 7-9</p> <p>~ Evenings- CNA's 1-2</p> <p>A. The Minimum Data Set (MDS) for a resident who wished to remain anonymous indicated a Brief Interview for Mental Status (BIMS) score of 15/15 indicating no cognitive impairment.</p> <p>In an interview on 12/02/24 at 1:12 PM the resident explained they have had the call light on for an hour or more at times- this happened on all shifts. They felt the facility was short staffed. The resident remarked one time they waited a very long time for the call light to be answered and tried to toilet themselves when they could not wait any longer. This resulted in physical injury.</p> <p>The facility policy titled Call Light, Use Of, undated instructed staff to answer all call lights promptly whether or not the resident was assigned to them. All call lights must be answered within 15 minutes. Five minutes for initial response is preferred, up to 15 minutes is allowed per state and federal regulation.</p> <p>B. The Minimum Data Set (MDS) for Resident #1 dated 9/2/24 documented a Brief Interview for Mental Status (BIMS) assessment score of 15 which indicated intact cognition. Diagnoses included spinal stenosis (narrowing of the spinal canal that compresses the spinal cord and nerves), stress incontinence, and other abnormalities of gait and mobility.</p> <p>During an interview on 12/2/24 at 11:52 AM Resident #1 stated she had experienced long call lights with 2 hours the longest she had kept track of. She reported that answering a call light in 15 minutes was fast at this facility. She said sometimes she did not put the light on because she knew they (staff) were not going to come. Resident #1 stated that morning she put the light on at 2:00 AM and nobody came until after 3:00 AM. She pointed to the clock in her room as her measure of time. She also felt some of the nurses could be more helpful answering the lights.</p> <p>During a follow up interview on 12/5/24 at 8:52 AM, Resident #1 stated she recently had an issue with her call light not working and had to use her cell phone to call the facility to get staff to come to her room. She reported that happened in the past week.</p> <p>On 12/4/24 at 2:53 PM Staff D, Certified Nursing Assistant (CNA) stated that a long call light is 15 minutes. She confirmed residents complained to her about call lights over 15 minutes. She indicated dinner time was especially difficult due to residents who remained in the dining room, some who wanted to go to their rooms, others wanted to go to bed, and some still needed bathing.</p> <p>C. The Minimum Data Set (MDS) for Resident #3 dated 9/4/24 documented a Brief Interview for Mental Status (BIMS) assessment score of 15 which indicated intact cognition. Diagnoses included Parkinson's disease, a history of falling, and sequelae of cerebral infarction (long term effects of a stroke).</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with Resident #3 on 12/2/24 at 11:31 AM he was observed in his room watching his TV and the door. He reported that the facility was definitely short staffed. He further stated that when he sat there all day, watched them work, and waited for them to come help him it was pretty obvious they needed more help. He reported the day before yesterday (Saturday, 11/30/24) he waited an hour on the toilet for someone to come help him. Resident # 3 stated he tried to make allowances for it but it still hurt him when he was left sitting there on the toilet for so long. He stated it got ' old, real old ' .</p> <p>At 1:10 PM on 12/4/24 Staff B, CNA stated that call lights of 15-20 minutes were long. She acknowledged that residents have complained about the call lights and that ' every resident ' complained about 2nd shift. She reported residents who have the ability to do so have turned their call lights on as early as 2:45 PM when they wanted to get to a 3:30 activity. She stated showers and activities impacted how long call lights took as well as the residents who needed help, other things going on, and who the staff were.</p> <p>On 12/5/24 at 8:55 AM the Director of Nursing stated she knew the facility had 15 minutes to answer call lights but they strived for 10-12 minutes. She acknowledged they have had a few complaints and stated the facility did call light audits.</p> <p>On 12/5/24 at 9:33 AM the Administrator stated meal times were the most difficult for call lights. She reported staff had been educated on answering them within 15 minutes and that all staff were responsible for answering them.</p> <p>48452</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>49976</p> <p>Based on observation, staff interviews, and policy review the facility failed to keep all medication locked in the medication cart as required. The facility reported a census of 31 residents.</p> <p>Findings include:</p> <p>In an observation on 12/02/24 at 8:00 AM the bottom drawer of a medication cart in the back hall was found open with medications exposed. This surveyor was able to approach the cart and access medications in the drawer. No nurse or staff were visualized next to the cart or down the hallway.</p> <p>In an interview on 12/03/24 at 1:40 PM Staff A, Registered Nurse (RN) explained the expectation for the medication cart was for it to be kept locked, the laptop screen to be locked out, and any personal health information to be covered when not directly at it. She admitted she thought the cart was locked this morning when she went to help another staff and it wasn't. She did not notice until she returned to the cart.</p> <p>In an interview on 12/04/24 at 10:18 AM the Director of Nursing explained she expected staff to always ensure the cart was locked if they were not there actively getting medications ready. If staff were not using the computer, it must be kept locked. She voiced concern that the cart was open and the access that could have given to other residents.</p> <p>The facility policy titled Storage of Medications, updated 2/2007 instructed compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals to be locked when not in use; and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452</b></p> <p>Based on observation, maintenance record review, resident interviews, and staff interviews the facility failed to maintain a clean and sanitary environment for resident bathing including holes in floor, missing floor tiles, stained wall tiles, and dirty/damaged air vents. The facility reported a census of 31 residents.</p> <p>Findings include:</p> <p>An observation at 10:49 AM on 12/2/24 in the shower room across from room [ROOM NUMBER] revealed a missing section of the gray floor. The top of the hole nearest the wall with the shower head measured 9 inches wide, the bottom of the hole towards the middle of the shower stall measured 4 inches wide, and the length of the hole was 2 feet. The inside of the hole contained a wet, black substance and a puddle of water sat between the hole and the drain. The drain was covered with light colored hair and fuzz.</p> <p>At 11:11 AM on 12/2/24 the stall in the shower room across from room [ROOM NUMBER] contained shower tiles along the floor and the wall marked with light orange and brown stains, with a bumpy substance coming out from the surface of the tile. The corners of the stall contained black and white spots. A musty smell came from the area of the shower and drain. At the entrance to the shower stall there was a 4 inch gap between the metal transition strip and the tile in the shower. One section of the gap to the left of center revealed a missing chunk of flooring approximately 4 inches by 2 inches, stained with a wet black substance. To the left of center another chunk was missing approximately 7 inches by 2.5 inches, stained with a wet black substance. On the outside of the transition strip a section of the gray floor was cut out and measured approximately 3 inches by 3 inches. The exposed floor underneath was wet and contained black and white substances. Inside the shower 5 tiles were missing, which created a hole in the floor about 3 inches x 2 inches, located about 6 inches from the sunken drain. The open areas inside and outside of the shower stall lacked the water repellent surfaces necessary to keep the under-floor dry. This prevented proper sanitizing and allowed these sections to hold standing water that encouraged bacteria growth.</p> <p>The vent around one of the ceiling lights contained fuzzy fibers, 3 of the vent slats were broken, and one of them hung down approximately 2 inches from the vent. Some of the slats were stained an orange/brown color and 4 of the slats were warped as though they melted.</p> <p>During an interview on 12/2/24 at 11:31 AM Resident #3 stated he felt mostly safe in the shower room, but the wheels of the shower chairs got stuck in the floor a lot and it was hard to get them to move where they (staff) want them. He said it was ' kind of dirty. '</p> <p>During an interview at 11:52 AM on 12/2/24 Resident #1 reported one of her biggest concerns was infection control in the shower room in her hallway. She stated the shower chair wheels often got stuck in the holes and the room was dirty. She did not think there was any good way to disinfect the holes in the floor and it was just getting worse. Resident #1 stated she had spoken to staff about it but nothing had been done.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/4/24 at 1:10 PM Staff B, Certified Nursing Assistant (CNA), stated the shower room had gotten worse over time. She reported she had been at the facility over a year and a half and there was already damage when she started.</p> <p>On 12/4/24 at 2:53 PM Staff D, CNA stated the damage in the shower room had been there quite awhile. She stated she reported it to the prior facility maintenance person and he kept saying it would get fixed but was never done. When asked if the current staff knew about the problem, she said yes. She stated it was scary moving the shower chairs because they had to push residents into the shower and they were afraid they would hit the ruts or missing tiles. She stated there was water that seeped out from under the tile no matter what they did to try to get rid of it.</p> <p>On 12/5/24 at 9:33 AM the Administrator confirmed she was aware of the shower damage. She reported that she had been talking to maintenance about the damage and they were looking for matching tiles.</p> <p>A policy titled Work Orders revised in 2004 documented it was the responsibility of the department directors to fill out and forward work orders to the maintenance director. It indicated work orders would be prioritized based on need.</p> <p>A document titled Maintenance Log revealed the shower room across from room [ROOM NUMBER] had chipped tiles on 8/29/24. The entry was crossed off without the floor being repaired.</p>