STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E718	A. Building B. Wing	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Humboldt County Memorial Hospital	1000 North 15th Street Humboldt, IA 50548

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and resident interview, the facility failed to ensure a resident's call light was in reach for 1 of 13 resident's reviewed (Resident #7). The facility reported a census of 25 residents.Findings include:According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #7 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident depended on staff for toileting hygiene, rolling left and right, and transfers. The resident's diagnoses included chronic kidney disease, diabetes, and coronary artery disease.The Care Plan revised 9/7/21 identified Resident #7 at risk for falls. Interventions included the resident used the call light, and the resident needed a safe environment with a working and reachable call light.On 2/4/26 at 11:05 a.m. Resident #7 stated staff did not give him his call light last night, and when he needed help, he had to yell out help until someone heard him. He said he was in bed and the call light on his walker. He said that upset him.On 2/4/26 at 3:25 p.m. Staff A Licensed Practical Nurse (LPN) verified she worked the previous night shift. She said sometime around 10:30 p.m. she thought she heard someone calling out. She did some checking and Resident #7 did not have his call light. She gave it to him and apologized. She planned to talk to the staff who put him to bed about this. They should have made sure he could reach his call light.On 2/5/26 at 12:29 p.m. the Assistant Director of Nursing (ADON) stated staff should ensure residents have the call light within reach. She said a resident should not have to yell out to get help.The facility's, Resident's [NAME] of Rights, modified 3/2/17 included the residents had a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

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	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on clinical record review, staff interviews and policy review, the facility failed to notify the Physician and family/resident representative of a condition change for 1 of 13 residents reviewed (Resident #26). The facility reported a census of 25 residents.Findings include: The Minimum Data Set (MDS) for Resident #26 dated 11/3/25 assessment identified a Brief Interview for Mental Status (BIMS) score was a 5, indicating severe cognitive impairment. Resident #26's MDS included diagnoses of Alzheimer's, Non-Alzheimer's disease, gastroesophageal reflux disease, anxiety, and depression.The Care Plan revised on 8/8/25 documented staff to monitor, document, and report as needed any signs and symptoms of dysphagia (difficulty swallowing) which included pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat and concerns during meals. The Progress Note dated 12/9/25 at 12:15 PM documented Resident #26 was in the dining room eating lunch. The note documented Resident #26 was drinking and eating then started to cough. A tablemate alerted staff that Resident #26 appeared to have choked and the nurse was summoned to the table. Resident #26 was able to cough, talk and reported drink went down the wrong pipe. Review of the Clinical Record lacked documentation Resident #26's Physician or family/resident representative was notified of the incident on 12/9/25. On 2/5/26 at 2:43 AM, Staff C, Quality of Assurance Nurse reported she could not locate family and Physician notifications for 12/9/25 and verified the notifications should have been completed. The facility policy titled Change in Resident's Condition or Status dated 7/14/25 documented nursing services to notify the resident's attending Physician and representative of changes in the resident's condition and/or status.

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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** Based on clinical record reviews and staff interviews, the facility failed to provide adequate nursing supervision to prevent accident and injuries for 1 of 1 residents reviewed (Resident #19) for falls. The facility reported a census of 25 residents. Citation considered past noncompliance as the facility completed the following interventions prior to the surveyor entering the facility on February 4, 2026:Staff education provided on always utilizing the gait belt with resident transfers on 10/22/25.Staff education provided to Staff D, Certified Nursing Assistant, on the importance of utilizing a gait belt with the resident transfers on 10/23/25. Findings include: Resident #19's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. The MDS identified Resident #19 required substantial/maximum assistance for all transfers. The MDS included diagnoses of heart failure, anemia and cancer. The Care Plan with a start date of 11/21/25 revealed Resident #19 had impaired cognitive/functional status and required assistance of two staff members for all transfers. The Incident Report (IR) dated 10/22/25 at 6:43 a.m. documented Resident #19 had a fall in his room with no apparent injuries. According to the IR, Staff D, Certified Nursing Assistant (CNA) reported Resident #19 slipped and landed on his right hip. The IR documented the gait belt was not used at the time of the fall. On 2/5/25 at 1:37 p.m. with Staff D, CNA, stated that she was getting Resident #19 ready for the day. Staff D stated his usual routine would be to stand up from the bed and utilize the urinal and then sit back down and then staff would get him ready for the day. Staff D stated he slept with a brief only. Staff D stated she did not utilize a gait belt during this transfer. Staff D stated Resident #19 got weak and his legs gave out and he was lowered to the floor. Staff D stated that she was educated regarding utilizing the gait belt. The facility policy titled Fall Prevention dated 9/29/2016 revealed the purpose it to outline the process to identify residents that are at risk for falls and those at risk for injuries related to falls. The Care Team will identify these residents on admission, quarterly with their MDS assessment, and as needed. The Care Team will then plan interventions and implement measures to decrease the incidence of falls and injury related to falls. The policy states the residents will be free from falls and injuries related to the falls. The policy states to utilize the gait belt while assisting residents with transfers and ambulation. On 2/9/26 with Staff E, Registered Nurse, stated the expectation of the staff is to utilize the gait belt when assisting the resident with transfers/ambulation, unless otherwise care planned.

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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 observations, clinical record review, staff interviews, and policy review, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 1 of 1 resident reviewed (Resident #37) with an indwelling catheter. The facility reported a census of 25 residents.Findings include: Resident #3's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The MDS identified Resident #3 required partial/moderate assistance with toileting hygiene. Resident #3's MDS included diagnoses of benign prostatic hyperplasia (BPH), neoplasm (tumor) of the bladder and overactive bladder. The MDS documented Resident #3 had an indwelling catheter. On 2/5/26 at 10:46 AM, Staff B, Certified Nursing Assistant (CNA), put on a gown and pair of gloves prior to entering Resident #3's room. Staff B carried a box of gloves into the room and sat the box of gloves on the floor without a barrier next to a towel on the floor that had a graduate and alcohol swabs on it. Staff B removed her gloves and applied a pair of gloves from the box of gloves sitting on the floor without completing hand hygiene. She then proceeded to cleanse the leg bag spout with an alcohol swab, empty the urine into the graduate and then cleanse the spout with a different alcohol swab. Staff B then took off her gloves and put on a pair of gloves from the box of gloves sitting on the floor without completing hand hygiene. Staff B pulled Resident #3's pant leg down and then went to the restroom to empty the graduate and rinse it out. Staff B acknowledged she put the box of gloves on the floor and did not do hand hygiene when changing gloves. On 2/5/26 at 1:19 PM, Staff C, Quality Assurance Nurse reported supplies should not be put on the floor without a barrier and hand hygiene should be completed when gloves are changed.A facility policy titled Hand Hygiene dated 4/23/25 documented the purpose of the policy was to establish guidelines for proper hand hygiene practices among patients, visitors and staff to prevent the spread of infections and ensure safety, following the Centers for Disease Control and Prevention (CDC) guidelines. The policy directed hand hygiene to be performed after removing sterile or non-sterile gloves.