

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165243	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/03/2025
NAME OF PROVIDER OR SUPPLIER CHAUTAUQUA GUEST HOME #3			STREET ADDRESS, CITY, STATE, ZIP CODE 302 NINTH STREET , CHARLES CITY, Iowa, 50616	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 ✓ OB	INITIAL COMMENTS Correction date: <u>7/25/25</u> The Chautauqua Guest Home #3 Nursing Home is not in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities due to the following deficiencies written during the facility's annual recertification survey with an investigation of complaint #128237-C conducted July 1, 2025, to July 3, 2025. The investigation of Complaint #128237-C didn't result in a deficiency. Total census: 42	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F0550	F550 The facility states with respect to F550, Chautauqua Guest Home #3 has educated Staff A regarding allowing residents time to eat at their own pace and explaining what you plan to do before doing it. She has completed additional education on Communication and Dementia, Dementia Training: Communication, Dementia Training: Behavior Management & Abuse Prevention, and Resident Rights. All other staff have been educated Resident Rights. Audits of interactions in the dining room will be conducted by the Director of Nursing and CQI Nurse on a periodic basis to ensure compliance. Date of correction: 7/25/2025	

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 reverse for further 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 LNHA	(X6) DATE 7/29/25
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F0550 SS = D	<p>Continued from page 1</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on clinical record review, review of staff training records, facility policies, observation and staff interviews, the facility failed to ensure residents are treated with dignity and respect for 1 of 1 resident (Resident #13) reviewed. The facility reported a census of 42 residents.</p> <p>Findings include:</p> <p>Resident #13's Minimum Data Set (MDS) assessment dated 4/30/25 identified a Brief Interview for Mental Status (BIMS) score of 99, indicating the inability to conduct the resident interview. The MDS documented Resident #13 ate independently. The MDS included diagnoses of Alzheimer's disease, non-traumatic brain dysfunction (brain damage that occurs due to internal factors, rather than external trauma), and depression.</p> <p>The Medication Review Report dated and signed by the Advanced Registered Nurse Practitioner (ARNP) on 4/15/25, listed Resident #13's diet as a general diet, regular texture, regular consistency, small portions and mechanical soft consistency as needed.</p> <p>Observation on 7/2/25 12:16 PM revealed Resident #13 sat at the second table away from the nurses' station. Resident #13 had her back towards the wall with the nurses' station located to her right with 2 medication carts between the nurses' station and the dining area. Staff B, Certified Nursing Assistant (CNA), sat to the</p>	F0550		

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F0550 SS = D	<p>Continued from page 2 left of Resident 13. The table had 2 other residents there. Resident #13 ate by herself with a spoon in her right hand and lowered her right hand below table height when Staff A, CNA/Certified Medication Aide (CMA), approached the table and forcibly pulled the spoon out of Resident 13's right hand. Staff A pulled up on the handle of the spoon raising Resident 13's hand above the table. Resident #13 had her hand clenched tightly to the handle of the spoon before letting go of the spoon. Resident #13 didn't grimace, make any expression, or speak during this interaction. Staff A used the spoon to cut Resident #13's chocolate cake into pieces. Staff A scooped up a piece of cake up and handed the spoon back to Resident #13. Resident #13 continued to eat independently. Staff A made no comment to Resident #13 or to Staff B prior to pulling the spoon from her hand. Staff A returned to the medication cart located closest to the front entrance after returning the spoon to Resident #13.</p> <p>In an interview on 7/2/25 at 12:19 PM, Staff A acknowledged they pulled the spoon away from Resident #13. Staff A verbalized she didn't explain to Resident #13 what she planned to do. Staff A admitted she shouldn't have pulled the spoon from her hand. Staff A commented if you cut her food and give her a bite, she will finish eating. Staff A reported Resident #13 didn't have other silverware provided as she had a known history of placing silverware up her sleeves.</p> <p>In an interview on 7/2/25 at 12:22 PM, Staff B witnessed Staff A pull the spoon from Resident #13's right hand. Staff B reported Staff A didn't verbalized anything prior to pulling the spoon away. Staff B reported it shouldn't have happened and revealed Resident #13 ate at her own pace.</p> <p>In an interview on 7/2/25 at 12:32 PM, the Administrator, Registered Nurse (RN)/ Bachelor of Science in Nursing (BSN), verbalized they allowed Resident #13 the time to eat independently. The Administrator described Resident #13 as a slow eater. The Administrator acknowledged staff members shouldn't pull the silverware away from a resident.</p> <p>Resident #13's July 2025 Documentation Survey Report related to eating listed on 7/2/25 at 12:27 PM Resident #13 completed the activity by themselves with no assistance from a helper. The Documentation Survey Report revealed staff documented Resident #13 ate 0-25%</p>	F0550		

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F0550 SS = D	<p>Continued from page 3 of the meal and drank 0-25% of fluids.</p> <p>Staff training records revealed the following:</p> <p>Staff A completed Dependent Adult Abuse Mandatory Reporter Training on 3/1/24.</p> <p>Staff B completed Dependent Adult Abuse Mandatory Reporter Training on 1/24/23.</p> <p>The facility's undated Resident' Bill of Rights stated the following:</p> <p>A. Residents Rights - The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>(1) A facility must treat each resident with respect and dignity and care for each resident in a manner in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>The undated Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy documented the following:</p> <p>All residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This includes prohibiting nursing facility staff from taking part in acts that result in person degradation, including taking or using photographs or recording in any manner that would demean or humiliate a resident, and prohibits using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep or distribute photographs and/or recordings on social media or through multimedia messages. Resident must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals.</p>	F0550		