DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165304	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montrose Health Center	400 South 7th Street Po Box 248, Montrose, Iowa, 52639

(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 ✓ KG	INITIAL COMMENTS Correction date: 10-09-25 The following deficiency resulted from the facility's annual recertification survey and investigation of complaints #1729874-C conducted September 29, 2025 to October 2, 2025. Complaint #1729874-C did not resulted in a deficiency. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and staff interviews, the facility failed to administer the correct amount of fluid and liquid nutrition to a	F0693		

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	(X6) DATE
Mallory Orton	Administrator	11/20/2025

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F0693 SS = D	Continued from page 1 resident dependent on tube feeding for 1 of 1 residents (Resident #1) reviewed for tube feedings. The facility reported a census of 36 residents. Findings include: Review of the admission Minimum Data Set (MDS) dated 7/23/25 revealed Resident #1 scored a 13 out of 15 on the BIMS exam, which indicated cognition intact. The MDS list of diagnoses included transient ischemic attack, malnutrition, and dysphagia (difficulty swallowing) following cerebral infarction (stroke). The MDS indicated eating not attempted due to medical condition or safety concern. The MDS indicated resident utilized a feeding tube. Review of the Care Plan, Date Initiated 7/29/25, revealed a Focus area to address The resident requires PEG (a percutaneous endoscopic gastrostomy tube is a feeding tube inserted through the skin and stomach wall with an endoscope to deliver nutrition, fluids, and medications directly to the stomach for those who cannot swallow normally) tube feeding. Date Initiated: 7/29/25. Interventions included, in part: a. The resident needs assistance with tube feeding and water flushes. See MD (medical doctor) orders for current feeding orders. Date Initiated: 7/29/25. b. The resident is dependent with tube feedings and water flushes. See MD orders for current feeding orders. Date Initiated: 7/29/25. A review of Physician Orders revealed the following; a. Strict NPO (nothing per mouth) diet order. Revision Date: 7/17/25. b. Flush PEG tube with 120 mL(milliliters) of water before and after feeding administration. Start date: 9/15/25. c. Osmolite 1.5 Cal Oral Liquid (Nutritional Supplements) - give 270 mL 4 times a day. Start date: 9/12/25. During an observation on 10/1/25 at 12:09 PM, Staff A, Registered Nurse (RN) administered 60 mL of water through Resident #1 PEG-tube, followed by 235 mL of Osmolite 1.5 calories through the PEG-tube, followed by an additional 60 mL of water. During an interview on 10/1/25 at 12:24 PM, Staff A, RN queried on Resident #1 orders for flushes and liquid	F0693		

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F0693 SS = D	Continued from page 2 nutrition and she stated the other liquid nutrition order was 270 mL and they didn't change it. Staff A stated she would double check the order. Staff A then stated she read the order for the 120 mL water flushes before and after feeding as 60 mL before and then 60 mL after the feeding. During an interview on 10/1/25 at 12:33 PM, the Advanced Registered Nurse Practitioner (ARNP) queried on the nutritional and flushing order for Resident #1 and the she stated she ordered the facility could switch the formula but the facility should follow the dietician recommendations. The ARNP confirmed the order for flushing before and after feeding indicated 120 mL before and 120 mL after the feeding, not for the 120 mL to be split in half. During an interview on 10/1/25 at 2:23 PM, Staff A, RN queried about the flushing order and liquid nutrition order and Staff A stated flushing with 60 mL before and after feeding was a nursing call. Staff A confirmed the liquid nutrition should have been 270 mL not the 235 mL that Staff A administered. Staff A stated she thought the 120 mL before and after the feeding would of been too much for Resident #1 tummy and Staff A was taught to flush with 60 mL before and 60 mL after. Staff A stated the previous order for liquid nutrition was 235 mL and when Staff A returned on Monday, Staff A should have noticed the new order. Staff A confirmed she had only been giving Resident #1 the 235 mL at each of the feeding Staff A administered. During an interview on 10/1/25 at 3:11 PM, the Dietician queried on Resident #1 orders for the flushes and the liquid nutrition and the she stated she documented 270 mL for the Osmolite. The Dietician stated the she changed the milliliters of the feeding to equal the calories of the previous liquid nutrition and added a protein supplement since Resident #1 previously lost weight. The Dietician stated she wanted the 120 mL water flushes before and after the feeding for Resident #1 to meet her fluids needs. During an interview on 10/2/25 at 12:12 PM, the Director of Nursing confirmed Staff A should of followed the order for the liquid nutrition and water flushes before and after feeding administration. Per email on 10/2/25 at 12:44 PM from the Administrator, the facility didn't have a policy for tube feedings and they followed doctor's orders.	F0693		

Plan of Correction – Tube Feeding Education

1. **Corrective Action for Affected Residents:**
   All residents receiving tube feedings were immediately assessed to ensure feeds were administered per physician orders and facility policy. No negative outcomes were identified.

2. **Systemic Change / Education:**
   Comprehensive re-education on tube feeding procedures—including verification of orders, rate checks, residual checks, documentation, and infection control—was provided to all licensed nursing staff. Competency validations were completed and placed in staff files.

3. **Monitoring:**
   The Director of Nursing (DON) or designee will conduct tube-feeding audits weekly for 4 weeks, then monthly for 2 months, ensuring compliance with policy and proper documentation.

4. **Responsibility:**
   The DON is responsible for ensuring ongoing compliance and addressing any identified concerns.

5. **Completion Date:**
   The facility will be in full compliance by 10/09/2025.