| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165177 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 11/25/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Community Memorial Health Center | 231 North Eighth Avenue West , Hartley, Iowa, 51346 |

| (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<br><br>X<br>DC | INITIAL COMMENTS<br><br>Correction date 11-28-25<br><br>Investigation of Complaint #2635744-C completed November 24, 2025 - November 25, 2025 resulted in the following deficiency. | F0000 | | |
| F0561<br>SS = E | Self-Determination<br><br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br><br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, record review, and staff | F0561 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165177 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 11/25/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Community Memorial Health Center | 231 North Eighth Avenue West , Hartley, Iowa, 51346 |

| (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 |
|---|---|---|---|---|
| F0561 SS = E | Continued from page 1<br>interview, the facility failed to ensure a residents right in self determining a time to get dressed/up for 5 of 5 residents reviewed with dementia (Resident #1, #2, #3, #4, and #5). The facility reported a census of 45 residents.<br><br>1) According to the Minimum Data Set (MDS) assessment dated 8/28/25 Resident #1 scored 3 on the Brief interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident depended on staff for toileting hygiene, upper and lower body dressing. The resident's diagnoses included Alzheimer's disease and insomnia.<br><br>The Care Plan revised 8/4/25 identified the resident had a diagnosis of insomnia and she took scheduled Melatonin for it. Interventions included monitoring the resident for any change in sleep pattern, and staff would encourage a consistent routine each night.<br><br>On 11/25/25 at 4:12 a.m. Staff A Certified Nursing Assistant (CNA) woke and checked Resident #1's (incontinent pad) and she was dry. Staff A then removed Resident #1's gown and dressed her with a top, and pants pulled up to the mid-thigh. Staff A covered Resident #1 and left the room.<br><br>On 11/25/25 at 4:57 a.m. Staff A stated they had 6 people they were responsible for dressing on last rounds. Today they only had to do 3, because 3 of them got baths. The 6 people they dressed had dementia and could not say no. They dressed them and they stayed in, or went back to bed. She said 1 of the 3 people they needed to dress had already been done.<br><br>2) According to the MDS assessment dated 10/2/25 Resident #2 scored 0 on the BIMS indicating severe cognitive impairment. The resident required substantial/maximal assistance with toileting hygiene, and partial/moderate assistance with upper and lower body dressing. The resident's diagnoses included non-Alzheimer's dementia.<br><br>The Readmit Assessment dated 10/1/25 documented Resident #2 had trouble staying asleep, and waking in the night. Staff and family reported up more in the night recently, up 5-10 times.<br><br>The Care Plan dated 4/23/25 identified Resident #2 had an Activity of Daily Living (ADL) deficit due to her cognitive loss and inability to initiate tasks. Interventions included Resident #2 required assist of 1 for all clothing tasks. Give her verbal prompts to move | F0561 | F0561<br>1. The residents involved will not be awakened and dressed prior to the time they wish to be awake.<br><br>2. All residents will not be awakened and dressed prior to the time they wish to be awake.<br><br>3. Nursing staff have been educated on the Resident Right of Self Determination to include not awaking a resident and getting them dressed when they wish to do so. If a resident is cognitively unable to make this decision, this will be discussed with their representative. If agreeable, the resident's care plan will state this.<br><br>4. Random audits will be performed to see if residents are being awakened and dressed prior to when they or their facility representative wishes for them to be awakened. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165177 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 11/25/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **Community Memorial Health Center** | **231 North Eighth Avenue West , Hartley, Iowa, 51346** |

| (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 |
|---|---|---|---|---|
| F0561 SS = E | Continued from page 2<br>her extremities to assist in changing.<br><br>The Care Plan Identified Resident #2 had dementia and took Memantine (medication to improve memory) as ordered daily. An attempt to discontinue Memantine caused increased confusion and was restarted. She did have some nights when awake more than others. Evaluate other factors that could cause insomnia such as excessive heat or cold, noise, lighting, facility routines, caffeine/medication and attempt to modify, if possible.<br><br>On 11/25/25 at 4:35 a.m. Staff B CNA and Staff A assisted Resident #2 stand with some resistance. They were able to get the resident to the bathroom and sitting on the toilet. Staff removed the resident's pajama top and pants, and put on a (day) top and pants. They assisted the resident off the toilet, provided incontinent care, and walked her back to bed where she promptly started to lay down. Staff assisted her to get in the bed, covered her up, and left the room.<br><br>3) According to the MDS assessment dated 10/9/25 Resident #3 scored 3 on the BIMS indicating severe cognitive impairment. The resident required partial/moderate assistance with toileting hygiene, and upper/lower body dressing. The resident's diagnoses included Alzheimer's disease.<br><br>The Care Plan dated 7/9/25 identified Resident #3 had an ADL self-care deficit related to cognitive loss and poor initiation of tasks. The resident required assist of 1 with toileting, toileting hygiene, and brief changes.<br><br>On 11/25/25 at 5:05 a.m. Resident #3 laid back in a recliner covered with blanket, in the common area of the Special Care Unit (SCU). Staff C CNA said Resident #3 slept in the recliner and she had already gotten her up to toilet, got her dressed, then brought her back to the recliner. She said they were expected to get 6 people up before the day shift CNA's got there at 6 a.m.<br><br>4) According to the MDS assessment dated 10/16/25 Resident #4 scored 0 on the BIMS indicating severe cognitive impairment. The resident required substantial/maximal assist with toileting hygiene and lower body dressing, and partial/moderate assist with upper body dressing. The resident's diagnoses included Alzheimer's disease. | F0561 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165177 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 11/25/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **Community Memorial Health Center** | **231 North Eighth Avenue West , Hartley, Iowa, 51346** |

| (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 |
|---|---|---|---|---|
| F0561 SS = E | Continued from page 3<br>The Care Plan dated revised 11/17/25 identified Resident #4 at risk for falls related to incontinence. Interventions included offering toileting 2 times nightly, approximately 1 and 4 a.m.<br><br>On 11/25/25 at 5:07 a.m. Resident #4 laid back in a recliner in the common area of the SCU, covered with a blanket. Staff C CNA stated the resident slept in the recliner and she already got her up and dressed and brought her back to the common area. She said she had also already assisted another resident up and dressed, and he went back to bed.<br><br>5) According to the MDS assessment dated 9/11/25 Resident #5 scored 0 on the BIMS indicating severe cognitive impairment. The resident depended on staff for toileting hygiene and lower body dressing, and required substantial/maximal assist with upper body dressing. The resident's diagnoses included non-Alzheimer's dementia and insomnia.<br><br>The Care Plan revised 11/24/25 identified Resident #5 had a diagnosis of insomnia for which he took Melatonin to sleep. Interventions included staff encouraged him to keep a consistent routine at night.<br><br>On 11/25/25 5:20 a.m. Staff C and Staff B went to get Resident #5 up. He slept in his bed. Staff told him they were getting him up. Staff assisted the resident in sitting up and walking to the bathroom with some difficulty, the resident taking short choppy steps. Staff dressed the resident while on the toilet, provided incontinent care, then walked the resident to the common area and sat the resident in a recliner, reclined with his feet elevated. At 5:30 a.m. Resident #5 asleep in the recliner. Staff C stated if she did not get at least 6 people up before the day shift got there she would hear about it.<br><br>During a meeting with the Administrator and the Director of Nursing (DON) on 11/25/25 at 10:50 a.m. the Administrator stated he didn't know they were getting residents up early. The DON stated they should start getting residents up at 6 a.m. unless residents were okay with getting up earlier or requested it.<br><br>The facility Bill of Rights documented in the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The resident representative has the right to exercise | F0561 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165177 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 11/25/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **Community Memorial Health Center** | **231 North Eighth Avenue West , Hartley, Iowa, 51346** |

| (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 |
|---|---|---|---|---|
| F0561 SS = E | Continued from page 4<br>the resident's rights to the extent those rights are delegated to the resident representative. The document included the resident had the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to right to choose schedules (including sleeping and waking times). | F0561 | | |