STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165177	A. Building B. Wing	01/22/2026

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

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review and facility policy review the facility failed to accommodate an appropriate bathing time to honor residents preference for 1 of 17 residents (Resident #6) reviewed. The facility reported a census of 47 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #6 documented diagnoses of anxiety, depression and cancer. The MDS showed a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Interview on 1/20/26 at 2:13 p.m., with Resident #6 revealed she likes to take her shower between 6:00 and 6:30 p.m., and has not been taking them because when the facility staff come and offer her a shower it is too early or too late. Resident #6 further revealed she likes to take it at this time as there are not as many people in the hallways during this time. Review of bathing documentation dated 12/25/25-1/19/26 revealed the resident had refused her bath on scheduled bathing days or was marked as not applicable. Review of resident's Progress Notes lacked documentation regarding reason for refusal of bathing during the reviewed timeframe. Interview on 1/21/26 at 11:20 a.m., with Resident #6 confirmed she has not taken a shower or bath in the facility for the last 30 days as she does not want to take them so late when the staff has been offering the shower. Resident #6 goes on to explain she takes her medications for bedtime earlier and by the time the staff ask she is sleepy. She explains she has been washing up in her room on her own so she does not have any foul odors but she would take it in the facility if they would offer her a bath between 6:00 and 6:30 p.m She understands they are busy with supper but this is when she would like her showers. Resident further explained sometimes the staff ask her before supper and she tells them when she would like to take and the staff has told her no as they are busy with supper and she doesn't want to take it then as the facility can be super busy as that affects her anxiety. Resident denies anyone from the facility coming to her room and talking to her about when she would like to take a shower or why she has not had an actual shower or bath in at least 30 days. Resident stated she had told the Social Worker during care conferences she did not want to take baths so late at night but nothing has changed. Resident explained she is a stubborn lady but she is not going to be told when she has to do something. She has the ability to make the choice when she would like to take her shower. Interview on 1/21/26 at 11:33 a.m., with the Director of Nursing (DON) revealed the resident does refuse her bath and appointments all the time. The DON revealed staff has offered her a shower before supper and after super and the resident has never expressed what time she would like to take it. The DON stated she has gone down and talked to the resident about her bathing and she has never been told a time she would be willing to take her bath. The DON would look and see if there was any information the resident brought up bathing preferences during care conferences as she does not attend those. At the time of exit no documentation from care conferences was presented to surveyors regarding Resident #6 expressing concerns. Review of facility provided policy titled Resident [NAME] of Rights (continued on next page)

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	undated revealed the following items: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. The right to participate in the development and implementation of his or her person-centered plan of care.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, plan of care and other applicable provisions of this part. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. Interview on 1/22/2016 at 8:51 a.m., with the DON revealed the residents can pick times they want to do things.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to refer 1 resident with a negative Level I result for the Preadmission Screening and Resident Review (PASRR), who was later identified with newly evident or possible serious mental disorder, intellectual disability, or other related condition, to the appropriate state-designated authority for Level II PASRR evaluation and determination for 1 out of 2 residents (Resident #4) reviewed for PASRR requirements. The facility reported a census of 47 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #4 documented diagnoses of anxiety disorder, depression and post traumatic stress disorder (PTSD). The MDS included a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. Review of the MDS dated [DATE] revealed the following diagnosis:Anxiety disorderDepressionPTSD The clinical record lacked an updated PASRR to include PTSD diagnosis. Review of the PASRR dated 3/19/24 lacked inclusion of PTSD diagnosis. Review of the facility provided policy titled [NAME] policy with a revised date of 9/2025 revealed change in status includes; Additionally, if new psychiatric diagnosis is present that was not included on the initial review. Interview on 1/22/25 at 8:45 a.m., with the Director of Nursing (DON) revealed the diagnosis of PTSD should be on the PASRR and it should be resubmitted.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to ensure a resident received appropriate treatment and services to prevent urinary tract infection for 1 of 2 residents reviewed (Resident #1). The facility reported a census of 47 residents.Findings include:According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored scored 13 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident had an indwelling urinary catheter. Diagnoses included renal insufficiency and retention of urine.The Care Plan revised 7/28/25 identified the resident had a urinary catheter. The interventions included changing the catheter monthly and for dislodgement, and keeping the urinary drainage bag covered at all times.The Progress Notes dated 1/19/26 at 11:43 a.m. documented the resident returned from the hospital after a stay for UTI.On 1/21/25 at 2:25 p.m. Resident #1 sat in the chair in his room. The catheter bag was in a dignity bag hanging from his walker. The catheter tubing (1-1/2 to 2 feet) laying on the floor. Staff B Certified Nursing Assistant (CNA) came in, washed her hands and donned a gown and gloves. She brought a barrier, graduate, and alcohol wipes to the chairside. She removed the catheter bag from the dignity bag, the drain from its port, and wiped with an alcohol wipe. The drain hit the inside of the graduate. After she finished draining the bag she wiped the drain with an alcohol wipe. She replaced the drain and put the catheter bag back in the dignity bag. She cleaned up the area and left the room, with the catheter tubing still laying on the floor.On 1/22/25 at 9:10 a.m. the Director of Nursing (DON) stated staff should keep the tubing off the floor. She also thought the drain should not touch the graduate.The facility policy for Foley Catheter Care reviewed 5/2025 documented measuring the drainage at the end of each 8 hours included disconnecting the tubing over a graduate and allowing the urine to drain completely (being sure not to contaminate the drain). The undated facility policy for Emptying a Urinary Drainage Bag included not allowing the drain spout to come into contact with the measuring container, hands, or any other object (if accidental contamination occurred, wipe the drain spout with an alcohol sponge or swab), and keeping the collection bag and tubing off the floor at all times to prevent contamination and damage.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, and staff interviews, the facility failed to accurately transcribe physician orders for psychotropic medications, including documenting the correct medication end dates in the electronic medical record, for 2 of 2 residents reviewed (Resident #3 and #22). The facility reported a census of 47 residents Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 documented diagnoses of Parkinson's Disease, dementia and Anxiety Disorder. The MDS showed the Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident unable to complete a cognitive interview. The Care Plan with an initiated date of 11/17/25 showed Resident #3 used anti-anxiety medications related to an anxiety diagnosis. Resident #3 became anxious, raised her voice, verbalized paranoia, and cried uncontrollably at times. The written Physician Order dated 12/25/25 for Resident #3 showed Lorazepam 0.5 milligram (mg) tablet every 6 hours as needed for 180 days. The electronic Clinical Physician Orders dated 12/11/25 for Resident #3 showed Lorazepam 0.5 mg tablet every 6 hours as needed with an end date of indefinite. 2. The MDS assessment dated [DATE] for Resident #22 documented diagnoses of dementia, Alzheimer's Disease and Anxiety Disorder. The MDS showed the Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident unable to complete a cognitive interview. The Care Plan with an initiated date of 9/5/25 showed Resident #22 used anti-anxiety medications routinely for physical aggression, increased periods of restlessness, and agitation. The written Physician Order dated 1/10/25 for Resident #22 showed Lorazepam 0.5 milligram (mg) tablet every 6 hours as needed for 180 days. The electronic Clinical Physician Orders dated 1/10/25 for Resident #22 showed Lorazepam 0.5 mg tablet every 6 hours as needed with an end date of indefinite. The Medications Orders policy last updated September 2025 identified:OBJECTIVE:The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders.RECORDING ORDERS:Medication Orders - When recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered. In an interview on 1/21/26 at 11:36 AM, the Director of Nursing (DON) reported staff failed to enter the physician's order into the electronic medical record as written. The DON stated the stop date should have been entered as 180 days. The DON further indicated that the responsible staff member has been identified and one-on-one education will be provided. In addition, education will be provided to all nursing staff to prevent recurrence.

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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. Based on observation, clinical record review, staff interview, and per the current Centers for Disease Control and Prevention (CDC) guidelines the facility failed to use Enhanced Barrier Precautions (EBP) to prevent the spread of multidrug-resistant organisms (MDROs) during catheter care for 1 out 2 resident reviewed (Resident #24). The facility reported a census of 47 residents. Findings include: Observation on 1/21/26 at 10:19 AM showed Staff A, Certified Nurses Assistant (CNA) performed catheter care for Resident #24 without donning personal protective equipment of a gown. A sign posted in the resident's room instructed staff to don Enhanced Barrier Precautions (EBP), which included a gown, when providing catheter care. In an interview on 1/21/26 at 11:36 AM, the Director of Nursing (DON) reported Staff A, CNA, should have worn a gown for personal protective equipment when performing catheter care. The DON reported that she is also the Infection Preventionist and would expect staff to follow the EBP guidelines posted in the resident's room. The Center for Clinical Standards and Quality/Quality, Safety & Oversight Group Ref: QSO-24-08-NH GUIDANCE Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with any of the following: Infection or colonization with a CDC-targeted MDRO when Contact Precautions do nototherwise apply; or Wounds and/or indwelling medical devices even if the resident is not known to beinfected or colonized with a MDRO.Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks orskin tears covered with an adhesive bandage (e.g., Band-Aid(R)) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. The Centers for Disease Control and Prevention website titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), visited 4/9/25, updated 7/12/22, and dated 4/2/24 revealed Enhanced barrier precautions expand the use of PPE and refer to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff and clothing. MDROs may be indirectly transferred from resident to resident during these high contact care activities. Nursing home residents with wound and indwelling medical devices are at especially high risk for both acquisition of and colonization with MDROs. The use of gown and gloves for high contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. The Centers for Disease Control and Prevention website titled, Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes dated June 28, 2024 identified question: May nursing homes stop using Enhanced Barrier Precautions if we screen the infected or colonized resident and they test negative for the novel or targeted MDRO? Residents colonized with a novel or targeted MDRO are intended to remain on Enhanced Barrier Precautions for the duration of their stay in a facility. Because MDRO colonization is typically prolonged and follow-up testing to determine clearance may yield false negatives, CDC does not recommend routine retesting of residents with a history of colonization or infection with a MDRO or discontinuation of Enhanced Barrier Precautions after a subsequent negative test.The Enhanced Barrier Precaution policy last review August 2023 identified:PURPOSE:To reduce the risk of transmission of multidrug-resistant organisms (MDROs) in the facility.DEFINITIONS:1. Enhanced Barrier Precautions are an infection control measure that (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	involves gown and glove use during high-contact resident care activities for residents who have open woundsor indwelling devices or who have a known recent colonization or infection with a MDRO (when Contact Precautions do not apply).2. High Contact activity includes activities that place the resident and the person helping them in close physical contact that increases the risk of transmission of MDRO between theresident and health care provider. These activities include:f. Device Care: Central Line, Urinary Catheter, Feeding Tube, Tracheotomy/Ventilator4. Indwelling Devices include any devices that are inserted into the resident and have contact with the external air such as foley catheters, central lines (including PICC lines),tracheostomies, feeding tubes or drains. They do not apply to peripheral IVs, dialysis shunts, AV fistulas, PortaCaths, Pacemakers or vascular stents.5. Personal Protective Equipment (PPE) used to reduce the risk of exposure to and transmission of microorganisms. EBP includes the use of gowns and gloves. In instanceswhere splashes/sprays are anticipated, face protection (mask or respirator) and eye protection (goggles or face shield) should also be applied.