STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165180	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Odebolt Specialty Care	801 South Des Moines Street Odebolt, IA 51458

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Resident #24's MDSassessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented Resident #24 was taking antianxiety medication during the last 7 days. Review of the January 2025 Medication Administration Record revealed Resident #24 was not receiving antianxiety medication as documented on the MDS. On 2/19/25 at 8:00 AM, Staff A, MDS Coordinator acknowledged and verified she had coded the MDS incorrectly as Resident #24 was not taking antianxiety medication. Based on clinical record review, staff interview, and policy review the facility failed to represent an accurate picture of the resident's status during the observation period of the Minimum Data Set (MDS) by not accurately recording medication use for 3 of 3 residents reviewed, (Resident #24,#26, and #27). The facility reported a census of 33 residents. Findings include: 1. Review of Resident #2's MDS dated [DATE] revealed diagnoses of anxiety disorder, and non-Alzheimers dementia. The MDS further revealed Resident #26 received hypnotic medications for 7 of the 7 days during the look back period. Review of Resident #26's Electronic Healthcare Record (EHR) page titled, Physician's Orders revealed no order for hypnotic medication. 2. Review of Resident #27's MDS dated [DATE] revealed diagnoses of non-traumatic subarachnoid hemorrhage, stroke, and moderate intellectual disabilities. The MDS further revealed Resident #27 received anticoagulant medications for 7 of the 7 days during the look back period. Review of Resident #26's EHR page titled, Physician's Orders revealed no order for anticoagulant medications. Interview on 2/18/25 at 12:10 PM with Staff A Registered Nurse (RN) confirmed that Resident #26 is not on hypnotic medications, and Resident #27 was not on any anticoagulant. Staff A revealed that her expectation would be for accurate MDS assessments to be completed. Interview on 2/18/25 at 12:23 PM with the Director of Nursing (DON) revealed that her expectation would be for accurate MDS assessments to be completed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility provided policy titled, Certifying the Accuracy of the Resident Assessment with a revision date of 11/2019 documented: A. The information captured on the assessment reflects the status of the resident during the observation period for that assessment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical document review, staff interview, and policy review the facility failed to provide a comprehensive care plan related to high risk medications for 2 of 5 residents reviewed (Residents #26, and #27) . The facility reported a census of 33 residents. Findings include: 1. Review of Resident #26's Minimum Data Set (MDS) dated [DATE] revealed Resident #26 had diagnoses of anxiety disorder, and non-Alzheimers dementia. The MDS further revealed Resident #26 received antidepressant medications for 7 of the 7 days during the look back period. Review of the Electronic Healthcare Record (EHR) page titled, Physicians Order revealed an order for Trazadone (antidepressant) 50mg tablet to be given 1 time daily. The page further revealed an order for Escitalopram (antidepressant) 10mg tablet to be given 1 time daily. Review of Resident #26's Care Plan with a revision date of 1/6/25 revealed no focus, goals, or interventions for antidepressant medications. 2. Review of Resident #27's MDS dated [DATE] revealed diagnoses of non-traumatic subarachnoid hemorrhage, stroke, and moderate intellectual disabilities. The MDS further revealed Resident #27 received anticoagulant medications for 7 of the 7 days during the look back period. Review of Resident #26's EHR page titled, Physician's Orders revealed no order for anticoagulant medications. Review of Resident #26's Care Plan with a revision date of 1/8/25 revealed no focus, goals, or interventions for antiplatelet, or anticoagulant medications. Interview on 2/18/25 at 12:10 PM with Staff A Registered Nurse (RN) confirmed that Resident #26 is taking antidepressant medications, and then confirmed that Resident #26's Care Plan did not reflect this medication. Staff A further confirmed Resident #27 is not on an anticoagulant, but is taking an antiplatelet medication. Staff A then revealed Resident #27's Care Plan should reflect that the Resident is taking an antiplatelet medication. Staff A confirmed that Resident #27's Care Plan also did not have antiplatelet goals, or anticoagulant goals. Staff A further revealed that her expectation would be for accurate care plans to be completed. Interview on 2/18/25 at 12:23 PM with the Director of Nursing (DON) revealed that her expectation would be for accurate care plans to be completed. Review of a facility provided policy titled, Care Plans Comprehensive Person Centered, with a revision date of 12/2016 revealed: a. The comprehensive, person centered care plan will describe the services that are to be furnished to attain or maintain the resident ' s highest practicable level of physical, mental, and psychosocial well-being.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review the facility failed to provide assessment and interventions necessary for the care and services, to maintain the residents' highest practical physical well-being for 1 of 14 residents reviewed (Resident #7). The facility failed to complete and document vital signs and nursing assessments after Resident #7 returned from the emergency room (ER) for chest pain. The facility reported a census of 33 residents. Findings include: Resident #7's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS included diagnoses of schizoaffective disorder, anxiety disorder, shortness of breath and chronic lung disease. A Progress Note dated 12/5/24 at 10:40 PM documented Resident #7 complained of chest pain and right arm pain. The note documented Resident #7's blood pressure was 85/55, pulse was 64 beats per minute and oxygen saturation (oxygen in the blood) was 90% on room air. The note indicated Resident #7 was a full code and made the choice to be seen in the ER. The note documented the nurse placed a call to the on-call Provider and received order to send Resident #7 by ambulance to the ER. The note revealed 911 was called and the ambulance service was dispatched to the facility. A Progress Note dated 12/6/24 at 1:20 AM documented the facility nurse received a phone call from the ER reporting Resident #7 labs had come back within normal limits except for her sodium level which had been an issue in the past. The ER reported the hospital was going to have Resident #7 stay until the morning to recheck her cardiac labs and then would discharge Resident #7 back to the facility. A Progress Note dated 12/6/24 at 6:59 AM documented the facility had received a phone call from ER that Resident #7 cardiac labs were negative and Resident #7 would be released from the hospital. Review of the Hospital Discharge Information dated 12/6/24 at 6:58 AM documented the diagnoses from the ER visit included chest pain and hyponatremia (low sodium level). The discharge orders directed Resident #7 to follow up with Primary Care Provider within 1 to 2 weeks. Review of the clinical record revealed Resident #7 was not seen by her Primary Care Provider until 12/26/24. Review of the Progress Notes lacked documentation on when/what time Resident #7 returned to the facility and how Resident #7's condition was when she returned. The clinical record lacked documentation that vital signs or a nursing assessment was completed upon return from the ER. The clinical record lacked any follow up focus nursing assessments related to chest pain. On 2/18/25 at 11:15 AM, the DON (Director of Nursing) acknowledged and verified the Progress Notes lacked documentation that Resident #7 returned from the hospital on [DATE]. The DON acknowledged and verified the clinical record lacked vital signs and an assessment upon return from the hospital. The DON reported she would expect vitals sign and a focus assessment be completed for 72 hours after return. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Acute Condition Changes revised September 2017 documented any acute changes of condition would be identified and managed properly. The policy further documented that the physician and nursing staff would review the details of recent hospitalizations and identify complications and problems that occurred that may indicate instability or the risk of having additional complications.

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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, staff interviews and policy review, the facility failed to provide adequate nursing supervision to prevent accident and injuries for 1 of 1 resident reviewed (Resident #5). The facility reported a census of 33 residents. Findings include: Resident #5's Minimum Data Set assessment (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 04, indicating severe cognitive impairment. The MDS identified Resident #5 required partial/moderate assistance with bathing, bed mobility, transfers, and ambulation. Resident #5's MDS included diagnoses of atrial fibrillation (irregular heart beat), heart failure (heart does not pump blood well), hypertension (high blood pressure), diabetes mellitus, non-alzheimer's dementia, and difficulty walking. The Care Plan with a target date of 5/12/25 revealed Resident #5 was at risk for falls and had a history of falls. The Care Plan directed the following interventions: - Encourage Resident #5 to use the call light for assistance. Date Initiated: 06/07/2024 - Encourage Resident #5 to wear proper footwear. Date Initiated: 06/07/2024 - Staff to ensure Resident #5's environment was safe and without clutter. Date Initiated: 06/07/2024 - Staff to monitor Resident #5 for unsteady gait. Date Initiated: 06/07/2024 - PT/OT evaluation and treatment as ordered. Date Initiated: 06/07/2024 - Staff to remind and help guide Resident #5's walker to remain in front of her. Date Initiated:7/26/24 - Staff to ensure the floor in the shower/bath house was not wet or slippery before or after a bath. Staff to place a towel down to aid in transferring on wet or slippery floors. Date Initiated: 11/15/2024 A Fall Risk Evaluation date 11/1/24 documented Resident #5's fall risk score was an 11. The form indicated a total score of 10 or above represents a high risk for falls. Review of the November 2024 Medication Administration Record (MAR) directed staff to administer eliquis (anticoagulant/blood thinner) 5 mg (milligrams) two times a day for atrial fibrillation and history of a TIA (transient ischemic attack/stroke) An Incident Report (IR) titled Witnessed Fall on 11/11/24 at 9:49 AM revealed Staff B, CNA (certified nursing assistant) assisted Resident #5 out of the whirlpool chair without a gait belt in the bathhouse that resulted in a fall. The IR documented Resident #5 was caught by Staff B and hit her right side of her back on the whirlpool tub. Resident #5 said the floor was slippery and that her feet (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	slid out from underneath her. The IR documented the nurse assessed Resident #5 and the assessment revealed Resident #5 had a red/bruised area to the right mid-upper back that could possibly turn into a hematoma. The IR documented the nurse provided education to Staff B that it was a requirement to always use a gait belt in the bathhouse for assistance. A note documented on the IR on 11/15/24 by the DON (Director of Nursing) documented Resident #5 was doing well after the fall and the bruise was healing without concern. The note documented the staff member was educated to ensure the bath and shower floors are dry prior to transferring residents and to have a gait belt on while transferring. A facility form titled Five Minute Meeting for Employees dated 11/21/24 documented even when a resident was in the bathhouse getting ready for a bath, staff need to utilize gait belts to help transfer residents safely and reduce the risk of falls in the bath/shower house. The form was signed by the DON and Staff B on 11/21/24. On 2/19/25 at 8:45 AM, the Administrator reported she would expect the staff to utilize a gait belt when assisting a resident with a transfer or ambulation. A facility policy titled Safe Lifting and Movement of Residents revised July 2017 documented in order to protect the safety and well-being of staff and residents, and to promote quality care, the facility would use appropriate techniques and devices to lift and move residents. The policy documented resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. The policy further directed the nursing staff, in conjunction with the rehabilitation staff, to assess individual residents' needs for transfer assistance on an ongoing basis and to document resident transferring and lifting needs in the care plan.

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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 2 residents reviewed for catheter care (Resident #9). The facility reported a census of 33 residents. Findings include: Resident #9's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS identified Resident #9 required substantial/maximal assistance with bed mobility, transfers and toileting. The MDS revealed Resident #9 had an indwelling catheter and was occasionally incontinent of urine. Resident #9's MDS included diagnoses of neurogenic bladder (urinary bladder problems due to disease or injury to the central nervous system), pneumonia, diabetes mellitus, and hemiplegia (paralysis) affecting the right side. The Care Plan with a target date of 3/31/25 revealed Resident #9 had a suprapubic catheter and was at risk for infections related to the catheter usage. The Care Plan directed staff to perform catheter care every shift, monitor for signs and symptoms of infection and to follow enhanced barrier precautions (EBP) when performing high contact care activities. A Physician Order dated 4/15/24 directed staff to follow EBP due to the suprapubic catheter. A Progress Note dated 2/17/25 at 1:51 PM title communication with the Physician documented Resident #9's urine was dark and malodorous. On 02/17/25 at 2:07 PM, observed EBP sign posted on Resident #9's door. The sign directed staff members to clean their hands, including before entering and when leaving the room. The sign directed providers and staff to wear gloves and gown for the following high contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy) and with wound care (any skin opening requiring a dressing). A Progress Note dated 2/17/25 at 10:54 PM documented the provider directed staff to obtain a urinalysis with culture and sensitivity reflex and to encourage oral hydration. On 2/18/25 at 12:55 PM, observed Staff C, CNA (certified nursing assistant) and Staff D, CNA complete Resident #9's catheter care and empty the catheter drainage bag. Staff C and Staff D washed their hands when entering Resident #9's room and applied gloves. Staff C and Staff D did not apply gowns. Staff C removed the gauze pad from Resident #9's suprapubic insertion site and threw the gauze pad in the garbage. Staff D handed Staff C a cleansing wipe from the wipe container that was sitting directly on the end of the bed without a barrier. Staff C cleansed the suprapubic insertion site with the cleansing wipe. Staff D handed Staff C another cleansing wipe from the container and he wiped Resident #9 lower abdominal folds. Staff C then reached for the peri spray bottle that was sitting directly on the end of the bed with no barrier with his dirty gloves. Staff C sprayed the peri wash on Resident #9 abdominal folds. Staff D handed Staff C a cleansing wipe and he cleansed the lower abdomen folds. Staff D then handed Staff C another cleansing wipe and he wiped down the catheter tubing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff C then took a clean towel and dried the abdominal area with the same pair of dirty gloves. Staff D sprinkled powder on Resident #9's abdominal folds and near the suprapubic insertion site. Staff C rubbed the powder on the abdominal folds and near the suprapubic site with the same pair of dirty gloves. Staff D then placed a new split gauze pad around the catheter at suprapubic insertion site. Staff C secured and fastened Resident #9's incontinence brief with the same pair of dirty gloves. After Resident #9's catheter care was completed, Staff C and Staff D removed gloves and used hand sanitizer. Staff C then emptied Resident #9's catheter bag and did not wear a gown during the process. Observed Resident #9's urine was dark tea colored and had a strong odor. Staff C and Staff D acknowledged they did not wear gowns during the catheter cares or when emptying the catheter drainage bag. Staff C and Staff D reported they had forgotten to put the gowns on. Staff C and Staff D reported they had been trained on EBP and were aware of the EBP sign on the door. Staff C reported he got caught up on getting all the supplies out and spaced off putting the gown on. On 2/18/25 at 2:35 PM, the DON (Director of Nursing) reported she would expect staff to use a barrier with supplies, wear a gown during catheter care/emptying bag, change gloves and complete hand hygiene between dirty and clean tasks. A facility policy titled Handwashing/Hand Hygiene revised 8/2019 documented the facility considered hand hygiene primary means to prevent the spread of infection. The policy documented the use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene was recognized as the best practice for preventing healthcare- associated infections. A facility policy titled Enhanced Barrier Precautions with an effective date of 3/28/24 documented it was the policy of the facility to implement EBP for the prevention of transmission of multidrug-resistant organisms. The policy documented EBP refers to an infection control intervention designed to reduce transmission of multi-resistant organisms that employ targeted gown and glove use during high contact resident care activities. The policy documented high-contact resident care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs/assisting with toileting, device care care/use (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes and wound care (any skin opening requiring a dressing). A facility policy titled Preventing Spread of Infections March 2013 Edition documented staff will follow procedures to prevent cross contamination, including hand washing and changing gloves.