STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165448	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Drumm Retirement Center	5837 Winwood Drive Johnston, IA 50131

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to notify the family/emergency contact when a resident had a significant change of condition for 1 of 3 residents reviewed (Resident #10). The facility reported a census of 114 residents.Findings include: Resident #10's Quarterly Minimum Data Set (MDS) dated [DATE] assessment identified a Staff Assessment for Mental Status indicating severely impaired cognition. The MDS identified Resident #10 was dependent on staff for eating . Resident #10's MDS included diagnoses of anemia, diabetes mellitus, traumatic brain injury, malnutrition and respiratory failure. The MDS documented Resident #10 had weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months and was not on a physician prescribed weight loss regimen. The MDS identified Resident #10 had a feeding tube and received 51% or more of the total calories through the feeding tube daily. A Progress Note dated 6/5/25 titled Dietary Note revealed Resident #10 had a weight loss of 8.8 pounds (5%) in one week. The note documented the dietician recommended switching tube feeding to prevent further weight loss. Review of the clinical record lacked documentation Resident #10's family/emergency contact was notified regarding the weight loss and recommendations from the dietician. A Progress Note dated 8/11/25 titled Dietary Note revealed Resident #10 triggered for weight loss. The note documented Resident #10 had a 11.9 pound weight loss (7.3%) in one month and 21.4 pound weight loss (12.4 %) in 3 months. A Progress Note dated 8/14/25 titled Dietary Note revealed the dietician recommended to increase the tube feeding rate to help prevent further weight loss. Review of the clinical record lacked documentation Resident #10's family/emergency contact was notified regarding the weight loss and recommendations from the dietician. On 9/16/25 at 9:00 AM, the Director of Nursing (DON) verified she could not locate family notification for the weight loss in the medical record. She said she would expect family notification to be documented in the clinical record. She said she had multiple conversations with the family and did not document the conversations. A facility policy titled Notification of Changes revised 3/5/25 documented the purpose of the policy was to ensure the facility promptly informs the resident, consults the resident's physician and notifies the resident's representative when there was a change requiring notification. The policy documented circumstances requiring notification include significant change in the resident's physical condition or a circumstance that required a need to alter treatment.

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **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 care and services according to accepted standards of clinical practice for 3 of 3 residents reviewed (Residents #10, #76, #15). The facility failed to obtain weekly weights per physician order for residents who have a feeding tube. The facility reported a census of 114 residents.Findings include: 1. Resident #10's Quarterly Minimum Data Set (MDS) dated [DATE] assessment identified a Staff Assessment for Mental Status indicating severely impaired cognition. The MDS identified Resident #10 was dependent on staff for eating . Resident #10's MDS included diagnoses of anemia, diabetes mellitus, traumatic brain injury, malnutrition and respiratory failure. The MDS documented Resident #10 had weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months and was not on a physician prescribed weight loss regimen. The MDS identified Resident #10 had a feeding tube and received 51% or more of the total calories through the feeding tube daily. The Care Plan initiated on 5/1/25 revealed Resident #10 was at a nutrition risk due to underweight status and the need for tube feeding via PEG (Percutaneous Endoscopic Gastrostomy) tube (thin, flexible tube inserted through the skin and into the stomach to provide nutrition and medication when a person cannot eat or drink adequately). The Care Plan directed staff to administer the tube feeding via PEG per physician order. A Physician Order dated 5/1/25 directed staff to obtain daily weight for three days and then weekly every Sunday for nutrition monitoring. Resident #10's Weight Summary revealed one weight documented the month of May on 5/29/25. Review of the May 2025 Treatment Administration Record (TAR) revealed no weights documented. A Progress Note dated 6/3/25 titled Dietary Note documented Resident #10 had not been getting weighed weekly as ordered. The note revealed Resident #10 had a large weight fluctuation with only two weights documented since admit. The note documented Resident #10 needed to have weekly weight obtained to identify weight trends. A Progress Note dated 6/5/25 titled Dietary Note revealed Resident #10 had a weight loss of 8.8 pounds (5%) in one week. The note documented the dietician recommended switching tube feeding to prevent further weight loss. On 9/15/25 at 11:45 AM, the Director of Nursing (DON) said she expected the staff to follow the physician order for Resident #10 to obtain weekly weights and to follow the facility weight protocol. 2. Resident #79's Quarterly Minimum Data Set (MDS) dated [DATE] assessment identified a Staff Assessment for Mental Status indicating severely impaired cognition. The MDS identified Resident #79 was dependent on staff for eating . Resident #79's MDS included diagnoses of anemia, diabetes mellitus, cerebrovascular accident (CVA) with hemiplegia affecting the right side and dysphagia (difficulty swallowing). The MDS identified Resident #79 had a feeding tube and received 51% or more of the total calories through the feeding tube daily. The Care Plan revised on 1/18/25 documented Resident #79 was at risk for dehydration due to being dependent on fluid intake related to dysphagia and requiring tube feeding. The Care Plan directed (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff to weigh Resident #79 and to note significant increases and decreases. A Physician Order dated 1/24/25 directed staff to obtain weekly weights every Sunday for nutrition monitoring. Review of Weight Summary and TARs for March to September 2025 revealed the weekly weights were not obtained for the following dates: 3/9, 3/16, 4/6, 5/11, 5/25, 6/8, 7/6, 7/27, 8/3, 8/17, 8/31 and 9/14. On 9/16/25 at 11:54 AM, the Dietician reported she expected residents with feeding tubes to have weights completed weekly to monitor their nutritional status. She said she had noticed obtaining weekly weights had been a problem. She reported she believed the Director of Nursing (DON) and Administrator were aware of the issue. She said some of the scales had been broken and needed to be repaired. She said a weight scale had been added to the shower room. She said there had also been concerns with staff obtaining accurate weights. On 9/16/25 at 10:45 AM, the Administrator in training/ Infection Preventionist said she expected staff to obtain weights according to physician orders. A facility policy titled Weight Monitoring revised 11/28/22 documented weights could be a useful indicator of nutritional status. Significant unintended changes in weight or insidious weight loss may indicate a nutritional problem. The policy directed staff to implement a weight monitoring schedule upon admission for all residents and weights should be recorded at the time they are obtained. 3. The Quarterly MDS for Resident #15, dated 7/24/25, included diagnoses of Muscular Dystrophy, respiratory failure, dysphagia (difficulty swallowing food or liquids), and malnutrition. The MDS identified the resident had a feeding tube (tube into the stomach to provide liquid nutrition) and was dependent on staff for eating, toilet hygiene. and transfers. The MDS indicated the resident had a suprapubic catheter (tube into the lower abdomen to drain urine from the bladder) and a tracheostomy (opening with tube into the windpipe to maintain an airway for breathing). The MDS indicated the resident had a BIMS score of 12, indicating mild cognitive impairment. Resident #15's Medication Administration Record (MAR) for 8/1/25 - 8/31/25 and 9/1/25 – 9/30/25 revealed the following physician orders: a. daily weights X 3 and then weekly for nutrition monitoring, on time a day every Sunday with start date of 5/4/25. b. weight monitoring every day shift every Friday with start date 6/13/25. Resident #15's MAR for 8/1/25 – 8/31/25 and 9/1/25 – 9/30/25 revealed only 1 weight on 8/31/25 of 124.4 pounds. Resident #15's Weights and Vitals record revealed weights documented on 7/4/25, 8/31/25, and 9/3/25 only.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, hospital clinical record review, hospital images, staff interviews and policy review the facility failed to identify a resident with a pressure ulcer/injury and to assure the resident received treatment and services, consistent with professional standards of practice, to promote healing of an unstageable pressure ulcer/injury for 1 of 3 residents reviewed (Resident #10). The facility reported a census of 114 residents.Finding include: The Minimum Data Set (MDS) assessment identifies the definition of pressure ulcers:Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is a partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, with slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III is full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue) which may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar.Unstageable Ulcer: inability to see the wound.Other staging considerations include:Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent skin. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The Clinical Census sheet for Resident#10 documented April 18, 2025 as the residents original admit date to the facility.Resident #10's Minimum Data Set (MDS) dated [DATE] assessment identified a Staff Assessment for Mental Status indicating severely impaired cognition. The MDS identified Resident #10 required substantial/maximal assistance with rolling left and right in bed and was dependent on staff with sitting up or lying in bed and with all transfers. Resident #10's MDS included diagnoses of anemia, diabetes mellitus, traumatic brain injury, malnutrition and respiratory failure. The MDS documented Resident #10 was at risk for developing pressure ulcers/injuries and had one or more unhealed pressure ulcer/injuries. The MDS documented Resident #10 had one unstageable pressure ulcer present. The MDS documented the following skin and ulcer/injury and treatments: pressure reducing device for chair/bed, nutrition/hydration to manage skin problems, pressure ulcer/injury care, application of nonsurgical dressing and application of ointments/medications.The Care Plan with a target date of 10/14/25 revealed Resident #10 was at risk for skin breakdown due to impaired mobility, impaired cognition, incontinence and taking high risk medications. In addition the care plan identified Resident #10 had a break in skin integrity but did not address an unstageable pressure ulcer/injury to the left heel. The care plan directed the following interventions:- Staff to educate resident and/or family regarding skin problem and treatment-Staff to provide treatment as ordered.-Staff to complete weekly skin checks.-Pressure reducing mattress.-Staff to clean and dry Resident #10's skin after each incontinent episode. The Care Plan lacked any interventions related to repositioning, turning or keeping Resident #10's heels floated or elevated off of a surface to reduce the risk for pressure ulcers and promote healing. The Braden Scale for Predicting Pressure Sore Risk documented the following scores:6/3/25- 8- Very High Risk7/2/25- 8- Very High [NAME] Progress Note dated 6/27/25 at 5:28 PM (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	revealed Resident #10 was not at his baseline and the on call Physician gave an order to transfer Resident #10 to the ER (emergency room) for an evaluation. A Progress Note dated 6/28/25 revealed Resident #10 was admitted to the critical care unit for sepsis (life threatening complication of an infection).Resident #10's discharge assessment, return anticipated MDS dated [DATE] documented Resident #10 did not have any unhealed pressure ulcer/injuries.A Hospital Image dated 6/27/25 at 10:36 PM revealed a wound to the left heel approximately the size of a two 50 cent pieces (half dollars). The wound bed was 100% black eschar (dead tissue) with wound edges dry and peeling. The heel was pink and boggy in appearance. The bottom of the left foot was dry and cracked. A Progress Note dated 7/2/25 documented Resident #10 returned to the facility. The note revealed Resident #10 returned to the facility with a dry eschar to the left heel. The progress note lacked documentation regarding wound measurements, staging, wound characteristics of the wound bed and peri wound. The assessment lacked any documentation regarding a wound treatment or intervention to assist with wound healing and reduce pressure to the left heel. A Progress Note titled N Adv Skin Check dated 7/2/25 lacked documentation regarding the pressure ulcer/injury to the left heel. A Progress Note titled N ADV Clinical admission dated 7/2/25 lacked documentation regarding the pressure ulcer/injury to the left heel.A Progress Note dated 7/9/25 revealed Resident #10 was admitted to the hospital. Resident #10's discharge assessment, return anticipated MDS dated [DATE] documented Resident #10 did not have any unhealed pressure ulcer/injuries.A Hospital Image scanned on 7/11/25 at 12:33 PM revealed a wound to the left heel that was approximately the size of a 50 cent piece. The wound bed was 100% black eschar with wound edges dry. The heel was red and boggy in appearance. The bottom of the left foot was dry and cracked. A Progress Note dated 7/16/25 documented Resident #10 returned to the facility from the hospital. A Progress Note title N Adv-Skin Check dated 7/16/25 lacked a skin assessment for the left heel. A Progress Note titled N ADV Clinical admission dated 7/16/25 lacked a skin assessment for the left heel. A Progress Note dated 7/18/25 revealed Resident #10 was sent to the emergency room (ER) and hospitalized . Resident #10's discharge assessment, return anticipated MDS dated [DATE] documented Resident #10 did not have any unhealed pressure ulcer/injuries.A Hospital Image scanned on 7/22/25 at 12:33 9:01 AM revealed a wound to the left heel approximately the size of a 50 cent piece. The wound bed was 100% black eschar with wound edges dry and peeling. The heel was pink and boggy in appearance. A Progress Noted titled N ADV Clinical admission dated 7/28/25 documented Resident #10 returned to the facility and had an unstageable pressure ulcer/injury to the left heel that measured 2 cm (centimeters)(length) x 3 cm (width). The assessment lacked any documentation regarding a wound treatment or intervention to assist with wound healing and reduce pressure to the left heel. The July 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) lacked documentation of a wound treatment or new skin intervention for the left heel pressure wound/injury until 7/31/25. The July 2025 TAR directed the following treatments with a start date of 7/31/25:1. Cleanse left heel with normal saline and apply betadine and cover with bordered gauze every evening shift.2. Apply heel protector boots every shift for protection.Review of Progress Notes titled N Adv-Skin Check for the following dates 7/30/25, 8/10/25, 8/19/25, 8/30/25 revealed the skin assessments for the unstageable pressure ulcer/injury to the left heel were incomplete and lacked documentation regarding wound measurements, wound characteristics of the wound bed and the peri wound. The assessments lacked documentation on the treatment/condition of the pressure ulcer/injury and whether the wound was improving or not. A Progress Note dated 8/14/25 revealed Resident #10 was sent to the ER and hospitalized . A Hospital WOC (Wound, Ostomy, Continence) Nurse Consult dated 8/18/25 documented an unstageable pressure ulcer/injury to the left heel that measured 3 cm (length) x 4 cm (width) with dry, necrotic (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	eschar/sloughing with calloused margins. A Hospital Discharge summary dated [DATE] documented a stage 3 pressure ulcer/injury of the left heel and the following wound care orders:1. Left heel: Cleanse with normal saline and gauze. Cover wound bed with betadine moistened gauze then cover with ABD (abdominal) pad. Secure loosely with kerlix and ace wrap. Perform wound care daily and as needed for saturation dressing. 2. Turn every 2 hours with TAPs system (turn and position system) and wedges3. Float both heels on pillows daily. Review of the July, August and September 20205 MAR and TAR lack any documentation regarding repositioning or turning. A Skin and Wound Evaluation dated 9/2/25 documented the left heel unstageable pressure ulcer measured 2.5 cm (length) x 2.3 cm (width) with 100% eschar and light serous drainage (clear, watery fluid). The assessment documented the heel was boggy and with unstable eschar. The note section of the assessment documented treatment order received to add opticell (gelling fiber wound dressing) to promote autolytic debridement (body's own enzymes to remove dead tissue) of the unstable eschar. On 9/11/25 at 9:05 AM, the Director of Nursing (DON) acknowledged Resident #10 had a pressure ulcer/injury to the left heel that was documented by the facility nurse on 7/2/25. The DON verified the left heel ulcer/eschar was omitted from the admission skin assessment on 7/16/25. The DON reported the facility did not receive any orders from the hospital related to the left heel wound on readmission on 7/2, 7/16 and 7/28.On 9/15/25 at 11:45 AM, the DON reported she did not have any further information regarding Resident #10 wound assessments. She said what was in the medical record was what the facility had. The DON said she expected wound measurements and characteristics to be included in the medical record documentation. She said the nurses are to measure the wounds with approximate measurements. She said the wound nurse would complete the official measurements when consulted. She said the wound nurse used an IPAD to assist with obtaining wound measurements and surface volume of the wound. She said once the wound nurse was consulted, the wound nurse would complete measurements weekly. She said Resident #10 was frequently in and out of the hospital and each time the wound nurse planned to see him he was in the hospital. She said Resident #10 was a very wiggly man and would move around in bed. When asked about turning and repositioning, the DON said the care plan addressed bed mobility and everything else related to repositioning/turning was a standard of practice. She said when Resident #10 first came to the facility in April he was dependent on staff for bed mobility but since then he had woken up some and has been having more movement. She said due to his frequent movement and medical diagnoses causing shearing and friction it was difficult to obtain proper pressure relief. On 9/16/25 at 9:00 AM, the DON reported Resident #10 had a cracked left heel on admission in April. She reported she was not aware of any pressure ulcers to Resident #10's left heel prior to hospitalization on 6/27/25. When asked if she would expect treatments and interventions to be in place for the left heel, the DON said she knew Resident #10 had heel lift boots for a while but was not sure when the boots were put in place. She reported the facility skin protocol did not address treatment for eschar. She said the nursing staff could implement treatments according to the skin protocol otherwise they would have to obtain an order from the Physician. On 9/16/25 at 11:23 PM, the Nurse Practitioner (NP) reported she was not sure that she had evaluated Resident #10 left heel pressure ulcer/injury and could not comment if the area was avoidable or unavoidable. The NP said she did not see the wound during rounds on 9/4/25. She reported Resident #10 had started moving around more and therapy was working on getting him up. A facility policy titled Turning and Repositioning dated 9/11/25 directed staff to implement turning and repositioning as part of a systemic approach to pressure injury prevention and management. The policy explanation and compliance guidelines documented all residents at risk of, or with existing pressure ulcer will be turned and repositioned unless contraindicated due to medical condition. The frequency of (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	turning and repositioning to be documented in the resident's care plan and be determined by the resident's tissue tolerance, level of activity/mobility, skin condition, overall medical condition, treatment goals, type of pressure redistribution support surface, comfort level and resident preferences. The policy further directed staff to ensure that heels are floated off the surface of the bed with pillows or devices designed to do so. If using a heel protector, the heel must still be floated. A facility policy titled Pressure Injury Prevention and Management revised 9/11/25 documented the facility was committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. The policy further documented the facility would establish and utilize a systemic approach for pressure injury prevention and management, including prompt assessment and treatment, intervening to stabilize, reduce, or remove the underlying risk factors; monitoring the impact of interventions, and modifying the interventions as appropriate. In addition the policy documented licensed nurses would conduct a full body skin assessment on all residents upon admission/readmission, weekly, and after any new identified pressure injury. The finding of the skin assessment would be documented in the medical record. After completing a thorough assessment/evaluation, the interdisciplinary team should develop a care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions.

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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. Based on observation, clinical record review, staff interview, and policy review the facility failed to provide appropriate suprapubic catheter (tube into the lower abdomen to drain urine from the bladder) care for 1 of 3 residents (Resident #15) reviewed. The facility reported a census of 114 residents.Findings include:The Quarterly Minimum Data Set (MDS) for Resident #15, dated 7/24/25, included diagnoses of Muscular Dystrophy, respiratory failure, dysphagia (difficulty swallowing food or liquids), and malnutrition. The MDS identified the resident was dependent on staff for eating, toilet hygiene. and transfers. The MDS indicated the resident had a suprapubic catheter and a tracheostomy (opening with tube into the windpipe to maintain an airway for breathing). The MDS indicated the resident had a BIMS score of 12, indicating mild cognitive impairment. Observation on 9/15/25 at 2 PM, Staff A, Registered Nurse with the same pair of gloves on completed the 2 wound treatments, removing the old dressings, cleansing the wounds, and applying new dressings on Resident #15. Staff A then proceeded to remove the old suprapubic catheter dressing on Resident #15, applied wound cleanser to a gauze pad and wiped around the suprapubic catheter insertion site 4 times continuing to wipe in the same areas with the same area of the gauze pad. Staff A continued with the same gloves on, and proceeded to apply a new dressing around the suprapubic catheter. Resident #15's electronic health record progress notes revealed the following:a. Nurse's Note 8/16/25 at 6:09 AM- Nurse was summoned to the resident's bedside for complaints of blood in the urine, blood observed in the tubing of the indwelling suprapubic catheter and large sediment in the catheter tubing. Resident transferred to the hospital emergency room (ER). b. Encounter Note, 8/21/25 - resident seen for an acute visit, recent ER visit for hematuria (blood in urine) in foley catheter bag. Resident returned to the facility. Received urinalysis culture and sensitivity (C&S) (test for bacteria and antibiotic that bacteria is sensitive to) report indicating a urinary tract infection. Order left in facility for antibiotic medication. Resident #15's lab report from the hospital revealed a urinalysis completed on 8/16/25 and C&S resulted on 8/19/25 with Enterococcus species(bacteria) count over 100,000. The facility Suprapubic Catheterization policy approved 9/17/25 revealed wash and dry hands, apply gloves, and clean the stoma (insertion site in abdomen of suprapubic catheter), cleansing outward from for the stoma in a circular motion using only 1 cotton ball or applicator for each stroke. Interview on 9/16/25 at 9 AM, the Infection Control Preventionist stated expectation when changing the dressing and cleaning the suprapubic catheter site to remove the old dressing, complete hand hygiene, apply new gloves and cleanse around the catheter working from the insertion site outward with the gauze pad or cotton ball, not wiping over the same area again.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, clinical record review, staff interview, and policy review the facility failed to flush an enteral gastrostomy tube (g-tube) (tube surgically inserted into the stomach to provide nutrition and medication) per facility policy prior to and after administering medication thru the g-tube for 1 of 3 resident (Resident #15) reviewed. The facility reported a census of 114 residents. Findings include:The Quarterly Minimum Data Set (MDS) for Resident #15, dated 7/24/25, included diagnoses of Muscular Dystrophy, respiratory failure, dysphagia (difficulty swallowing food or liquids), and malnutrition. The MDS identified the resident had a g-tube and was dependent on staff for eating, toilet hygiene. and transfers. The MDS indicated the resident had a suprapubic catheter (tube into the lower abdomen to drain urine from the bladder) and a tracheostomy (opening with tube into the windpipe to maintain an airway for breathing). The MDS indicated the resident had a BIMS score of 12, indicating mild cognitive impairment.Observation on 9/15/25 at 2:30 PM, Staff A, Registered Nurse was sitting on the side of Resident #15's bed and applying tape to the g-tube adaptor port (end of g-tube that attaches to the tubing from the container that provides the feeding product). Staff A had a syringe with approximately 25 milliliters (ml) of pink liquid. Staff A proceeded to attach the syringe to the g-tube and administered the liquid into the resident's g-tube, without flushing the g-tube before or after administering the liquid in the syringe. Staff A stated the pink liquid was 3 of the resident's medication and an unknown amount of water, as there was no set amount for the water flush so it didn't really matter.The facility's Medication Administration via Enteral Tube policy revised 9/16/25, revealed flush enteral tube with at least 15 ml. of water prior to administering medications, dilute the solid or liquid medication as appropriate and administer, and flush tube again with at least 15 ml. water.Interview on 9/16/25 at 9 AM, the Director of Nursing stated her expectation to follow the physician's order for flushing a g-tube before and after medication administration, and if no order to follow the protocol which is 30 or 60 ml. of water to flush before and after medications given.

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	165448	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Drumm Retirement Center	5837 Winwood Drive Johnston, IA 50131

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on resident council minutes review, resident and staff interviews, record review, and policy review the facility failed to answer call lights in a timely manner (15 minutes or less) for 3 of 3 residents (Residents #26, #39, and #79) reviewed and failed to ensure the call light was within reach for 2 of 5 residents (Residents #1 and #15) reviewed. The facility reported a census of 114 residents. Findings include:1.Review of Resident Council Minutes for August 2025 documented the residents in attendance expressed continued concerns regarding the length of time it takes staff to respond to call lights. Interview on 9/8/25 at 2 PM, Resident #79, with a Brief Interview for Mental Status (BIMS) score of 15 (indicating cognitively intact) stated the call light response time had not gotten any better, that it still takes quite a while. During the same interview, Resident #26 with a BIMS score of 14 (indicating cognitively intact) agreed that the call light response time had not gotten any better. Interview on 9/8/25 at 2:15 PM, Resident #39, with a BIMS score of 15, stated the call light response time had gotten better on day and evening shifts but the night shift still needs to get better as they can take up to 40 minutes as she times it. Interview on 9/16/25 at 9 AM, the Director of Nursing stated the standard and expectation for answering call lights is less than 15 minutes. 2. The Quarterly Minimum Data Set (MDS) for Resident #1, dated 7/14/25, included diagnoses of Non-Alzheimer's Dementia and hemiplegia (paralysis of 1 side of the body). The MDS identified the resident was dependent on staff for toilet hygiene and transfers and was always incontinent of bowel and bladder. The MDS indicated the resident had a BIMS score of 13, indicating mild cognitive impairment.Resident #1's Care Plan Report with goal target date of 10/12/25, identified a focus of resident at risk for injury related to falls due to gait/balance problems and history of falls with an intervention to be sure my call light is within reach when I am in my room and encourage me to use it before attempting to transfer. Observation on 9/11/25 at 2:40 PM, Resident #1 was in her room sitting in a high-backed wheel chair with smaller wheels that are unable to be reached to propel by the resident. Resident's call light was attached to the bed cover below the pillow approximately 5 feet from the resident. Resident #1 stated she was unable to reach the call light. 3.The Quarterly MDS for Resident #15, dated 7/24/25, included diagnoses of Muscular Dystrophy, respiratory failure, dysphagia (difficulty swallowing food or liquids), and malnutrition. The MDS identified the resident had a feeding tube (tube into the stomach to provide liquid nutrition) and was dependent on staff for eating, toilet hygiene. and transfers. The MDS indicated the resident had a suprapubic catheter (tube into the lower abdomen to drain urine from the bladder) and a tracheostomy (opening with tube into the windpipe to maintain an airway for breathing). The MDS indicated the resident had a BIMS score of 12, indicating mild cognitive impairment.Resident #15's Care Plan Report with goal target date of 10/22/25, identified the following focus areas with interventions:a. resident at risk for falls and injury related to deconditioning and gait/balance problems with an intervention to be sure my call light is within reach when I am in my room and encourage me to use it before attempting to transfer. b. I have a tracheostomy related to respiratory failure with intervention to suction as necessary. Observations of Resident #15 in bed on 9/15/25 from 11:40 AM - 2 PM with call light not within reach for 2 hours and 20 minutes:c. 11:40 AM - resident in bed, call light on floor not within reach of the resident.d. 11:50 AM - staff member took lunch tray into room and placed on tray table, call light remained on the floor.e. 11:56 AM - Director of Nursing (DON) entered room and spoke to resident, call light remained on the floor.f. 11:58 AM - Staff nurse in room with resident, call light remained on the floor.g. 12:30 PM - Staff member removed meal tray from resident's room, call light remained on the floor.h. 1:59 PM - Infection Control Preventionist (ICP) in resident's (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room, providing oral care to resident. Call light remained on the floor.i. 2 PM - 3 staff entered the resident's room and provided cares. Call light picked up off floor and placed within reach of resident after cares completed. Facility policy Call Lights: Accessibility and Timely Response, last approved 8/5/25, revealed the purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside to allow residents to call for assistance and staff will ensure the call light is within reach of resident and secured, as needed. Interview on 9/16/25 at 9 AM, the DON stated expectation for call lights to be within reach of the residents.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on review of the facility's Quality Assurance Performance Improvement (QAPI) plan, the facilities past surveys, and staff interview, the facility failed to correct their own deficiencies and have an effective quality assurance program in place to assist in the provision of quality of care for residents and attain substantial complaining with Federal regulation and State rule. The facility reported a census of 114 residents. Findings include: Review of the Department of Inspections Appeals and Licensing (DIAL) website under the facility's visit history revealed the facility had the following concerns identified at the current revisit and complaint survey, that were also cited at past surveys in the last two and half years. a. F686- Pressure Sores b. F658- Services to Meet Professional Standardsc. F725- Sufficient Nursing Staffingd. F880- Infection ControlThe following surveys revealed repeated deficiencies from 6/29/23 to current survey:7/21/25- Recertification, Complaint, Incident Survey: F725, F8804/3/25- Complaint, Incident: F7259/19/24- Recertification, complaint, Incident: F8808/18/24- Complaint revisit: F6866/27/24- Complaint: F686, F7255/3/24- Complaint: F6582/27/24- Complaint, Incident: F658, F686, F88010/9/23- Complaint, Incident, Recertification revisit, Complaint Revisit, Incident Revisit: F725, F8806/29/23- Recertification, Complaint, Incident: F725, F880A Quality Assurance and Performance Improvement Plan (QAPI) dated 2/26/25 documented the facility used a systematic approach to determine when in-depth analysis was needed to fully understand identified problems, causes of the problems, and implications of a change. The policy further documented that to prevent future events and promote sustained improvement the facility would develop actions to address the identified root cause and/or contributing factors of an issue/event that would affect change at the systems level. To ensure the planned changes/interventions are implemented and effective in making and sustaining improvements, the facility would choose indicators/measures that tie directly to the new action and conduct ongoing periodic measurement and review to ensure that the new action has been adopted and was performed consistently.In an interview on 9/17/25 at 1:45 PM, the surveyor asked the Administrator what the facility had done to improve and address the repeat deficiencies from the current survey and prior surveys. The Administrator acknowledged the repeated deficiencies and stated that the facility had put in place quite a few things to improve and address the deficiencies. He said the facility had implemented new wound assessments/tracking and had hired a wound nurse. The Administrator reported he thought the facility had a good process in place for pressure wounds until the current survey identified concerns. He said the facility was tracking infection control in a different way so trends could be identified easier. He said the facility was conducting routine audits and reviewing resident infections. The Administrator reported the facility was working with an outside quality of care coalition on a monthly basis to share information, resources and review quality of care outcomes. He said the facility had been tracking call lights and had made some changes on how the staff were scheduled and supported. He said he felt call lights had improved. The Administrator reported the concerns identified through the survey process would be reviewed and discussed through QAPI.

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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 observations, clinical record review, staff interviews, and policy review the facility failed to maintain infection control practices for 1 of 5 residents reviewed (Resident #15). The facility failed to ensure use of enhanced barrier precautions (EBP)when required and failed to complete hand hygiene and change gloves when completing treatments. The facility reported a census of 114 residents. Findings include:1.The Quarterly Minimum Data Set (MDS) for Resident #15, dated 7/24/25, included diagnoses of Muscular Dystrophy, respiratory failure, dysphagia (difficulty swallowing food or liquids), and malnutrition. The MDS identified the resident was dependent on staff for eating, toilet hygiene. and transfers. The MDS indicated the resident had a gastrointestinal feeding tube (g-tube) (tube into the stomach to provide liquid nutrition) a suprapubic catheter (tube into the lower abdomen to drain urine from the bladder) and a tracheostomy (opening with tube into the windpipe to maintain an airway for breathing). The MDS indicated the resident had a BIMS score of 12, indicating mild cognitive impairment. Resident #15's Care Plan with revision date 11/13/24 documented the resident required Enhance Barrier Precautions (EBP) with close contact due to presence of catheter. 2.Observation on 9/15/at 1:59 PM, the Infection Control Preventionist (ICP)was in Resident #15's room providing oral care with only gloves on, no gown on. 3.Observation on 9/15/25 at 2 PM, Staff A, Registered Nurse (RN) applied a gown and gloves and entered Resident #15's room. Staff A removed an old dressing off the resident's left buttock, cleansed an open wound with wound cleanser and a gauze pad, and applied a new dressing with an ordered treatment paste. Staff A continued with the same gloves on and remove an old dressing from the resident's right buttock, cleansed the wound area and applied a new dressing. Staff A then proceeded with the same gloves on and removed the old suprapubic catheter dressing on the resident, cleansed the catheter insertion site, and applied a clean dressing to the site. Staff A, still with the same gloves on, removed the old dressing from the g-tube site, cleansed the site area with wound cleanser and gauze, and applied a new dressing. Staff A continued with the same gloves on and removed the tracheostomy dressing, cleansed around the tracheostomy, and applied a clean dressing. 4.Observation on 9/15/25 at 2:30 PM, Staff A, was sitting on the side of Resident #15's bed administering to the resident per g-tube, without a gown or gloves on. Facility Enhanced Barrier Precautions policy, revised 9/16/25, revealed EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities with high-contact resident care activities include device care of feeding tubes, tracheostomy tubes, urinary catheters, and wound care. Facility Hand Hygiene policy, revised 9/16/25, revealed hand hygiene is indicated and will be performed under the conditions listed: after handling contaminated objects and before and after handling clean or soiled dressings. Interview on 9/16/25 at 9 AM, the ICP acknowledged she observed Staff A not complete hand hygiene or change gloves when completing dressing changes for Resident #15 and stated expectation to complete hand hygiene and change gloves when going from dirty to clean when completing dressing changes. The ICP additionally stated her expectation for staff to wear gown and gloves with high contact care such as administering medications per a g-tube.