STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165481	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayflower Home	616 Broad Street Grinnell, IA 50112

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 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. Based on observation, clinical record review, policy review, and staff interview, the facility failed to follow physician's orders for 1 of 3 residents reviewed for pressure ulcers (Resident #32). The facility reported a census of 31 residents. Findings include: The Minimum Data Set assessment tool, dated 5/16/25, listed diagnoses for Resident #32 which included heart failure, diabetes, and obesity. The MDS listed the Brief Interview for Mental Status(BIMS) score as 14 out of 15, which indicated intact cognition. The MDS documented the resident had 1 unhealed pressure ulcer. A 5/27/25 Health Status Note stated the facility received a signed order from the primary care physician (PCP) which directed to apply betadine (an iodine solution used to treat wounds) to the left heel and cover with Optifoam (a type of foam dressing). During an observation on 5/28/25 at 9:06 a.m., Staff A Registered Nurse (RN) applied betadine to a dry, flaky scab-like area on the resident's left heel. Staff A stated that the provider told her last week that they did not want Optifoam applied and staff should keep the area open to air. Staff A did not apply Optifoam to the resident's heel. The May Treatment Administration Record (TAR) listed a 5/28/25 order for betadine to the left heel with Optifoam to cover, every other day until healed. The entry for 5/28/25 contained Staff A's initials and a check to indicate the completion of the treatment. During an interview on 5/29/25 at 10:08 a.m., Staff A stated she looked at orders prior to carrying out a treatment. She stated the Hospice provider did not want the Optifoam but the primary provider did. She stated the clinic failed to dispose of the order. During an interview on 5/29/25 at 10:41 a.m. the Director of Nursing stated nurses should look at the order prior to carrying out a treatment. Review of the facility policy Notification to Physician, Physician Assistant, Nurse Practitioner, revised May 2025, revealed the direction that staff would note and document physician treatments.

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 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. Based on clinical record review, facility policy review, and staff interviews, the facility failed to assess, intervene, and notify the physician as directed to ensure bowel regularity for 3 of 4 residents (Residents #2, #18, and #21) reviewed. The facility reported a census of 31 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment tool, dated 3/21/25, for Resident #2 revealed a list of diagnoses which included a seizure disorder, depression, and severe obesity. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 14 out of 15, which indicated intact cognition. Review of the Bowel Elimination Report revealed a lack of documentation to indicate if Resident #2 had a bowel movement from 5/20/25 to 5/28/25. The report indicated Resident #2 had a bowel movement on 5/19/25 at 1:41 p.m. Review of the electronic health record revealed an Alert Note, dated 5/23/25 on 4:39 AM, which indicated the resident On list for intervention for No BM (bowel movement) in 3 days. Review of the May 2025 Medication Administration Record (MAR) revealed the following scheduled and PRN (as needed) medication orders: a. MiraLax (a laxative) Oral Packet 17 GM (grams)/SCOOP .Give 8.5 gms by mouth one time per day every other day for constipation. Mix with 4-8 ounces of fluid. Start Date: 2/8/24. Per the MAR the resident refused this on 5/13/25, 5/23/25 and 5/27/25. b. Dulcolax (a laxative) suppository 10 milligrams (mg). Insert 1 suppository rectally every 24 hours as needed for constipation. IF NOT RESOLVED WITHIN 48 HOURS CONTACT PHYSICIAN. Start Date: 11/29/24. The MAR lacked documentation the resident offered/refused or received the medication from 5/1/25 to 5/28/25. c. Milk of Magnesia (a laxative) Oral Suspension .Give 30 milliliters (ml) every 24 hours as needed for constipation. IF NOT RESOLVED WITHIN 48 HOURS CONTACT PHYSICIAN. Start Date: 11/29/24. The MAR documented the resident received the medication one time on 5/28/25 at 2:30 p.m. and it was unsuccessful. The MAR lacked documentation the resident offered/refused or received the medication at any other time in the month. d. MiraLax Oral Packet 17 GM (grams)/SCOOP .Give 17 gram by mouth every 24 hours as needed for promoting bowel movement. Mix with 4-6 ounces of fluid. IF NOT RESOLVED WITHIN 48 HOURS CONTACT PHYSICIAN. Start Date: 11/29/24. The lacked documentation the resident offered/refused or received the medication from 5/1/25 to 5/28/25. Review of the Progress Notes in the electronic health record from 5/20/25 until 5/28/25 at 2:30 p.m. revealed a lack of documentation regarding the status of Resident #2's bowel movements. The review also revealed a lack of physician notification of the lack of bowel movements during this period. During an interview on 5/29/25 at 10:08 a.m., Staff A Registered Nurse (RN) stated yesterday Resident #2 was on the list as having had no recent bowel movement so she administered Milk of Magnesia (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	yesterday afternoon [5/28/25 at 2:30 PM] before she left. This morning [5/29/25] she found out that the resident had a bowel movement on 5/25/25 as this was noted on the calendar in her room. She stated she had the list yesterday morning. 2. Review of the MDS assessment tool, dated 3/7/25, for Resident #21 revealed a list of diagnoses which included heart failure, non-Alzheimer's dementia, and depression. The MDS stated the resident had problems with memory. Review the Care Plan, dated 4/23/24, revealed a Focus area to address The resident has constipation with contributing diuretic (medication used to rid the body of fluid) use for edema (swelling). He has impaired cognition and does prefer to perform toileting tasks himself. Interventions included, in part: a. Administer routine bowel medications, monitor effectiveness and report ineffectiveness. Date Initiated: 4/23/24 b. Follow facility bowel protocol for bowel management. Date Initiated: 4/23/24 Review of the Bowel Elimination Report revealed Resident #21 had a bowel movement on 5/23/25. The report listed no subsequent bowel movements as of 5/29/25 at 1:18 p.m. Review of the May 2025 MAR revealed the following scheduled and PRN medication orders: a. MiraLax Oral Power 17 GM/SCOOP .Give 1 scoop by mouth in the afternoon for constipation. Start Date: 4/30/25. Per the May 2025 MAR the medication administered daily from 5/1/25 to 5/29/25. b. Dulcolax suppository 10 mg. Insert 1 suppository rectally ever 24 hours as needed for constipation IF NOT RESOLVED WITHIN 48 HOURS CONTACT PHYSICIAN. Start Date: 12/4/24. Review of MAR's from 3/23/25 to 5/28/25 lacked documentation the resident offered/refused or received the medication. c. Milk of Magnesia, give 30 ml by mouth every 24 hours as needed for constipation. IF NOT RESOLVED WITHIN 48 HOURS CONTACT PHYSICIAN. The lacked documentation the resident offered/refused or received the medication from 5/1/25 until administered on 5/28/25 at 2:32 p.m. Review of the Progress Notes in the electronic health record from 5/23/25 to 5/28/25 at 2:32 p.m., revealed a lack of documentation regarding the status of Resident #21's bowel movements. The review also revealed a lack of physician notification of the lack of bowel movements during during this period. During an interview on 5/28/25 at 2:27 p.m., Staff D, RN stated nurses looked for BM documentation in the computer. She stated they had a paper list and stated there was only one resident on it currently and Resident #2 and Resident #21 were not on the list. Upon request, Staff D looked at Resident #21's electronic health record BM record and stated he had not had a bowel movement since 5/23/25. During an interview on 5/29/25 at 8:21 a.m., Staff C, Certified Nursing Assistant (CNA), stated the nurse informed staff if the resident is on on the BM list. She stated there was no one on the list currently. During an interview on 5/29/25 at 11:24 a.m., Staff E, Assistant Director of Nursing (ADON) stated (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the list generated from the computer was not congruent with the actual dates. She stated until they resolved the issue, the facility would complete paper lists. She stated when she worked on 5/16/25, the BM report sheets were not correct. She stated she directed staff not to rely on that report but stated if the resident's were not on the printed list, staff did not dig deeper to investigate. During an interview on 5/29/25 at 10:41 a.m., the Director of Nursing (DON) stated the facility had routine orders to follow if resident's had not had a BM. She stated she expected staff to notify the physician if they did not have a BM after 5 days. 3. Review of the MDS Assessment, dated 3/14/25, revealed a list of diagnoses for Resident #18 which included seizure disorder, anxiety disorder, and a mild cognitive impairment. The BIMS score of 11 out of 15 indicated a moderate cognitive impairment. Review of the Care Plan, Revision on: 7/15/24 revealed a Focus area to address [Name redacted] at risk for symptoms of constipation r/t (related to) decreased decreased mobility, need for assistance with toileting and transfers, hx (hx) of constipation. and a history of constipation. 7/12/24 Non compliant with interventions to promote normal bowel pattern and prevent complications related to constipation. Interventions included, in part: a. Follow facility bowel protocol for bowel management. UPDATED 7/12/24: [Name redacted] refusing to accept protocol for promoting normal bowel pattern. Report refusals if indicated and continues. b. Monitor the medications for side effects of constipation. Keep physician informed of any problems. Date Initiated: 4/27/23. Review of the Bowel Elimination Report revealed no documented bowel movement from 4/20/25 to 5/02/25 at 9:59 p.m.; from 5/3/25 to 5/19/25 at 1:01 p.m.; and from 5/20/25 to 5/26/25 at 9:54 p.m. Review of the electronic health record revealed the following a. Alert Note dated 4/25/25 at 6:32 a.m., On BM list for intervention No BM in 3 days b. No Type Specified dated 4/26/25 at 1:57 a.m., Resident refuses intervention for BM protocol. No documentation that physician notified of refusal. c. Alert Note dated 5/09/25 at 1:36 a.m., On BM list for intervention No BM in 3 days. d. Alert Note dated 5/16/25 at 1:00 a.m., LBM (last BM) updated to 5/12/25 -counseled res (resident, Resident #18) about regular bowel movements and available interventions. Res reports I am fine and I will poop when I'm ready. No documentation that physician notified of refusal. e. Health Status Note dated 5/18/25 at 2:14 p.m., Res refused any intervention for bowels at this time. No documentation the physician notified of refusal. f. Health Status Note dated 5/19/25 at 1:22 p.m., CNA was taking resident to bathroom and called this nurse to bathroom. Bright red blood noted small amount mixed in with B.M. Fax prepared to [physician name redacted]. Will continue to monitor. Follow up note entered at 10:00 p.m., documented Received response from PCF (primary care physician), no new orders received, no action needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. Health Status Note dated 5/25/25 at 9:31 p.m., Resident given prune juice to promote bowel movement. No BM noted during shift. No documentation that physician notifed of lack of bowel movement. During an interview on 5/29/25 at 9:23 a.m., Staff B, RN stated would often refuse bowel interventions and sometimes would go 5 days without bowel movement. Staff B stated that if more then 5 days with no bowel movement for Resident #18, the physician should be notified. Staff B revealed that nursing staff working overnights would run a bowel report in the facility's Electronic Health Records to determine which residents required bowel intervention or follow up. Staff B believed the bowel report may have recently had a system glitch. At 9:25 a.m., Staff B ran a bowel report which revealed no residents currently required intervention for facility bowel protocol. During an interview on 5/29/25 at 10:42 a.m., the DON stated Resident #18 would sometimes go 7 days with no bowel movement. The DON stated nursing staff should notify the physician by day 5 of no bowel movement, or determine accuracy of bowel movement documentation. Review of the facility policy, titled Notification to Physician, Physician Assistant, Nurse Practitioner revised May 2025, revealed the direction that staff would notify the provider of a resident change in condition in a timely manner. Review of the undated facility policy Bowel Management Program, revealed a Purpose section, which declared, in part: To ensure that the resident has adequate bowel movements to prevent problems. The policy directed staff to a. Administer Milk of Magnesia if no BM or only a small BM in 2 days. b. Administer a Dulcolax suppository if no BM by the end of the following shift. c. Administer a Fleets enema (a procedure where liquid was inserted into the rectum through the anus to empty the bowels) on that shift.