STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165486	A. Building B. Wing	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruthven Community Care Center	2701 Mitchell Street Box 0 Ruthven, IA 51358

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 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 review, staff interviews and policy review, the facility failed to provide adequate nursing supervision to prevent accidents for 1 of 3 residents reviewed (Resident #5) for falls. Findings include: Resident #5's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 05, indicating severe cognitive impairment. The MDS identified Resident #5 required substantial/maximal assistance with bed mobility, transfers and ambulation. Resident #5's MDS included diagnoses of schizophrenia, depression, anxiety, unsteadiness on feet, and history of falling. The Care Plan dated 2/12/15 documented Resident #5 required assistance with activities of daily living and was at risk for falls. The Care Plan directed the following interventions with dates:-Staff to transfer Resident #5 with assistance of 2 staff members- 7/19/25-Staff to ambulate Resident #5 in hallway, distance as tolerated with front wheeled walker, gait belt, wheelchair to follow with assistance of 2 staff members- 3/28/25- Staff reeducated to utilized 2 staff members with all transfers- 8/1/25Resident #5's Fall Risk Assessments documented the following scores and fall risk:6/25/25=22-High Risk8/1/25= 18- High [NAME] Progress Note titled Fall dated 6/25/25 at 2:42 AM documented Resident #5 walked into the bathroom with the Certified Nursing Assistants (CNA's) and once in the bathroom before Resident #5 made it to the toilet, he started to sit and the CNA's lowered him to the floor. The note documented the intervention for the fall was re-educating staff on using a gait belt at all times for transfers or using a wheelchair if not comfortable with walking the resident. The clinical record lacked documentation that the family/resident representative was notified regarding the fall.The facility forms titled Corrective Action Notice dated 6/26/25 for Staff B, CNA and Staff C, CNA documented verbal coaching completed by the Director of Nursing (DON) via phone due to the CNA's transferred Resident #5 without a gait belt and lowered him to the floor.A Progress Note titled Fall dated 8/1/25 at 8:55 PM documented Resident #5 was being transferred into the recliner chair when he began sitting too soon. The CNA who was assisting with the transfer was unable to fully support Resident #5's weight and lowered him to the floor. The note documented the intervention for the fall was to re-educate the staff to utilize 2 staff members with every transfer.On 10/1/25 at 1:12 PM, Staff D, Registered Nurse (RN) reported on 8/1/25 Staff E, CNA attempted to transfer Resident #5 to the recliner by herself. Staff D said there was another aide present standing in front of Resident #5's walker but was not providing any assistance. She said Staff D was the only aide that had physical hands on Resident #5. On 10/1/25 at 2:00 PM, the DON agreed it was an expectation for the staff to follow the care plan regarding assistance levels and use a gait belt with all transfers.A facility policy titled Gait Belt Usage dated 2025 documented all employees providing direct resident care are required to utilize a gait belt whenever hands on assistance was needed for resident transfer and/or ambulation unless otherwise contraindicated.A facility policy titled Accident and Supervision dated 2025 documented the resident environment would remain free of accident (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165486	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruthven Community Care Center	2701 Mitchell Street Box 0 Ruthven, IA 51358

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hazards as possible. Each resident would receive adequate supervision and assistive devices to prevent accidents. In addition, the policy documented the facility would implement interventions to try to reduce resident's risk from hazards in the environment and ensure that the interventions are put into action, implemented correctly and consistently.

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NAME OF PROVIDER OR SUPPLIER Ruthven Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2701 Mitchell Street Box 0 Ruthven, IA 51358	

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, pharmacist interview, manufacturer's instructions and policy review, the facility failed to administer insulin medication appropriately and discard the insulin pen 28 days after opened for 1 out of 1 resident (Resident #8) reviewed for insulin administration. The facility reported a census of 43 residents.Findings include: Resident #8's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMs) score of 11, indicating moderately impaired cognition. The MDS included diagnosis of type 2 diabetes mellitus with hyperglycemia (high blood sugar levels). The MDS identified Resident #8 received insulin injections for 7 days during the look back period.A Physician Order dated 6/12/25 directed staff to administer Lispro (rapid acting insulin) 6 units subcutaneously (fatty tissue layer beneath the skin) one time a day via a KwikPen for diabetes.On 9/30/25 at 11:00 AM, observed Staff A, Registered Nurse (RN) obtain Resident #8's Lispro insulin pen from the medication cart. The insulin pen was labeled opened as of 8/27/25. When the surveyor asked the RN how long the pen was good for after opening, the RN said she was not sure and would need to check on it. The RN proceeded to administer 6 units of Lispro insulin via pen with an open date as of 8/27/25.On 9/30/25 at 11:34 AM, Staff A, RN verified the Lispro insulin pen was good for 28 days after opening. She acknowledged the insulin pen was dated opened as of 8/27/25 and should have not been given. On 9/30/25 at 11:37 AM, the Director of Clinical Services reported the RN should have gotten a new insulin pen out. On 9/30/25 at 12:09 PM, the Pharmacist verified the Lispro insulin pen was good for 28 days after being removed from the refrigerator and opened. She said the manufacturer would question the strength of the insulin after 28 days. She said the insulin may be less potent and less likely to control the blood sugar.The Instructions for Use for Insulin Lispro revised July 2023 documented not to use the insulin pen and to discard it after 28 days of usage, even if the pen still had insulin left in it.The facility Medication Management Policy dated 2025 directed staff to check expiration date on package/container.