STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165792	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Carmel Bluffs	1160 Carmel Drive Dubuque, IA 52003

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, clinical record review, resident interview, staff interview and review of the facilities Resident's Rights form revealed the staff failed to treat 2 out of 3 residents with dignity and respect during care as a means to maintain their individual resident rights. (Residents #4 and #5)Findings include:1. Resident #4's Minimum Data Set (MDS) assessment form dated 4.8.25 identified a Brief Interview for Mental Status score of 15, indicating intact cognition. The MDS listed Resident #4 as non-ambulatory, required substantial to maximum assistance with toileting hygiene, and partial to moderate assistance with toilet transfers. The MDS included diagnoses of renal insufficiency (impaired kidney function), diabetes mellitus (DM) and chronic respiratory failure. During an interview on 6/25/25 at 4:24 PM Resident #4 reported one night she put on her call light to use the bathroom. When Staff C, Certified Nursing Assistant (CNA), answered she presented as not nice. Resident #4 explained Staff C failed to say hello when she responded to her request for assistance and just abruptly took her to the bathroom, assisted her back to bed and slapped her CPAP (continuous positive airway pressure) mask over her nose and mouth used for sleep apnea (absence of breathing) on her face. Resident #4 felt most staff members explained their intentions prior to touching them, but Staff C acted stern which caused Resident #4 to feel a little scared. 2. Resident #5's MDS assessment form dated 4.19.25 identified a BIMS score of 15, indicating intact cognition. During an interview on 6/26/25 at 4:52 PM Resident #5 described staff as some being better than others but she preferred not to talk about any specific situations because she didn't want to get anyone in trouble with the facility. Resident #5 added the staff member she referred to, worked the night shift. She felt they had a language barrier as the staff member came from another country. Resident #5 described the unknown staff member as not Mrs. Personality, just cold. 3. Resident #6's MDS assessment dated 6.13.25 Resident #6 had a BIMS score of 13, indicating intact cognition.During an interview on 6/27/25 at 7:57 AM Staff E, Registered Nurse (RN) confirmed she worked with Staff C on the night shift and indicated Resident #6 told her about being afraid to put on her call light because Staff C had an attitude but never shared any other specifics. During an interview on 6/27/25 at 7:50 AM Staff D, RN, indicated some residents complained about Staff C not being so patient or friendly. However, she couldn't recall their names because she only worked at the facility for a short period of time.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 observations, clinical record review, staff interview and facility policy review, the facility failed to complete an adequate assessment and intervention for 3 of 3 residents following a change in condition (Residents #3, #6 and #7). The facility identified a census of 56 residents. Findings include:Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS indicated Resident #3 depended on the staff to rolling left and right in bed, she didn't attempt to walk due to safety concerns or medical conditions and didn't use a wheelchair.An observation on 6/25/25 at approximately 3:05 PM revealed Resident #3 had a bandage on her left lower forearm. Noted drainage approximately 1/2 a pea sized and dark in color. The bandage lacked a date or initials indicating when someone placed the bandage. During an interview on 6/25/25 at 4:13 PM the Director of Nursing (DON) indicated she didn't know Resident #3 had a band aide or injury. She added if a resident had a bandage present, she would expect the staff to assess the area and intervene.During an observation on 6/25/25 at 4:20 PM Staff B removed the bandage. The bandage contained a scant amount of sanguineous (red drainage similar to blood) drainage and an approximate 2 centimeter (cm) sized skin tear. The skin appeared partially scabbed over at the point closest to Resident #3's hand with the rest of the area moist with active drainage and a small amount of sanguineous drainage. Staff B replaced the bandage but failed to clean the area. During an interview on 6/25/25 at 5:10 PM Staff B verbalized she didn't have treatment supplies available in Resident #3's room except a bandaide and the area required 4x4's, measuring tape, etc. Staff B explained she didn't keep the area open to air while she gathered supplies so covered it with a bandaide. In addition, Staff B reported she felt nervous, making it so she failed to think clearly and just didn't want to leave a wound open to air with the inspectors present. During an interview on 6/25/25 at 4:25 PM the Director of Nursing (DON) confirmed the facility provided nursing staff with standing orders and she would have expected Staff B to have cleansed the skin tear prior to the placement of a new bandage and she would have expected the staff to have reported the skin tear to her along with an investigation as to the cause. Resident #3's clinical record review lacked assessments or interventions to the area prior to the above date and time. On 6/26/25 at 11:56 AM Staff B confirmed she didn't know about the bandage present on Resident #3's left lower arm prior to the above event. During an interview on 6/26/25 at 12:03 PM Staff F, Registered Nurse (RN), confirmed she took care of Resident #3 on 6/24/25 and no one reported a skin tear to her. Staff F indicated if a resident sustained a skin tear, the staff notified the physician for a treatment order, documented an assessment in the Progress Notes and notification of family. During an interview on 6/26/25 at 12:37 PM a Sister/Nun confirmed she accompanied Resident #3 to a physician's appointment on Saturday 6/21/25 or Sunday 6/22/25. She explained the hospital staff mentioned Resident #3 sustained a skin tear when they drew her blood. During an interview on 6/26/25 at 3:40 PM Staff H, Certified Nurse Aide (CNA), reported she gave Resident #3 a bath the previous week and noticed a bandage on her left lower arm. The bandage peeled back so she informed the nurse.2. Resident #6's Nursing MDS - V 13 evaluation completed 6/11/25 reflected she had no functional limitations to her upper or lower extremities. The evaluation indicated she used a 4 wheeled walker and wore eye glasses. She could walk independently and see adequately with her glasses. She last fell on 4/27/25.The Fall Note dated 6/24/25 at 11:58 AM indicated the staff found Resident #6 on floor at 8 AM with no initial injuries. The General Note labeled late entry dated 6/24/25 at 1:04 PM documented Resident #6 complained of pain to her right ribs where she hit the waste bin when she fell.The General Note labeled late entry dated 6/24/25 at 1:08 PM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	listed Resident #6's apical pulse (heart rate) as 76 beats per minute (bpm). Resident #6's progress notes lacked assessments after 1:08 PM on 6/24/25.The Fall Follow-Up Note dated 6/25/25 at 12:29 AM identified Resident #6 complained of pain 10 out of 10 on the pain scale (0 - no pain, 10 worst pain) to her right-sided rib. The nurse obtained vitals, checked range of motion, and gave Resident #6 some Tylenol for her pain. Resident #6's clinical record lacked an assessment from 6/25/25 at 1:20 PM until 6/27/25 at 11:24 PM.The General Note dated 6/27/25 at 11:34 PM reflected Resident #6 approached the nurse and requested to be placed on the list to see her Physician due to her right rib pain at an 8 out of10. Resident #6's clinical record lacked an assessment from 6/27/25 at 11:34 PM until 6/30/25 at 11:09 AM.The General Note dated 6/30/25 at 11:09 AM identified Resident #6 reported to the nurse she thought she should get checked out. She explained she had a pain rating of 3 out of 10. She added she could do her normal things, but it still hurt. Resident #6 received some Tylenol for her comfort.The General Note dated 6/30/25 at 2:42 PM indicated Resident #6 had an appointment for the next day to have an x-ray before her appointment with the physician. Resident #6 refused to go to the emergency room (ER) or acute care.The General Note dated 7/1/25 at 5:56 PM identified Resident #6 returned from an X-ray and a visit with her physician. The visit progress notes reflected she had multiple right rib fractures and new orders for Tylenol 500 milligrams (mg) 2 tablets twice a day along with her as needed (PRN) for a maximum of 8 tablets daily.The Pain Note dated 7/2/25 at 11:00 AM indicate Resident #6 reported being ok, not too bad. The General Note dated 7/3/25 at 12:27 PM reflected Resident #6 complained of dizziness. The staff assessed Resident #6's vital signs.Resident #6's clinical record lacked an assessment following the 7/3/25 at 12:27 PM through 7/8/25. The clinical record lacked an assessment on her lungs following the fall.3. Resident #7's MDS assessment dated [DATE] identified a BIMS score of 99, indicating they couldn't complete the interview. The General Note dated 6/4/25 at 1:58 PM identified Resident #7 ate a large lunch and then had a 60 cubic centimeter (cc) emesis (vomit) of a yellow liquid. The nurse conducted an assessment and notified her physician.The Lab Note dated 6/5/25 at 2:36 PM reflected Resident #7 tested negative for COVID-19. Resident #7's clinical record lacked an assessment following 6/4/25 and the lab test.A Communication and Notification - Staff, Practitioners and Resident Representatives policy modified July 2024 defined the purpose of the policy as implementation and an effective communication system across all shifts which included a change in medical condition.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, clinical record review, staff interview and facility policy review, the facility failed to assure all residents remained in a safe and secure environment with all hazardous items locked and/or contained in a safe area not accessible to residents (Residents #7, #8 and #9). The facility identified a census of 56 residents. Findings include: On 6/25/25 at 2:24 PM observed an unattended 4 wheeled utility cart that had 2 open shelves positioned outside of occupied room [ROOM NUMBER]. The cart contained deodorant spray and disinfectant wipes. Both bottles directed to keep out of reach of children. In addition, noted 3 pairs of pointed edged scissors accessible on the cart. During an interview at the same time, Staff A, Registered Nurse (RN), confirmed the facility policy directed the facility staff to keep the items locked up. Staff A identified Resident #8 as a resident who wandered in that area of the campus. She witnessed the cart supplied with the above items prior to the investigation at that time she redirected the staff and/or visitors to the facility. Resident #8's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 3, indicating severely impaired cognition. The observation noted an unsecured container of disinfectant wipes on a shelving unit in a lounge area on the first floor of the facility accessible to all residents. During the observation witnessed an unattended 4 wheeled utility cart with 2 shelves positioned outside of an occupied room [ROOM NUMBER]. The cart contained 3 pairs of pointed edged scissors accessible to anyone. At the time Staff A confirmed 3 pairs of scissors present. Staff A identified Resident #9 wandered in that area of the campus. Resident #9's MDS assessment dated [DATE] identified a BIMS score of 5, indicating severely impaired cognition.During an interview on 6/25/25 at 2:38 PM Staff A confirmed Resident #9 wandered. According to an email dated 6/25/25 at 2:52 PM the Director of Nursing (DON) identified Residents #7, #8, and #9 as residents who wandered. A PHS Chemical Policy revised 12/15/20 defined the purpose of the policy as a means to have established a chemical purchasing, storage, disposal and use program. The policy directed to use, store, transport, and dispose chemicals in compliance with applicable laws and regulations. The section related to storage instructed to store under locked storage and used by trained personnel.