STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165420	A. Building B. Wing	08/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Traditions Memory Care of Newton	2130 West 18th Street South Newton, IA 50208

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 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. 50471 Based on clinical record review, observation, resident interview, staff interview, and facility policy review, the facility failed to develop a comprehensive care plan that included targeted behaviors for 2 of 5 residents reviewed for unnecessary medication review (Resident #37, #19). The facility also failed to develop a comprehensive care plan that included focus, goal, and intervention for 1 of 1 residents reviewed for Edema (Resident #19). The facility reported a census of 44 residents. Findings include: 1. The Quarterly Minimum Data Sheet (MDS) assessment for the Resident #37 dated 8/8/24 identified a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. The MDS revealed the resident independent with eating, maximal assistance with toileting hygiene, shower/bathe self, dressing upper and lower body, supervision/touching assistance with personal hygiene. The MDS revealed the resident frequently incontinent of urine and bowel. The MDS documented diagnoses that included: Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side, Diabetes Mellitus (DM), Non-Alzheimer's Dementia, Seizure Disorder or Epilepsy, Anxiety Disorder, Depression, Unspecified Mononeuropathy of unspecified lower limb (a condition that occurs when a nerve or group of nerves in the left lower limb is damaged), Coronary Artery Dissection, Unspecified Tremor, and Insomnia. The MDS revealed Insulin, Antipsychotic, Antianxiety, Antidepressant, Antibiotic, Opioid, and Antiplatelet. The Care Plan revised 5/24/24 for the Resident #37 revealed no documentation for targeted behavior for unnecessary medication. On 8/11/24 at 12:43 PM MDS Coordinator, LPN revealed that the care plan should reflect the targeted behaviors the resident is taking the antipsychotic medication for. 2. The MDS assessment for the Resident #19 dated 7/2/24 identified a BIMS score of 12 which indicated moderate cognitive impairment. The MDS revealed the resident had rejection of care 1 to 3 days. The MDS revealed the resident independent with eating, set-up assistance with oral hygiene, toileting hygiene, dressing for upper/lower body, putting on/taking off footwear, and personal hygiene. The MDS revealed the resident occasionally incontinent of urine and always continent of bowel. The MDS documented diagnoses that included: Unspecified Dementia without behavioral disturbance, Hypertension, Dysphagia, Age-Related physical debility, and Generalized Edema. The MDS revealed no documentation for high-risk drugs. (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan revised 7/1/24 for the Resident #19 revealed no documentation for goal and intervention related to generalized edema. The Care Plan revealed the focus of Dementia without behaviors, disturbance, psychotic disturbance and mood, anxiety, vitamin D deficiency, constipation, age related physical debility, edema hypertension, dysphagia, low cognitive functions. On 8/9/24 at 2:19 PM The resident sat in recliner with bilateral lower extremities slightly elevated. The right lower extremity edema appeared to be a +3 and left lower extremity edema appeared to be a +2. On 8/10/24 at 2:27 PM The resident sat in recliner with bilateral lower extremities slightly elevated. The resident denied any pain and any concerns related to the edema. The resident stated, they are fine, they always look like that. On 8/11/24 at 1:13 PM The MDS Coordinator, LPN and Director of Nursing (DON) reported the Care Plan should reflect the assessment and interventions for edema. The staff denied knowledge of the residents baseline regarded to bilateral lower extremities edema and any nurse documentation of monitoring. The staff stated the house Doctor assessed during the residents visits. The facility policy titled Comprehensive Care Plan revised 1/30/24 instructed the staff to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive Care Plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. The Care Plan will be updated in a timely manner to ensure that services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The comprehensive Care Plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented as needed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 50471 Based on clinical record review, observation, staff interview, and facility policy review, the facility failed to revise the Care Plan for 2 of 12 residents reviewed for revision of care plan (Resident #37, #31). The facility reported a census 44 residents. Findings include: 1. The Minimum Data Sheet (MDS) assessment for the Resident #37 dated 8/8/24 identified a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. The MDS revealed the resident independent with eating, maximal assistance with toileting hygiene, shower/bathe self, dressing upper and lower body, supervision/touching assistance with personal hygiene. The MDS revealed the resident frequently incontinent of urine and bowel. The MDS documented diagnoses that included: Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side, Diabetes Mellitus (DM), Non-Alzheimer's Dementia, Seizure Disorder or Epilepsy, Anxiety Disorder, Depression, Unspecified Mononeuropathy of unspecified lower limb (a condition that occurs when a nerve or group of nerves in the left lower limb is damaged), Coronary Artery Dissection, Unspecified Tremor, and Insomnia. The MDS revealed Insulin, Antipsychotic, Antianxiety, Antidepressant, Antibiotic, Opioid, and Antiplatelet. The Care Plan revised 5/24/24 for the Resident #37 revealed no documentation for pain, including the resident started on Gabapentin (Anticonvulsants) scheduled started 6/28/24, Tramadol (opioid) scheduled and as needed started 8/6/24, and Tylenol scheduled started 8/6/24 and as needed 11/1/23. The Care Plan lacked personalized interventions or assessment for Pain and Mononeuropathy of unspecified lower limb. The Care Plan also revealed no documentation for Hemiplegia of left limb including goal and interventions. On 8/9/24 at 1:48 PM The resident #37 revealed pain increased in legs. The resident stated pain has been going on for a while, I know they started me on some more medicine to help my pain. The resident also stated my left hand does not seem to work much since my stroke, I wish it would do more. On 8/11/24 at 12:50 PM The Minimum Data Set (MDS) Coordinator, Licensed Practical Nurse (LPN) stated pain should be listed as a focus with a goal and interventions. On 8/11/24 at 12:54 PM MDS Coordinator, Licensed Practical Nurse (LPN) and Director of Nursing (DON) stated the resident's dominant hand is her right hand, staff will correct the diagnosis. The staff stated the resident refused restorative program for her left hand, the resident does her own exercises in her room to keep her hand moving. The resident recently finished skilled therapy from having the stroke. The resident also refused any splint or brace that was recommended. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The Quarterly MDS assessment for the Resident #31 dated 6/25/24 identified a BIMS score of 1 which indicated severe cognitive impairment. The MDS documented the resident independent with eating, supervision with oral hygiene, dependent with toileting hygiene, dressing upper and lower body, personal hygiene, and maximal assistance with shower/bathe. The MDS revealed the resident frequently incontinent of urine and occasionally incontinent of bowel. The MDS documented diagnoses that included: Alzheimer's disease, Coronary Artery Disease, Non-Alzheimer's Disease, Malnutrition, Depression, Unspecified Mood Disorder, Primary Insomnia, Unspecified Osteoarthritis, Fibromyalgia, and Malaise. The MDS revealed Antipsychotic and Antidepressant. The Care Plan revised 6/21/24 for the Resident #31 lacked documentation for oxygen therapy, including assessment, monitoring pulse ox, diagnosis, changing the tubing, etc. On 8/9/24 at 1:56 PM The Resident # 31 revealed oxygen therapy at 2 liters nasal cannula, the concentrator was on, oxygen tubing was on bedside, the resident was sitting at side of bed, pleasantly confused. The staff member passing by placed oxygen therapy back on the resident. On 8/10/24 at 2:26 PM The resident #31 observed sleeping in bed with oxygen therapy in place, oxygen concentrator on at 2 liters nasal cannula, and tubing dated 8/8/24. On 8/11/24 at 8:00 AM The Resident #31 sat in the dining room, for the breakfast meal, the resident attempted to remove the oxygen therapy multiple times, the staff intervened and adjusted the tubing, and the staff provided education each time for the resident. On 8/11/24 at 1:09 PM The MDS Coordinator and DON stated the Care Plan should be updated with oxygen therapy as a focus, goal, and intervention. The staff stated the oxygen tubing should be changed weekly and the pulse ox monitoring as ordered by the doctor. The staff documents in the orders for these particular assessment and maintenance of tubing. The facility policy titled Comprehensive Care Plan revised 1/30/24 instructed the staff to develop and implement a comprehensive person-centered Care Plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive Care Plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. The Care Plan will be updated in a timely manner to ensure that services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50471 Based on clinical record review, observations, staff interview, and facility policy review, the facility failed to provide staff assistance for activities of daily living by not offering an opportunity to complete oral hygiene for 1 of 2 residents reviewed (Resident #197). The facility reported a census of 44 residents. Findings include: The Admission Minimum Data Sheet (MDS) assessment for the Resident #197 dated 8/14/24 revealed the resident admitted to the facility on [DATE]. The Baseline Care Plan initiated 8/7/24 documented the resident is assist of one staff for oral hygiene. The Care Plan initiated 8/10/24 revealed the resident is assist of one staff for grooming and hygiene. The Certified Nurses Aides documentation dated 8/7/24 to 8/11/24 revealed the staff supervised, set up/clean up assistance, moderate assistance, independent, or not applicable assistance with completion of oral hygiene. On 8/9/24 3:38 PM Noted a strong mouth odor from the resident during conversation. On 8/10/24 at 2:20 PM Noted the residents oral hygiene products: toothpaste dated 8/8/24 no signs of usage, toothbrush in plastic wrapper sat in oral basin, and mouthwash dated 8/8/24 sealed and full of liquid. The resident noted to have strong mouth odor during conversation. On 8/11/24 at 8:50 AM Noted the residents oral hygiene products: toothpaste no signs of usage, toothbrush had plastic wrapper on, and mouthwash sealed and full of liquid. On 8/11/24 at 12:03 PM Staff C, CNA stated the resident is assist of one with oral hygiene. The staff stated she supervised the resident, completed oral hygiene. The staff revoked statement, stated oh no I didn't someone else did the oral care on the resident. The staff unable to state who completed the oral hygiene for the resident. The staff confirmed she charted the resident oral hygiene, stated she had so many residents to chart on, it was an accident. The staff confirmed location of the residents oral hygiene products. The staff member acknowledged the toothbrush in plastic wrapper sat in basin, mouth wash full and sealed, and toothpaste, I see the residents oral care apparently is not getting done, if the tooth brush is still in the wrapper. On 8/11/24 at 1:23 PM Director of Nursing (DON) stated the resident is assist of one with hygiene. The staff should be assisting with oral care as the resident allows. The Administrator stated the facility does not have a specific policy related to oral hygiene, we follow standards of care.