STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165599	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Manor Nursing Home	1200 Mulberry Street Tipton, IA 52772

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on medical record review, facility policy review, resident, family, and staff interview, the facility failed to treat two of eight residents reviewed with dignity and respect (Residents #1 and #5). The facility reported a census of 51 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 2, indicating severely impaired cognition. The MDS included diagnoses of Alzheimer's disease, anxiety disorder and unspecified atrial fibrillation (an abnormal heart rhythm). Resident #1 required substantial/maximal assistance with oral hygiene, toilet use, and showers. Resident #1 required total assistance from staff for lower body dressing, putting on and taking off footwear. The Care Plan Focus revised 4/16/24 identified Resident #1 had a problem of impaired cognitive function related to dementia and forgetfulness. The Health Status Note dated 4/15/24 at 9:38 PM indicated a certified nurse aide (CNA) notified the nurse Resident #1 had a raised bruise to the left side of her forehead. Upon assessment, the nurse noted Resident #1 had a 3-centimeter (cm) x 3 cm raised yellowish-purple bruise. Resident #1 appeared alert per baseline and showed no signs or symptoms of discomfort. The Health Status Note dated 4/15/24 at 9:47 PM reflected the staff reported Resident #1 often laid in bed on her left side against the wall. The nurse put an intervention in place to place a pillow against the wall. On 4/17/24 at 1:48 PM observed Resident #1 asleep in her recliner with her feet elevated, properly positioned, and appeared comfortable. When she woke up, observed a bruise on the left side of her forehead (above her eyebrow). The bruise appeared yellowish-purple in color and approximately 2 inches in diameter. When asked how she bruised her forehead, Resident #1 did not answer. On 4/18/24 at 8:40 AM, witnessed Resident #1 sitting in her wheelchair in her room, properly positioned and appeared comfortable with both feet on the foot pedals. She had a fading bruise above her left eyebrow, that appeared yellowish-purple in color and looked approximately 1 1/2 inches in diameter. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/17/24 at 1:48 PM, Resident #7 reported she lived at the facility for over a year as Resident #1's roommate. She overheard staff talking to her and treating her roughly for as long as she lived there. Resident #7 overheard Resident #1 yelling ow, ow, ow! After Resident #1 yelled, the aides said don't hit me and I won't hit you The other day when they got her up, Resident #7 told the aide she needed to comb Resident #1's hair and the aide replied Why? No one will care. 2. Resident #5's Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 with a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #5 required substantial/maximal staff assistance with showers and walking up to 50 feet. In addition, Resident #5 required total assistance from staff for toilet use, lower body dressing, and putting on and taking off footwear. The MDS included diagnoses of chronic congestive heart failure (impaired heart function that results in a fluid imbalance), renal insufficiency (impaired kidney function), urinary tract infection (UTI), diabetes mellitus, other fracture and chronic obstructive pulmonary disease (COPD). In an interview on 4/17/24 at 2:00 PM, Resident #5 reported some of the staff (she was afraid to mention names and feared retaliation) felt she wet her pants on purpose. She said she couldn't help it because she took Bumex. They have told her there are other people that take that and they don't wet as much as you do. Resident #5 explained the aides complained about her urinating a lot. She told them 3 days ago that she had a UTI, as they didn't clean her very well. The Care Plan Focus revised 12/10/23 identified Resident #5 used diuretic therapy (medication to help remove excess fluid) related to hypertension (high blood pressure) and heart failure. The Interventions directed the staff to: a. Administer diuretic medications as ordered by physician. b. Monitor for side effects and effectiveness. c. Monitor/document/report PRN (as needed) adverse reactions to diuretic therapy: dizziness, postural hypotension, fatigue, and an increased risk for falls. Resident #5's Urine Culture Test Results from 12/12/23 to 4/20/24 reflected the following results: a. 12/12/23: 100,000 cFu (colony forming units) of Escherichia Coli (E. Coli bacteria normally found in stool). b. 3/2/24: 100,000 cFu of E. Coli c. 4/20/24: 10,000 to 50,000 cFu E. Coli In an interview on 4/22/24 10:15 AM, Resident #7 reported she overheard Staff J, Certified Nurse Aide (CNA), tell a resident across the hall about Resident #5 being lazy, fat and disgusting. She added Resident #5 pushed her button all the time to use the bathroom. She called Resident #5 a b_ch. She heard the aides yelling at Resident #5 God damn it, you're wet all the time. You're a f___g b__ch for hitting my daughter. Resident #7 reported this to the Administrator and the Director of Nursing (DON), who reported they already knew about it. Their solution was to remove the three CNAs from working the hallway and make them work on the other 2 halls. (continued on next page)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/24/24 at 11:06 AM, Resident #5's family member reported he didn't like the way they let Resident #5 urinate in her pants instead of taking her to the bathroom. They make her sit in her pants, telling her it wasn't time to take her to the bathroom. She takes a pill that makes her urinate a lot. She said they do not clean her very well down there and she always has a UTI (Urinary Tract Infection). She said that it is degrading to her and it's very embarrassing. She'll call to say she went in her pants again and had her call light on for at least half an hour. This happens several times a week. In an interview on 4/24/24 at 1:26 PM, the DON reported she expected staff to toilet residents after meals, before bed, and as needed (PRN). If a resident called to have their incontinent briefs changed, she expected staff to change the briefs as soon as possible. When informed what Resident #5 reported the staff said to her earlier and what Resident #7 had reported, the DON reported that is absolutely unacceptable for staff to speak to residents in that manner. The Administrator reported the facility didn't have a policy on dignity, however, they provided the Resident's [NAME] of Rights which indicated: the resident has the right to dignified existence and the facility must treat the resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the residents.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review, staff interview and facility policy review, the facility failed to update Care Plans for three of eight residents reviewed. (Residents #1, #2, and #4). The facility failed to update the residents Care Plans after the staff discovered Resident #1 had an injury of unknown origin. After Resident #2 sustained burns to her thighs after she spilled coffee on her lap. Then after Resident #4 had a choking episode which required the Heimlich maneuver (first-aid treatment used to try to remove a blockage from someone's airway). The facility reported a census of 51 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 2, indicating severely impaired cognition. Resident #1 required substantial/maximal assistance with oral hygiene, toilet use, and showers. Resident #1 required total assistance from staff for lower body dressing, putting on and taking off footwear. The MDS included diagnoses of Alzheimer's disease, anxiety disorder and unspecified atrial fibrillation (an abnormal heart rhythm). The Health Status Note dated 4/15/24 at 9:38 PM indicated a certified nurse aide (CNA) notified the nurse Resident #1 had a raised bruise to the left side of her forehead. Upon assessment, the nurse noted Resident #1 had a 3-centimeter (cm) x 3 cm raised yellowish-purple bruise. Resident #1 appeared alert per baseline and showed no signs or symptoms of discomfort. The Incident Report dated 4/15/24 at 9:40 PM indicated Resident #1 had a yellowish purple bruise that measured 3 cm by 3 cm to the left side of her forehead. Resident #1 didn't show signs or symptoms of pain. The Health Status Note dated 4/15/24 at 9:47 PM reflected the staff reported Resident #1 often laid in bed on her left side against the wall. The nurse put an intervention in place to place a pillow against the wall. On 4/17/24 at 1:48 PM observed Resident #1 asleep in her recliner with her feet elevated, properly positioned, and appeared comfortable. When she woke up, observed a bruise on the left side of her forehead (above her eyebrow). The bruise appeared yellowish-purple in color and approximately 2 inches in diameter. When asked how she bruised her forehead, Resident #1 did not answer. On 4/18/24 at 8:40 AM, witnessed Resident #1 sitting in her wheelchair in her room, properly positioned and appeared comfortable with both feet on the foot pedals. She had a fading bruise above her left eyebrow, that appeared yellowish-purple in color and looked approximately 1 1/2 inches in diameter. The linked Health Status Note dated 4/19/24 at 4:23 PM indicated Resident #1 continued to have a 3 by 3 cm bruise on her forehead, that looked yellow and light blue. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/24 at 10:36 AM witnessed Resident #1 sitting in her wheelchair in the South Hall Family Room. She wore clean clothing, eyeglasses, and gripper socks. She had both of her feet on the foot pedals of wheelchair. The wheelchair contained a pressure reducing cushion on the seat. The bruise above her left eyebrow remained and looked faded yellow and light purple in color. The Health Status Note dated 4/22/24 at 1:39 PM identified Resident #1's bruise on the left side of her forehead looked yellow in color with no drainage noted. The area measured 3 cm by 3 cm and she didn't show signs of pain at the time. The Health Status Note dated 4/26/24 at 2:22 PM reflected Resident #1's bruise healed on the left side of her forehead. Resident #1's Care Plan reviewed on 4/30/24 lacked injury of unknown origin (bruise to her forehead) identified on 4/15/24. 2. Resident #2's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. Resident #2 required substantial/maximal staff assistance with toilet use and lower body dressing. Resident #2 required total staff assistance with putting on and removing footwear. The MDS included diagnoses of chronic congestive heart failure, renal insufficiency (kidney failure) and diabetes mellitus. On 4/18/24 at 8:28 AM observed Resident #2 sitting up in wheelchair in the family room by the north dining room, wearing clean clothing with blanket on her lap covering both feet resting on the floor. She looked properly positioned and comfortable. On 4/18/24 at 11:10 AM Resident #2 continued sitting in the recliner in her room with both feet elevated. She still looked properly positioned and comfortable. When asked about the incident with the coffee spill, she reported being careless. When she took the lid off the coffee cup, she spilled the coffee on her lap, burning herself. She added she went to the wound clinic once a week. In an interview on 4/22/24 at 1:59 PM, the Assistant Director of Nursing (ADON) reported after Resident #2's accident with the coffee, she expected the Care Plan updated within 24 hours to 48 hours. The ADON reported the MDS coordinator is responsible for updating the Care Plans. In an interview on 4/22/24 at 3:10 PM, the Director of Nursing (DON) reported she expected the Care Plan updated as soon as possible after the incident occurred, within 48 hours. She described the MDS coordinator as the person responsible for updating the Care Plans. She added Staff K, Licensed Practical Nurse (LPN) could also assist with Care Plans. In an interview on 4/22/24 at 3:55 PM, Staff E, CNA, reported after Resident #2 burned herself by spilling her coffee on her lap, she didn't know the new interventions added to her Care Plan. On 4/23/24 at 10:57 AM observed Staff C, Registered Nurse (RN), complete Resident #2's wound care. Staff C measured the wound to the left thigh as 5.2 cm long by 3.0 cm wide, before applying a dressing. Then Staff C measured wound to right thigh as 3.6 cm long by 1.3 cm wide, before applying a dressing. The wounds appeared to be healing with a small amount of serous (clear to yellow wound drainage) drainage. The wound had no signs of infection to wound bed or surrounding skin. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/24/24 at 12:12 PM, the MDS Coordinator reported she receives information on changes on the residents' conditions on a daily basis in the morning meetings and when she makes observations on the residents. The administrative staff participate in Medicare meetings every Thursday to discuss changes on the residents. When a resident has a change, such as a new burn to the skin, she explained the Care Plan should address it within 24 to 48 hours. She also reported she was not informed of Resident #2's burns until 3/28/24 and she added the intervention of keeping the lid on coffee cups that day. She admitted she forgot to address the burns on the Care Plan until 4/23/24, after the surveyor's inquiry. In an interview on 4/24/24 at 1:26 PM, the DON remarked the floor nurses didn't usually update the Care Plan. The MDS Coordinator did it, but the DON could also update the Care Plan. They review the Care plans as needed, such as, when therapy makes updates. They review the long-term care residents quarterly. 3. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] identified a BIMS score of 2, indicating severely impaired cognition. Resident #4 required total assistance from staff for all activities of daily living (ADLs). The MDS included diagnoses of renal insufficiency (kidney failure), non-Alzheimer's dementia and anxiety disorder. Resident #4 received a mechanically altered diet. The Incident Note dated 1/2/24 at 8:11 AM identified a CNA informed the nurse they did the Heimlich on Resident #4 after she choked on a banana. The CNA told the nurse no CNAs on that hall had a 2-way radio to call the nurse. The assessment revealed clear lungs bilaterally with stable vital signs. On 4/18/24 at 11:51 AM watched Staff L, CNA, sit beside Resident #4 in the North dining room and assisted her with her meal. No episodes of Resident #4 choking occurred. An additional observation on 4/23/24 at 5:15 PM witnessed Staff I, CNA, help Resident #4 eat without any choking episodes. The Care Plan Focus revised 2/6/24 identified Resident #4 had a potential altered nutritional status due to her poor cognition as she required assistance with intake. The Care Plan directed the staff to serve her diet as ordered (pureed). Then offer substitutes for foods she didn't like or eat. The Care Plan lacked her choking episode from 1/2/24 which required the Heimlich maneuver. The undated Care Plans policy described the facility's policy as to initiate and update Care Plans as needed for each resident. The policy directed to update Care Plans within 72 hours of a significant change in condition.

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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 - 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** 25855 Based on observation, record review, resident and staff interview and facility policy review, the facility failed to properly document assessments for two of eight residents reviewed (Residents #2 and #3). The facility failed to document Resident #2's weekly wound assessments. In addition, the facility failed to document the time Resident #3's seizure lasted and failed to document follow-up assessments. The facility reported a census of 51 residents. Findings include: 1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #2 required substantial/maximal staff assistance with toilet use and lower body dressing. Resident #2 required total staff assistance with putting on and removing footwear. The MDS included diagnoses of chronic congestive heart failure, renal insufficiency (kidney failure) and diabetes mellitus. The Incident Report dated 3/19/24 at 11:39 AM reflected while in the dining room, Resident #2 called out she spilled her coffee in her lap. The nurse went over to her and observed she spilled hot coffee on her left and right upper thigh. They removed Resident #2 from the dining room after applying a cool towel to her legs, then took her to her room. The Incident Report indicated she had a large red, blistered area on her upper left thigh, another area on her left thigh, and another area on the right upper thigh. The Non-Pressure Skin Condition Report paper document from 3/19/24 through 4/17/24 identified Resident #2 had burns to bilateral upper thighs that measured the following: a. Date first observed - 3/19/24: i. #1 right upper thigh - 1 cm (centimeter) by 1 cm blistered area ii. #2 left upper thigh - 9 cm by 2.5 cm blistered area iii. #3 left thigh above knee, reddened and tender, no measurements documented - The documentation of tissue type, surrounding skin color, wound edges, and pain, did not address which wound described. The form included all wounds on one sheet. The form lacked an assessment from 3/22/24 until 4/2/24. The Wound Clinic Notes dated 4/10/24 at 3:14 PM listed the following: a. Principal wound diagnosis: third degree burn left leg; second degree burn right leg. Comes from the care center with burns on her right and left leg. She reported she removed the lid to the coffee and spilled it on her jeans causing burns to her legs. Not sure when it occurred, but, it happened a few weeks ago. She has received appropriate treatment with Silvadene cream but the wound didn't improve. Resident #2 came in for debridement of her wounds as no one did this yet. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	b. Measurements of the burns: i. Right leg burns measurements = length 2.5 cm, width 1.1 cm - Wound base moist with fibrin, slough, biofilm, yellow small amount serosanguinous drainage - Peri wound clean and dry ii. Left leg medial thigh burns measurements = length 7.8 cm, width 2.4 cm - Wound base moist with fibrin, slough, biofilm, yellow/gray small amount serosanguinous drainage - Peri wound clean and dry - Multiple open areas on thigh from tape tears The Care Plan Focus revised 2/20/24 indicated Resident #2 had an activities of daily living (ADL) self-care performance deficit related to confusion, impaired balance, stroke, trauma caused by a fall with a subdural hematoma (bleeding on the brain). The Intervention revised 3/27/24 indicated Resident #2 could feed herself. She did require a lid on her coffee cup. The Care Plan did not identify Resident #2 with problems of the burns to both thighs after the incident on 3/19/24 until 4/23/24. On 4/18/24 at 8:28 AM observed Resident #2 sitting up in her wheelchair in the family room by the north dining room, wearing clean clothing with blanket on her lap covering both feet resting on the floor. She looked properly positioned and comfortable. On 4/18/24 at 11:10 AM Resident #2 continued sitting in the recliner in her room with both feet elevated. She still looked properly positioned and comfortable. When asked about the incident with the coffee spill, she reported being careless. When she took the lid off the coffee cup, she spilled the coffee on her lap, burning herself. She added she went to the wound clinic once a week. In an interview on 4/22/24 at 9:36 AM, Staff C, Registered Nurse (RN), reported Resident #2 spilled her coffee in March, while in the dining room. She pulled her pants away from her skin and placed cool towels on her upper thighs. When they took her to her room, she had red marks to both of her upper thighs. The ones on the left thigh appeared larger than the one on the right thigh. Staff C said they should have updated the Interventions on her Care Plan to keep the cups for hot liquids. As a result of the incident, she ended up with burns that needed treatment from the wound clinic for 2 or 3 weeks afterward as the burns didn't heal. In an interview on 4/22/24 at 1:47 PM, the Administrator reported she expected the nurses to document on wounds at least once a week and each wound have its own sheet with correlating wound assessments. Upon review of the facility form, she verified the documentation of the assessment didn't identify which wound the assessment reflected as the form included all 3 wounds on the left side of the form. This is the way they always documented when a resident had more than one wound. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 4/22/24 at 3:55 PM, Staff E, Certified Nurse Aide (CNA), reported after Resident #2 burned herself by spilling her coffee on her lap, she didn't know the new interventions added to her Care Plan. On 4/23/24 at 10:57 AM observed Staff C complete Resident #2's wound care. Staff C measured the wound to the left thigh as 5.2 cm long by 3.0 cm wide, before applying a dressing. Then Staff C measured wound to right thigh as 3.6 cm long by 1.3 cm wide, before applying a dressing. The wounds appeared to be healing with a small amount of serous (clear to yellow wound drainage) drainage. The wound had no signs of infection to wound bed or surrounding skin. In an interview on 4/22/24 at 11:07 AM, Staff A, CNA reported Resident #2 had an incident, but, she couldn't recall the exact date. The Care Plan should have received an Intervention added to the Care Plan to keep the lid on any hot liquids. In an interview on 4/22/24 at 11:36 AM, Staff D, CNA, reported after Resident #2 spilled her coffee on her lap. Staff D explained the facility should have updated her Care Plan to keep the lid on any cup of coffee she received. In an interview on 4/22/24 at 1:59 PM, the Assistant Director of Nursing (ADON) reported she expected the nurses to document wound assessments weekly on the skin sheet. In addition, she verified Resident #2 didn't have a documented assessment and she should have for the week of 3/22/24 to 4/1/24. Also, the ADON added each wound should have their own sheet for assessments. In an interview on 4/22/24 at 3:10 PM, the Director of Nursing (DON) reported she expected the nurses to document an assessment at least once a week and document it on the non-pressure skin forms. The DON added the nurses generally document all wounds on one sheet as they don't usually come across multiple burns very often. If a pressure ulcer, she expected one wound per sheet. She verified they didn't have any other assessments documented. They should have documented on Resident #2's wounds during the week of 3/24/24 through 3/30/24. The DON denied Resident #2 stayed in the hospital during that time. She is the facility wound nurse and couldn't explain the lack of documentation. After reviewing Resident #2's wound assessments, she verified the form didn't specify which wound it addressed. In an interview on 4/24/24 at 9:11 AM, Staff H, RN, reported when a resident has a wound, the nurse should document the assessments and measurements once a week, on paper form in the DON's office. Each wound should have its own sheet and would need to document measurements, color, drainage, odor or any granulation. The undated Skin Assessment policy directed the nurse to assess the resident's skin on day of admission and immediately implement a Care Plan for any resident at risk for pressure ulcers. Instruct nursing assistants to identify and report signs of breakdown such as a purple or dark area. Document the status of resident's skin weekly and PRN (as needed) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2. Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Resident #3 had an impairment to one side of their body. Resident #3 required substantial/maximal staff assist with showers/baths and repositioning, In addition, Resident #3 required total assistance from staff with toilet use, dressing, putting on and removing footwear, and personal hygiene. The MDS included diagnoses of cancer, hemiplegia (paralysis of one side of the body), and seizure disorder. The Health Status Note dated 12/2/23 at 1:21 PM indicated a CNA alerted the nurse of Resident #3 hunched over and jerking at the table. Resident #3 noted to be diaphoretic and pale, with stable vital signs. When assessed, Resident #3 didn't respond to verbal stimuli, but did respond to a sternal rub (rubbing on the chest bone to attempt arouse someone). The nurse spoke with the primary care physician (PCP) who gave an order for lorazepam (antianxiety medication) for seizure activity. The staff transferred Resident #3 into bed with the full-body mechanical lift and changed her brief. The Health Status Note dated 12/14/24 at 11:58 AM indicated the nurse went to Resident #3's room at 11:35 AM. Upon arrival, the nurse found Resident #3 sitting on the toilet unresponsive. The nurse noted Resident #3 with seizure-like activity for 10 seconds on the toilet and then became unresponsive again. The nurse called for another nurse for assistance. The Licensed Practical Nurse (LPN) assisted by administering 0.5 ml (milliliter) Ativan (lorazepam) as ordered at 11:37 AM. After ensuring Resident #3's safety they transferred her to the bed from the toilet. The staff placed Resident #3 lying down on her be with the head of the bed (HOB) elevated, call light within reach, and the bed in lowest position. The assessment revealed stable vital signs. The nurse notified the family and the nurse practitioner. The Incident Note dated 12/14/23 at 5:19 PM indicated the staff alerted the nurse of Resident #3 having seizure-like activity in the dining room at 5:07 PM. The staff took her to her room and gave her 0.5 ml of PRN Ativan at 5:09 PM. The nurse notified Resident #3's PCP about the seizure, who ordered to continue to monitor her and she would review her medications for any necessary adjustments. The nurses' notes included two assessments on 12/14/23 at 8:52 PM and 12/15/23 at 5:02 AM. Resident #3's clinical record lacked additional follow-up assessments. The Health Status Note dated 3/12/24 at 10:48 AM reflected upon arrival to Resident #3's room, she found her unresponsive on the bathroom toilet. She noted to have seizure like activity. The nurse administered her PRN lorazepam at 10:45 AM. The then safely transferred Resident #3 to bed from the toilet. They positioned her in bed lying down on her side with the HOB elevated. The nurse notified her PCP. The Health Status Note dated 3/13/24 at 8:10 PM indicated a CNA said Resident #3 didn't act normal, she turned herself sideways in the bed three times, she didn't appear to know the nurse. Due to the possible seizure activity, the nurse gave her PRN Ativan. Resident #3's clinical record lacked documentation from 3/13/24 at 8:10 PM until 3/21/24 at 2:21 PM. In an interview on 4/24/24 at 9:11 AM, Staff H reported after Resident #3 had a seizure, the nurse should document how long the seizure lasted, any vomiting, any incontinence, what led up to the seizure, and any signs of a possible infection. (continued on next page)

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	165599	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Manor Nursing Home	1200 Mulberry Street Tipton, IA 52772

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 4/24/24 at 12:12 PM, the MDS Coordinator reported when a resident has a seizure, the nurse should she chart what they observed, how long the seizure lasted, level of consciousness, orientation, aura (visual or mental disturbances that signal a migraine or seizure), and if the resident could answer questions. In an interview on 4/24/24 at 1:26 PM, the Director of Nursing (DON) reported after a resident has a seizure, she expected the nurse to document the seizure activity, and follow the seizure policy. She didn't expect them to document the length of time the seizure occurred. Most of the time the nurse isn't always in the room when it starts, but she did expect them to document how long the seizure lasted while they were in the room. The Prolonged Seizure policy revised August 2022 instructed the nurse to assess the resident upon observation/notification of any seizure activity. If a nurse observes seizure lasting more than 2 minutes, give lorazepam 2 milligrams (mg) IM (shot into the muscles) unless contraindicated. A staff member will remain with the resident so nurse can notify the physician and family urgently. Repeat lorazepam 2 mg IM in 10 minutes after initial dose if resident continues to seize. The Nurse will notify the physician for further instructions and update the family. The policy failed to direct staff on what to document after seizure activity

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F 0689 Level of Harm - 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** 25855 Based on observation, record review, resident, family and staff interview and review of facility policies, the facility failed to ensure the safety of 2 of 8 residents reviewed (Resident #1 and #5). Resident #5 fell while transferring with a Certified Nurse Aide (CNA). The fall resulted in 3 fractured ribs and a hemothorax (a condition where blood collects in the pleural space, the hollow area between lungs and rib cage). In addition, the facility failed to determine the cause of Resident #1's a facial bruise. The facility reported a census of 51 residents. Findings included: 1. Resident #5's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #5 required substantial/maximal staff assistance with showers and walking up to 50 feet. In addition, Resident #5 required total assistance from staff for toilet use, lower body dressing, and putting on and taking off footwear. The MDS included diagnoses of chronic congestive heart failure (impaired heart function that results in a fluid imbalance), renal insufficiency (impaired kidney function), urinary tract infection (UTI), diabetes mellitus, other fracture and chronic obstructive pulmonary disease (COPD). The Incident Report dated 2/1/24 at 3:40 PM reflected Resident #5 fell in her room while transferring with a CNA from her wheelchair to her recliner. The CNA lowered Resident #5 flat on the ground. The nurse assisted Resident #5 with the laceration on her lower left back. The area measured 5x1 (unknown measurement units). The nurse cleansed, applied steri strips, and covered the wound with bordered gauze. The Health Status Note dated 2/1/24 at 6:23 PM identified as Resident #5 transferred from her wheelchair to her recliner, she fell . The CNA lowered Resident #5 to lay flat on the ground. The nurse assessed Resident #5 and found a laceration on her lower left back, measuring 5x1 (unknown measurement units). The nurse cleaned, steri-stripped, and covered the area with a bordered gauze. Two staff members assisted Resident #5 up and transferred her to the recliner. The nurse notified her primary care provider (PCP) and family. The Health Status Note dated 2/2/24 at 9:14 AM described the assessment as a fall assessment due to her fall on 2/1/24 at 3:40 PM. The note indicated while assisting Resident #5 from the wheelchair to her recliner, the CNA noticed her beginning to fall and promptly lowered her to the floor. Resident #5 sustained a laceration on her lower back. Her last fall occurred on 6/9/23, and she saw her PCP on 1/23/24 with no new orders issued. Resident #5 experienced hallucinations and had a scheduled appointment with psychiatry for 2/9/24. She required the assistance of two staff members for pivot transfers and enrolled in a restorative program. The details are available in the progress notes. Resident #5 last received acetaminophen (mild pain reliever) as needed (PRN) dose medication on 2/1/24 at 2:12 AM. The pharmacy reviewed her chart on 1/2/24 and requested psychiatry notes. Psychiatry services evaluated Resident #5 on 1/12/24. She wore gripper socks with a blood glucose level of 118. Her BIMS score was 15 on 12/10/23, which remained unchanged from her previous score on 9/26/23, indicating intact cognition. The facility implemented a fall intervention plan to ensure to properly position the wheelchair next to the recliner during transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #5's Minimum Data Set (MDS) assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. Resident #5 required substantial/maximal staff assistance with showers and walking up to 50 feet. In addition, Resident #5 required total assistance from staff for toilet use, lower body dressing, and putting on and taking off footwear. The MDS included diagnoses of chronic congestive heart failure, renal insufficiency (kidney failure), and diabetes mellitus. The Incident Report dated 2/29/24 at 6:15 AM identified Resident #5 fell . Upon enter Resident #5's room, she found her lying on the floor on her left side. Resident #5 complained of left rib pain and had a laceration on left cheek that measured 4x0.5 (unknown measurement units). The staff transferred Resident #5 with an assist of two and a full-body mechanical lift. Resident #5 stated both her legs gave out while transferring with the staff to wheelchair. The Health Status Note dated 2/29/24 at 10:36 AM reflected a CNA called the nurse to Resident #5's room. Upon entering, the nurse found Resident #5 lying on her left side on the floor. Resident #5 complained of left rib pain and had a laceration on left cheek that measured 4x0.5 (unknown measurement units). The staff transferred Resident #5 to bed with an assist of 2 staff and a full-body mechanical lift. She said as she transferred with a staff member to her wheelchair, her legs gave out. Resident #5's vital signs reflected abnormal results for her blood pressure of 86/51 (average 120/80) and oxygen saturation of 76% (average greater than 90%) on room air (RA). The Nurse contacted Resident #5's PCP who gave the following orders: 1) X-ray of left rib with posterior chest and left facial bone 3 views. 2) Hold Bumex (diuretic to remove excess fluids) that day. 3) Push fluids that day. The facility contacted the portable x-ray company who completed the ordered x-rays. The Health Status Note dated 2/29/24 at 5:11 PM identified Resident #5's X ray results. The results reflected a mildly displaced left eighth rib fracture. The facial bones x ray results revealed no displaced maxillofacial fracture. The facility faxed a copy of the results her PCP. 3/11/24 at 3:19 PM the staff called the nurse to Resident #5's room due to her complaints of left-sided chest pain. Resident #5 said her pain went from her left breast and radiated up to her neck. The staff called the PCP, who gave orders to send to the emergency department (ED) for further evaluation. The facility notified her son and transferred Resident #5 by ambulance at 3:33 PM to the ED. The Hospital History and Physical dated 3/11/24 indicated Resident #5 presented to the ED with complaints of severe left chest pain radiating to her left jaw. She fell at the nursing home approximately one week before. She reported hitting her head. She explained she had 3 falls in February where the nursing assistants didn't properly hold her wheelchair in place when she went to sit down. The workup in the ED showed a CT angiogram revealing fractures to her left 7th through 10th ribs with associated large pleural effusion that appeared as a mixture of blood and fluid. The ED contacted the Cardiothoracic surgery for a consult, who inserted a chest tube (tube inserted into the chest to drain air, fluid, or blood that could cause the lung to collapse or affect the heart or esophagus) on 3/12/24. The hospital removed the chest tube on 3/21/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Admission Summary dated 3/22/24 at 12:50 PM reflected Resident #5 arrived from the hospital after she had a fall resulting in multiple rib fractures on her left side which caused a hemothorax on the left. Resident #5 required a chest tube while in the hospital. The Incident Report dated 3/25/24 at 6:15 PM directed to read the attached progress note dated 3/25/24 labeled Incident Note. Upon entering the room, the nurse observed Resident #5 lying on her left side in front of recliner with her head partially under the bed, on top of the tray table (broken during fall). The nurse noted the recliner completely elevated, which caused her fall. Resident reported she had the controller under her. When it started going up, she couldn't reach it to stop it. The recliner went all the way up, causing her to fall out of the recliner on to her left side, landing on the tray table and falling to the ground. When she fell she hit the left side of her face on the table. The Health Status Note dated 3/26/24 at 2:26 PM reflected the facility called the ambulance at 1:52 PM. Resident #5 went to the hospital at 2:24 PM by ambulance. The Health Status Note dated 3/26/24 at 9:17 PM indicated Resident #5 returned from the hospital by ambulance. She complained of shoulder pain of 7, indicating moderate pain. The nurse gave her Dilaudid. The Incident Note dated 3/29/24 at 6:23 PM documented a CNA called the nurse to Resident #5's room at 6:03 PM because they found her on the floor. Upon entering the room, the nurse found Resident #5 on the floor in front of the recliner. When asked how she got on the floor, she replied while looking for her lift chair remote, she pushed her tray table away from her, and she slid out of the chair. She denied pain or injury. The staff assisted back to her chair. On 4/17/24 at 2:00 PM observed Resident #5 sitting in her recliner in her room. She wore an oxygen (O2) nasal cannula with continuous oxygen flow maintained at 3 liters per concentrator. She had even and unlabored respirations. Resident #5 reported the staff used the lift lately to transfer her from the bed to her recliner. When they transfer her with the lift, her knees will hit the lift and this is where she has a lot of pain. This happens every time they used the lift on her. In addition, she reported other times they forgot to lock the wheelchair when they transferred her, resulting in her falling before she sits down. On 4/22/24 at 10:30 AM witnessed Resident #5 sitting in her recliner with eyes closed, feet elevated, wearing continuous O2 maintained at 2.5 liters per nasal cannula per concentrator. She had even and unlabored respirations. She looked properly positioned and appeared comfortable. In an interview on 4/24/24 at 11:22 AM Staff F, CNA, reported she transferred Resident #5 from her bed to her wheelchair when she fell on [DATE]. She couldn't recall if she had a gait belt on Resident #5 or not. Staff F thought Resident #5 needed to have a gait belt on with transfers. As Resident #5 tried to sit in her wheelchair, she didn't catch the wheelchair and fell forward. Resident #5's face hit the oxygen concentrator first then the trash can. Staff F explained she couldn't stop her from falling. She went to the hospital, but not that same day. After she went to the hospital, she had a few rib fractures. The day Resident #5 fell , Staff F didn't know she had a history of falls. Staff F was not sure, if it would've been on the Care Plan with all the falls she had, however, someone should have written it in the communication book on each shift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 4/24/24 at 9:36 AM, Staff G, CNA, reported when she arrived to work on 2/29/24, she heard over the two-way radio that there was a resident on the floor. She went to Resident #5's room and Staff F, CNA was in the room with her. Resident #5 was laying on the floor by her recliner, bleeding from a laceration to her left cheek. She said you need to kick Staff F's a__ because she felt it was her fault that she fell to the floor. Staff F said she went to pivot Resident #5 to her wheelchair when Resident #5 leaned forward and hit her face on the trash can. Staff G explained Staff F didn't have the gait belt around Resident #5 as the Care Plan directed to transfer her using a gait belt. When asked if Resident #5 had a history of falls prior to that fall, Staff G responded she had one on 2nd shift. Resident #5 told her, she only fell because the staff person didn't pay attention and didn't lock her wheelchair. In an interview on 4/24/24 at 9:11 AM, Staff H, RN reported on 2/29/24, the aides reported that Resident #5's legs got weak and she fell . One aide transferred her with a gait belt from her recliner to the wheelchair when her legs buckled. Staff H wasn't in the room when Resident #5 fell and when she arrived to the room, she witnessed Resident #5 lying face down next to the bed. She hit her face on the trash can. She did have some bleeding from a laceration to her cheek it measured about 4 cm (centimeters) by 1 cm. She had good range of motion to both arms and legs. She complained of left rib pain. Resident #5 appeared pretty upset with a facial grimace of pain The Care Plan directed to transfer her with an assist of one using a gait belt. She now required two to assist, using the gait belt, and a pivot transfer. Staff H reported Resident #5 had more falls after that fall. She would accidentally hit the wrong button on her recliner (mechanical lift chair) and dump herself out of the chair. They would take the remote and put it in the side pocket so she can't use it without the staff there. Resident #5 did not go to the hospital that day as the portable x-ray company did x rays and they found a fracture to her eighth left rib. A couple of weeks later, Resident #5 complained of chest pain. She does have a cardiac history, so they sent her to the hospital. She was gone for a couple of weeks with a hemothorax and required a chest tube. In an interview on 4/24/24 at 1:26 PM, the DON (Director of Nursing) reported the cause of Resident #5's falls, one of them was because she had a UTI. Resident #5 recently had a fall when Biotech found an 8th rib fracture and a laceration to her face. She went to the hospital a few weeks later when she complained of an onset of acute chest pain that radiated to her neck, she does have a cardiac history. On 4/25/24 at 8:12 AM, Resident #5 reported the following as she sat up in bed without oxygen on, respirations even and unlabored, properly positioned and appeared comfortable. In an interview on 4/29/24 at 9:51 AM, Staff F, CNA, reported when she came to work on 2/29/24, she worked as the only aide in the South hall and took care of 16 residents from 6:00 AM to 6:30 AM. As she got Resident #5 out of bed and into the wheelchair, she put a gait belt around her. When she went to fall forward, I went to grab her and she just had a hospital gown on. If she didn't have a gait belt on, Staff F wouldn't have had anything to grab. When she fell , Staff F explained she called the nurse on the 2-way radio and said she had a resident on the floor. Staff F removed the gait belt because she knew Resident #5 needed transferred with the full-body mechanical lift. In a follow-up interview on 4/29/24 at 11:01 AM, Staff H reported when Resident #5 fell on [DATE], she had Staff F in the room with her. Staff H added Staff F did have a gait belt around Resident #5. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In a follow-up interview on 4/29/24 at 12:07 PM, Staff G reported after Resident #5 fell , and she arrived to the room, Resident #5 did not have a gait belt on her. In an interview on 5/1/24 at 10:20 AM, the Administrator reported the facility did not have a policy on fall prevention. 2. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 2, indicating severely impaired cognition. The MDS included diagnoses of Alzheimer's disease, anxiety disorder and unspecified atrial fibrillation (an abnormal heart rhythm). Resident #1 required substantial/maximal assistance with oral hygiene, toilet use, and showers. Resident #1 required total assistance from staff for lower body dressing, putting on and taking off footwear. The Care Plan Focus revised 4/16/24 identified Resident #1 had a problem of impaired cognitive function related to dementia and forgetfulness. The Interventions directed the following: a. Monitor for safety and gait stability. b. Monitor for safety as she may need redirection. The Health Status Note dated 4/15/24 at 9:38 PM reflected the CNA notified the nurse of a raised bruise to left side of forehead. Upon assessment, the nurse noted a 3 cm (centimeter) by 3 cm raised yellowish purple bruise. The Incident Report dated 4/15/24 at 9:40 PM identified Resident #1 with a yellowish purple raised bruise that measured 3 cm (centimeters) by 3 cm to the left side of her forehead. Resident #1 didn't show signs/symptoms of pain. On 4/17/24 at 1:48 PM witnessed Resident #1 asleep in her recliner with feet elevated, wearing eyeglasses, clean clothing, and nonskid shoes. She looked properly positioned and appeared comfortable. She had a bruise to the left side of forehead above her eyebrow which appeared approximately 2 inches in diameter, yellowish and purple in color. Resident did not respond when asked how she bruised her forehead. On 4/18/24 at 8:40 AM observed Resident #1 sitting in her wheelchair in her room, wearing eyeglasses, clean clothing and nonskid shoes. She looked properly positioned and comfortable with both feet on the foot pedals. Her forehead still had a fading bruise above her left eyebrow, yellowish purple in color and approximately 11/2 inches in diameter. In an interview on 4/18/24 at 2:10 PM, Staff B, CNA reported she thought Resident #1 got the bruise last weekend which was my weekend off (April 13 and 14). When Staff B saw her before her weekend off on Friday the 12th, she did not have a bruise. The Health Status Note dated 4/19/24 at 4:23 PM indicated Resident #1's 3 cm by 3 cm bruise remained on her forehead. She had no pain. The bruise looked yellow and light blue. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/22/24 at 10:36 AM watched Resident #1 sit in her wheelchair in the South Hall Family Room. She wore clean clothing, eyeglasses, and gripper socks. Both feet sat on foot pedals of wheelchair and she sat on a pressure reducing cushion. The bruise remained above her left eyebrow but appeared as a fading yellowish and light purple in color. The Health Status Note dated 4/22/24 at 1:39 PM described Resident #1's bruise on the left side of her forehead as yellow in color with no drainage noted. The area measured 3 cm by 3 cm. In an interview on 4/22/24 at 1:59 PM, the Assistant Director of Nursing (ADON) denied knowing about Resident #1's bruise until the previous week. She expected the staff to report it as soon as they saw it. By the time she learned of the bruise, it already turned yellow. When she interviewed the staff, no one seemed to know how or when it happened. In an interview on 4/22/24 at 3:10 PM, the DON reported she expected her staff to report bruises such as Resident #1's as soon as they first see it. By the time they reported it on 4/15/24 the bruise already turned yellow and purple. She reported the nurse who cared for Resident #1 over the weekend didn't report it to her. In an interview on 4/24/24 at 9:36 AM, Staff G reported when she came in that Monday, 4/15/24 she noticed the bruise on top of Resident #1's left forehead. The bruise's size looked a little bigger than a half dollar coin and purple. No one seemed to know what caused the bruise. Resident #1 didn't talk much and didn't respond when staff asked her what happened. The Health Status Note dated 4/26/24 at 2:22 PM bruise to left side of Resident #1's forehead healed. The Care Plan review completed on 4/25/24 revealed it failed to address the bruise of unknown origin identified on 4/15/24. The undated Skin Assessment policy directed the nurse to assess the resident's skin on day of admission and immediately implement a Care Plan for any resident at risk for pressure ulcers. Instruct nursing assistants to identify and report signs of breakdown such as a purple or dark area. Document the status of resident's skin weekly and PRN (as needed)