STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165156	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Dodge Health and Rehabilitation	728 14th Avenue North Fort Dodge, IA 50501

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to identify, assess, document, and provide interventions for pressure ulcers for 2 out of 2 residents reviewed (Residents #23 and #26). The failure to manage Resident #26's pressure wounds resulted in Stage 3 pressure ulcers to her right and left heels. The facility reported a census of 59 residents.Findings include:The MDS assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only, it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. Other staging considerations include:Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. 1. Resident #26's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of polyarthritis (arthritis in 5 or more joints), lymphedema (swelling caused by an accumulation of protein rich fluid), and obesity. The MDS indicate Resident #26 had a risk for developing pressure ulcers/injuries but did not have any pressure ulcers/injuries. (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 0686 Level of Harm - Actual harm Residents Affected - Few	An 802 Form provided by the facility on 2/9/26, reflected the facility had no pressure ulcers not present at admission. On 2/9/26 at 4:16 PM, this resident stated she wears the boots for wounds on her feet. She stated she believes the boots are helping her wounds heal. Has had the boots on during every observation she was seen today. On 2/10/26 at 2:02 PM, She stated that last week the facility had to cancel one of her appointments and so it was rescheduled on Thursday of last week. She stated something today about this and her appointment was cancelled. She does not want to miss her appointments as she wants her wounds to heal. She said they plan to reschedule today's missed appointment. The Skin/Wound Note dated 11/6/25 at 3:06 PM reflected Resident #26's left heel wound resolved. The nurse recommended to discontinue the current treatment and leave the wound open to air. Continue with compression socks on daily and off at bedtime (HS). The Condition Follow-up dated 11/27/25 at 5:48 PM indicated the facility monitored Resident #26 for a right knee replacement, left lower ankle (LLA) skin tear, scattered bruising, and soreness to her left heel. The note reflected Resident #26 had a history of a deep pressure injury (DPI) to her left heel and complained of soreness when the nurse inspected the left heel. The skin looked intact, pink, and dry. Resident #26 requested to elevate her heel due to fear of the injury reoccurring. Resident #26's clinical record included a Condition Follow-up Note for 11/28, 11/29, 11/30, 12/1, 12/2, 12/3, 12/4, 12/5, 12/7, and 12/8 that reflected she had soreness to her left heel. The notes lacked assessments of her left heel. The Nursing Note dated 12/19/25 at 5:33 PM reflected Resident #26 complained of pain to her previously healed left heel. Upon the nurse's assessment observed a scab that measured 1 centimeter (cm) by 0.8 cm. The nurse applied skin prep to the heel and covered it with Medipore dressing for protection. The nurse faxed Resident #26's provider for a new treatment order. Resident #26's clinical record lacked documentation of her heel after 12/8/25 – 12/19/25. A LN-Skin Evaluation-PRN Weekly form dated 12/27/25, documented Resident #26's left heel as a scab measuring 1 by 1 cm without depth and no applicable stage. The form described the right heel as a red/soft area measuring 0.8 cm by 0.8 cm without depth and no applicable stage. The form reflected the facility sent a fax to the Primary Care Provider (PCP) for a new order (NO) for skin prep BID (twice a day) to bilateral heels and cover with foam border every 3 days and PRN (as needed), float heels while in recliner and in bed. A LN-Skin Evaluation -PRN Weekly form dated 1/3/26, documented Resident #26 had an unstageable pressure ulcer on her left heel. It described it as a 1 cm by 1 cm scab. The nurse applied skin prep to bilateral heels. The note reflected the right heel, healed. The Condition Follow-up Note dated 1/4/26 at 10:49 AM reflected the nurse cleaned Resident #26's bilateral (both) heels with normal saline, patted them dry, applied skin prep, and a Mepilex border dressing due to previous dressing peeling off. The nurse placed a pillow under her heels to prevent further irritation to the area especially to the left side with the scab. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Condition Follow-up Note dated 1/5/26 at 5:42 AM indicated the nurse applied new treatments to Resident #26's heels at 3:00 AM. A LN-Skin Evaluation-PRN Weekly form dated 1/10/26, documented that Resident #26 had a scab to her left heel measuring 0.5 cm by 0.5 cm with 0 depth. The form labeled the stage as not available. It documented Resident #26 had a Stage 1 pressure ulcer on the right heel measuring 0.5 by 0.5 with no depth. The right heel is slightly erythematous (redness of skin) and the left heel still continued to have a scab. The nurse applied betadine to areas and covered with mepilex dressings. The evaluation reflected Resident #26 tolerated treatment well. No complaints of pain at the time with the above areas. Treatment done as ordered with monitoring. A LN-Skin Evaluation-PRN Weekly form dated 1/18/26, documented that Resident #26's heel wounds were unstageable scabs. Left heel measured 1.8 by 0.8 cm and the right heel measured 1 by 1 cm. No depth on either of them. The note reflected the nurse applied skin prep to bilateral heels and covered with a foam border. The Condition Follow-up Note dated 1/18/26 at 11:51 PM documented the nurse applied skin prep to Resident #26's bilateral heels and covered them with a foam border. A LN-Skin Evaluation-PRN Weekly form dated 1/25/26, documented that Resident #26's skin was pink, warm and dry. Skin prep applied to bilateral heels and covered with foam border. The Evaluation lacked an assessment of the heels. A Wound Healing Center Visit Report dated 1/29/26 signed by Staff K, Wound Healing Center Registered Nurse (RN), documented Resident #26 had an open unstageable pressure ulcer acquired on 11/29/25 measuring 0.5 centimeters (cm) in length, 0.6 cm in width and 0.1 cm in depth on her right, posterior calcaneus. Resident #26 had an open unstageable pressure ulcer acquired on 7/29/25 measuring 0.4 cm in length, 0.7 cm in width and 0.1 cm in depth. At the appointment, they debrided (process of removing dead skin and foreign material from a wound) both pressure ulcers on 1/29/26. They documented the tissue debrided as necrotic/eschar (dead, thick, leathery tissue that forms a dry black or brown covering over a wound), subcutaneous, slough (dead tissue beneath the skin's surface). The measurements documented after debridement were 0.5 cm by 0.6 cm by 0.2 cm for the right heel ulcer and 0.4 cm by 0.7 cm by 0.2 cm for the left heel. Resident #26's February 2026 Treatment Administration Record (TAR) directed licensed staff to cleanse the Right and Left Posterior (back) Calcaneus (heels). Cleanse with normal saline daily, apply a thin layer to the wound bed of Santyl ointment (prescription topical enzyme used to remove dead or damaged tissue from chronic skin ulcers promoting wound healing), and cover with Mepilex Border (self-adherent foam dressing) one time a day for wound care. A LN-Skin Evaluation-PRN Weekly form dated 2/2/26, documented that Resident #26's skin was pink, warm and dry. Clean the right and left calcaneus with normal saline daily, apply a thin layer of Santyl (wound ointment) to the wound bed, and cover with Mepilex Border four by four (4x4) one time a day for wound care. Apply heel lift boot bilaterally at all times to bilateral lower extremities. The Evaluation reflected Resident #26 tolerated the treatment well. No other skin issues noted or reported. The Evaluation lacked an assessment of the heels. A Wound Healing Center Visit Report dated 2/3/26 signed by Staff K, documented Resident #26's right calcaneal wound measured 0.8 cm by 1.1 cm by 0.3 cm. Her left calcaneal wound measured 0.1 cm by (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	0.2 cm by 0.1 cm. The documentation labeled both wounds as Stage 3 pressure ulcers. At the visit, the debrided both wounds and after debridement the right heel ulcer measured 0.8 cm by 1.1 cm by 0.4 cm and the left heel ulcer measured 0.1 cm by 0.2 cm by 0.2 cm. On 2/11/26 at 8:37 AM, watched Staff A, Licensed Practical Nurse (LPN), and Staff B, LPN, wash their hands in preparation to do wound care. Resident #26 asked if her wound appointment got rescheduled. Staff A answered she had not had time to check yet that morning but she would. Staff B stated Resident #26 had a wound appointment yesterday and Resident #26 cancelled the appointment. Staff A removed the mepilex dressing from the left lateral leg, cleaned the wound, and applied Santyl to the wound. Staff A left the room to get a dressing for the left anterior calf dressing and the right lateral heel wound. Staff A returned to the room, washed her hands, and put on gloves. Staff A placed a new dressing on the left posterior leg wound, she removed the right heel wound dressing, disposed of it in the trash, opened a normal saline vial, and cleansed the wound by rinsing it with the normal saline. Staff A disposed of the normal saline, opened the dressing and applied the dressing. Staff A didn't remove her gloves nor disinfect her hands in between applying the dressing to left posterior lower leg and applying the new dressing to the right heel wound, including the removal of an old dressing, cleaning of the wound, and applying the new dressing on the right heel. When asked about the treatment for the left heel, Staff A stated that she didn't need to do that one as it was just a scab. Noted a mepilex dressing on the left heel. Directly after this observation, Staff A acknowledged she should have removed her gloves and disinfected her hands in between the separate wound dressings and in between the dirty and clean steps. On 2/11/26 at 9:30 AM, when asked about her cancelled appointment, Resident #26 replied her appointments have been mixed up for the last couple of weeks. She said that last weeks' appointment got moved to Thursday as the facility cancelled it. The previous day, she asked about the appointment that was scheduled as she was just there on Thursday, and they ended up cancelling that one. She stated she wanted to go to her appointments so that her wounds heal. On 2/11/26 at 2:10 PM, Staff B stated she was trying to let Resident #26 know (help this resident understand) that it is important to go to the Wound Clinic because her wounds are not good when she had told the resident that she refused to go to the Wound Clinic. She stated that she could have explained her thoughts about the need to go to the wound clinic better and was probably too harsh in her comment. When Staff B was asked if last week's appointment was cancelled and rescheduled for Thursday, Staff B stated she knew nothing about that. Staff B stated she had been off for 10 days, so didn't know Resident #26 just had her last appointment on Thursday. She stated she was also distracted by the wound treatment and not disinfecting hands or changing gloves. On 2/11/26 at 2:44 PM, Staff K, RN Wound Healing Center, reported the Wound Center diagnoses the ulcers on both of Resident #26's heels as pressure ulcers. On 2/11/26 at 3:30 PM, the Director of Nursing (DON) reported Resident #26 admitted to the facility with the areas on her heels and they didn't develop at the facility. She stated she would get records for the weekly assessments. When asked about why they didn't have Resident #26 coded on the 802 form as having a facility acquired pressure ulcer. She stated the heel wounds weren't pressure ulcers; they were just scabs. She stated the Wound Clinic made the wounds worse by debriding them, and they became larger. The DON stated the heel wounds didn't need debrided, as they were just scabs. When asked if the scabs could hide tunneling or worse wounds underneath them, she stated she didn't (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	feel they were pressure ulcers. When asked about the Wound Clinic diagnosing them as pressure ulcers, she said she would need to look into it more. Following the above interview, the DON said there were 3 types of wound notes, and if the wound assessments weren't found in one of the three types of wound notes, then they weren't done. On 2/11/26 at 4:13 PM, the DON reported the facility didn't do what they should for the pressure and non-pressure wound/skin area weekly assessments. She stated the facility went back and forth with labeling something pressure and then non pressure. She added she knew they are inconsistent. Staff A stated that morning when she didn't do the treatment to the left heel, it was because Resident #2 only had preventative treatment to the left heel and she thought it is to be done every third day. She described the left heel wound as just a skin flap. She acknowledged she called it just a scab that morning. The DON concurred the treatment was preventative. They reviewed the doctor's order and the DON acknowledged the left heel wound treatment needed done daily. Staff A stated she didn't realize that. The DON stated she did the treatment the last 2 days. After Staff A left the room and the Administrator walked into the room. Concerns were shared with the Administrator and the DON regarding the infection control issues observed during the wound treatment completed that morning. Both the Administrator and the DON acknowledged the concerns. They described Staff A as normally so good with infection control and that is why they chose her to do the treatment. On 2/12/26 at 12:00 PM, when asked if Resident #26 had her left heel treatment completed the night before, Staff B and the DON responded Staff A said would it later the previous night as she worked until 10:00 PM and it was an evening shift dressing. The DON asked if the treatment was signed. When reminded that the treatment was for both heels and they are signed as both done in one spot, the DON agreed. After checking Resident #26's dressing on her left heel for the date, observed the date of 2/10/26, indicating that the treatment didn't get one. The DON acknowledged the staff didn't do the treatment to the left heel as ordered. On 2/12/26 at 1:17 PM, attempted to call Staff A, her phone reported it didn't accept messages. A text was sent to Staff A at 1:20 PM, requesting a return call. Prior to the end of the survey, Staff A didn't return the call. The Skin and Wound Monitoring and Management policy reviewed December 2023 instructed the facility to ensure a resident who entered the facility without a pressure injury didn't develop a pressure injury unless individual's clinical condition or other factors demonstrate that a developed pressure was unavoidable. In addition, a resident who had a pressure injury(s) received the necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing. The purpose of the policy directed the following:a. Promote interventions that prevent pressure injury development;b. Promote the healing of pressure injuries that are present (including prevention of infection to the extent possible); andc. Prevent the development of additional, avoidable pressure injury.The procedure instructed ongoing skin and wound assessments. A licensed nurse would assess/evaluate at least weekly each area of alteration/injury, whether present on admission or developed after admission, which exists on the resident. The assessment/evaluation should include but not limited to:a. Measuring the skin injuryb. Staging the skin injury (when the cause is pressure)c. Describing the nature of the injury (e.g., pressure, stasis, surgical incision)d. Describing the location of the skin alteratione. Describing the characteristics of the skin alterationf. Describing the progress with healing, and any barriers to healing which may existg. Identifying any possible (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	complications or signs/symptoms consistent with the possibility ofinfection 2. Resident #23's Census reflected an admission to the facility on [DATE]. Resident #23 transferred and admitted to the hospital on [DATE]. Resident #23 returned from the hospital and was re-admitted to the facility on [DATE]. Resident #23's MDS assessment dated [DATE] identified a BIMS score of 11, indicating moderate cognitive impairment. The MDS included diagnoses of hypertension, acute respiratory failure, and weakness. The Hospital Record dated 11/13/25 noted a skin tear on Resident #23's left buttocks present on admission. Resident #23's admission Record - Skin assessment dated [DATE] failed to indicate altered skin integrity on or around their buttock area. The Nursing Note dated 11/21/25 at 11:51 PM documented a full assessment for Resident #23 prior to an emergency room transfer for altered mental status. The Note included findings of the following skin alterationsa. A wound to Resident #23's lower left buttock measuring 6.2 cm x 3 cm with black center.b. Reddened border and wound on his right buttock measuring 4 cm x 2 cm. The Nursing Note dated 11/22/25 at 1:13 AM reflected the same wound information as the note documented on 11/21/25 at 11:51 PM, but included the right wound appeared scabbed over without drainage. The Hospital emergency room Records dated 11/22/25 at 12:20 AM noted the nursing home staff discovered a wound under Resident #23's left buttocks that day and didn't know when it developed. The record included the following notes:a. 11/22/25 at 7:00 AM of Resident #23's assessment. The assessment noted an area of black with reddened border to Resident #23's left upper thigh. Resident #23 reported area as tender to the touch and appeared to have some skin breakdown to the sacrum (above tailbone).b. 11/24/25 at 3:27 PM documented Resident #23's initial hospital wound nurse skin screening found an unstageable pressure wound to his left gluteus (buttock) and coccyx (tailbone) area; a stage 3 pressure wound on his left elbow. The deep tissue injury on Resident #23's right gluteus present on hospital admission on [DATE] appeared to be resolving and a surgical wound upper abdomen. Resident #23's Hospital Discharge records dated 11/28/25 included orders to cleanse all wounds with mild soap and water, gently pat dry. Apply Santyl ointment to left buttock wound, left elbow wound, and coccyx wound. Cover all wounds with border dressing, changing dressing daily, and as needed. Resident #23 to follow up with the wound center, appointment scheduled on 12/2/25 at 9:45 AM. Resident #23's Hospital Records dated 11/28/25 at 10:45 AM documented, the hospital nurse called report to Staff L, RN, at the facility. They notified of Resident #23's hospital discharge with orders to follow up with the wound center, primary care provider, and neurology. Resident #23's Progress Notes failed to indicate transportation to scheduled wound center appointments, wound center visit notes, or future scheduled appointments. During a phone interview on 2/11/26 at 11:00 AM, the wound center receptionist stated Resident #23 (continued on next page)

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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** Based on clinical record review, staff interviews, and facility policy review, the facility failed to ensure residents received safe and appropriate assistance during transfers for 2 of 3 residents reviewed (Residents #4 and #2). The facility's failure to follow established transfer procedures and provide the necessary assistance placed residents at risk for injury and failed to ensure a safe environment. Resident #4 slid from a mechanical lift sling during a transfer and fell to the floor, sustaining a rib fracture. Resident #2 experienced a fall during a transfer when the staff failed to provide the required level of assistance resulting in complaints of shoulder pain. The facility reported a census of 59 residents.Findings include:1. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. The MDS listed Resident #4 as dependent on staff for all cares and used a wheelchair for mobility. The MDS included diagnoses of Parkinson's disease (a disease process that affects the brain resulting a balance problems), with contractures of left- and right-hand muscles, stiffness of left and right knees, reduced mobility, bipolar disorder, depression and anxiety. The Care Plan Focus dated 5/20/24 reflected Resident #4 had an activity of daily living (ADLs) self-care performance deficit related to limited mobility, impaired balance, pain, and Parkinson's disease. The Intervention directed to use a full body mechanical lift with the sling sized per his weight. The Nursing Progress note dated 1/5/26 at 4:00 PM indicated as the Certified Nursing Assistants (CNAs) transferred Resident #4 with the use of a full body mechanical lift, one of the full body sling loops came off the top left corner hook. As a result, Resident #4 slid out of the sling feet first to the floor. When Resident #4 began to slide out of the sling, Staff G, CNA, and Staff H, CNA, managed to assist Resident #4 all the way to the floor with his upper body leaning on Staff G to preventing him from hitting his head on the floor. The Director of Nursing (DON) assessed Resident #4 at the time and found no apparent injury. The staff transferred Resident #4 to bed with the assistance of 4. Resident #4 informed Staff I, LPN (Licensed Practical Nurse), who assisted, his right middle ribs were a little sore but didn't feel anything was broken. The nurse administered Tylenol to Resident #4 and continued monitoring to evaluate for further pain or changes. The Nursing Note dated 1/6/26 at 7:05 PM reflected Resident #4 complained of rib pain. Their provider gave new orders to obtain x-rays. The X-Ray results dated 1/6/26 at 8:51 PM noted the detection of an acute right rib fracture of #10 (lower rib). In an interview on 2/9/26 at 3:20 PM, the Director of Nursing (DON) stated the facility provided education and a step for CNAs to stop and check the sling loops were securely on the lift bars during the full-body mechanical lift transfer process. In an interview on 2/11/26 at 3:05 PM, Staff H explained she ran the controls for the mechanical lift while Staff G guided Resident #4 in the sling. As Resident #4 laid in bed, they attached all four loops on the sling to the four hooks on the mechanical lift. They lifted Resident #4 above the bed, and as she started to rotate the lift towards his chair the left loops closest to her came off. When that happened Resident #4 started sliding down out of the sling with his feet landing on the floor. She (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Dodge Health and Rehabilitation	728 14th Avenue North Fort Dodge, IA 50501

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F 0689 Level of Harm - Actual harm Residents Affected - Few	managed to hold an area of the sling while Staff G held another area and supported Resident #4 while lowering him to the ground using her legs and torso to support his upper body to prevent him from hitting his head. Staff G radioed to the nursing staff for assistance. The DON came and assessed Resident #4. With the help of the nurses, they lifted Resident #4 and transferred him back into bed. On 2/12/26 at 12:40 PM Resident #4 stated Staff G and Staff H, lifted him above his bed to transfer him. Once he got off the bed and hanging in the sling, he started to slide down with his feet landing first on the floor. Staff G and Staff H lowered him to the floor and made she he didn't hit his head. After the incident, the staff checked him over and assisted him to bed. Later he started to have having rib pain. The got him x-rays and found a fracture. Resident #4 stated they transferred okay but sometimes it felt like the CNAs rushed to get it done. The Facility's Investigation provided Staff G's written statement. The statement documented Staff H helped her change, dress, and hook Resident #4 up to the full-body mechanical lift. Staff H raised Resident #4 into the air over his bed. As they pulled Resident #4 back from the bed the loop on Resident #4's right came undone. She held the left side of the sling with her left hand and the back strap handle with her right hand to guide him during the transfer. Resident #4 began to slide out of the sling feet first. As this happened, she used her right arm and leg to try to guide Resident #4 down to the floor. Once Resident #4 got to the floor, she radioed for help. The In-service Attendance Record listed a course title of Time out to ensure all 4 corners of the lift are attached dated 1/7/26 related to the subject lift time out during lift procedure. The facility provided an undated Mechanical Lift Application and Use document with yellow writing of Master indicated it was a checklist to identify the steps to apply and use a mechanical lift. The steps to apply and use a mechanical lift identified the following key steps: a. Attach the sling to the lift by lowering the sling bar and attaching the sling as directed by the manufacturer, examining and position and stability of all hooks and fasteners. (Highlighted in green on the paper)b. Prepare to engage the lift by standing close to the person, depressing the up button on the lift or remote until there is tension on the sling, adjust the lift brackets so the person is in a sitting position. c. Engage the lift to raise the person 2 inches off the bed, then check that the person is secure and comfortable. Continue to lift the person until free of the surface. d. Transfer the person by unlocking the lift wheels, moving the lift away from the bed toward the chair, positioning the lift with the legs on each side of the chair and locking the lift wheels. e. Lower the person onto the chair by having your coworker move the sling into the correct position over the chair. Lowering the lift until the person is in contact with the seat. Standing next to the person and grasp the lift bracket so it does not move or make contact with the person. f. Remove the lift by lowering the sling bar to unhook the sling. Unlocking the wheels and pulling the lift away from the chair, closing the legs of the lift and applying the lift brakes. During a follow-up interview on 2/26/26 at 2:40 PM Staff G said she hooked up Resident #4 at the head of his bed and raised the head of his bed. She explained the facility had 2 machines both the same in the front and the back. They used a blue sling for Resident #4 when they transferred him. All of the slings are blue mesh slings with a hole where their bottom goes. Staff G said as they lifted him the strap on his right side of his legs came off. When this happened, he slowly slid to the floor. This allowed her to get under him to help guide him to the floor. She reported she wracked her brain trying to figure out what happened. The only thing she could think of was that they didn't get the strap all the way on the hook. Since then, the head of therapy did audits on them. Following the incident, they are supposed to talk through the process step by step as they go, no matter. Staff G explained when it happened only her and Staff H were in the room at the time. They are supposed to have 2 people (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	when they transfer with the Hoyer lift. They make sure they communicate as they go. During a follow-up interview on 2/26/26 at 2:50 PM Staff H reported the bottom right strap for him or left side for her had the strap come off. When this happened, his legs came out then his upper torso. Staff H said he used a green outline blue mesh woven grip sling. Staff H reported she might have hooked up his legs but thought she hooked up his head. She added she thought they may have moved/pivoted him in the wrong direction that caused a displacement in the pressure and caused it to pop off. They have a full-body mechanical hook there with safety hooks in the front of the building. They used the one in the back of the building, that didn't have them. Staff H said they had 3 full-body mechanical lifts in the building, 2 of the same and one different. The 2 that were the same didn't have the safety hooks. She thought the one with the safety hooks was older, and she thought they got the other two from a local facility after they closed. 2. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #2 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The MDS included a diagnosis of chronic (long-term) kidney disease. The Care Plan initiated 6/16/25 identified Resident #2 at risk for falls related to taking an antidepressant, an opioid and diuretic medications. Resident #2 had diagnoses of coronary artery disease, atrial fibrillation, congestive heart failure, and anxiety. The Progress Notes dated 2/1/26 at 5:51 p.m. documented while the CNA assisted Resident #2 to transfer from the bed to the wheelchair around 4:30 p.m., they fell backward into the bed. Resident #2 stated while both arms landed on the bed, she felt like her right arm hit something. After the incident, she reported right shoulder pain (at 10 out of 10, indicating the worst pain imaginable) and received her scheduled hydrocodone (narcotic pain medication). Resident #2 had slightly limited range of motion (ROM) on the right upper arm. Resident #2 reassessed for pain at 5:50 p.m. and reported at 7/10. After, super Resident #2 assisted and transferred back to bed without complaint. On 2/11/26 at 2:43 p.m. Staff F, CNA (agency), stated she assisted Resident #2 in getting up. No one told her what assistance they needed. She asked Resident #2 what help she needed, and she said she could get herself up. She stood up and Staff F held onto her pants. She took 1 step and fell back on the bed. She got back up and said her shoulder hurt. She reported it to the nurse, and she had a history of shoulder pain. On 2/12/26 at 8:15 a.m. the DON stated the staff member should have used a gait belt on the resident when assisting her.

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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** Based on observations, interviews, and record review, the facility staff failed to provide respect and dignity for 2 out of 19 residents reviewed (Resident #11 and Resident #22). The facility failed to cover Resident #11's catheter bag with a dignity bag. During a wound treatment, the staff spoke disrespectfully to Resident #22. The facility reported a census of 59 residents. Findings include:1. A Minimum Data Set (MDS) dated [DATE], documented diagnoses for Resident #11 included non-Alzheimer's dementia, reduced mobility and depression. A Brief Interview for Mental Status (BIMS) documented a score of 6 out of 15, which indicated severely impaired cognitive functioning. This resident had an indwelling catheter. On 2/9/26 at 10:30 a.m., observed Resident #11 from the hallway as he laid in bed, his catheter bag hanged off of his bed without a covering. At 3:00 p.m., he continued to have no covering on his catheter bag. At 4:00 p.m., he still didn't have a covering over the catheter bag. On 2/10/26 at 10:00 a.m., witnessed Resident #11 from the hallway, he still didn't have a covering on his catheter bagOn 2/10/26 at 2:30 p.m., observed Resident #11 through an open door from the hallway. His urinary catheter contained urine and didn't have a covering.On 2/10/26 at 2:30 p.m., Staff J, Hospice Nurse, stated she hadn't seen a covering of his urine bag since he had got the catheter. The nurse verified he didn't have a dignity/cover bag over his catheter bag and verified it they could see it from the doorway. On 2/10/26 at 2:45 p.m., observed Resident #11 with a dignity bag on his catheter bag. On 2/10/26 at 3:50 p.m., the Director of Nursing (DON) acknowledged the concern with the catheter not having a dignity bag over the urine bag. The Administrator concurred that it was a silly thing that staff didn't put the covering over the bag, as it should have one over the catheter bag. 2. A MDS dated [DATE], documented diagnoses for Resident #28 included polyarthritis (arthritis in 5 or more joints), lymphedema (swelling caused by an accumulation of protein rich fluid), and obesity. A BIMS revealed a score of 15 out of 15, which indicated intact cognition. It documented that this resident was at risk for developing pressure ulcers/injuries but did not have any pressure ulcers/injuries. On 2/10/26 at 2:02 p.m., Resident #26 stated that her wound appointment was cancelled today because she just went on Thursday (2/5/26). She normally goes to the wound clinic once a week for the wounds on her foot. When asked if she had a wound on just one of her feet, she stated she had a wound on each of her feet. She stated she felt the wounds have improved. She stated last week the facility had to cancel one of her appointments and so they rescheduled it to Thursday of last week. She told the staff that day and they cancelled her appointment. She didn't want to miss her appointments as she wanted her wounds to heal. She said they planned to reschedule the missed appointment.On 2/11/26 at 8:37 a.m., Staff A, Licensed Practical Nurse (LPN), and Staff B, LPN, washed their hands (preparing to get ready to do Resident #26's wound treatments). Resident #26 asked if they rescheduled her wound appointment. Staff A answered she didn't have time to check yet that morning, but she would. Staff B asked Resident #26 if she was talking about the wound appointment, and Staff A answered yes. Staff B stated Resident #26 had a wound appointment yesterday, and Resident #26 cancelled it herself. Staff B said this using a harsh tone. Resident #26 waited for a few seconds, and then said, she didn't want to miss her appointments, she wanted to go to wound clinic, and she wanted her wounds to get better.' Staff B did not respond. On 2/11/26 at 9:30 a.m., when asked how it made her feel when it was brought up that she cancelled the appointment, Resident #26 responded said it made her feel bad. She stated the appointments have been mixed up for the last couple of weeks. She said it made her feel like the missed appointments were all her fault and that she should feel guilty about them. She said that last weeks' appointment was moved to Thursday as the facility cancelled it, and yesterday she asked about the appointment scheduled as she was just there on Thursday, and they ended up cancelling that one. She added she wanted to go to her appointments so that her wounds heal. On 2/11/26 at 10:18 a.m., Staff A stated that if it were her, (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she would not have said what Staff B said to Resident #26 about the appointment being missed, because Resident #26 refused to go. Staff A stated Staff B said it harshly and it didn't need said. On 2/11/26 at 2:10 p.m., Staff B stated that when she told Resident #26 that she (Resident #26) refused to go to the Wound Clinic, Staff B was trying to let Resident #26 know that it is important to go to the Wound Clinic because her wounds are not good. She stated that she could have explained her thoughts about the need to go to the wound clinic better and was probably too harsh in her comment. When Staff B was asked if last week's appointment was cancelled and rescheduled for Thursday, Staff B stated she knew nothing about that. Staff B stated she had been off for 10 days, so didn't know she just had her last appointment on Thursday. 2/11/26 at 4:13 p.m., concerns were shared with the Administrator and the DON regarding the dignity issue observed during Resident #26's wound treatment this a.m. Both the Administrator and the DON acknowledged the concerns. A Resident Rights Dignity and Respect policy revised on 5/6/21, directed the following:POLICY: It is the policy of this facility that all residents be treated with kindness, dignity and respect. PROCEDURES: The staff shall display respect for Resident's when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings.Schedules of daily activities allow maximum flexibility for residents to exercise choices about what they will do and when they will do it. Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, and entertainment are elicited and respected by the facility.Residents will be appropriately dressed in clean clothes arranged comfortably on their persons, and be well groomed.Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the Resident from passers-by. People not involved in the care of the Resident shall not be present without the resident's consent while they are being examined or treated. Staff members shall knock before entering the Resident's room.Privacy of a Resident's body shall be maintained during toileting, bathing and other activities of personal hygiene, except when staff assistance is needed for the Resident's safety.Violations of the Resident's right to dignity and respect should be promptly reported to the Director of Nursing Services and/or the Administrator.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to ensure personal privacy during care for 1 of 6 residents reviewed (Resident #7). The facility reported a census of 59 residents.Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #7 scored 11 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident depended on staff for all activities of daily living (ADL's). Diagnoses included traumatic spinal cord injury, aphasia (neurological language disorder affecting a person's ability to speak), and quadriplegia (paralysis of all 4 extremities). Resident #7 had a feeding tube.The Care Plan dated 8/29/22 included Resident #7 required a tube feeding related to a swallowing problem. The interventions included the resident would remain free of side effects or complications related to tube feeding.On 2/11/2026 9:46 a.m. Staff B Licensed Practical Nurse (LPN) went to discontinue Resident #7's feeding and treat the area to the feeding tube insertion site. The resident's abdomen and incontinent pad were uncovered through the treatment and the door (to her room) remained open (leaving the resident exposed from the hall).On 2/12/26 at 8:15 a.m. the Director of Nursing (DON) stated the door to the resident's room should be closed for privacyThe undated facility policy for Dignity and Respect included a residents should be examined and treated in a manner that maintained the privacy of their bodies. A closed door or drawn curtain shielded the resident from passers-by.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to notify the Ombudsman for 2 of 3 residents reviewed (Residents #3 and #35). The facility reported a census of 59 residents. Findings include: 1) A Discharge Summary Note dated 1/22/26 at 3:09 p.m., documented Resident #35 admitted to the facility for Post-Acute Care/Skilled Nursing and Rehabilitation Services. Resident #35 improved and no longer required facility services. Planned discharge date [DATE]. A Census Page documented the facility stopped billing Resident #35 on 1/23/26. On 2/10/26 at 4:45 p.m., an email sent to the Administrator asked for the Ombudsman Notifications for the months of July, August, October, and November 2025 and January 2026. Another email sent on 2/11/26 at 1:19 p.m., asked again for the notices. On 2/11/26 at 1:35 p.m., the Administrator stated that the facility failed to do the Ombudsman Notifications. On 2/12/26 at 1;30 p.m., the DON stated the facility didn't have an Ombudsman policy, as they just follow the guidelines. 2) According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #3 scored 10 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident's diagnoses included chronic obstructive pulmonary disease. The Census tab in the Electronic Health Record (EHR) listed a hospitalization for Resident #3 on 10/7/25 and active again on 10/13/25. The MDS tab in the EHR documented Resident #3 discharged [DATE] with return anticipated. The facility lacked documentation they notified the Ombudsman of the resident's hospitalization.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and review of CMS's Resident Assessment Instrument (RAI) Version 3.0 Manual, Preadmission Screening and Resident Review (PASRR) conditions, the facility failed to complete the Minimum Data Set (MDS) assessment accurately for 1 of 20 residents reviewed (Resident #8). The facility reported a census of 59 residents.Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #8 was not considered by the state level II PASRR process to have a serious mental illness. The resident scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident's diagnoses included bipolar disorder and anxiety disorder.The most recent PASRR dated 12/5/23 documented a PASRR Level1 identification Screen reviewed for potential PASRR status showed Resident #8 had evidence of a serious mental illness. However, his condition did not require further PASRR evaluation because his serious mental illness needs had not significantly changed since his previous PASRR Level 2 evaluation. His previous PASRR summary of findings remained valid for his stay at the nursing facility. The services identified in the previous PASRR remained appropriate and should continue.Review of CMS's, Resident Assessment Instrument (RAI) Version 3.0 Manual, PASRR conditions, A1500 directed to code 1, yes: if PASRR Level II screening determined the resident had a serious mental illness, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions.On 2/12/26 at 3:15 p.m. the Director of Nursing (DON) stated they reached out to their contact at PASRR and found out they had answered the question in error.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to have a baseline Care Plan for 1 of 22 (Resident #55). The facility reported a census of 59.Findings include:Resident #55's Minimum Data Set (MDS) assessment dated [DATE] listed an admission date of 1/2/26. Resident #55's Census reviewed on 2/16/26 listed an admission date of 1/2/26.Resident #55's clinical record lacked a Baseline Care Plan.On 2/11/26 at 5:02 PM the Director of Nursing (DON) said she couldn't locate a Baseline Care Plan at all in the documents.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to revise the care plan to reflect a resident's current status for 2 of 20 residents reviewed (Resident #8 and #23). The facility reported a census of 59 residents.Findings include:1) According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #8 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. Diagnoses included bipolar disorder and anxiety disorder. The Care Plan dated 12/4/23 identified Resident #8 had Chronic Obstructive Pulmonary Disease (COPD) related to smoking. The Care Plan initiated 11/4/24 identified Resident #8 had the potential for injury related to smoking. The goal read Resident #8 would be compliant with the individual smoking plan until next review. Interventions included completion of a smoking assessment as needed, educating Resident #8 on safe smoking practices, maintaining smoking materials at the nurses' station or other designated area, requiring a smoking apron, smoking times were 8am - 12pm - 4pm, and staff would show Resident #8 the designated smoking areas upon admission and as needed. A Smoking Evaluation dated 12/14/25 at 2:04 p.m. documented Resident #8 had a dexterity problem, smoked 0-3 times a day, and liked to smoke in the afternoon. The resident used a vape and smoked when a friend or his son came to take him out. On 2/9/26 at 2:15 p.m. the Administrator stated they didn't have residents who smoked residing in the facility. On 2/12/26 at 8:15 a.m. the Director of Nursing (DON) stated Resident #8 did not keep smoking materials at the facility, and staff did not assist the resident with smoking. Sometimes they would see him in a family member's vehicle smoking. She said the Care Plan related to smoking did not reflect the resident's status. 2) Review of Resident #23's admission MDS dated [DATE] revealed admission to the facility on [DATE], with a BIMS of 11. The resident's diagnoses included hypertension (high blood pressure), respiratory failure (lung failure), and muscle weakness requiring supervision or touch assist with the use of a walker. A Quarterly MDS dated [DATE] revealed Resident #23's readmission from the hospital on [DATE]. The resident required supervision or touching assist for ambulation with a walker. Review of Resident #23's Care Plan documented the ADL care performance initiated 1/9/26, including the resident's need for supervision or touch assistance with ambulation. The undated facility Care Planning policy instructed the interdisciplinary team (IDT) should develop a Comprehensive Person-Centered Care Plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment. The Care Plan would be revised as needed, and interventions would be implemented. The resident's comprehensive plan of care would be reviewed and/or revised by the IDT after each assessment and updated as appropriate.

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Fort Dodge Health and Rehabilitation	728 14th Avenue North Fort Dodge, IA 50501

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide bowel interventions for a resident that went without a bowel movement from 2/6/26 at 11:57 a.m. until 2/16/26 at 1:59 p.m. for 1 of 1 resident reviewed (Resident #11). The facility reported a census of 59 residents. Findings include: Resident #11's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 6, indicating severely impaired cognition. The MDS included diagnoses of non-Alzheimer's dementia, reduced mobility and depression. The MDS identified Resident #11 had an indwelling catheter and listed him as always incontinent for bowel movements. Resident #11's Census printed 2/12/26 documented his primary payor as Hospice Medicaid effective 12/12/25. The Bowel Movement/Bowel Continence Response history for the previous 14 days printed 2/12/26 at 3:00 p.m., documented Resident #11 had a medium sized bowel movement on 2/6/26 at 11:57 a.m. The documentation reflected he did not have another bowel movement until 2:12/26 at 1:59 p.m. Resident #11's February 2026 Medication Administration Record (MAR) included the following orders: a. Senna 8.6 mg (milligrams) 1 time a day for bowel regimen. The MAR included documentation Resident #11 received the medication from 2/1/26 to 2/12/26. b. Milk of Magnesia (MOM) suspension 400 mg/5 ml(milliliters), 30 ml by mouth as needed for constipation. The documentation reflected Resident #11 didn't receive MOM from 2/1/26 to 2/12/26.On 2/12/26 at 12:20 p.m., observed Staff C, Certified Nurse Aide (CNA), and Staff D, CNA, talked with Resident #11 and obtained permission to do peri care. As they cleaned Resident #11's back side, they revealed an approximate baseball sized firm stool. On 2/12/26 at 2:35 p.m., Staff E, Registered Nurse (RN), concurred Resident #11's clinical record didn't have documentation he had a bowel movement since the one documented on 2/6/26 at 11:57 a.m., until documented on 2/12/26 at 1:59 p.m. She stated she couldn't find any documentation of bowel intervention. She stated she talked with a nurse and the nurse told her it was because he didn't eat or move much. Staff E stated they should have intervened and are working on getting some as needed bowel medications as he currently only took Senna. On 2/1/226 at 1:30 p.m., the Director of Nursing (DON), stated Staff E let her know what happened with Resident #11. She reported being disappointed with the lack of communication between Hospice and the facility about his lack of bowel movements. She reported the situation as the first time it had happened. She said the CNA informed the DON Resident #11 had a hard time passing stool. She said they are working on how to ensure communication is happening. A Bowel Care Management policy revised May 2021 directed staff that it was the facility's policy to follow physician orders and implement bowel care interventions. The procedure instructed the following: a. Monitor and record resident bowel movements.b. Administer bowel care as ordered.c. If no bowel movement in three days, implement prn bowel care orders per physician orders.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview the facility failed to perform a feeding tube procedure per the physician's order for 1 resident with a feeding tube (Resident #7). The facility reported a census of 59 residents.Findings include:According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #7 scored 11 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident depended on staff for all activities of daily living (ADL's). Diagnoses included traumatic spinal cord injury, aphasia (neurological language disorder affecting a person's ability to speak), and quadriplegia (paralysis of all 4 extremities). Resident #7 had a feeding tube.The Care Plan dated 8/29/22 included Resident #7 required a tube feeding related to a swallowing problem. The interventions included the resident would remain free of side effects or complications related to tube feeding.The Physician's Orders in the facility Electronic Health Record (EHR) included every day and night shift Check tube placement and patency prior to each feeding/flush/medication administration via air bolus auscultation or residual aspiration. On 2/11/26 at 7:07 a.m. Staff B Licensed Practical Nurse (LPN) prepared medications and entered the resident's room. Staff B stopped the feeding at the pump and disconnected the feeding from the g-tube. Staff B flushed the g-tube with 75 cc's water from the sink, administered the medications and flushed with another 75 ccs. Staff B then checked tube placement. On 2/12/26 8:15 a.m. the Director of Nursing (DON) stated they should check the feeding tube for placement before administering medications.The undated facility policy for Tube Feeding included checking tube for correct placement every shift or every medication administration by auscultation and aspiration. If not in place, hold feeding and medications, and notify the physician for orders.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review, the facility failed to complete post dialysis assessments for 1 resident reviewed on dialysis (Resident #2). The facility reported a census of 59 residents.Findings include:According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #2 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident's diagnoses included chronic kidney disease and she received dialysis.The Care Plan identified Resident #2 needed dialysis related to renal failure Initiated 4/19/25. Interventions included the resident had dialysis Monday, Wednesday, and Friday, and obtaining vital signs and reporting significant changes in pulse, respirations and blood pressure immediately.The Nursing Dialysis Communication Records for 12/1, 12/5, 12/8, 12/10, 12/12, 12/17, 12/19, 12/22, 12/23, 12/26, and 12/29/25, lacked vital signs on return from dialysis.The Nursing Dialysis Communication Records for 1/5, 1/9, 1/14, 1/16, 1/19, 1/21, 1/23, and 1/30/26 lacked vital signs on return from dialysis.The Nursing Dialysis Communication Records for 2/2, 2/4, 2/6, and 2/9/26 lacked vital signs on return from dialysis.On 2/12/26 at 8:15 a.m. the Director of Nursing (DON) stated they listed vitals on the return from dialysis for a reason. They needed to be done.The undated facility policy, Dialysis (Renal), Pre and Post Care, documented it was the policy of the facility to assist the resident in maintaining homeostasis (the self-regulating process) pre- and post-renal dialysis.

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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 record review, policy review, staff and provider interview, the facility failed to ensure medication administrations met the accepted professional standards for 2 of 12 residents reviewed (Residents #1 and #32). The Nursing staff failed to administer a prescribed cancer medication to Resident #1 and failed to notify the physician they didn't give the medication. In addition, the nursing staff administered Resident #32 insulin doses higher than ordered by the physician, placing the residents at risk for adverse health outcomes related to omitted and/or incorrectly dosed medications. The facility reported a census of 59 residents.Findings include:1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. The MDS included diagnoses of multiple myeloma (blood cancer), prostate cancer, anemia (low blood iron), heart failure, kidney failure, type 2 diabetes, bipolar disorder, anxiety disorder, and obsessive-compulsive disorder. Resident #1's Physician's Orders included the following orders dated:a. 11/24/25: Bicalutamide (medication used to treat blood cancer) 50 milligrams (mg), one tablet by mouth once daily for multiple myeloma.b. 6/21/25: Zytiga 250 mg, four tablets on an empty stomach one time daily for malignant neoplasm of prostate (prostate cancer). Resident #1's September 2025 through February 12, 2026, Medication Administration Records (MAR) included documentation of multiple doses of Bicalutamide and Zytiga not administered due to not receiving the medications from the pharmacy. Review of Resident #1's Nursing Progress Notes failed to indicate notification to the Hematology/Oncology Physician of the Bicalutamide and Zytiga missed doses. Resident #1's Hematology/Oncology progress note dated 1/21/26, the Physician noted they discussed that day Resident #1 received Bicalutamide incorrectly for a long time with the care facility he lived, as marked in multiple places on the paper packet Resident #1 brought from the care center. Stage 1 prostate cancer, high risk, Resident #1 has been incorrectly maintained on Bicalutamide secondary to misunderstanding from his nursing home, marked today 1/21/26 on the paperwork needed discontinued. In an interview on 2/12/26 at 9:08 AM, a Registered Nurse (RN) for Hematology/Oncology Physician, reported all communication from patients, their family, and/or the care facility is documented in the patients' chart. The RN reviewed Resident #1's records and couldn't locate documented communication from the care facility notifying the Physician of missed Bicalutamide or Zytiga doses. Further review of Resident #1's records, the RN, stated Resident #1's Hematology/Oncology Physician documented incorrectly maintained on Bicalutamide by the facility, after previous order to discontinue. In an email dated 2/16/26 at 12:40 PM, the DON stated she expected when medications are not available from the pharmacy, the Certified Medication Aide (CMA) must notify the nurse and the nurse is to contact the Doctor, pharmacy, and the resident's family and/or Power of Attorney (POA). 2. Resident #34's MDS assessment dated [DATE], identified a BIMS core of 15, indicating intact cognition. The MDS included diagnoses of diabetes, anxiety disorder and depression. The MDS documented Resident #34 received insulin injections for 7 out of 7 days during the MDS observation (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	period. Resident #34's July through January 2026 MAR/ Treatment Administration Record (TAR) included an order dated 8/18/25 to inject 7 units of Insulin Aspart (short acting insulin) 100/unit/ml (milliliter) two times a day. Notify the provider of glucose (blood sugar) levels less than 70 or greater than 350. The MAR/TARS reflected the facility didn't follow the doctor's order for 7 units of insulin in each of the months. Resident #34's February 2026 MAR/TAR documented on 2/11/26 Day 1(12:00 PM to 3:00 PM) Resident #34's blood sugar (BS) as 189. The MAR/TAR directed to inject 7 units of Insulin Aspart 100/unit/ml two times a day. The order dated 8/18/25 instructed to notify the provider of glucose levels less than 70 or greater than 350. On 2/11/26 documentation reflected he received 9 units. Documentation from 2/1/26 – 2/11/26, indicated Resident #34 received more than 7 units at least once every day. On 2/12/26 at 11:30 AM, Staff B, Licensed Practical Nurse (LPN), stated she administered the insulin on 2/11/26. She reported she gave 9 units as Resident #34 did a carbohydrate count and then told the nurses how many units he needed related to what he has or has not ingested. She stated the facility did this with Resident #34 for as long as she remembered. On 2/12/26 at 11:40 PM, the Director of Nursing (DON), stated Staff B came to her about the situation. She concurred with Staff B they did this with Resident #34 for quite a while now. She stated they messaged the provider to get a clarification order. The DON acknowledged the facility didn't follow the provider's order. On 2/12/26 at 12:02 PM, a message was left for this resident's doctor/provider requesting a return call. This provider did not return the call. The Pharmacy Services Physician Orders policy revised May 2019 directed the facility that drugs shall be administered only upon the written order of a person duly licensed and authorized to prescribe such drugs. The procedure instructed no drugs or biologicals shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illnesses.

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident with transportation to and from laboratory services outside of the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to transport 1 of 2 residents reviewed for wound care (Resident #23) to their Wound Center appointment. The facility failed to ensure transportation for Resident #23 to attended their scheduled wound treatment appointment, resulting in a delay in wound care. The facility reported a census of 59 residents.Findings include:Resident #23's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The MDS included diagnoses of hypertension (high blood pressure), acute respiratory failure (new short-term lung failure), and weakness. The Nursing Progress Note dated 11/21/25 at 11:51 PM documented a full assessment for Resident #23 prior to an emergency room transfer for altered mental status. The note included findings of skin alteration to Resident #23's lower left buttock with red areas to his right buttock. Resident #23's Hospital Records dated 11/28/25 at 10:45 AM documented the nurse report called to Staff L, Registered Nurse (RN), at the facility, to notifying of Resident #23's hospital discharge orders to follow up with the wound center, primary care provider, and neurology. Resident #23's Hospital Discharge records dated 11/28/25 at 11:15 AM, directed Resident #23 to follow up with the wound center. Resident #23 had an appointment scheduled on 12/2/25 at 9:45 AM. Resident #23's Nursing Progress Notes failed to indicate transportation to scheduled wound center appointment, wound center visit notes, or future scheduled appointments. During a phone interview on 2/11/26 at 11:00 AM, the wound center receptionist stated Resident #23 was a no show for the scheduled appointment on 12/2/25. They didn't receive any follow up communication from the facility. In an interview on 2/11/26 at 4:27 PM, the DON reported after reviewing Resident #23's 11/28/25 hospital discharge document, they had a wound center appointment scheduled. She couldn't find additional documentation to indicate if Resident #23 attended the appointment.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on record review, staff interviews, facility policy review, and review of prior survey history, the facility failed to develop, implement, and maintain an effective, comprehensive, data-driven Quality Assurance and Performance Improvement (QAPI) program to address and prevent the recurrence of previously cited deficiencies. The facility reported a census of 59 residents. Findings include:Review of the facility's Provider History Report revealed the facility received the same deficiency during the current survey and a complaint survey in November 2025 of the deficiency category free of accident hazards and provision of adequate supervision/assistive devices to prevent accidents (F689).In an interview on 2/9/26 at 3:20 PM, the Administrator stated, QAPI meetings are done monthly with the facility's Medical Director attending at least quarterly. They identified resident falls and the QAPI committee looked at the mechanical lift transfers with the previous incidents with the lift happening a few months before. In an interview on 2/9/26 at 3:20 PM, the Director of Nursing (DON) stated the facility provided education and a step for CNAs to stop and check the sling loops were securely on the lift bars during the full-body mechanical lift transfer process. Review of the facility provided Performance Improvement (QAPI) Plan policy reviewed directed the following:a. The design and scope of the QAPI plan is ongoing and comprehensive. Its purpose is to correct identified deficiencies in quality of services and put mechanisms in place so that our performance can consistently be improved. b. The facility used a systematic approach to determine when an in-depth analysis is needed to fully understand the problem, its causes, and implications of a change. c. The facility applied a thorough and highly organized/structured approach to determine whether and how identified problems may be caused or exacerbated by the way care and services are organized or delivered. d. The facility's approach comprehensively assesses all involved systems to prevent future events and promote sustained improvement. e. The facility developed policies and procedures regarding expectations for the use of root cause analysis when problems are identified. This element includes a focus on continual learning and continuous improvement. f. The facility will put in place systems to monitor care and services, drawing data from multiple sources. Feedback systems will actively incorporate input from staff, residents, families, and others as appropriate. It will include using performance indicators to monitor a wide range of care processes and outcomes, and reviewing findings against benchmarks and/or goals the facility has established for performance. It also includes tracking, investigating, and monitoring adverse events every time they occur, and action plans implemented through the plan, do, study, act (PDSA) cycle of improvement to prevent recurrences.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to provide Enhanced Barrier Precautions (EBP) for 1 of 3 resident's reviewed (Resident #7), failed to adhere to appropriate Hand Hygiene (HH) practices for 3 of 3 residents reviewed (Resident #7, #11, and #26), and failed to employ infection control practices with catheter care for 1 of 2 residents reviewed (Resident #26). The facility reported a census of 59 residents.Findings include: 1. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #7 scored 11 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident depended on staff for all activities of daily living (ADL's). Diagnoses included traumatic spinal cord injury, aphasia (neurological language disorder affecting a person's ability to speak), and quadriplegia (paralysis of all 4 extremities). Resident #7 had a feeding tube. The Care Plan dated 8/29/22 included Resident #7 required a tube feeding related to a swallowing problem. The interventions included the resident would remain free of side effects or complications related to the tube feeding. On 2/11/26 at 7:07 a.m. Staff B, Licensed Practical Nurse (LPN), prepared medications and entered the Resident #7's room. Staff B washed her hands and put on gloves. Staff B informed the resident what she was doing. After stopping the feeding at the pump, and disconnecting the feeding from the tube, Staff B changed gloves without hand hygiene. Staff B failed to utilize EBP when working with the feeding tube. On 2/11/26 at 9:46 a.m. Staff B went to discontinue Resident #7's feeding. Staff B washed her hands, gloved, and left the room. Staff B returned to the room with washcloths, put them (directly without a barrier) in the sink and ran water over them. Staff B put on gloves, wrung out excess water from the washcloths, and placed them on a barrier. Staff B removed the feeding tubing from the gastric (g)-tube and changed gloves without hand hygiene (HH). Staff B removed the dressing from the g-tube insertion site and changed gloves with no HH. Staff B wiped around the g-tube insertion site with the washcloths and changed gloves with no HH. She then applied antifungal with a cotton tipped applicator and placed a split dressing around the g-tube. Staff B failed to utilize EBP when working with the feeding tube. The undated Policy for EBP documented it was the policy of the facility to implement EBP for the prevention of transmission of multidrug-resistant organisms (MDROs). CMS notes that facilities had some discretion when implementing EBP and balancing the need to maintain a homelike environment for residents. High-contact resident care activities were activities that had been demonstrated to result in the transfer of MDROs to hands or clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. Examples of high-contact resident care activities requiring gown and glove use for residents on EBP included but are not limited to a feeding tube. The undated facility Hand Hygiene policy documented it was the policy of the facility to cleanse hands to prevent the transmission of possible infectious material and to provide a clean, healthy environment for residents and staff. Hand washing/hand hygiene was generally considered the most important single procedure for preventing the transmission of infection. Except for situations where hand washing was specifically required, antimicrobial agents such as alcohol-based hand rubs were also appropriate for cleaning hands and could be used for direct care. For specific handwashing and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	waterless hand hygiene procedures, this facility refers to CDC's most current guidelines. The CDC's Hand Hygiene for Healthcare Workers included gloves were not a substitute for hand hygiene and if the task required gloves, performing hand hygiene before putting on gloves and touching the patient or the patient's surroundings. Always clean hands after removing gloves. 2. A MDS dated [DATE], documented diagnoses for Resident #11 included non-Alzheimer's dementia, reduced mobility, and depression. The MDS identified a Brief Interview for Mental Status (BIMS) score of 6, indicating severely impaired cognitive functioning. Resident #11 had an indwelling catheter. The MDS listed him as always incontinent with bowel. A Care Plan focus initiated 10/3/25, reflected Resident #11 had an indwelling catheter related to an obstruction. On 2/12/26 at 12:20 p.m., Staff C, CNA (Certified Nurse Aide), and Staff D, CNA, talked with Resident #11 and obtained permission to do cares. Both donned their gowns and gloves, then pulled the front of his briefs down and cleansed his groin. Staff C used a separate wipe to wipe the catheter tubing toward his urinary meatus. She cleaned Resident #11's back side that had fecal matter present in his brief. Staff C removed the brief with the bowel movement and cleaned the area. Staff C removed her gloves and clipped the urinary catheter tubing to the sheet, hung the catheter bag on the side of the bed, and clipped the call light to bed within Resident #11's reach. Staff C lowered his bed back to the low position and put the floor mat back into place next to his bed. Both staff washed their hands. Talked with Staff C directly after the observation. Staff C confirmed she wiped the catheter tubing toward the urinary meatus instead of away from it. She acknowledged after removing her gloves after peri-care she didn't wash her hands and before she put on new gloves. Rather she touched several items, including briefs, catheter tubing, a wipes package, bed controls and the call light. Following the observation, when updated about the concerns, the DON acknowledged the infection control concerns. 3. Resident #26's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of polyarthritis (arthritis in 5 or more joints), lymphedema (swelling caused by an accumulation of protein rich fluid), and obesity. The MDS indicate Resident #26 had a risk for developing pressure ulcers/injuries but did not have any pressure ulcers/injuries. Resident #26's February 2026 Treatment Administration Record (TAR) directed licensed staff to cleanse the Right and Left Posterior (back) Calcaneus (heels). Cleanse with normal saline daily, apply a thin layer to the wound bed of Santyl ointment (prescription topical enzyme used to remove dead or damaged tissue from chronic skin ulcers promoting wound healing), and cover with Mepilex Border (self-adherent foam dressing) one time a day for wound care. The TAR Right and Left Posterior Calcaneus (wounds to the heels) cleanse with normal saline daily apply a thin layer to the wound bed of Santyl ointment cover with Mepilex Border 4x4 one time a day for wound care. On 2/11/26 at 8:37 a.m., when Staff A, Licensed Practical Nurse (LPN) and Staff B, LPN, washed their hands, they didn't have paper towels available to dry their hands. Without drying their hands, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165156	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Dodge Health and Rehabilitation	728 14th Avenue North Fort Dodge, IA 50501

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they applied gloves. Staff B held up Resident #26's left leg while kneeling on the floor as Resident #26 sat in her w/c. Staff A removed the dressing, then cleaned the wound. She applied Santyl (ointment that removed dead skin from wounds) to the wound. Staff A left the room to get a dressing for both the lateral lower left leg dressing and to also get a dressing for the right lateral heel wound. Staff A returned to the room and washed her hands, then turned off the water with her right hand. Again, she put on gloves without drying her hands as the room didn't have no paper towels available to dry her hands. Staff A placed a new dressing on the left lateral lower leg. She then removed the right heel wound dressing, disposed of it in the trash, opened a normal saline vial and cleansed the wound by rinsing it with the normal saline. Staff A disposed of the normal saline, opened up and applied the dressing. Staff A did not remove her gloves nor disinfect her hands in between applying the dressing to left lateral lower leg and applying the new dressing to the right heel wound, including removal of an old dressing, cleaning of a wound and applying a new dressing on the right heel. Directly after this observation, Staff A acknowledged she should have removed her gloves and disinfected her hands in between the separate wound dressings and between the dirty and clean steps. On 2/11/26 at 4:13 p.m., concerns shared with the Administrator and the DON regarding the infection control issues that morning. The Administrator and the DON acknowledged the concerns. They said Staff A is normally so good with infection control and that is why they chose her to do the treatment. An Indwelling Urinary Catheter Care policy reviewed December 2023, directed the facility that each resident with an indwelling catheter would receive catheter care daily and as needed (PRN) to promote hygiene, comfort, and decrease the risk of infection. The procedure directed the following:a. Gather equipment and supplies. i. Soap or cleanser ii. Basin with water (disposable wipes may be used as a substitute for soap and water) iii. Gloves iv. 2 clean washcloths and trash bagb. Identify the resident.c. Assemble equipment on a clean surface. Place open trash bag on the bed.d. Explain procedure to the resident.e. Provide privacy with beside curtain (and room door if able). f. Position resident comfortable. Do not unnecessarily expose the resident. g. Perform hand hygiene, using soap and water.h. [NAME] (apply) gloves.i. Moisten the washcloth and apply soap to the washcloth or using moistened disposable wipes, clean the catheter in a downward motion (front to back) beginning at the urinary meatus (insertion point) and at least 4 inches down (from resident toward the collection bag). Use a clean portion of the washcloth or fresh disposable wipe for one cleansing motion. j. Remove gloves and perform hand hygiene with soap and water. A Hand Hygiene policy reviewed July 2014, directed the staff to cleanse their hands to prevent transmission of possible infectious material and to provide clean, healthy environment for residents and staff. The purpose of the policy described hand washing/ hand hygiene is generally considered the most important single procedure for preventing the transmission of infection. Antiseptics control or kill microorganisms contaminating skin and other superficial tissues and are sometimes composed of the same chemicals that are used for disinfection of inanimate objects. Except for situations where hand washing is specifically required, antimicrobial agents such as alcohol-based hand rubs are also appropriate for cleaning hands and can be used for direct care. Some situations require hand washing in areas where sinks are not readily available. In these limited circumstances, alcohol-based waterless hand-washing products may be used. For specific handwashing and waterless hand hygiene procedures, this facility refers to CDC's most current guidelines.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and staff interview, the facility failed to ensure residents were offered/administered influenza and or pneumonia vaccines for 4 of 5 residents reviewed (Resident #2, #5, #6, and #7). The facility reported a census of 59 residents.Findings include: 1) Based on review of a record printed off by the Director of Nursing (DON) on 2/12/26 at 10:12 a.m. Resident #2 was due for an influenza vaccine on 9/1/26. The resident's clinical record lacked documentation she had been offered the flu vaccine. In an email dated 2/16/26 at 11:18 a.m. the DON It appeared Resident #2 was due for the flu vaccine on 9/1/25. The DON had not found that she received them. Unfortunately, the vaccine provider had not sent a list of vaccines he provided. 2) In an email on 2/16/26 at 11:18 a.m. the DON documented Resident #5 was not up to date with the influenza vaccine. The resident's clinical record lacked documentation he had been offered the flu vaccine. 3) In an email on 2/16/26 at 11:18 a.m. the DON documented Resident #6 had the flu vaccine 11/8/25, but not up to date on other vaccines. The resident's clinical record lacked documentation she had been offered/given a pneumonia vaccine. 4) In an email on 2/16/26 at 11:18 a.m. the DON documented Resident #7 was not listed as up to date on current vaccines. The resident's clinical record lacked documentation she had been offered/given the flu or pneumonia vaccine. On 2/12/26 at 10:33 a.m. the DON stated the vaccine provider came in and did vaccine clinics, but they didn't give the facility a list of the residents that received the vaccines.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and staff interview, the facility failed to ensure residents were offered/administered COVID vaccines for 5 of 5 residents reviewed (Resident #2, #5, #6, #7 and #10). The facility reported a census of 59 residents. Findings include:1) Review of an immunization record printed off by the Director of Nursing (DON) on 2/12/26 at 10:12 a.m. indicated Resident #2 was due for a COVID-19 vaccine on 9/1/25. The resident's clinical record lacked documentation she had been offered the COVID-19 vaccine. In an email dated 2/16/26 at 11:18 a.m. the DON It appeared Resident #2 was due for the COVID vaccine on 9/1/25. The DON had not found that she received them. Unfortunately, the vaccine provider had not sent a list of vaccines he provided. 2) In an email on 2/16/26 at 11:18 a.m. the DON documented Resident #5 was not up to date with the COVID-19 vaccine. The resident's clinical record lacked documentation he had been offered the COVID vaccine. 3) In an email on 2/16/26 at 11:18 a.m. the DON documented Resident #6 was not up to date with vaccines. The resident's clinical record lacked documentation she had been offered/given the COVID vaccine. 4) In an email on 2/16/26 at 11:18 a.m. the DON documented Resident #7 was not listed as up to date on current vaccines. The resident's clinical record lacked documentation she had been offered/given the COVID vaccine. 5) Review of an immunization record printed off by the Director of Nursing (DON) on 2/12/26 at 10:08 a.m. indicated Resident #10 was due for a COVID-19 vaccine on 9/1/26. The resident's clinical record lacked documentation she had been offered/given the COVID vaccine. On 2/12/26 at 10:33 a.m. the DON stated the vaccine provider came in and did vaccine clinics, but they didn't give the facility a list of the residents that received the vaccines.