STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165196	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Opco Dayton IA LLC	508 2nd Street NE Dayton, IA 50530

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, pharmacy interview and policy review, the facility failed to provide care and services according to accepted standards of clinical practice for 1 of 16 residents reviewed (Resident #23) for Physician orders. The facility reported a census of 35 residents. Findings includes: Resident #23'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 cancer, anemia, arthritis, seizure disorder, and secondary malignant neoplasm of the brain (metastatic brain tumor).The Care Plan revised 11/3/25 revealed Resident #23 had chronic pain and had a risk for adverse (unwanted) effects due to the use of anticonvulsants medication to aid in the treatment of seizures/convulsions. The Care Plan directed staff to anticonvulsant and pain medications as ordered. The November and December 2025 Medication Administration Record (MAR) directed staff to administer Tramadol HCL (narcotic pain medication) 50 mg (milligrams) one tablet every 8 hours. A Progress Note dated 11/19/25 documented Resident #23 went out to a doctor appointment with family. The note revealed Resident #23 returned with new orders to discontinue Keppra (anticonvulsant medication) and change Vimpat (anti-epileptic medication) to 100 mg (milligrams) twice daily. In addition, the note directed to stop Rizatriptan (medication used to treat migraines) when Nurtec (medication used to treat migraines) was approved. A Telehealth Neurology Progress Note dated 11/19/25 documented Resident #23 reported daily headaches and frequent migraines. In addition, the note revealed Resident #23 continued to have tonic-clonic seizures (causes a loss of consciousness and violent muscle contractions) and agitation per the report of the nursing home and her family. The note documented the follow new orders/medication changes: 1. Start Brivaracetam (Briviact) (antiepileptic medication)100 mg two times a day (BID) for focal epilepsy.2. Increase Vimpat to 2 tabs (100 mg total) two times daily. 3. Start Nurtec 75 mg take one table by mouth every other day for migraine headachesThe Neurology Progress Note dated 11/19/25 documented the Physician directed to discontinue the Keppra medication and change to Briviact medication for seizure control and to reduce the agitation. In addition, the note directed to increase the Vimpat dose from 50 mg to 100 mg BID due to continued seizures. In addition, the note reflected Resident #23 would be a good candidate for Nurtec every other day dosing for both preventative and abortive therapy (stop migraine attack as it starts). The note documented the Rizatriptan (medication used to treat migraines) had not been beneficial due to the medication being PRN (as needed) and requiring Resident #23 to ask for it. A Physician Progress Note dated 11/24/25 documented the DNP (Doctor of Nursing) reviewed Resident #23's neurology progress notes from 11/19/25. The DNP documented Resident #23 was supposed to be on Briviact 100 mg BID for focal epilepsy and she did not see this on Resident #23's MAR. In addition, the DNP documented Nurtec was suggested in place of Rizatriptan and did see this had been given. The DNP requested the facility look into the medications. Review of the November and December MAR lacked documentation that the Briviact and the Nurtec medication had been started. The clinical record lacked documentation of clarification or follow-up for the Neurology Progress Notes from 11/19/25 and the Physician Progress Notes from 11/24/25. A Progress Note dated 11/25/25 documented (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #23 went to a doctor's appointment and returned. The note documented Resident #23's Tramadol orders needed to be clarified. The Hematology Oncology Progress Notes dated 11/25/25 documented the Physician advised the use of the Tramadol pain medication every 6 hours for better control. Review of the Clinical Record lacked documentation of clarification or follow-up for the Tramadol order. On 12/10/25 at 2:30 PM, the Director of Nursing (DON) stated the pharmacy reported they last received a script for Tramadol medication on 11/4/25 for every 8 hours. The DON reported the pharmacy did not have orders for the Nurtec or Briviact medication. The DON reported she could not locate the Physician Appointment Note with the written Physician orders from the Neurology appointment. She said the Physician Appointment Note would have been faxed to the Pharmacy. When asked about the Physician Progress Note from 11/24/25, the DON said she was going to call the DNP to see how those orders were communicated to the facility, whether through dictation or verbally. On 12/10/25 at 3:30 PM, the DON provided an Order Summary Report for Resident #23. She reported Staff B, Registered Nurse (RN), received the summary with written changes on it when Resident #23 returned from the Neurology appointment on 11/19/25. Review of the Order Summary Report for 11/19/25 revealed writing in red ink that documented to discontinue the Keppra, change the Vimpat dose to 100 mg and wait for Nurtec to be approved, and to stop Rizatriptan medication when Nurtec was started. The form lacked directions on how to take the Nurtec. The forms lacked a Physician signature or documentation of who wrote the changes on the order summary form. The order summary form did not address starting the Briviact medication. On 12/10/25 at 3:45 PM, Staff B reported Resident #23's family handed her the Order Summary Report form when Resident #23 returned to the facility from the appointment. She said she put the changes on the MAR and faxed the summary to the Pharmacy. She said she did not call the Neurology office to clarify any of the orders. Staff B verified that she made the changes to the medication orders without a Physician signature. Staff B said she was going off what was written on the order summary form and what the family had told her. She reported Resident #23 returned with a blank Physician Appointment Communication form. On 12/11/25 at 8:25 AM, the DON verified the facility didn't initiate the Briviact and Nurtec medications. The DON reported the pharmacy did not receive any new orders from the neurology office including the script for the increase of the Vimpat. She said the DNP sent the script for the Vimpat on 11/20/25. She said she expected when the nurse obtained physician orders to transcribe them in the computer and notify the pharmacy. She said if the physician orders needed to be clarified then she expected the nurse to call the Prescribing Physician and if not available to call the Primary Care Physician. The DON reported she expected the nurse to clarify the written orders for Resident #23 on the order summary form on 11/19/25 as it didn't have a physician signature. She said she expected physician orders to be followed through. On 12/11/25 at 9:56 AM, the Pharmacist reported the pharmacy did not receive any orders for Briviact or Nurtec on 11/19/25 for Resident #23. The Pharmacist reported the physician discontinued the Keppra medication on 11/19/25 and increased the Vimpat medication to 100 mg BID. The facility policy titled Administering Medications revised December 2012 documented medications shall be administered in a safe and timely manner and as prescribed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and policy review, the facility failed to change oxygen tubing and water humidifier for 1 of 2 residents reviewed (Resident #4) for respiratory services. The facility reported a census of 35 residents. Findings Include: Resident #4's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe impaired cognition. The MDS included diagnoses of hypertension (high blood pressure), pulmonary fibrosis (a condition in which the lungs become scarred over time), respiratory failure and other disorders of the lung. The MDS documented Resident #3 received oxygen while a resident within the last 14 days. A Physician order dated 7/7/25 directed Resident #4 to wear oxygen at 2 liters per minute per nasal cannula to keep oxygen saturation above 88% every shift for hypoxia (low levels of oxygen in body tissue) related to chronic respiratory failure.A Physician order dated 11/8/22 directed staff to change oxygen tubing every week on Sunday. The Care Plan revised 9/15/25 documented Resident #4 used continuous oxygen and was at risk for alterations in oxygen levels due to diagnosis of pulmonary fibrosis, chronic obstructive pulmonary disease (COPD), and chronic respiratory failure with hypoxia. The Care Plan directed to change oxygen tubing and humidifier per facility policy. On 12/9/25 at 7:22 AM, observed Resident #4's oxygen tubing dated 11/23/25 and water humidifier dated 10/26/25. On 12/9/25 at 10:55 AM, the Director of Nursing (DON) acknowledged Resident #4's oxygen tubing was dated for 11/23/25 and the water humidifier dated for 10/26/25. The DON removed the oxygen tubing and put it in the trash can. The DON reported she would replace the tubing and water bottle. Review of the November and December 2025 Treatment Administration Record (TAR) revealed the oxygen tubing was signed off as being changed on 11/23/25, 11/30/25 and 12/7/25. The TAR lacked direction on how often to change the water humidifier. On 12/9/25 at 11:18 AM, the DON reported she expected the staff to change the oxygen tubing weekly per the physician order. The facility policy titled Oxygen Administration dated 2/1/25 directed staff to change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. In addition, the policy directed to change the humidifier bottle when empty, every 72 hours or per facility policy, or as recommended by the manufacturer.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to have a complete and accurately documented medical record for 1 of 16 residents reviewed (Resident #2). The facility reported a census of 35 residents.Findings include: Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS identified Resident #2 as dependent on staff for transfers and toileting hygiene. The MDS documented Resident #2 as always incontinent of bowel. Resident #2's MDS included diagnoses of anemia (low blood iron level), heart failure (heart does not pump enough blood), hypertension (high blood pressure), and seizure disorder. The Care Plan revised 10/6/25 directed the staff to observe for side effects of narcotic analgesic medication which included constipation and decreased bowel sounds. Review of the bowel elimination records for October 2025 revealed Resident #2 had a large bowel movement (BM) on 10/12/25 and did not have a BM from 10/13/25 to 10/16/25. Review of the form titled Daily BM Management Audit dated 10/14/25 documented Resident #2 on day 2 without a BM. The form directed staff to offer prune juice. The form had a line/check mark documented next to Resident #2's name indicating they received prune juice. Review of the form titled Daily BM Management Audit dated 10/15/25 documented Resident #2 on day 3 without a BM. The form directed staff to give milk of magnesia (laxative). The form had a line/check mark documented next to Resident #2's name indicating they received milk of magnesia. Review of the form titled Daily BM Management Audit dated 10/16/25 documented Resident #2 on day 4 without a BM. The form directed staff to give a suppository. The form had a line/check mark documented next to Resident #2's name indicating they received a suppository.A Skilled Nursing Facility (SNF) assessment dated [DATE] documented Resident #2 had constipation and received a laxative early in the morning. The October 2025 Medication Administration Record (MAR) lacked documentation of the administration of milk of magnesia on 10/15/25. In addition, the MAR lacked documentation of a physician order for a suppository or Resident #2 received one on 10/16/25. Review of the clinical record lacked documentation regarding the administration of bowel medications, or any follow up on the effectiveness of the PRN (as needed) medication. On 12/10/25 at 2:56 PM, Staff A, Licensed Practical Nurse (LPN), reported the BM list for the morning of 10/16/25 included Resident #2. Staff A said the night nurse/Assistant Director of Nursing (ADON) told her in report he gave Resident #2 something for constipation. Staff A said she didn't know for sure what he gave. On 12/10/25 at 3:45 PM, the ADON reported when passing medications in the morning, he reviewed the BM list and give interventions/medications if needed. He said the morning of 10/16/25 he gave Resident #2 a suppository. He said he provided Resident #2 with education regarding the need for the suppository to prevent a hospitalization. He said Resident #2 agreed to take the suppository. The ADON reported he used the facility standing order according to the bowel protocol. He said the only thing he failed to do was document that he administered the suppository. He said it was at the end of his shift. He reported he thought all the residents had PRN laxatives on their orders sets. The ADON said he listened to his bowel sounds but he did not document it.On 12/11/25 at 8:25 AM, the Director of Nursing (DON) reported she expected the staff to document the bowel management interventions and assessments in the medical record. She reported she expected standing orders to be transcribed on the MAR/TAR (treatment administration record) when initiated [NAME] documented when given. The DON said she would expect the staff to follow up on PRN medication given and document the effectiveness in the medical record. On 12/11/25 at 8:50 AM, the DON confirmed the check mark/line documented on the Daily BM Management Audit form indicated what intervention or medication was given. The DON verified the Daily BM Management form as the facility process for BM monitoring.

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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 observations, clinical record review, staff interviews, and policy review, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 1 of 2 residents reviewed (Resident #2) for pressure ulcer care. The facility reported a census of 35 residents.Findings include: Resident #2's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS identified Resident #2 required substantial/maximal assistance for transfers and toileting. Resident #2's MDS included diagnoses of a pressure ulcer to the right buttocks, stage 4 (full thickness tissue loss where skin, fat, muscle, tendon or bone can be exposed). On 12/9/25 at 1:20 PM, observed Staff A, Licensed Practical Nurse (LPN), complete wound care to Resident #2's pressure ulcer to the right buttocks. Staff A gathered supplies at the medication cart outside of the room and placed the supplies on top of a blue towel. Staff A carried the supplies on the towel along with a handful of loose gloves into the room. Staff A placed the towel with supplies on the dresser in front of the TV and then placed the loose gloves on top of the dresser without a barrier. Staff A closed the door to the room, and without completing hand hygiene, put on a blue gown and put on gloves. Staff A took Resident #2's urinal with urine in it off the tray table and emptied it in the toilet. She then rinsed the urinal out with soap and water and placed it on the side of the trash can. She removed her gloves and washed her hands at the sink. Staff A then moved the towel with the supplies on top of the towel to the tray table where the urinal had sat, without disinfecting the area beforehand. She proceeded to take the loose gloves off the dresser and put them on the towel on the tray table with the other supplies. Staff A then left the room to get the hand sanitizer off the medication cart from outside the door. She returned to the room and put the hand sanitizer on the tray table. Staff A then put on a pair of gloves from the towel on the tray table. Staff A failed to complete hand hygiene prior to putting on the gloves. Staff A proceeded to complete wound care with the gloves that sat on the dresser without a barrier (dirty surface). The contaminated gloves touched the wound care supplies including the wound cleanser bottle, gauze pads used to cleanse the wound, sliver alginate rope (dressing used to pack the wound), and the Mepilex dressing used to cover the wound. Staff A used her gloved finger to apply the Baza cream to the peri (around) ulcer skin of the wound. Staff A acknowledged she should not have placed the gloves on the dresser as it was a dirty surface. On 12/9/25 at 3:25 PM, the Director of Nursing (DON) and Infection Preventionist said she expected the nurse to place the gloves on a barrier and not on a dirty surface. In addition, she agreed they should have disinfected the tray table prior to use. A facility policy titled Infection Prevention and Control Program reviewed March 2020 documented the facility strived to prevent transmission of infections and communicable diseases, development of nosocomial infections and effectively treat and manage infections. A coordinated process was established to reduce the risk of infection in residents and employees. The process included prevention, surveillance and control which included barrier precautions, cleaning and disinfecting. A facility policy titled Handwashing and Hand Hygiene Policy documented the facility considered hand hygiene the primary means to prevent the spread of infection. The policy directed hand washing/hand hygiene to be completed before handling clean or soiled dressing and after contact with objects in the immediate vicinity of the resident.