

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165198	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/10/2026
NAME OF PROVIDER OR SUPPLIER  Iowa City Rehab & Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE  3661 Rochester Avenue Iowa City, IA 52245	
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 0693  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, clinical record review and staff interviews, the facility failed to maintain the head of the bed elevated during a continuous tube feeding and failed to apply an abdominal binder per physician order for 1 of 1 resident (Resident #1) reviewed for g tube feedings. The facility reported a census of 45 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] identified Resident #1 as cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 99 [a code used to indicate an incomplete interview]. The MDS list of diagnosis included paraplegia, non-Alzheimer's dementia and malnutrition. The MDS indicated Resident #1 had a gastric tube with tube feedings continuously. A review of the Care Plan, dated 9/22/25, revealed Resident #1 with the problem of being at risk for altered nutritional status as he was dependent on tube feedings to meet estimated needs. A review of Physician orders revealed: a. Percutaneous Endoscopic Gastrostomy (a tube placed into the stomach for the delivery of fluids, nutrients and medications. Commonly referred to a PEG tube) Feeding diet NPO (nothing by mouth) texture. Start date 12/3/25. b. Continuous feeding pump continuous: Glucerna 1.2 at 75 cc (cubic centimeters, 1 cc = 1 milliliter (mL)) per hour for 24 hours via pump per PEG tube. Start date 12/16/25. c. Abdominal Binder to be worn at all times. Please it on backwards to prevent removal by resident every shift. Start date: 1/8/26. Observations of Resident #1 completed on 1/18/26 revealed: a. At 10:36 AM, Resident #1 in his room, sitting in a wheelchair. Resident not wearing an abdominal binder. Resident independently self-transferred from wheelchair to his bed. During the transfer tubing to PEG noted to have increased tension. Resident laid down in his bed, with the bed in a flat position. The PEG tube feeding remained attached to a pole fixed on the wheelchair. The pump continued running with the feeding at the prescribed 75 mL hour. b. At 10:38 AM, the State Agency (SA) informed Staff B, Registered Nurse that Resident #1 transferred to his bed with tension on the PEG tube and the feeding pump running. c. At 11:50 AM, 12:20 PM, and 12:30 PM, Resident #1 in bed, asleep and not wearing an abdominal binder. Resident's bed remained in a flat position, while the feeding pump ran at 75 mL per hour. Resident #1 did not have an abdominal binder applied. d. At 12:32 PM, Staff B, RN walked into Resident #1's room and walked right out without elevating the head of the bed. e. At 12:41 PM, Staff B, RN walked by Resident #1's room pushing a medication cart, did not elevate the Resident #1's head of the bed as she walked by. f. At 12:46 PM, Staff B, RN, walked into Resident #1's room, did not elevate the head of the bed before she left the room. g. At 12:50 PM, door to room closed to Resident #1, Staff B, RN, stood outside his room by the nurse's station with the medication cart. h. At 12:53 PM, Staff A, Certified Nursing Assistant (CNA) walked out of Resident #1's room. The resident remained asleep in bed, with the bed in a flat position and the feeding pump running at running at 75 mL/hr. i. At 12:58 PM, the SA The Surveyor informed the ADON (Assistant Director of Nursing) of the head of the bed in the flat position while the continuous feeding pump ran. The ADON and Staff B, RN into the room</p> <p>(continued on next page)</p>		

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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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>immediately and elevated the head of the bed. During an interview after raising the head of the bed, the ADON stated the head of the bed should be elevated while the tube feeding ran as there would be a risk of aspiration (inhalation of substance into the lungs. During an observation on 1/29/26 at 8:36 AM, Resident #1 laid in bed with the head of bed elevated at least 30 degrees. Resident #1 not wearing an abdominal binder. During an interview on 2/4/26 at 10:06 AM, Staff A, CNA stated Resident #1 had a continuous tube feeding running 24 hours a day, 7 days a week. She stated when the resident is in bed, the head of his bed should be positioned at 45 degrees. When asked what could happen if the feeding pump ran with the resident lying flat, Staff A stated something bad, but unsure of what. Staff A stated the resident should be wearing an abdominal binder when he is up out of bed. She stated when the resident is in bed she will remove the binder. Staff A stated nurses and aides are responsible for making sure he has the abdominal binder on. During an interview on 2/4/26 at 11:50 AM, Staff B, RN stated Resident #1 had a continuous tube feeding running at all times and when he is in bed, the head of the bed should be elevated at least 30 degrees. Staff B stated the resident had a history of pulling out his PEG tube and both nurses and aides are responsible to check to see he has his abdominal binder on to keep him from pulling it out. Review of the undated facility policy titled Care and Treatment of Feeding Tubes, revealed the facility would utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. The policy did not give direction on the position of the head of the bed while a feeding pump ran.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, facility policy review, and staff interviews, the facility failed to ensure routine medications were re-ordered prior to the exhaustion of the supplying causing 1 of 4 residents (Resident #2) to miss three full days of medications. The facility reported a census of 45 residents. Findings include: Review of the Minimum Data Set (MDS) dated [DATE], identified Resident #2 with a moderate cognitive impairment based on a BIMS (Brief Interview for Mental Status) score of 11 out of 15. The list of diagnoses included Alzheimer's disease, diabetes mellitus, thyroid disease and atrial fibrillation (irregular heart beat). The MDS documented an admission date of 12/08/2026. Review of the electronic health record (EHR) revealed an ED (Emergency Department Note) dated 1/3/26 which revealed, in part: Chief Complaint. Pt from [name of facility redacted]. Daughter called EMS (emergency medical services) regarding pt cares. Pt missing appointments and medications stopped without explanation. Daughter endorses pt appears more confused and is not eating. AxOx3 (alert and orientated by three (person, place and time). Glucose 318. The ED course of the note revealed, in part: ED Course as of 1/3/26 0706 (7:06 AM) .at 0234 (2:34 AM) Upon speaking with the pharmacy it appears that the pt discharge meds from previous visits had not been renewed while she was going between rehab hospitals. Review of the December 2026 Medication Administration Record (MAR) revealed the following orders started on 12/8/25 and 12/9/25 for 20 days: a. Aspirin Oral Tablet Chewable 81 MG (milligrams). Give 1 tablet by mouth in the morning related to Chronic Fibrillation for 20 days. Start date: 12/9/26. Per the MAR the medication administered in the AM (morning) on December 9, 10, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 and 28. b. Atorvastatin Calcium Oral Tablet 20 mg (milligrams) Give 1 tablet by mouth in the evening related to Alzheimer's Disease for 20 Days. Start date: 12/8/25. Per the MAR the medication administered in the evening on December 9, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, and 27 c. Bupropion HCl ER (XL) Oral Tablet Extended Release 24 Hour 300 Give 1 tablet by mouth in the morning related to Major Depressive Disorder for 20 Days. Start date: 12/9/25. Per the MAR the medication administered in the AM on December 9, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, and 28. d. Cholecalciferol (Vitamin D3) Oral Tablet 25 MCG (micrograms or 1000 units). Give 1 tablet by mouth in the morning for Supplement for 20 days. Start date: 12/9/26. Per the MAR the medication administered in the AM on December 9, 10, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, and 28. e. Divalproex Sodium Oral Tablet Delayed Release 125 mg Give 1 tablet by mouth at bedtime related to Major Depressive Disorder for 20 Days. Start date: 12/8/25. Per the MAR the medication administered at HS (bedtime) on December 8, 9, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, and 27. f. Donepezil HCl Oral Tablet 5 mg Give 1 tablet by mouth at bedtime related to Major Depressive Disorder for 20 Days. Start date: 12/8/25. Per the MAR the medication administered at HS on December 8, 9, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, and 27. g. Duloxetine HCl Oral Capsule Delayed Release Sprinkle 60 mg (Duloxetine HCl) Give 1 capsule by mouth in the morning related to Alzheimer's Disease for 20 Days. Start date: 12/9/25. Per the MAR the medication administered in the AM December 9, 10, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, and 28. h. Empagliflozin Oral Tablet 10 mg (Empagliflozin) Give 1 tablet by mouth in the morning related to Type 2 Diabetes Mellitus for 20 Days. Start date: 12/9/25. Per the MAR the medication administered in the AM December 9, 10, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, and 28. i. Levothyroxine Sodium Oral Tablet 150 mcg (Levothyroxine Sodium) Give 1 tablet by mouth in the morning related to Hypothyroidism for 20 Days. Start date: Per the MAR the medication administered in the AM December 9, 10, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, and 28. j.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Pantoprazole Sodium Oral Tablet Delayed Release 40 mg Give 1 tablet by mouth in the morning related to Alzheimer's Disease for 20 Days-Start Date 12/9/25 k. Polyethylene Glycol 3350 Powder (Polyethylene Glycol 3350 (Bulk)) Give 17 gram by mouth in the morning for Constipation for 20 Days. Start date: 12/9/25. Per the MAR the medication administered in the AM December 9, 10, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, and 28. l. Amiodarone HCl Oral Tablet 200 mg Give 1 tablet by mouth two times a day related to Chronic Atrial Fibrillation for 20 Days. Start date: 12/8/25. Per the MAR the medication administered in the AM and HS December 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28. m. Budesonide Inhalation Suspension 0.5 mg/2ml 1 application inhale orally two times a day for Wheezing for 20 Days. Start date: 12/8/25. Per the MAR the medication administered in the AM and HS December 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28. n. Eliquis 5 mg. Give 1 tablet by mouth two times a day related to Chronic Atrial Fibrillation for 20 days. Start date: 12/8/25. Per the MAR the medication administered in the AM and HS December 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28. o. Formoterol Fumarate Inhalation Nebulization Solution 20 mcg/ml 1 application inhale orally two times a day for Wheezing for 20 Days. Start date: 12/8/25. Per the MAR the medication administered in the AM and HS December 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28. p. Metoprolol Tartrate Oral Tablet 25 mg Give 1 tablet by mouth two times a day related to Essential Hypertension for 20 Days. Start date: 12/8/25. Per the MAR the medication administered in the AM and HS December 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, and 28. q. Senna Oral Tablet 8.6 MG. Give 2 tablet by mouth two times a day for Constipation for 20 days. Start date: 12/8/25. Per the MAR the medication administered in the AM and HS December 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, and 28. r. Carbidopa-Levodopa Oral Tablet 25-250 mg Give 1 tablet by mouth three times a day related to Alzheimer's Disease for 20 Days. Start date: 12/8/25. Per the MAR the medication administered in the AM, Noon and HS December 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, and 28. Review of the December 2025 MAR, revealed Resident #2 the last dose of the medications listed above administered on the 28th and no further doses scheduled for the month as evidenced by an x for all scheduled times from December 29th through December 31st. did not have any of the above medication administered in December from the last dose on the 28th through the 31st. Review of the January 2026 MAR revealed the following medications not scheduled for administration: aspirin, atorvastatin, bupropion, divalproex sodium, donepezil, duloxetine, empagliflozin, levothyroxine, pantoprazole, polyethylene, amiodarone, budesonide, fumarate inhaler, metoprolol tartrate, senna, and carbidopa-levodopa. During an interview on 2/4/26 at 11:50 AM, Staff B, Registered Nurse (RN) stated when a resident has medications to give for a certain time frame, (ie: when being admitted after a hospitalization and orders only good for 20 days), the nurse is responsible for notifying the physician to renew the orders. Staff B thought a reason why Resident #2 did not get her medications for 3 full days was that perhaps the pharmacy did not send the medications. She also reported it was the pharmacy's responsibility to notify the doctor to obtain renewal orders. During an interview on 2/5/26 at 8:59 AM, Staff C, RN verified Resident #2's medications were not administered on December 29, 30, 31, 2025. She recalled that in December 2025, Resident #2 had quite a few medications that were stopped, but without a discontinue date. Staff C stated if the resident went to the hospital, she would put the meds on hold. Staff C explained if she were to see an X [on the MAR] that means the med would've been scheduled. Otherwise, if the med was not given there should be another # code entered to show if hospitalized, etc. If the medication was discontinued, it wouldn't show up on the computer during the medication pass. Staff C also reported the</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility Nurse Practitioner was responsible for looking at the resident after returning from the hospital and reviewing the medications. During an interview on 2/4/26 at 12:45 PM, Staff D, Nurse Practitioner (NP) stated he could not recall Resident #2's issue with her medications after she arrived from the hospital. He could not explain why some of her medications had been discontinued. During an interview on 2/4/26 at 1:09 PM, the Assistant Director of Nursing (ADON) and Director of Nursing (DON), the DON stated she would have expected the nurse to question why the medications were written to be discontinued after 20 days, and talk to the provider about renewing the orders. The ADON added that the nurse should always give the discharge paperwork to the provider. The DON verified that there was no documentation by the nurses that they brought the 20 days duration of the discharge medications to the provider's attention. The ADON stated after she reviewed the NP progress notes, she discovered he had discontinued some medications when she complained about abdominal pain. Review of the undated facility policy titled, Medication Reconciliation revealed a Policy statement which declared This facility reconciles medications frequently through a residents stay to ensure that the resident is free of any signification medication errors, and theta the facility error rate is less then 5 percent. The Policy Explanation and Compliance Guidelines directed, in part:4. admission Processes:a. Verify resident identifiers on the information received.b. Compare orders to hospital records, etc. Obtain clarification orders as needed.c. Transcribe orders in accordance with procedures for admission orders.d. Have a second nurse review transcribed orders for accuracy and cosign the orders, indicating the review.e. Order medications from pharmacy in accordance with facility procedures for ordering medications.f. Verify medications received match the medication orders.g. Obtain home list of medications from resident/representative. Place on chart for physician review and revision of medication regimen, if warranted. Review of the undated facility policy titled, Medication Reordering revealed a Policy statement which declared It is the policy of this facility to accurately and safely provide or obtain pharmaceutical services including the provisions of routine and emergency medications and biologicals in a timely manner to meet the needs for each resident. The Policy Explanation and Compliance Guidelines directed, in part:1. The facility will utilize a systematic approach to provide or obtain routine and emergency medications and biologicals in order to meet the needs of each resident.3. Each time a nurse is administering medications and observes (6) or less doses left of one kind, that nurse will reorder the medication, time permitting.</p>		