STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165198	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iowa City Rehab & Health Care	3661 Rochester Avenue Iowa City, IA 52245

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. Based on clinical record reviews, staff interview, and facility policy review, the facility failed to ensure that 4 out of 5 residents reviewed for unnecessary medications were provided with education regarding the risks and benefits of psychotropic medications (Resident #4, Resident #6, Resident #7, Resident #43). Additionally, the facility failed to offer alternative treatment options prior to the administration of the medications. The facility reported a census of 47 residents. Findings include:1. The Minimum Data Set (MDS) Assessment for Resident #4 dated 2/12/26 documented diagnoses that included: Non Alzheimer's dementia, depression and schizophrenia. The MDS recorded an admission date to the facility of 2/22/22. The MDS recorded a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated severe cognitive impairment. The Medication Administration Record (MAR) for Resident #4 for August 2025 reflected the resident had an order for Sertraline, an antidepressant medication, start date 8/29/25 at 25 mg (milligram) for seven days, increasing to 50 mg daily following the initial seven days. A clinical record review of the Resident's Electronic Health Record (EHR) failed to reveal consent obtained for any of the medications prior to administration. Additionally, no progress notes or assessments revealed education was provided of the side effects, risk versus (vs) benefits of psychotropic medications or offering of any alternative treatments. The EHR revealed a Care Conference was held on the morning of 8/29/25, though no resident representative was recorded as being present. The social work summary documented increased symptoms of depression resulting in medication changes. No documentation of education, side effects or alternative treatments were found. 2. The MDS Assessment for Resident #6 dated 3/19/26 documented diagnoses that included: Non Alzheimer's dementia and anxiety disorder. The MDS recorded an admission date to the facility of 9/17/25. The MDS identified a BIMS score of 10 out of 15, which indicated moderate cognitive impairment. The MAR for Resident #6 for September 2025 reflected that the resident had an order for fluvoxamine, an antidepressant medication, lorazepam, an antianxiety medication, and seroquel, an antipsychotic medication.A clinical record review of Resident #6's EHR failed to reveal consent obtained for any of the medications prior to administration. Additionally, no progress notes or assessments revealed education was provided of the side effects, risk vs benefits of psychotropic medications, or offering of any alternative treatments. 3. The MDS Assessment for Resident #7 dated 3/4/26 documented diagnoses which included depression and insomnia. The MDS recorded an admission date to the facility of 3/8/24. The MDS identified a BIMS score of 15 out of 15 which indicated cognition intact.The MAR for Resident #7 for August 2025 reflected that the resident received a new order for Zaleplon, a hypnotic medication on 8/4/25.A clinical record review of Resident #7's EHR failed to reveal consent obtained for the medication prior to administration. Additionally, no progress notes or assessments revealed education provided of the side effects, risk vs benefits of psychotropic medications, or offering of any alternative treatments. 4. The MDS Assessment for Resident #43 dated 4/23/26 documented diagnoses that included: Non Alzheimer's dementia, anxiety, and depression. The MDS recorded an admission date to the facility of 10/22/24. The MDS identified a BIMS score of 15 out of 15, which indicated cognition intact. The MAR of Resident #43 for July of 2025 reflected the resident's order for Mirtazipine, an antidepressant, was increased from 7.5 mg to 22.5 mg. The MAR for August 2025 documented an additional increase of (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Mirtazapine to 30 mg daily. A third increase of the medication was documented in January of 2026 to 45 mg daily. Resident #43 was additionally ordered Aripiprazole, an antipsychotic medication on 10/30/25 at a dose of 2 mg daily, which was increased on 12/29/25 to 5 mg daily. Resident #43 received an order for Ambien, a hypnotic medication, on 12/17/25 at a dose of 5 mg, then raised to 10 mg on 3/3/26, which was discontinued on 3/9/26. Resident #43 then began a new order for Trazodone, also an antidepressant medication on 3/10/26 at a dose of 25 mg daily. A clinical record review of Resident #43's EHR failed to reveal consent being obtained for any of the above medications prior to administration. Additionally, no progress notes or assessments were revealed of education provided of the side effects, risk vs benefits of psychotropic medications. or offering of any alternative treatments. On 5/7/26 at 1:17 pm, the Director of Nursing (DON) stated the facility Nurse Practitioner often would provide education when she ordered new psychotropic medications. The expectation for the facility was to notify the resident and resident representative of the order, the information about the medicine, and obtain consent at that time. She added staff should then monitor for effectiveness and report findings to the provider. The undated facility policy titled Use of Psychotropic Medications documented the following:Point 9: Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase.Point 10: The resident has the right to accept or decline the initiation or increase of a psychotropic medication.Point 11: The facility will document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and the preferred option to accept or decline in a format the facility deems to use (e.g., written consent form, narrative note, etc.).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, and staff interview the facility failed to maintain a sanitary, orderly, and comfortable interior in facility dining room [ROOM NUMBER] of 2 dining observations, ensure furniture (chairs) in good condition in 1 of 2 entrance areas, and failed to ensure a clean environment in a resident's room (Resident #43). The facility reported a census of 47 residents. Findings include: 1.On 5/05/2026 9:18 AM, observed chairs in the main entrance areas. Noted two wooden dining arm chairs with brown vinyl back of chair and chair seat. The dining room chairs showed significant signs of wear and tear. The varnish was worn, indicating that the finish had faded. Additionally, the arms were loose. Two arm chairs were also in this area, one was light green and the other was brown. Visible peeling and cracking of the upholstery noted on the seat, arms and backrest of the chairs. 2.On 5/05/25 at 1:00 PM, observation in the North dining room (DR) revealed five dining chairs. Five of Five dining chairs had cracked or peeling vinyl upholstery. Noted visible imprints or indentation on the seats. The varnish of the chairs was worn. On 5/6/26 at 3:30 PM, the Administrator verbalized his expectation was that the furniture was in good repair. The policy titled Quality of Life-homelike Environment, last revised May 2017, stated Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belonging to the extent possible. The Policy interpretation and implementation revealed, 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: 2(a) clean, sanitary and orderly environment 2(c) inviting colors and decor. 3. The Minimum Data Set (MDS) revealed Resident #43 had diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and diabetes. The Brief Interview for Mental Status score of 15 out of 15 indicated intact cognition. On 5/4/26 at 10:09 AM, Resident #43 relayed gets weekly housekeeping. The resident reported staff only swept and did toilets, do not clean any tables. The resident pointed to table, multiple sticky rings. On 05/05/26 at 4:05 PM, Maintenance, Staff E conducted tour in absence of housekeeping supervisor, relayed did not have a current housekeeping manager, and further relayed were some budget cuts and staff changes. On 5/7/26 at 10:30 AM, the Administrator explained was actively looking for a housekeeping manager to replace the one that left to improve housekeeping.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on review of Quality Assurance and Performance Improvement(QAPI) meeting documentation, policy review, and staff interview, the facility failed to carry out Quality Assessment Assurance (QAA) activities to obtain feedback, use data, and take action to conduct structured, systematic investigations and analysis of underlying causes or contributing factors of problems affecting facility-wide processes that impacted quality of care, quality of life, and resident safety. The facility reported a census of 47 residents.Findings include: The Centers for Medicare and Medicaid Services(CMS) 2567, dated 12/15/25 listed, in part, the following concerns:F584 and F688The current survey, conducted 5/4/26 to 5/7/26, also identified the above concerns.On 5/7/26 at 2:28 p.m., the Administrator, stated the facility had no documentation related to QA activities targeted at restorative services and staffing. The facility QAPI and QAA Plan, revised 1/2/25, stated the facility would gather QAPI data from sources such as survey findings. The facility carried out systematic action and analysis in order to achieve the desired outcome.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on review of Quality Assurance and Performance Improvement (QAPI) meeting documentation, policy review, and staff interview, the facility failed to carry out Quality Assessment Assurance (QA), the facility failed to carry out quarterly QA meetings to identify issues with respect to QAA activities.Findings included: Review of QAPI Meeting Attendance Logs from the period of the last survey on 5/8/25 to the current survey on 5/4/26 revealed the facility lacked documentation of a QAPI meeting from 6/26/25 to 12/31/25. The facility QAPI and QAA Plan, revised 1/2/25, stated the facility would establish Performance Improvement Plans (PIPs) and staff would review them no less often than quarterly.On 5/7/26 at 1:42 p.m., the Administrator stated the facility conducted QA monthly meetings but it was clear some months (in the last year) were missed.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, facility policy review, resident and staff interviews, the facility failed to interviews, observations clinical record review and policy review, the facility failed to be honor resident request, that those that entered the room wear a mask to prevent further respiratory complications for 1 of 1 resident reviewed for choices (Resident #5). The facility reported a census of 47 residents. Findings include:The Minimum Data Set (MDS) dated [DATE] for Resident #5 revealed diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and respiratory failure. The Brief Interview for Mental Status scored 15 out of 15 indicating intact cognition. The Care Plan revised on 3/18/26 for Resident #5 documented, potential for infection related to history of pneumonia and influenza. Interventions included that Resident #5 prefers to have staff wear a mask, please ask her before entering room. On 5/4/26 at 10:20 AM, Registered Nurse (RN) Staff B observed leaving Resident #5 room without a mask, quired if was required due to the signage on the door. Staff B responded that is only for strangers. On 5/4/2026 at 12:55 PM, Resident #5 relayed wanted staff to wear a mask, understood it to be hard when staff come in and out of the room, had asked staff to put on a mask and asked staff to bring masks to have, never received any and assumed would have to self-pay for them. Resident #5 relayed asked for sign to be on the door, reading, Please wear a mask. Thank youOn 5/5/26 at 12:50 PM, Licensed Practical Nurse (LPN) Staff B observed leaving resident room wearing a mask, quired about the mask, Staff B responded Resident #5 wanted masks worn for her protection.On 5/7/26 at 8:50 AM Resident in bed utilizing oxygen, relayed again preference for masking before entering the room, relayed varies some do and others don't, varied with compliance despite sign on the door. Resident relayed felt wearing masks is beneficial due to respiratory complications.On 5/7/26 at 10:30 AM The Administrator, Staff H relayed resident preference should be supported, was aware of the sign on the door of Resident #5 room that requested those entering to wear a mask, had supplies of masks and would expect staff to respect resident choice.Policy provided Resident Rights dated 2026 documented, the resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on personnel file review, policy review, and staff interview, the facility failed to conduct a criminal background check prior to hire for 1 of 2 newly hired employees. The facility reported a census of 47 residents.Findings included:The facility undated New Hire List and Roster listed a hire date for Staff J Certified Medication Aide as 8/14/25.Staff J's personnel file lacked documentation of a criminal background check completed upon hire. On 5/7/26 at 9:20 a.m, Staff H Interim Administrator stated that he had no other employee file documentation. He stated he was aware there were concerns with the files.On 5/7/26 at 11:36 a.m., the Director of Nursing(DON) stated criminal background checks should be done before hire.The Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy, dated 3/18/26, stated the facility would carry out criminal record checks on all prospective employees .

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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 clinical record review, policy review, and staff interview, the facility failed to provide bed hold information for 2 of 2 residents admitted to the hospital(Residents #8 and #49) and failed to notify the ombudsman of hospitalizations for 1 of 2 residents admitted to the hospital(Resident #8). The facility reported a census of 47 residents.Findings included: 1. The Minimum Data Set(MDS) assessment tool, dated 4/23/26, listed diagnoses for Resident #8 which included end stage renal(kidney) disease, blindness, and abnormalities of breathing. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. A 12/26/25 General Progress Note stated the resident transferred to the Emergency Room. A 1/6/26 General Progress Note stated the resident returned from the hospital. A 1/9/26 General Progress Note stated the resident transferred to the Emergency Room. A 1/13/26 General Progress Note stated the resident returned to the facility. The facility lacked documentation of bed hold information provided to the resident and ombudsman notification for the above hospitalizations. The facility Transfer Notice/Bed-hold Notice Policy, updated 6/10/24, stated the facility would notify the resident of their rights regarding holding a bed when transferred to the hospital. On 5/7/26 at 11:36 a.m., the Director of Nursing(DON) stated staff should provide bed hold information when residents transfer to the hospital. She stated they did not provide Resident #8 bed hold information because he transferred to the hospital directly from dialysis. On 5/7/26 at 12:38 p.m., via email, the interim Administrator stated the facility did not have a specific policy for ombudsman notification but he expected the facility to notify in accordance with the regulation. 2. The census line of the Electronic Health Record (EHR) for Resident #49 reflected an initial admission to the facility on [DATE]. The resident's status was reflected as unpaid hospital leave on 1/27/26, and returned on 2/3/26. The resident's status was again changed to unpaid hospital leave on 2/8/26, returning to the facility on 2/19/26. The resident was then again sent to the hospital on 3/8/26. Review of Progress Notes revealed a bed hold form was sent with the resident for his 2/8/26 hospitalization only. The EHR failed to document whether a bed hold was completed for the hospitalization beginning 1/27/26 or the hospitalization beginning 3/8/26. On 5/6/26 at 1:48 pm, the interim Administrator stated the facility staff had recently learned there was no process in place for ensuring bed holds were completed. He clarified they were working on a plan to resolve the issue.

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	165198	A. Building B. Wing	05/07/2026

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on clinical record review, staff interview, guidance from the 2024 Resident Assessment Instrument (RAI) Manual, and facility policy review, the facility failed to complete and transmit a Comprehensive Minimum Data Set (MDS) Assessment following a significant change within federal guidelines for 1 of 1 resident (Resident #6) reviewed for Hospice Admission. The facility reported a census of 47 residents.Findings include:The Census Line portion of the Electronic Health Record (EHR) of Resident #6 documented the resident enrolled in hospice care on 4/14/26. The MDS section of the resident's EHR documented a Significant Change MDS for Resident #6 as in process (incomplete), with an Assessment Reference Date (ARD) of 5/6/26. On 5/6/26 at 2:26 pm, the MDS Coordinator stated nobody had informed her Resident #6 had enrolled in hospice, so therefore, she had not set up or completed a Significant Change assessment. She stated the facility needed better communication and other staff were supposed to notify her. She added she regularly checked the census line of facility residents but if she did not catch a change and was not informed by other staff then the assessment could get missed. According to the 2024 RAI, a Significant Change (comprehensive) assessment, the ARD must be no later than the 14th calendar day after determination that a significant change in the resident's status occurred. The RAI stated a Significant Change MDS is required to be performed when a terminally ill resident enrolls in a hospice program. The undated facility policy titled MDS 3.0 Completion, documented the following: Point 2d: Significant Change in Status Assessment (SCSA) - a comprehensive assessment completed within 14 days of the identification of a status change that meets the requirements outlined in Chapter 2 of the Version 3.0 RAI Manual.ii. A SCSA is required when a resident enrolls in a hospice program or changes hospice providers and remains in the facility, or a resident in the facility receiving hospice services discontinues those services (known as revocation of hospice care) and remains in the facility.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on clinical record review, facility policy review, and staff interview, the facility failed to ensure 2 of 4 residents reviewed for activities of daily living received adequate bathing assistance (Resident #11 and Resident #27). The facility reported a census of 47 residents. Findings included: 1. The Minimum Data Set (MDS) assessment tool, dated 3/17/26, listed diagnoses for Resident #11 which included hemiplegia (one-sided paralysis), stroke (a condition in which blood flow to part of the brain was interrupted), and bipolar disorder (a chronic mental health condition characterized by severe mood swings). The MDS stated the resident required substantial/maximal assistance with bathing and listed her Brief Interview for Mental Status (BIMS) score as 14 out of 15, indicating intact cognition. On 5/4/26 at 10:55 a.m., Resident #11 stated staff did not assist her regularly with showers. She stated a week had elapsed between showers and this made her feel dirty and stinkin'. She stated staff was stretched too thin to complete the showers. On 5/5/26, the Director of Nursing (DON) provided the completed paper shower sheets which documented resident showers. She stated she had no additional sheets. Review of the Paper Shower/Skin Check Sheets for the period of 4/1/26 to 4/30/26, combined with review of the electronic health record April 2026 Documentation Survey report revealed Resident#11 had baths on the following dates for the month: 4/3/26, 4/8/26, 4/11/26, 4/12/26, 4/13/26 and 4/29/26. The sheets indicated the resident declined a shower on 4/7/26.The facility lacked documentation of additional baths given during the month of April 2026 and lacked documentation staff re-approached the resident later when she declined a bath.Care Plan entries, dated 2/28/25, stated the resident required the assistance of 1 staff for bathing and directed staff to encourage bathing twice per week. 2. The MDS assessment tool, dated 4/7/26, listed diagnoses for Resident #27 which included heart failure, diabetes, and seizures. The MDS stated the resident required partial to moderate assistance with bathing and listed her BIMS score as 13 out of 15, indicating intact cognition. On 5/4/26 at 10:33 a.m., Resident #27 stated that two weeks elapsed between showers. She stated this was normal around here. She stated Staff L Certified Nursing Assistant (CNA)told her that she would not be able to have a shower today because there were only two aides. The resident stated this made her feel dirty. Review of Paper Shower/Skin Check Sheets for the period of 4/1/26 to 4/30/26, combined with review of the electronic health record April 2026 Survey Report revealed Resident #27 had baths the following days: 4/3/26, 4/10/26, 4/11/26, 4/12/26, 4/13/26, 4/17/26, 4/24/26, and 4/28/26. The facility lacked documentation of additional baths given during the month of April 2026 and lacked documentation staff re-approached the resident later when she declined a bath.Care Plan entries, revised 5/8/25, stated the resident required the assistance of 1 staff for bathing and directed staff to encourage bathing twice per week.On 5/7/26 at 10:35 a.m., Staff C, CNA stated baths were not completed due to staffing issues. She stated on 5/4/26, baths did not get done because she was the shower aide and had to work on the floor. She stated baths were missed before. She stated both Residents #11 and #27 will take a shower if you asked them to.On 5/7/26 at 10:49 a.m., Staff N, Certified Medication Assistant (CMA) stated staffing was terrible and affected care because staff could not get showers done or answer call lights in a timely manner. On 6/7/26 at 10:55 a.m., Staff O, CNA stated residents missed baths because of staffing. She stated staff took care of other residents so could not complete baths.On 5/7/26 at 11:09 a.m., Staff L, CNA stated that staffing was rough and residents missed showers due to this. She stated both Residents #11 and #27 had told her they had to go days without a shower. On 5/7/26 at 11:36 a.m., the Director of Nursing (DON) stated if a resident missed baths, they received it on another day.The facility policy Resident Showers, dated 2024, stated it was the practice of the facility to assist a resident with bathing to maintain proper hygiene, stimulate circulation, and prevent skin issues. The policy stated staff would provide showers per request or per facility schedule.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff interview, the facility failed to provide a restorative program in order to maintain mobility for 1 of 3 residents reviewed for restorative services (Resident #11). The facility reported a census of 47 residents.Findings included:1. The Minimum Data Set (MDS) assessment tool, dated 3/17/26, listed diagnoses for Resident #11 which included hemiplegia(one-sided paralysis), stroke (a condition in which blood flow to part of the brain was interrupted), and bipolar disorder (a chronic mental health condition characterized by severe mood swings). The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 14 out of 15, indicating intact cognition. On 5/4/26 at 1:44 p.m., Resident #11 stated she had a decline every time she finished with therapy services. She stated she walked with Physical Therapy (PT) but after she finished, staff did not walk with her. She could not recall when she walked last.Care Plan entries, revised 6/20/25, stated the resident had a self-care deficit and required assistance with walking. A Care Plan entry, revised 9/17/25, stated the resident required the assistance of 1 staff for walking. The Care Plan directed staff to utilize an upright walker, ankle-foot orthosis (AFO, a splint used to assist in walking), and a strap for the left lower arm for walking up to 50 feet. A PT Discharge summary, dated [DATE], stated at discharge(3/13/26), the resident walked 75 feet with contact guard assist(CGA-a level of assistance in which staff provided constant, light hand contact for safety). The summary stated a functional maintenance program was not indicated at this time. The resident's clinical record lacked documentation staff walked with her from her PT discharge date of 3/13/26 to current(5/7/26). On 5/6/26 at 11:12 a.m., Staff K Physical Therapy Assistant (PTA) stated Resident #11 walked 80 feet in February 2026. She stated the therapists should have made restorative program recommendations. She stated they did not do so because the facility did not have staff to carry out a restorative program. She stated the facility started a new restorative program last week.On 5/7/26 at 10:35 a.m., Staff C Certified Nursing Assistant (CNA) stated the facility started a restorative program 2 weeks ago but there was not one prior to this. She stated she did not walk with Resident #11 and only saw therapy do this. She stated she did not receive direction to walk with her. On 5/7/26 at 11:36 a.m., the Director of Nursing (DON) stated the restorative program at the facility was new and she did not know why there was not one prior. She stated she would expect a restorative program in place at all times. The facility policy Restorative Nursing Programs, dated 2025, stated the facility would provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level.

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	165198	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iowa City Rehab & Health Care	3661 Rochester Avenue Iowa City, IA 52245

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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. Based on clinical record review, policy review, and staff interviews, the facility failed to assess a dialysis (a treatment which filters waste and fluid from the blood when the kidneys failed) access site (a surgically created location allowing blood removal and return for cleansing) on non-dialysis days for 1 of 1 residents reviewed for dialysis care (Resident #8). The facility reported a census of 47 residents.Findings include:The Minimum Data Set (MDS) assessment tool, dated 4/23/26, listed diagnoses for Resident #8 which included end stage renal (kidney) disease, blindness, and abnormalities of breathing. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. A 1/25/25 Care Plan entry directed staff to complete a dialysis flow sheet daily to observe for access site complications.The April and May 2026 Medication Administration Records (MARs) directed staff to assess the resident's dialysis access site on Mondays, Wednesdays, and Fridays(dialysis days) to check for signs and symptoms of infection or bleeding. The MARs directed staff to remove the site pressure dressing on Tuesdays, Thursdays, and Saturdays. During the time frame of 4/1/26 to 5/4/26, the MAR lacked documentation staff assessed the arm every Sunday including 4/5/26, 4/12/26, 4/19/26, 4/26/26, and 5/3/26.The facility policy Hemodialysis, dated 2025, stated the facility would carry out ongoing assessment and oversight of the resident before, during, and after dialysis. The nurse would check the dialysis access site every shift.On 5/5/26 at 1:40 p.m., the Assistant Director of Nursing (ADON) stated she could not locate documentation of site assessments on non-dialysis days. On 5/5/26 at 1:50 p.m., Staff F Registered Nurse (RN) stated staff checked the access site before and after dialysis treatments but did not assess the site on non-dialysis days. 5/7/26 at 11:00 a.m., Staff A Licensed Practical Nurse (LPN) stated they completed a site assessment on dialysis days but did not complete this on non-dialysis days. She agreed if assessments were not completed, there would not be a way to determine if complications occurred. On 5/7/26 at 11:36 a.m., the Director of Nursing (DON) stated staff should assess the access site on non-dialysis days.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on personnel file review, policy review, and staff interview, the facility failed to verify Certified Medication Assistant (CMA) certification validity prior to hire for 1 of 1 newly hired CMAs. The facility reported a census of 47 residents. Findings included:1. The facility undated New Hire List and Roster listed a hire date for Staff J CMA as 8/14/25.The facility lacked documentation of verification of Staff J's CMA certification. The facility policy License Verification, revised 2025, stated the facility would verify all personnel certifications.On 5/7/26 at 11:36 a.m., the Director of Nursing(DON) stated CNA verification and criminal background checks should be done before hire.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, resident and staff interviews, the facility failed to ensure prescribed stock medications were available for 2 of 4 residents (Resident #6 and Resident #2) reviewed for medication administration. The facility reported a census of 47 residents.Findings include:1. Review of Resident #6's April 2026 Medication Administration Record (MAR) revealed the following orders:a. MiraLax Oral Powder 17 GM/SCOOP (Polyethylene Glycol 3350) Give 17 gram by mouth in the morning for Constipation. The MAR indicated Miralax scheduled to be administered in AM.A review of the April 2026 MAR revealed a code of 11 used for the AM scheduled Miralax on 4/27/26, 4/28/26, 4/29/26, and 4/30/26. Per the MAR Chart Codes, the use of an 11 indicated Med not available.b. Lidocaine External Patch (Lidocaine) Apply to lower back topically two times a day for pain, 4% OTC (over the counter). The MAR indicated the patch to be ON 0800 (8:00 AM) and OFF 2000 (8:00 PM). A review of the April 2026 MAR revealed a code of 11 for the AM used for the ON and OFF scheduled times of the [NAME] and APPLY scheduled times of the Lidocaine patch on: 4/16/26, 4/17/26,4/18/26, 4/19/26, 4/20/26, 4/21/26, 4/22/26, 4/23/26, 4/28/26, 4/29/26, and 4/30/26.2. Review of Resident #2 April 2026 MAR revealed an order for: Lidocaine Pain Relief External Patch 4%. Apply to left upper arm topically at bedtime for pain and remove per schedule. The MAR indicated patch to be REMOVE at 0759 (7:59 AM) and APPLY at 2000 (8:00 PM). A review of the April 2026 MAR revealed a code of 11 used for the REMOVE and APPLY scheduled times of the Lidocaine patch on: 4/17/26, 4/18/26, 4/19/26, 4/20/26, 4/21/26, 4/22/26, 4/25/26, 4/28/26, 4/29/26, and 4/30/26. A code of 11 used for APPLY on 4/26/26 and 4/27/26. he did not receive Lidocaine Pain Relief Patch on 3/17, 3/18, 3/19,3/20, 3/21, 3/22,3/26,3/28,3/29.3/30.During an interview on 5/04/26 at 12:45 PM, Resident #2 stated that last week he went 5 days without lidocaine patches and the week prior he went 4 days without them. Resident #2 stated, I have one today. They (the facility) run out of medication frequently.During an interview on 5/5/26 3:10 PM, Staff F, Registered Nurse (RN) stated the facility frequently runs out lidocaine patches, senna, etc. Staff F explained medications are ordered on Tuesday and delivered on Thursday. She stated if the facility runs out of a medication over the weekend, they do not get anything until the following Thursday, unless someone goes to Walmart to get some. During an interview on 5/6/26 7:18 AM, Staff G, RN stated sometimes the facility does run out of stock medications like vitamins and lidocaine patches.During an interview on 5/05/2026 2:30 PM, the Director of Nursing (DON) stated that stock medication orders has been a problem so she started to order extra supplies.Review of the facility policy titled, Medication Reordering, date 2026, revealed a Policy statement which declared: It is the policy of this facility to accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals in a timely manner to meet the needs of each resident.The Policy Explanation and Compliance Guidelines section, 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.2. Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner.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.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, clinical record review, policy review, and resident and staff interviews, the facility failed to ensure call lights functioned or were within reach for 2 of 24 residents reviewed for call light accommodations (Residents #1 and #11). The facility reported a census of 47 residents.Findings included:1. The Minimum Data Set (MDS) assessment tool, listed diagnoses for Resident #1 which included heart failure, depression, and alcohol dependence. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition.On 5/4/26 at 10:46 a.m., Resident #1 stated his call light stopped working 3 weeks ago.On 5/4/26 at 11:24 a.m., Staff F, Registered Nurse (RN) pushed the resident's call light and it did not turn on. When she tried it a second time, it turned on but when she tried it a third time, it did not work. On 5/5/26 at 1:48 p.m., the Maintenance Director stated staff did not report that Resident #1's call light did not work prior to yesterday. He stated a new part was needed in order to fix it.On 5/7/26 at 8:10 a.m., Resident #1 stated he informed Staff M, Certified Nursing Assistant (CNA) about 3 weeks ago that his call light did not work.2. The MDS assessment tool, dated 3/17/26, listed diagnoses for Resident #11 which included hemiplegia(one-sided paralysis), stroke(a condition in which blood flow to part of the brain was interrupted), and bipolar disorder(a chronic mental health condition characterized by severe mood swings). The MDS listed the resident's BIMS score as 14 out of 15, indicating intact cognition. On 5/4/26 at 9:57 a.m., Resident #11 laid in bed and her call light was on the floor out of reach. The State Agency informed staff and they provided her the call light. The facility policy Call Lights: Accessibility and Timely Response, dated 2025, stated staff would ensure the call light was within resident reach and would report problems with the call system immediately.On 5/7/26 at 11:36 a.m., the Director of Nursing (DON) stated if a call light was not working, staff would provide residents with a bell and put in a maintenance order. She stated call lights should be in reach of the resident.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on personnel file review, policy review, and staff interview, the facility failed to ensure 1 of 5 staff members reviewed for Dependent Adult Abuse(DAA) Mandatory Reporter's Training had current training. The facility reported a census of 47 residents.Findings included:The facility undated New Hire List and Roster listed a hire date for Staff J Certified Medication Aide as 8/14/25.Staff J's personnel file lacked documentation of a DAA Mandatory Reporter's Training completed within 6 months of hire. On 5/7/26 at 9:20 a.m, Staff H Interim Administrator stated that he had no other employee file documentation. He stated he was aware there were concerns with the files.The Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy, dated 3/18/26, stated the facility would carry out criminal record checks on all prospective employees and stated within 6 months of hire, each employee was required to complete 2-hour DAA training.