

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165204	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/16/2026
NAME OF PROVIDER OR SUPPLIER  Country Lane Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  819 Country Lane Road Keosauqua, IA 52565	
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)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>Based on clinical record review, facility policy review, staff and resident interviews, the facility failed to ensure resident free from financial exploitation when a staff member didn't return change from a purchase made on behalf of a resident for 1 of 10 (Resident #3) reviewed. The facility reported a census of 46 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #3, dated 1/20/26 included a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated intact cognition. The MDS identified the resident as always able to make herself understood and always able to understand others. A list of diagnoses included chronic obstructive pulmonary disease, acute and chronic respiratory failure and muscle weakness. A review of the electronic health record (EHR) revealed Resident #3 diagnosed with COVID on 3/19/26. Review of the facility's self-reported incident submitted 3/26/26 described Resident #3 reported she gave a Housekeeper (Staff A) \$20 on 3/23/26 to purchase bottled water and chips for her, and Staff A returned with 3 bottles of water, 2 bags of chips, and used \$3 for a drink for herself. The resident reported she gave Staff A an additional \$10 for bottled water, she had not received the water and Staff A owed her \$17. The document detailed Staff A was suspended pending investigation results, law enforcement notified, staff educated and they reimbursed the resident \$17. Review of Resident #3 Care Plan, dated 3/26/26 revealed a Focus area to address [Name redacted, Resident #3] was involved in an allegation of misappropriation of funds by a staff member. Interventions included the following, in part: a. Administrative staff will assist [Name redacted, Resident #3] in using her personal funds for personal items. Date Initiated: 3/27/26. b. [Name redacted, Resident #3] will not give staff members money to purchase items for her. Date Initiated: 3/27/26. c. Document all actions taken, including dates, times, and persons involved. Date Initiated: 4/2/26. d. Psychosocial well-being check in 2x per week for 2 weeks. Date Initiated: 3/27/26. During an interview on 4/14/26 at 10:32 a.m., Resident #3 stated she gave Staff A, Housekeeper, money in the past to buy things for her and it was never a problem, she always bought them and provided the receipt with the items. When she was in isolation for COVID on a Monday (March 23, 2026) she gave Staff A a \$20 bill and asked her to get her bottled water and 2 bags of chips. Staff A brought her 3 bottles of water and said that was all they had (normally \$1 apiece) and 2 bags of chips, there was no receipt and the resident estimated the purchases would have totaled \$14. The resident stated she gave Staff A a \$10 bill at that time and asked her to get her more water, and asked for a hand-held pencil sharpener, like what kids used in elementary school. Staff A came back with an electric pencil sharpener, said it cost \$7 and the store didn't have her bottled water, did not provide a receipt, said she used \$3 to buy herself an energy drink and she would pay her back the next time she worked. She had not seen Staff A since that time and reported the information to facility staff on 3/26/26. The resident stated the facility reimbursed her \$17 for her loss. During an interview on 4/15/26 at 10:13 a.m., the Administrator stated the facility had designated staff for personal shopping for the residents, either the Activity Director or the Social Service Director, and not aware that residents asked other staff to shop for them until 3/26/26, when reported by Resident #3. The Administrator stated she initiated an investigation immediately, reimbursed the resident \$17 from facility funds, the amount estimated by the resident's report, suspended Staff A pending investigation, reported the incident to the Sheriff and the Iowa Department (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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>of Inspections, Appeals &amp; Licensing (DIAL) as required, and educated staff and residents that designated staff were available to shop for residents. The Administrator stated it was not acceptable for staff, other than the designated staff, to handle resident's money or finances, there was a process for the designated staff at the facility to handle and document resident finances and expenses. During an interview on 4/15/26 at 9:45 a.m., Staff A, Housekeeper, stated the resident had asked her to get flavored bottled water for her 3 times that she purchased at a local store. The resident was in isolation and asked her to shop for her when she cleaned her room. Most recently the resident gave her \$20, requested flavored bottled water and a bag of chips, she purchased 8 bottles of water because that's all they had and a bag of chips, brought them to the resident with the receipt and her change of \$6. The resident gave her \$10 to get a pencil sharpener and more bottled water, she bought the pencil sharpener for \$7, the store was out of the water she liked, she bought herself an energy drink from a vending machine at the facility for \$3 and told the resident she would get her change to her when she came back to work. She hadn't returned to work when she received a phone call from the Administrator and asked about shopping for the resident. She would have returned the resident's change but was suspended over that and directed she could not be at the facility. During an interview on 4/15/26 at 8:14 a.m., Staff B, registered nurse (RN) stated Resident #3 was very alert and oriented, able to communicate her needs, and had not known her to exaggerate things or make false statements. During an interview on 4/15/26 at 10:22 a.m., Staff C, Maintenance Supervisor stated he was Staff A's supervisor, she did her job duties, she was not insubordinate and was not aware of any complaints about her work performance. Resident #3 was a family member of his and he often shopped for her when she requested, and was surprised to hear that she asked Staff A to shop for her. He had never known his family member or Staff A to be dishonest, and did not know what to make of the allegation. During an interview on 4/16/26 at 7:41 a.m. Staff D, Activity Director, stated she shopped for residents when requested, Resident #3 had asked her 5 or 6 times to shop, she always wanted her favorite flavored bottled water that they could get at a local store. The last time she requested her to shop was on 4/10/25, prior to that it was on 3/31/26, and some time in mid-March prior to that. The resident usually gave her cash, when she returned with the requested items she counted the change back to the resident and had the resident sign the receipt. Staff D was not aware the resident asked other staff to shop for her, she was off work due to a Covid infection during the time the allegation occurred and at that time 21 of the residents including Resident #3 were in isolation for Covid infections. During an interview on 4/16/26 at 8:06 a.m. Staff E, Business Office Manager (BOM) stated Resident #3 has a Resident Trust Account and asked to withdraw money 2 times since she [the BOM] worked at the facility. The resident was accurate and knew her balance in the account, she had not returned or deposited funds into the account and she believed the resident also had funds from another source that was not part of the Resident Trust Account. Review of the facility undated policy titled, Abuse Policy directed staff, in part: a. The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. b. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. c. Exploitation is defined as taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion. d. All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) or a reasonable suspicion of a crime shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by the administrator and or designee. Those who report allegations of potential or actual abuse and neglect shall be free from retaliation or reprisal. e. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source, misappropriation of resident property) and reasonable suspicion of a crime resulting in bodily injury will be reported immediately, but not later than: 1. Two (2) hours if the alleged violation involves abuse OR has resulted in serious (continued on next page)</p>		

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F 0602  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	bodily injury; or Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. f. If the investigation reveals that the allegation(s) of abuse are founded, the employee(s) may have disciplinary action up to and including termination taken.		