STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165215	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lyon Specialty Care	1010 South Union Rock Rapids, IA 51246

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility record review, staff interviews and facility policy review the facility failed to report an allegation of abuse to the Iowa Department of Inspections & Appeals and Licensing (DIAL) within 2 hours of an allegation of abuse for 1 of 4 residents reviewed for abuse (Resident #1). The facility reported a census of 40 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented diagnoses of non- Alzheimer's Dementia, anxiety disorder and muscle weakness. The MDS showed the Brief Interview for Mental Status (BIMS) score of 8 indicating moderate cognitive impairment. Review of written statement by Staff A, Licensed Practical Nurse (LPN) dated 12/22/25 revealed it was reported to her by Staff B, Certified Nursing Assistant (CNA) that Staff C, CNA and Staff D, CNA were assisting Resident #1 to his room when Resident #1 was talking and Staff D told Resident #1 to shut up and be quiet. Staff B then reported she saw Staff D pinch Resident #1's lip together. This was not witnessed by Staff A. Staff A revealed she only heard what was said to Resident #1 and when she looked up from her charting she did see Staff D's hand moving away from Resident #1's face. Interview on 1/26/26 at 10:33 a.m., with the Director of Nursing (DON) stated the alleged incident occurred on 12/22/25. The DON revealed Staff A sent her a message on the evening of 12/23/25 and stated she had concerns and had left the DON a note and wanted to know if she had received it. The DON revealed she did not work on 12/23/25 and was unaware of what Staff A was talking about. The DON stated at approximately 5:00 p.m., she called Staff A regarding her concerns. The DON confirmed Staff D worked her entire shift on 12/22/25 and returned to the facility on [DATE] for her shift and worked until the DON became aware of the situation. The DON confirmed on 12/23/25 she sent Staff D home from her shift, called the Administrator, immediately turned the incident into DIAL and began the investigation into the alleged incident. Interview on 1/26/26 at 11:06 a.m., with Staff B revealed Staff C was pushing pushing Resident #1 in his wheelchair past the nurses station. Resident #1 was yelling out which is normal for him as he cannot control that. Staff D walked out from behind the nurses station and with her index finger and thumb grabbed his lips and closed his mouth and held his mouth closed for approximately 5 seconds and told him to shut the fuck up. Staff C and Staff D assisted the resident to bed. Staff A was sitting at the nurses station when this occurred. Review of the facility intake information the facility submitted a self report on 12/23/25 at 5:15 p.m Review of facility provided policy titled Dependent Adult Abuse dated November 2019 revealed all allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the Charge Nurse. The Charge Nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative. All allegations of resident abuse shall be reported to the Iowa Department of Inspections and Appeals no later than two (2) hours after the allegation is made. Interview on 2/2/26 at 10:17 a.m., with the Administrator revealed the facility should have reported the (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	allegation of abuse within 2 hours.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and facility record review, the facility failed to separate vulnerable residents from the staff member of an alleged abuse incident (Residents #1). The facility reported a census of 40 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented diagnoses of non- Alzheimer's Dementia, anxiety disorder and muscle weakness. The MDS showed the Brief Interview for Mental Status (BIMS) score of 8 indicating severe cognitive impairment. Review of written statement by Staff A, Licensed Practical Nurse (LPN) dated 12/22/25 revealed it was reported to her by Staff B, Certified Nursing Assistant (CNA) that Staff C, CNA and Staff D, CNA were assisting Resident #1 to his room when Resident #1 was talking and Staff D told Resident #1 to shut up and be quiet. Staff B then reported she saw Staff D pinch Resident #1's lip together. This was not witnessed by Staff A. Staff A revealed she only heard what was said to Resident #1 and when she looked up from her charting she did see Staff D's hand moving away from Resident #1's face. Interview on 1/26/26 at 10:33 a.m., with the Director of Nursing (DON) revealed the alleged incident occurred on 12/22/25. The DON stated Staff A sent her a message on the evening of 12/23/25 and stated she had concerns and had left the DON a note and wanted to know if she had received it. The DON revealed she did not work on 12/23/25 and was unaware of what Staff A was talking about. The DON stated at approximately 5:00 p.m., she called Staff A regarding her concerns. The DON confirmed Staff D worked her entire shift on 12/22/25 and returned to the facility on [DATE] for her shift and worked until the DON became aware of the situation. The DON confirmed on 12/23/25 she sent Staff D home from her shift, called the Administrator, immediately turned the incident into DIAL and began the investigation into the alleged incident. Interview on 1/26/26 at 11:06 a.m., with Staff B revealed Staff C was pushing pushing Resident #1 in his wheelchair past the nurses station. Resident #1 was yelling out which is normal for him as he cannot control that. Staff D walked out from behind the nurses station and with her index finger and thumb and pinched his lips and closed his mouth and held his mouth closed for approximately 5 seconds and told him to shut the fuck up. Staff C and Staff D assisted the resident to bed. Staff A was sitting at the nurses station when this occurred. Interview on 1/26/25 at 3:02 p.m., with Staff A revealed it was roughly 9:00 p.m., on 12/22/25 and she was at the nurses station charting when Staff C went to get Resident #1. Resident #1 was yelling out which is common for him and as Staff C was pushing Resident #1 in his wheelchair to his room as he was rounding the nurses station she heard Staff D tell Resident #1 shut the fuck up. Staff A looked up and said to Staff D really. Staff C and Staff D proceeded to put the resident to bed that night. Staff A verified she did not assist with Resident #1 going to bed. After the evening shift went home Staff B sent her a message she had seen Staff D pinch Resident #1's lips closed when she told him to shut the fuck up. Staff A revealed she did not see Staff D pinch his lips together but did hear her say shut the fuck up. Staff A further revealed looking back she should have handled it differently and should have separated the resident and staff. Review of the facility provided policy titled Dependent Adult Abuse dated November 2019 revealed Upon receiving a report of an allegation of resident abuse, the facility shall immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. If this involves an allegation of abuse by an employee, this will be accomplished by separating the employee accused of abuse from all residents through the following or a combination of the following, if practicable: (1) suspending the employee; (2) segregating the employee by moving the employee to an area of the facility where there will be no contact with any residents of the facility. Interview on 2/2/26 at 10:17 a.m., with the Administrator revealed the facility should have (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	separated the staff member from others at the time of the incident.

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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 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 record review and staff interviews the facility failed to provide and maintain accurate resident records to reflect an incident occurring in the facility for 1 of 4 residents (Residents #1). The facility reported a census of 40 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented diagnoses of non- Alzheimer's Dementia, anxiety disorder and muscle weakness. The MDS showed the Brief Interview for Mental Status (BIMS) score of 8 indicating severe cognitive impairment. Review of written statement by Staff A, Licensed Practical Nurse (LPN) dated 12/22/25 revealed it was reported to her by Staff B, Certified Nursing Assistant (CNA) that Staff C, CNA and Staff D, CNA were assisting Resident #1 to his room when Resident #1 was talking and Staff D told Resident #1 to shut up and be quiet. Staff B then reported she saw Staff D pinch Resident #1's lip together. This was not witnessed by Staff A. Staff A revealed she only heard what was said to Resident #1 and when she looked up from her charting she did see Staff D's hand moving away from Resident #1's face. Interview on 1/26/26 at 10:33 a.m., with the Director of Nursing (DON) revealed the alleged incident occurred on 12/22/25. The DON stated Staff A sent her a message on the evening of 12/23/25 and stated she had concerns and had left the DON a note and wanted to know if she had received it. The DON revealed she did not work on 12/23/25 and was unaware of what Staff A was talking about. The DON stated at approximately 5:00 p.m., she called Staff A regarding her concerns. The DON confirmed Staff D worked her entire shift on 12/22/25 and returned to the facility on [DATE] for her shift and worked until the DON became aware of the situation. The DON confirmed on 12/23/25 she sent Staff D home from her shift, called the Administrator, immediately turned the incident into DIAL and began the investigation into the alleged incident. Review of the facility intake information the facility submitted a self report on 12/23/25 at 5:15 p.m. regarding an allegation of abuse. Review of Resident #1's Progress Notes lacked documentation of the incident occurring on 12/22/25. The facility does not have a policy on maintaining accurate and complete resident records. Interview on 2/2/26 at 11:07 a.m., Regional Nurse Consultant revealed there was nothing charted in the chart regarding the incident and did not have an incident report of any type.