STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165219	A. Building B. Wing	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurens Care Center	304 East Veterans Road Laurens, IA 50554

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure residents and/or their representatives had the right choose a pharmacy for 1 of 3 resident's reviewed (Resident #4). The facility reported a census of 27 residents.Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #4 scored 13 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident's diagnoses included diabetes, Alzheimer's disease, anxiety disorder, restlessness and agitation. The resident's drug regimen included antianxiety, antiplatelet, and hypoglycemic medications. The Care Plan identified the resident on Antiplatelet therapy (Aspirin) revised 4/7/25, antianxiety medication (lorazepam) initiated 5/7/25, and antidepressant medication (Trazadone) initiated 9/23/25. An admission Information form dated 3/28/25 documented yes for Resident #4 being a veteran and yes for Veterans Administration (VA) meds. The Progress Notes documented the following:On 7/23/25 at 1:38 p.m. the Social Services Coordinator (SSC) received a phone call from the Clinic on behalf of Resident #4's spouse requesting his VA benefits be reviewed. The caller shared the resident paid full price for multiple medications, and the spouse questioned if VA insurance would cover the cost of the medications. The SSC shared the inquiry with the administrator and Director of Nursing (DON). The SSC would follow up as needed.On 7/30/25 at 12:39 a.m. call placed to pharmacy, and they were unable to find prescriptions with VA for Resident #4. He was seen on 6/12/25 and had advanced dementia - Dr through Veteran Affairs and local Primary Care Provider (PCP) Physician Assistant Certified (PA-C). Per pharmacy send Medication Administration Record (MAR)/Treatment Administration Record (TAR) to VA provider so she could order medications through VA. At 1 a.m. fax prepared and sent to provider at VA attaching her faxed orders, 2, from visit on 6/12/25, copy of face sheet and copies of Resident #4's MAR and TAR. At 1:27 a.m. Fax completed and 19 pages confirmed sent.On 8/1/25 at 3:18 p.m. call from VA informing Resident #4 approved to see provider closer to his home at local clinic scheduled for 8/18/25 PA:C and she could send orders to VA and would get meds sent, but if needed sooner let VA know and a provider would okay for 30 day supply until seen by PCP.On 8/18/25 at 2:42 p.m. Resident #4 out of facility in van to appointment at clinic at 2:15 p.m. Returned to facility at 2:25 p. m Appointment had been cancelled 8/17/25 by text confirmation. Appointment scheduled for [DATE] at 4 p.m. On 9/2/25 at 5:22 p.m. appointment with PA-C, initial community care for VA visit. Due for labs this month. The record lacked any additional information r/t VA meds.On 10/6/25 at 5:05 p.m. Staff E Licensed Practical Nurse (LPN) stated they had 2 residents on VA meds, but not Resident #4.On 10/8/25 at 9 a.m. the Administrator stated she went to the resident's home to do the admission paperwork. She marked yes on the form for VA meds. She gave the paperwork to the Assistant Director of Nursing (ADON) (no longer employed by the facility) to process. She assumed it would be taken care of appropriately. She said then they received a call in July about getting him on VA meds. She said the previous DON was working on the VA meds for Resident #4, and then she left suddenly. She assumed this was taken care of. She did not realize they still did not have VA meds. They still needed to get his meds through the VA. The Administrator admitted with the staff changes this had been missed. She planned to take the paperwork to the clinic.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to ensure residents were free from abuse for 2 of 3 residents reviewed (Resident #2 and #3) by another resident (Resident #1). Resident #1 touched Resident #2 inappropriately on the chest on 2 separate occasions, and Resident #3 on 1 occasion. The facility reported a census of 27 residents.Findings include:1) According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #2 scored 2 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required partial to moderate assistance wheeling self in wheel chair 50 feet and making turns, and when wheeling self 150 feet in a corridor or similar space. The resident's diagnoses included aphasia (language disorder affecting a person's ability to communicate), non-Alzheimer's dementia and traumatic brain injury.The Care Plan revised 11/21/24 identified Resident #2 had impaired cognitive function/dementia or impaired thought processes related to (r/t) dementia and a history of traumatic brain injury. Interventions included: a. Using Resident #2's preferred name, identifying yourself at each interaction, facing her when speaking and making eye contact, reducing any distractions, turning off the TV, radio, close door etc. providing her with necessary cues, stop and return if agitated. b. Supervision/assistance with all decision making. c. Keeping routine consistent and trying to provide consistent care givers as much as possible in order to decrease confusion.The Progress Notes documented the following:On 5/6/25 at 7:30 p.m. the nurse heard Resident #2 calling for help. When she entered the living room, she observed a male resident in a wheelchair reaching over hugging Resident #2 with his right arm and his left hand was under Resident #2's shirt touching her right breast. Resident #2's bra was in place between his hand and her breast. The male resident immediately removed from the area. Resident #2 taken to room to be assessed. Resident #2 voiced he grabbed her. No red or bruised areas noted to breast area. When asked resident if she felt safe at facility resident responded yes.On 5/7/25 at 8:48 a.m. Resident #2's family member called to speak with the DON regarding the incident. The DON relayed information regarding what had occurred. The family member voiced understanding and stated that she had worked in healthcare for many years. She was aware accidents happened and that they were doing everything they could to ensure it did not happen again. On 9/25/25 at 9:35 a.m. Resident #2 sat in her w/c in the living room, when a CNA noted a male resident (Resident #1) touching her chest over her shirt. The CNA snapped her fingers and said Resident #1's name to get his attention away from Resident #2. The CNA then removed Resident #1 from the living room. No anxiety was noted with Resident #2 and she smiled at the nurse when asked if she was okay and if she felt safe. The Social Worker would visit with Resident #2's family member.On 9/2625 at 9:23 a.m. Resident #2 was pleasant smiled when spoken to continuing to smile when asked if she felt safe. No appearance of distress. During an observation on 10/06/25 at 11:22 a.m. Resident #2 in sat in the dining room at the assist table, receiving cues from a CNA to pick up her fork and start to eat. Resident #2 picked to the left of her plate at table cloth, nothing there and brought her hand to her mouth as if to eat something but had nothing in her hand. A CNA guided her hand and fork to the plate. The CNA instructed her to pick up a glass to drink. She reached for salt. The CNA continued to guide Resident #2, and give cues to self feed.On 10/06/25 at 11:35 a.m. Resident #1 entered the dining room away from Resident #2 at a table near the window with back facing residents. No contact noted. 2) According to the MDS assessment dated [DATE], Resident #3 scored 10 on the BIMS indicating moderate cognitive impairment. The resident required substantial to maximal assistance wheeling self in wheel chair 50 feet and making turns, and when wheeling self 150 feet in a corridor or similar space. The resident's diagnoses included Parkinson's disease. The Care Plan dated 6/27/22 and revised 5/20/25 identified Resident #3 had impaired cognition related to dementia. Interventions included: a. Identifying yourself at each interaction, facing her when speaking and make eye contact, reducing any distractions, turning off the TV, radio, close door etc. b. Engaging Resident #3 in simple, structured activities that avoided overly demanding tasks. The Care Plan revised 9/10/23 identified trauma informed care and indicated past physical abuse endured while staying with a former friend. Interventions included Resident #3 tried not to think about past abuse, that was her coping mechanism. The Progress Notes dated 5/25/25 documented at 11:20 a.m. a CNA reported she walked residents down the hall to lunch when she noticed another resident's wheel chair (w/c) very close to Resident #3's. The CNA approached the residents and noticed the male resident touching Resident #3's breast over the top of her blouse. The CNA advised the male resident (Resident #1) he needed to keep his hands to himself, and he