STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165222	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corydon Specialty Care	745 East South Street Corydon, IA 50060

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, policy review, and staff interview, the facility failed to ensure residents received timely feeding assistance for 2 of 2 residents reviewed for nutrition (Residents #21 and #37). The facility reported a census of 56 residents.Findings:1. Resident #21's Minimum Data Set (MDS) assessment, dated 12/11/25, identified a Brief Interview for Mental Status (BIMS) score as 5 out of 15, indicating severely impaired cognition. The MDS listed Resident #21 as dependent on staff for eating. The MDS included diagnoses of Alzheimer's, non-Alzheimer's dementia, and Parkinson's disease (a disease which caused stiffness and tremors). The Care Plan Focus dated 10/3/25 related to activities of daily living (ADL's) included an Intervention that Resident #21 required staff assistance of 1 with eating.The Dietary Note dated 12/11/25 at 10:06 AM reflected the staff assisted Resident #21 with eating.On 1/26/26 at 12:15 PM, observed Resident #21 with a plate of food (breaded fish and mashed potatoes) in front of her. The staff didn't assist her with eating after the delivery of her plate. Resident #21 didn't eat herself until 12:26 PM when she tore a small bite of fish off the filet with her fingers and placed it in her mouth. Resident #21 didn't eat anything else by herself. The staff didn't assist her until 12:31 PM when Staff A, Certified Nursing Assistant (CNA), began to help her.2. Resident #37's MDS assessment dated [DATE], identified a BIMS score as 4 out of 15, indicating severely impaired cognition. Resident #37 required supervision or touch assistance, a helper provided verbal cues and/or touching/steadying and/or contact guard assistance until the resident finished the activity, with eating. The MDS included diagnoses of Alzheimer's disease, non-Alzheimer's dementia, and unspecified macular degeneration (a condition which resulted in a distortion or loss of central vision).The Care Plan Focus dated 10/3/23 related to ADLs included an Intervention that Resident #37 required setup assistance with verbal cues and oversight as needed for eating.The Nutritional assessment dated [DATE] reflected Resident #37 fed herself with setup assistance/supervision.The Dietary Note dated 1/19/26 at 8:41 AM indicated Resident #37 fed herself with supervision.The untitled Kardex (an at-a glance Care Plan staff used for reference) as of 1/29/26 directed Resident #21 required setup assistance and verbal cues with oversight.On 1/26/26 at 12:22 PM, Resident #37 attempted to remove the lid of her ice cream container. Resident #37 continued to attempt to remove the lid without success until a dietary staff member came over and helped her at 12:31 PM. At the time, Resident #37 attempted with one hand to get the top off without success. At 12:34 PM, Resident #37 struggled to take a bite out of the ice cream container and pushed her ice cream over to a male resident who sat at her table. Resident #37 continued to struggle getting a bite out and at 12:42 PM, she placed a large spoonful of ice cream into her glass of water and then ate it. During that time, Staff A and Staff B, CNA, sat at other tables assisting other residents and didn't appear to notice Resident #37 had ice cream in her water. From 12:22 PM until 12:44 PM, the staff didn't assist or encourage Resident #37 to eat. Resident #37 only ate a few bites of her ice cream with difficulty. At 12:44 PM Staff C, Licensed Practical Nurse (LPN), asked Resident #37 if her lunch was good but didn't assist her. At 12:45 PM, Staff B sat down and assisted Resident #37 with eating.The facility policy Assistance with Meals, revised 2017, instructed to assist residents with meals in a manner that met the individual needs of each resident.On 1/29/26 at 8:21 AM, via phone, (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corydon Specialty Care	745 East South Street Corydon, IA 50060

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff B described Resident #21 as dependent on staff because she couldn't lift the spoon to her mouth. She stated she tried to look over at Resident #37 during meals but didn't know if she did on 1/26/26. On 1/29/26 at 8:36 AM, Staff D, CNA, stated Resident #37 required staff assistance to set up her food including opening ice cream containers. Staff D stated Resident #37 may not be interested in eating but she got mad if staff encouraged her to eat. Staff D stated she did approach Resident #37 and got her to smile and eat.On 1/29/26 at 8:58 AM, Staff E, CNA, stated if staff delivered a resident's tray, they should assist them in a timely manner. She stated Resident #37 required prompting by the staff and it didn't bother her. Staff E stated she observed Resident #37 mix her food, for example she put her cereal in her water. She stated when this occurred, staff would direct her what to eat. She stated they kept an eye on Resident #37 while she ate.On 1/29/26 at 9:13 AM, Staff A stated staff fed one resident then moved on to another resident. She stated they usually had 3 staff in the dining room but if one needed to leave (to provide care for a resident) it could be tough. She stated they kept an eye on Resident #37 during meals as she needed prompts.On 1/29/26 at 10:01 AM, the Director of Nursing (DON) stated staff try to start feeding residents within 10 minutes after staff delivered the tray. She stated Resident #21 needed assistance from staff to eat. She stated if Resident #37 mixed her food, the staff should attempt to intervene. She stated they need to work on staff providing assistance in the dining room.