STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165235	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lenox Care Center	111 East Van Buren Lenox, IA 50851

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, kitchen cleaning checklist and policy review the facility failed to maintain clean and sanitary conditions in the kitchen, failed to label and store food items and discard leftovers after 3 days in order to maintain food quality and reduce the risk of food-borne illness in the kitchen for two of two kitchen observations. The facility staff also failed to conceal hair completely in a hairnet for two of two meal service observations. The facility reported a census of 25 residents. Findings include:1.Initial Kitchen observations starting on 3/21/26 at 1:10 PM revealed the following: a. The door inside the Kenmore refrigerator contained one open carton of liquid whole eggs without an open date. The directions on the outside of the contain revealed to use the product within 3 days of the open date. The bottom shelf had a plastic bag that contained what appeared to be uncooked hamburger patties. The bag had no label or date listed on it. b. The Troulsen refrigerator had a container of whipped salad dressing with splatters of the contents on the outside and the lid of the container. The refrigerator also contained a large package of shredded lettuce that was open and lettuce had spilled out and onto the shelf. c. The Frigidaire freezer had a heavy build up of ice on the roof (inside top) of the freezer and shelves inside. d. The Victory refrigerator had a carton of apple juice that had the top corner of the container torn off and juice exposed to air. The carton of apple juice had a use by date 10/20 but no open date listed on the carton. e. A vent/screen on the ceiling above the food prep counter had a dust in-between the appeared dusty.2. On 3/22/26 at 11:49 AM, Staff C, Cook, had a hair restraint on but a moderate portion of beard/facial hair under his chin was uncovered. The hair restraint also had a dime sized hole and several pin sized holes in the front side of the hair restraint. Staff C had no hair restraint over his mustache. Staff C prepared and served food to residents in the dining room for lunch. 3. A follow up tour of the kitchen on 3/22/26 at 1:00 PM revealed: a. The Kenmore refrigerator continued to contain an open plastic bag with what appeared to be hamburger patties on the bottom shelf of the refrigerator, and the item remained unlabeled and not dated. b. The Troulsen refrigerator still had a container of whipped salad dressing with contents splattered on the outside of the container, and an open bag of shredded lettuce spilled on the shelf inside the refrigerator. c. The Frigidaire freezer continued to have a heavy build-up of ice. d. The vent/screen above the food prep counter remained dusty/ dirty. 4. On 3/23/26 at 7:06 AM, Staff D, cook, was observed in the kitchen cooking omelettes on a griddle without a hair net. She stated cooks should absolutely wear a hairnet while in the kitchen. She said she forgot and left hers in her car. In an interview 3/22/26 at 1:15 PM, the Dietary Manager (DM) reported he had worked as the DM at the facility since 2/2/26. The DM reported he expected food and beverage items labeled with the received date when it was taken off the delivery truck. The DM reported food and beverages needed labeled and dated when opened. He stated It's a work in progress. At the time, the Surveyor reported the items found during the initial tour of the kitchen and again during a follow-up visit to the kitchen. The DM then took the bag of hamburger patties and the bag of shredded lettuce and threw it in the trash. The DM reported a cleaning schedule was posted on the refrigerator with tasks for staff to complete daily, weekly, and some deep cleaning tasks. The DM reported they had some issues with the Frigidaire freezer building up with ice and thought maybe it was due to an overstock of food in 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165235	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2026
NAME OF PROVIDER OR SUPPLIER Lenox Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 111 East Van Buren Lenox, IA 50851	

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	freezer. Staff told him the freezer had been defrosted just before he took over as the DM. The DM reported the screen above the food prep counter was a Maintenance duty. He thought Maintenance would clean it soon. The light fixtures in the kitchen also had a fair amount of dust on top, and one light fixture by the refrigerators had several cracks in it. The DM reported he expected facial hair such as a beard and/or mustache needed to be covered while staff in the kitchen and whenever prepared or served food. The DM reported Staff C's beard restraint melted when he got things out of the oven. In an interview 3/23/26 at 9:45 AM, Maintenance reported he did not clean the lights or vent above the food prep cart in the kitchen. Dietary staff were supposed to clean it. He used a TELS system for maintenance tasks that needed done in the in kitchen but cleaning the lights or vent was not a task for maintenance. A Kitchen Cleaning Checklist dated 3/15 through 3/21 revealed the daily, weekly and deep-cleaning tasks. The checklist lacked a task for defrosting freezers, cleaning/dusting light fixtures and cleaning the vent/screen above the food prep counter. The facility's Food Safety Requirement Policy dated 2025 revealed food stored, prepared, distributed and served in accordance with professional standards for food service safety and in a way that prevented foodborne illness. Food safety practices shall be followed including storing food in a manner that helped to prevent deterioration or contamination of the food and growth of microorganisms. Food needed to be labeled and dated including items that had a use-by date. Dietary staff must wear hair restraints (such as a hairnet, hat, and/or beard restraint) to prevent hair from contacting food.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff interview and policy review the facility failed to utilize enhanced barrier precautions (EBP's) and failed to ensure staff followed infection control practices to protect against cross contamination and potential spread of infection for 2 of 4 residents sampled on EBP's (Resident #1 and #22). The facility staff also failed to use a barrier and utilize appropriate wound care techniques, and failed to handle soiled linens to prevent the potential spread of infection for 1 of 3 residents observed for wound care (Resident #22). The facility also failed to develop a comprehensive water management program and identify areas or devices in the building to reduce the risk and prevent the growth of Legionella or other waterborne pathogens. The facility reported a census of 25 residents. Findings include: 1.The Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 had diagnoses of heart failure, diabetes, and chronic obstructive pulmonary disease (COPD). The MDS documented the resident had a Brief Interview for Mental Status of 14 out of 15 indicating cognition intact. The MDS indicated the resident required partial to moderate assistance for bed mobility, and dependent for transfers and toileting hygiene. The MDS indicated the resident had an indwelling catheter. The Care Plan initiated 1/19/26 revealed the resident required EBP's related to the presence of an indwelling catheter. The Care Plan directed staff to use EBP's during the completion of high contact activities, and ensure hand hygiene completed prior to and after cares. The Care Plan also directed staff to assist with toileting and provide peri-care as needed, and use a mechanical lift and two staff for transfers. Observations revealed the following: a. On 3/21/26 at 2:20 PM, an EBP sign was posted on the door to the resident's room. The resident sat in a wheelchair and had a catheter in a dignity bag. b. On 3/21/26 at 2:28 PM, Staff A, certified nursing assistant (CNA), and Staff B, CNA, were in Resident #1's room. Staff A and Staff B had gloves on and attached a sling under the resident to the mechanical lift, then placed the resident's urinary catheter by his waist and transferred the resident from the wheelchair to the bed. Staff A placed the resident's catheter on the lower bedframe, then removed the resident's pants and brief and placed a bedpan under the resident. Staff removed their gloves and washed their hands and left the room.At 2:44 PM, Staff A and Staff B re-entered the resident's room. Staff A and Staff B donned a pair of gloves. Staff B performed pericare for Resident #1, then took additional wipes and cleansed around the catheter site. Staff assisted the resident to roll onto his right side and removed the bed pan under him. Staff B took disposable wipes and cleansed the buttocks area. Two foam dressings were observed to the bilateral upper buttocks. Staff B removed the gloves on her hands. Staff A placed a clean brief under the resident, rolled the resident onto his back and attached the brief tabs. Staff A removed her gloves. Staff A and Staff B did not wear a gown during high contact care activities such as when the resident was transferred, catheter was handled and when cares were provided for Resident #1. The facility's Enhanced Barrier Precautions (EBP) Policy date 3/25/24 revealed EBP's are utilized to reduce and prevent the spread of multi-drug resistant organisms (MDROs) to residents. EBPs are indicated for residents with chronic wounds and/or indwelling medical devices. Gloves and gown are applied before performing high-contact resident care activities. High-contact resident care activities requiring the use of a gown and gloves include for transfers, changing briefs or assisting with toileting, and catheter care or use. 2. The annual MDS assessment dated [DATE] revealed Resident #22 had diagnoses of diabetes, (continued on next page)

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	165235	A. Building B. Wing	03/24/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	peripheral venous insufficiency (veins valves are damaged and cause blood to pool in leg), and lymphedema (swelling caused by buildup of lymph fluid between the skin and muscle). The Care Plan revised 6/24/25 revealed the resident had diabetic ulcers on the toes of his left foot. The Care Plan directed staff to administer treatments as ordered and per facility protocol. The Treatment Administration Record (TAR) for March 2026 revealed an order to cleanse the left toes/foot with Vashe solution, apply betadine to the wounds, cover wounds with absorbent gauze, then secure with a dry gauze daily. The TAR revealed Staff H documented treatment completed on 3/23/26. During observation on 3/23/26 at 9:55 AM, an EBP's hung on the door to Resident #22's room. Staff H, Registered Nurse (RN) placed a bottle of Vashe wound cleanser solution and interdry dressing on top of the dressing supply cart. Staff H pushed the cart down the hall, donned a mask, gown and gloves and then pushed the cart into Resident #5's room. Staff H opened two small bottles of saline, then opened the drawer to the cart to obtain a pile of gauze. Staff H closed the drawer to the cart, then proceeded to pour saline onto a gauze. Staff H took the saline soaked gauze and cleansed under the resident's abdominal folds. Staff H took another gauze and cleansed the groin. Staff H changed her gloves, placed a pad and towel on the floor, then removed the resident's sock and soiled dressings (with green and brownish drainage) from the left foot and between the toes. The toes were swollen and had a grayish appearance to the wound between the big and second toe as well as slough by the base of the toes. Staff H changed gloves, poured Vashe wound cleanser onto the gauze and cleansed the toes on the left foot, scrubbing the skin with the gauze. Staff H took a betadine swab and painted the area between the toes. Staff H changed her gloves, then opened the drawer on the cart, took out gauze and kerlix, closed the drawer on the cart then proceeded to place gauze between the toes and over the top of the toes. Staff H took a kerlix roll and wrapped the dressing over the area. Staff H opened the drawer on the cart again, took out a roll of tape, tore off a piece of tape and stuck the tape on top of the cart. Staff H opened the drawers on the cart, then moved the isolation gown and reached into her uniform pocket to get a pen. Staff H wrote the date on the piece of tape that was stuck to the top of the cart, then placed the tape over the dressing on the resident's foot. Staff H applied the resident's sock, the took a box of gloves on top of the cart and placed the box of gloves in a rack on the side of the cart. Staff H picked up the soiled pad and towel from the floor and placed it on the top of the cart, then removed her gown and placed the gown in the trash receptacle on the side of the supply cart. Staff H put supplies she left on top of the cart into the drawers, then pushed the same cart to room [ROOM NUMBER]. Staff H then donned a pair of gloves, picked up the soiled pad/towel on the cart and took them down the hall. The ADON stood in the room with the surveyor during the observation of Staff H. In an interview on 2/23/26 at 10:30 AM, the ADON reported EBP's are used to prevent the spread of germs and to make sure residents and staff were protected. The ADON confirmed the dressing supply cart should not have been taken into the room when a resident was on EBP's. The ADON also confirmed Staff H touched drawers and items in the cart with contaminated gloves. She expected staff to change gloves and sanitize hands when soiled or whenever went from a dirty to a clean area. A Wound Care policy revised 10/2010 revealed wound care completed to promote healing. Place all items to be used during the procedure on a disposable cloth or paper towel as a barrier. Use one gauze and wash the tissue around the wound. Disposable items should be discarded into a designated container. Disposable supplies cannot be returned to the cart. An Infection Prevention and Control Policy dated 1/1/26 revealed all staff are responsible for (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	following all policies and procedures related to infection control. Equipment shall be cleaned and disinfected according to the facility's policy. Soiled linen shall be collected at the bedside and placed into a linen bag, and placed in a soiled utility room. A Handwashing / Hand Hygiene policy revised 8/2019 revealed the use of gloves does not replace hand washing/ hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing the spread of infections. 3. On 3/23/2026 at 12:00 PM, the Maintenance Director stated he didn't know where the water flow diagram was and didn't know who was responsible for performing Legionella preventative procedures. He also stated he was not sure which part of the building the two (2) water heaters supplied. At 12:20 PM, a facility blueprint review did not identify the service area for each water supply line that entered the facility nor did it provide the location of high-risk stagnant water areas. At 12:30 PM, Staff E, Housekeeping supervisor stated staff flushes the sinks and toilets in the rooms during deep cleaning tasks. She stated it was not on the checklist. An undated facility document titled Deep Clean Checklist did not include toilet or sink flushing. At 12:40 PM, the Administrator stated the whirlpool next to the Director of Nursing's (DON) office was temporarily nonfunctioning and, to her knowledge, it was the last water supplied device in the hall water supply sequence. At 12:44 PM, the Administrator contacted the previous Maintenance Director who confirmed the water heaters' supply destinations. The Administrator confirmed the facility was licensed to house more resident's than their current census. A facility document titled Annual Legionella Environmental Assessment Form dated 1/21/26 revealed the facility had a whirlpool with no filter change or filter backwash documentation. It also revealed the facility had a fish aquarium with water at 77 degrees Fahrenheit (degrees F) but no maintenance protocol and was last cleaned on 1/15/26. A policy titled Water Management Policy dated 10/2022 indicated the facility will complete an assessment of the water system annually. It also indicated the assessment data will identify where Legionella and other opportunistic waterborne pathogens could grow and spread. It further indicated the assessment will include interventions performed by the facility if risks were identified to prevent the growth of opportunistic waterborne pathogens as well as how the facility will monitor them. On 3/23/26 at 4:11 PM, the Administrator stated the facility could've done better at implementing the water management plan.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, resident and staff interview, policy review and the National Fire Protection Association (NFPA), the facility failed to ensure that oxygen was not in the vicinity of residents that were smoking for 1 of 1 resident observed with oxygen in use (Resident #13). The facility reported a census of 25. Findings include: The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 had diagnoses of cerebrovascular accident (CVA) (stroke), anemia, and hypertension (high blood pressure). The MDS indicated the resident did not use tobacco. The resident used oxygen (O2). The MDS dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS recorded the resident was on O2. The Care Plan initiated on 12/2/25 revealed the resident used continuous O2 and at risk for alterations in O2 levels due to a diagnoses of CHF (congestive heart failure). She also had a risk of chest pain and shortness of breath. The Care Plan indicated the resident needed O2 via nasal cannula (NC). The Order Summary dated 3/21/26 revealed continuous O2 via NC at 1.5- 2 liters (L) per minute. During observations on 3/21/26 at 3:02 PM, Staff F, certified nursing assistant (CNA), stood outside as 5 residents were smoking on the patio outside. Resident #13 sat in a wheelchair with a nasal cannula / tubing that was connected to a portable O2 tank on the back of her wheelchair. At the time, the O2 was set at 2 liters and the gauge indicated there was O2 in the bottle. A male resident with a beard sat approximated 2 to 3 feet from Resident #13's portable O2 tank as he held a lighted cigarette and smoked. On 3/21/26 at 3:42 PM, Resident #13 continued to sit in a wheelchair on the patio with portable O2 on at 2 L per NC. At the time, Resident #13 reported she did not know the smokers would be coming out to smoke. The residents that came out to smoke did not bother her but she would just like to give them a lecture about what smoking could do to them.In an interview on 3/23/26 at 2:30 PM, Staff B, CNA, reported any available staff took residents out to smoke at designated smoke times at 10 AM, 3 PM and 8 PM. The front patio is for nonsmoking residents and the other patio (on the North Hall) are where the residents go to smoke. Staff B responded she did not know how far a resident that is smoking would be kept from someone that is on O2. Staff B stated a fire or an explosion could occur if oxygen came in contact with someone that was smoking. In an interview on 3/23/26 at 2:35 PM, Staff G, non-certified nursing assistant, reported he generally took the residents who smoked outside to smoke at 3 PM and 8 PM. The nonsmoking residents were supposed to go to the front patio when they wanted to go outside. The residents who smoked went to the patio on the back patio (North Hall). When the surveyor asked what could happen if someone smoking came in contact with oxygen, Staff G stated it would be bad, it could cause an explosion. Staff G stated he thought a distance of 6 to 8 feet would be best to keep someone that was smoking away from someone that had oxygen in use or in an area with a portable O2 tank. In an interview on 3/23/26 at 2:45 PM, Maintenance reported if someone that was smoking came close to an oxygen apparatus that would not be good. It could cause a fire or an explosion. Maintenance reported the front patio was designated for non-smoking residents and the back patio (by the exit door by the ice machine) was the designated area for residents that smoked. In an interview on 3/23/26 at 3:29 PM, the Administrator reported they generally do a smoking assessment on residents. Nonsmoking residents were allowed to go outside along with smoking residents. The Administrator stated she preferred a resident on O2 to be a little ways away from someone who is smoking so sparks don't fly. When asked how many feet is a little ways away, the Administrator stated probably 20 feet. The Administrator reported staff completed on-line education about oxygen use and safety on Healthcare Academy.An undated Resident Smoking policy revealed the facility provided a safe and healthy environment for residents, visitors and employees, including safety related to smoking. Oxygen use in the smoking area is prohibited. The policy revealed the number of feet from exits and common space utilized by other residents in order to protect non-smoking residents from second-hand smoke was (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	left blank. The National Fire Protection Association (NFPA) website (https://www.nfpa.org/downloadable-resources/safety-tip-sheets/medical-oxygen-safety-tip-sheet) dated 2026 revealed the following medical oxygen safety: a. Smoking materials is the leading heat source resulting in medical oxygen related fires, injuries and deaths.b. There is no safe way to smoke in the home when oxygen is in use. c. Keep oxygen cylinders at least five feet from a heat source or open flame.d. Post No Smoking and No Open Flames signs in and outside to remind people not to smoke (when oxygen in area)e. Oxygen saturates fabric covered furniture, clothing, hair and bedding and made it easier for a fire to start and spread.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interview, and policy review, the facility failed to identify and consistently document non-pharmacologic behavior interventions for 3 of 3 residents (#3, #6, #7) who received psychotropic medications (medications that affect a person's mental state, emotions, and behavior). The facility reported a census of 25 residents. Findings include:1) Resident #3's Minimum Data Set (MDS) assessment identified a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition It included diagnoses of non-Alzheimer's dementia, anxiety, depression, psychotic disorder, and schizophrenia. It indicated the resident required setup assistance with eating, moderate assistance with oral hygiene, maximal assistance with upper body dressing, and was dependent with all other Activities of Daily Living (ADLs) and mobility. It further revealed the resident took antipsychotic and antidepressant medications in the 7-day look-back period.The Care Plan dated 10/14/25 directed staff to attempt nonpharmacological interventions before using PRN (as needed) medications. It did not direct staff what nonpharmacological interventions to use.The Electronic Health Record (EHR) included a Behavior Symptoms Monitoring response history dated 2/21/26 through 3/22/26 that did not include non-pharmacological interventions.Review of the Progress Notes failed to contain non-pharmacological interventions for multiple documented behaviors.On 3/22/26 at 1:44 PM, Staff I, Certified Medication Aide (CMA) stated the non-pharmacological intervention she used was to let the resident sleep.On 3/22/26 at 1:53 PM, Staff J, Registered Nurse (RN) stated she was not aware of non-pharmacological interventions staff were to use for his behaviors.On 3/22/26 at 2:03 PM, Staff K, Licensed Practical Nurse (LPN) stated the non-pharmacological intervention she used was approaching him in a nonconfrontational, calm tone.2) Resident #6's MDS assessment dated [DATE] revealed a BIMS score of 05 out of 15 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia, anxiety, depression, and psychotic disorder. It indicated the resident required setup assistance with eating, supervision with shower transfers, moderate assistance with toileting and showering, and was independent with all other Activities of Daily Living (ADLs) and all forms of mobility. It further revealed the resident took antianxiety, antidepressant, and antipsychotic medications in the 7-day look-back period.The Care Plan revised 5/29/25 included alterations in mood related to depression, anxiety, and dementia but did not identify nonpharmacological interventions for staff to attempt.The Orders Administration Note Progress Note dated 2/15/26 and 2/16/26 revealed staff observed resident behaviors but no non-pharmacological interventions were identified or documented.The Electronic Health Record (EHR) included a Behavior Symptoms Monitoring response history dated 2/21/26 through 3/22/26 that did not include non-pharmacological interventions.On 3/22/26 at 1:44 PM, Staff I, CMA stated the non-pharmacological intervention she used was to let the resident sleep.On 3/22/26 at 1:53 PM, Staff J, Registered Nurse (RN) stated she was not aware of non-pharmacological interventions staff were to use for his behaviors but assumed it was to encourage the resident to participate in social activities.On 3/22/26 at 2:03 PM, Staff K, Licensed Practical Nurse (LPN) stated the non-pharmacological intervention she used was to talk to the resident about his family and to keep him socializing.3) Resident #7's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of anxiety, depression, and post-traumatic stress disorder (PTSD). It indicated the resident required setup assistance with eating, supervision with shower transfers, and was independent with all other Activities of Daily Living (ADLs) and all forms of mobility. It further revealed the resident took an antidepressant and antipsychotic medications in the 7-day look-back period.The Care Plan revised 8/26/25 included alterations in mood related to depression, anxiety, and PTSD but did not identify nonpharmacological (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions for staff to attempt.The Orders Administration Note Progress Note dated 3/19/26 and 3/20/26 revealed staff observed resident behaviors but no non-pharmacological interventions were identified or documented.The Electronic Health Record (EHR) included a Behavior Symptoms Monitoring response history dated 2/21/26 through 3/22/26 that did not include non-pharmacological interventions.On 3/22/26 at 1:44 PM, Staff I, CMA stated the non-pharmacological intervention she used was offer the resident conversation or snacks.On 3/22/26 at 1:53 PM, Staff J, Registered Nurse (RN) stated the non-pharmacological intervention she used was talking to him.On 3/22/26 at 2:03 PM, Staff K, Licensed Practical Nurse (LPN) stated the non-pharmacological intervention she used was to encourage him to socialize.A policy titled Use of Psychotropic Medication(s) dated 2025 indicated non-pharmacological approaches must be attempted, unless clinically contraindicated, to minimize the need for psychotropic medications, use the lowest possible dose, or discontinue the medications.On 3/23/26 at 3:55 PM, the Director of Nursing (DON) stated staff should have implemented non-pharmacological interventions and documented them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165235	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lenox Care Center	111 East Van Buren Lenox, IA 50851

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to identify an expired medication before it was administered to 1 of 4 residents (#17). The facility reported a census of 25 residents.Findings include:Resident #17's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated completely intact cognition. It included diagnoses of multiple sclerosis, seizure disorder, and respiratory failure. It indicated the resident required setup assistance with eating and oral hygiene, and moderate assistance with all other Activities of Daily Living (ADLs) and all forms of mobility. It revealed the resident received an anticonvulsant medication in the 7-day look-back period.The Medication Administration Record (MAR) included a physician's order dated [DATE] for a 200 milligrams (mg) anticonvulsant medication by mouth twice per day. It further revealed the resident received 42 doses since [DATE].The Care Plan revised [DATE] directed staff to administer the anticonvulsant medication as ordered.On [DATE] at 8:16 AM, a continuous medication observation revealed Staff I, Certified Medication Aide (CMA) commit to administering the anticonvulsant medication to Resident #17. The medication card had five (5) pills remaining and contained two (2) labels. One label indicated the medication was received on [DATE] and directed staff to reorder the medication after [DATE]. The other label had an expiration date of 10/2024. Staff I stated she would remove the medication from the resident's medication stock and pull the replacement from the emergency medication kit (e-kit) and destroy the expired medication. At 8:25 AM, the Assistant Director of Nursing (ADON) stated the medication was just received from the supply pharmacy on [DATE]. She stated the pharmacy needed to be contacted to get the medication replaced.A policy titled Medication Administration dated 2025 directed staff to identify the medication expiration date. If expired, notify the nurse manager.On [DATE] at 3:55 PM, the Director of Nursing (DON) stated staff should have checked the expiration date prior to being administered. If expired, staff should destroy the medication and replace it through the pharmacy. If the medication had been previously administered, then staff should complete an incident report, and notify doctor and the resident's family.