STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165245	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Health Care Center	2121 Avenue L Hawarden, IA 51023

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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 - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility record review, resident and resident family interviews, staff interviews and facility policy the facility failed to appropriately implement interventions to protect 2 out of 3 residents (Resident #3 and #50) reviewed from abuse. The facility reported a census of 57 residents.Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 documented diagnoses of muscle weakness, stroke and diabetes mellitus. The MDS showed the Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Review of facility provided Incident Report dated 3/8/26 at 3:21 p.m., revealed Staff I, Registered Nurse (RN) was at the nursing station paging at about 3:21 p.m., to get update on another resident when caregiver came up to nurse and stated, just letting you know Resident #2 was in this resident room attempting to get in bed with her. This writer hung up and immediately rushed down the hall with a caregiver. Staff I met Resident #3 in her bed, resting in bed, and call light within reach. Resident #3 stated, I was in bed, my door was halfway closed when this man came in and just kept coming towards me. He touched my leg and I told him to stop immediately. He moved my bedside table away from me and I thought he wanted to take my dentures on the table, but he had this weird look you know, placed his hand under my blanket and tried to touch me. I pushed my call light and screamed twice. My neighbor heard me and pushed his call light as well, and he took off then the aide came in and I told them. Interview on 3/17/2026 at 11:08 a.m., with Resident #3 revealed she had been laying in bed and her door opened and a guy in a wheelchair came into her room and touched her feet. He then moved her tray over that was next to the bed and all of a sudden his wheelchair was going up the side of her bed and his hand was going up her leg. She stated she screamed twice and pushed the call light. After she screamed he scooted out of her room. Resident #3 further revealed it is not a secret that she is trying to get out of here because he is still in the. There are times she cannot sleep when she sees him and she feels he is just a creep. She has told everyone that she will kill him if he touches her again. Resident #3 stated that it isn't that she feels unsafe in the facility but it bothers her that he also violated another person and it is sad to think about it wasn't just me. She continues that her heart starts to race when she is in the dining room when he is there and sees him. She doesn't understand why the facility allows him to sit at the table where they assist people with eating as they are not able to defend themselves from him. The facility was really short that night and they would have been able to handle it better with more people. 2. The MDS assessment dated [DATE] for Resident #50 documented diagnoses of need for assistance with personal care, hypertension and unspecified symptoms and signs with cognitive (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 0600 Level of Harm - Actual harm Residents Affected - Few	functions and awareness. The MDS showed the Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. Review of facility provided Incident Report dated 3/8/26 at 3:22 p.m., revealed Staff I, RN was at the nursing station paging at about 3:21 p.m., to get update on another resident when caregiver came up to nurse and stated just letting you know, Resident #2 was in Resident #3's room attempting to get in bed with her. Staff I immediately rushed down the hallway to make sure the resident was safe. Staff I and caregiver check rooms to make sure Resident #2 is out of the hallway and is safe. At about 3:22 p.m., Staff I and caregivers found Resident #2 in bed with Resident #50 with her pant and brief halfway down and Resident #2's left hand was in this resident's pants on her buttocks. Resident #2's wheelchair was parked in front of Resident #50's bed and door was locked. Resident #50 was lying in bed on her right side facing the window half asleep and Resident #2 was on bed and not moving. Review of Resident #50's Progress Notes revealed Staff I, RN was at the nursing station paging at about 3:21 p.m., to get update on another resident when caregiver came up to nurse and stated just letting you know, Resident #2 was in Resident #3's room attempting to get in bed with her. Staff I immediately rushed down the hallway to make sure the resident was safe. Staff I and caregiver check rooms to make sure Resident #2 is out of the hallway and is safe. At about 3:22 p.m., Staff I and caregivers found Resident #2 in bed with Resident #50 with her pant and brief halfway down and Resident #2's left hand was in this resident's pants on her buttocks. Resident #2's wheelchair was parked in front of Resident #50's bed and door was locked. Resident #50 was lying in bed on her right side facing the window half asleep and Resident #2 was on bed and not moving. Resident #50 was unable to state or describe what happened. Both residents were separated immediately. Notified Director of Nursing (DON) immediately via phone call. 3. The MDS dated [DATE] for Resident #2 documented a BIMS of 11 indicating moderate cognitive impairment. On 3/17/26 at 9:33 AM Resident #3's Daughter stated her mother was still living at the facility. Resident #3's Daughter stated her mother was in bed and Resident #2 entered her room and put his hands under the blanket. Resident #3's Daughter stated her mother called her first and the facility called 6 hours later. Resident #3's Daughter stated it was Staff I, Registered Nurse (RN) who called her. Resident #3's Daughter stated did not know which nursing staff her mother had talked to. Resident #3's Daughter stated her understanding was the police were called. Resident #3's Daughter stated the police were not called until 7:00 PM and after they left she was called by the facility. Resident #3's Daughter stated there was a second assault the same day and the nurse had to pull Resident #2 off the resident. Resident #3's Daughter stated from what she understood the second incident was worse than the incident with her mother. Resident #3's Daughter stated the trauma advocate told her about the second assault. Resident #3's Daughter stated the incident occurred on 3/8/26. Resident #3's Daughter stated another CNA told her mother the DON told the nurse not to do anything about it. Resident #3's Daughter stated the nurse said she needed to because she was worried about her license. Resident #3's Daughter stated her mother said she was able to scare the resident before he fondled her. Resident #3's Daughter stated he did not put his hands up her shirt or down her pants. Resident #3's Daughter stated her mother acted like she was not scared but inside she felt she was. Resident #3's Daughter stated her mother seemed to have some increased sadness since the incident. Resident #3's Daughter stated there was no penetration. Resident #3's Daughter stated her mother felt assaulted but not abused or sexually abused. On 3/26/26 at 8:08 AM Resident #3's Daughter stated her mother had called her at 2:15 pm on 3/8/26 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	and told her about the incident and the facility called her at 8:17 PM on 3/8/26 to tell her. Resident #3's Daughter stated previously her mother would talk to another resident frequently and now after the incident her mother was much more self isolating. Resident #3's Daughter stated her mother left the faciity on 3/24/26. The incident had increased her want to leave as soon as possible. On 3/24/26 at 1:17 PM Staff I, Registered Nurse (RN) acknowledged she worked 3/8/26 when the incident with Resident #2, #3 and #50. Staff I stated she called Resident #2's family. Staff I stated she called Resident #3 and #50's family. Staff I stated she called the police also. Staff I explained that she called the Director of Nursing (DON) immediately and did not remember what the DON said. Staff I stated the DON said that since Resident #2 had not penetrated the resident's vagina then she just needed to call the police later. Staff I explained that the DON stated the police would probably only take the report over the phone. Staff I explained that when she called the police they said they were going to come up. Staff I stated she called all the resident's families after that. Staff I stated Staff J, LPN was the other nurse working with her on 3/8/26. Review of Resident #2's EHR dated 3/8/26 at 3:21 PM entered by Staff I documented Staff I was at the nursing station when a Certified Nurse Assistant (CNA) came to the nurse station and stated Resident #2 was in another resident's room trying to get into bed with Resident #3. Staff I immediately went down the hall Resident #2 was seen in Resident #50's room in her bed with the door locked at 3:22 PM, Resident #50's pants were halfway down her buttocks with Resident #2's left hand on Resident #50's buttocks. Resident #2's wheelchair was backed in front of the bed. Resident #50 was unable to state what had happened. Resident #2 was immediately moved out of Resident #50's bed to his wheelchair and out of the room. Staff I assessed both Resident #3 and #50. DON was notified at 3:22 PM. Resident #2 was taken to the nursing station for 1:1 monitoring. Resident #50 stated bathroom and was helped to the bathroom. Staff I documented Staff J explained Resident #2 was last seen about 2:20 PM when she administered his medications. Sheriff was notified at 7:09 PM, Resident #2's Power of Attorney (POA) notified at 8:30 PM. Resident #2's POA stated if Resident #2 took Carbidopa-levodopa, then the resident would get sexual. On 3/24/26 at 2:58 PM Staff N, Licensed Practical Nurse (LPN) stated she was working the day of 3/8/26 and received a report from Staff I. Staff N explained that she worked at 6:00 PM that evening. Staff N stated the incident with Resident #2, #3 and #50 had happened several hours before she came in. Staff N stated Staff I was the nurse that completed an assessment on Staff #50 and on Resident #2. Staff N stated Staff I was told not to document the incident because they did not know what he was exactly doing. Staff N stated she was not going to take the assignment at the facility unless Staff I reported the incident because it needed to be reported. Staff N stated the Administrator and the DON did not come to the building. Staff N explained Staff I called the family members after that and the police. Staff N stated the police were at the facility for an hour or two. Staff N stated there was also another resident involved Resident #3. Staff N stated Resident #2 did not get as far with Resident #3 as with Resident #50. Staff N explained Resident #3 was very upset. Staff N stated Resident #50 was probably unaware of what was happening because of her lower cognitive function. Staff N stated Resident #3 was very upset that Resident #2 was allowed to stay at the facility. Staff N explained Resident #3 was in therapy room one day and they brought Resident #2 in and she asked to leave. Staff N stated Resident #3 was planning on going to another facility because Resident #2 remained at the facility. On 3/25/26 at 11:28 AM Staff J, Licensed Practical Nurse (LPN) stated it was about 2:00 PM on 3/8/26. Staff J explained she had taken 2 or 3 residents outside and Staff I came out and asked when she had last seen Resident #2 and she said last time she medicated him. Staff J stated she was (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	outside around 3:00 PM or 3:15 PM and gave him his medication at 2:30 PM and saw him about 15 minutes later. Staff J stated he appeared to be sleeping when she last saw him. Staff J stated she had not seen Resident #2 for about 30 minutes. Staff J stated she came inside at that time and gave Staff I a brief statement about what was going on. Staff J stated she went back outside with the residents. Staff J stated Staff I was on the phone with the DON. Staff J stated all the residents were brought in and she was still talking to the DON about the incident. Staff J stated Staff I said she was told by the DON not to make a note of it because they could not be sure what actually happened with the residents. Staff J stated Resident #3 used to participate in activities, sit in the dining room with other residents and talk before the incident with Resident #2. Staff J explained Resident #3 very rarely comes out to participate in activities now. Staff J stated Resident #3 asked to be taken back to her room during the meal the other day when Resident #2 came out and that was not normal for her. Staff J stated where Resident #3 normally sits her back would be towards Resident #2. Staff J stated Resident #3 usually would stay out and chat with the other residents but left because she was uncomfortable. Staff J stated there were no attempts to call the police, the family, or the physician because it was not physically witnessed. Staff J stated Staff I said it was witnessed she had witnessed it at the time. Staff J stated the DON told her it did not need to be reported. Staff J stated Staff N said if Staff I did not report the incident to the police, the POA's and the physicians she was going to have to. Staff J said that was when Staff I reported the incident. Review of a policy provided by the facility reviewed on 1/22 titled, Abuse: Prevention of and Prohibition Against documented it was the policy of the facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The Facility will provide oversight and monitoring to ensure that its staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be free from abuse, neglect, misappropriation of resident property, and exploitation. To assist the Facility's staff members in recognizing incidents of possible abuse, neglect, misappropriation of resident property, or exploitation, the following definitions are provided: Abuse is willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Sexual abuse is non-consensual sexual contact of any type with a resident.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Records (EHR) review, observations, resident interview, and staff interview the facility failed to provide the residents with a comfortable / clean homelike environment when bed linens were not applied to beds in a timely manner and rooms were not clean for 3 for 20 residents reviewed (Resident #17, #30 and #55). The facility reported a census of 57 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] for Resident #30 documented a Brief Interview of Mental Status (BIMS) of 14 indicating no cognitive impairment. An observation on 3/18/26 at 10:20 AM revealed the linen on Resident #30's bed rolled up at the foot of the bed and the bed was not made. On 3/18/26 at 10:20 AM Resident #30 explained she would like her bed to be made in the morning. Resident #30 said it would be nice if it was made by the time breakfast was over but for sure before the lunch meal. An observation on 3/18/26 at 10:42 AM revealed the linen on Resident #30's bed remained rolled up at the foot of the bed and the bed remained unmade. 2. The MDS dated [DATE] for Resident #55 documented a BIMS of 9 indicating moderate cognitive impairment. The MDS documented Resident #33 had diagnoses of unspecified intellectual disabilities, muscle weakness and need for assistance with personal care. An observation on 3/18/26 at 11:37 AM revealed Resident #55's lying in bed with a small lap blanket on and all bedding at the bottom of his bed wrapped up. On 3/18/26 at 11:38 AM Resident #55 stated a lady placed all the bedding at the bottom of the bed that morning and had not been back to make the bed. An observation on 3/18/26 at 11:41 AM revealed down hall G bedding not on the bed at all in Resident #40 and #58 On 3/18/2026 3:06 PM Staff F, Certified Nurse Assistant (CNA) stated she usually made the resident's bed when she got the resident up in the morning. On 3/18/26 at 3:17 PM Staff G, CNA stated it was the first time he had worked at the facility. Staff G explained the morning was very busy and he was working on the hardest hall. Staff G acknowledged he worked on hall G that morning. Staff G explained he was all over the place that morning and had to do so many bed strips. Staff G explained he was pulled away from the hall at 10:00 PM. Staff G stated he tried to get beds made before 10:00 AM but did not have the time. On 3/18/26 at 3:34 PM Staff D, Licensed Practical Nurse (LPN) stated each day of the week they strip certain beds on certain halls and wash them. Staff D explained she had noticed frequently that resident beds are not made until after 11:00 AM. Staff D said she usually told the staff to make the bed or she will make the bed herself. On 3/18/26 4:21 PM Staff H, CNA stated he came in at 10:00 AM on 3/18/26. Staff H stated when he (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	came in that morning the beds had been stripped, linen was not changed and beds were not made on hall G. Staff H explained he had to help with resident care and was unable to make the beds until after care for all the residents was completed. On 3/25/26 at 2:18 PM the Director of Nursing (DON) stated the resident's beds are stripped and house keeping will come behind, clean the mattress and remake the bed on certain days of the week. The DON acknowledged 3/18/26 was not the day that hall G was supposed to have the beds stripped, the mattress cleaned and bed remade by housekeeping. The DON acknowledged she would expect the beds would have been made by 10:30 AM. On 3/26/26 at 12:00 PM the Administrator stated she expected the linen would have been placed on the bed and the beds made for the residents on hall G by 10:40 AM. Review of a facility provided policy revised on 05/07 titled, Homelike Environment documented it was the policy of this facility to provide a homelike environment, and to encourage and provide opportunities for each resident to occupy an area reflecting his/her interests, family, and/or is made personalized by bringing photos or items from home. 3. Observation on 03/18/2026 at 11:29 a.m., of Resident # 17's room. The room was noted to have the bed pulled away from the wall and the floor was noted to have streaks of dried fluid. The baseboard heat was noted to have brown debris scattered along the area next to the bed. The baseboard heat was also noted to have a white object in the baseboard. The wall above the baseboard heat noted to have several areas of brown debris on the wall. Resident #17 confirmed the areas had been there for a while and unsure what the debris is. Review of the facility provided policy titled Homelike Environment with a revised date of 5/2007 revealed it is the policy of this facility to provide a homelike environment Interview on 03/25/26 at 2:59 p.m., with the Administrator revealed the rooms should be clean.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, Medication Administration Records and Treatment Administration records (MAR-TAR) review, resident and resident family interviews, staff interviews and facility policy review the facility failed to provide physician ordered medications and failed to notify the physician of missed medications for 3 of 3 residents reviewed (Resident #7, #20 and #35) and the facility failed follow physician ordered interventions to notify the physician for a resident with weight fluctuations for 1 of 3 residents (Resident #10). The facility reported a census of 57 residents.Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #7 documented diagnoses of insomnia, depression and Multiple Sclerosis. The MDS showed the Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. Review of the facility provided document titled Order Summary Report signed by the physician 6/4/25 revealed the following orders: Fibercon tablet with an order date of 8/20/23 Melatonin tablet with an order date of 3/29/25 Fluvoxamine tablet with an order date of 2/20/25 Omeprazole tablet with an order date of 5/20/21 Review of Resident #7's Progress Notes revealed the following: On 2/6/26 at 11:36 a.m., omeprazole tablet- medication not available. On 2/25/26 at 10:55 a.m., fluvoxamine tablet- medication not found. On 3/15/26 at 6:58 p.m., melatonin tablet- medication not available. On 3/16/26 at 7:20 p.m., FiberCon tablet- medication not available. Review of Resident #7's Electronic Health Records (EHR) failed to indicate physician notification for omitted administrations. 2. The MDS assessment dated [DATE] for Resident #20 documented diagnoses of anxiety disorder and depression. The MDS showed the BIMS score of 12, indicating moderate cognitive impairment. Review of the facility provided document titled Order Summary Report signed by the physician 10/6/25 revealed the following orders: Pantoprazole tablet with an order date of 10/6/25 Lactulose solution with an order date of 1/13/25 Famotidine tablet with an order date of 1/28/25 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Duloxetine capsule with an order date of 9/10/25 Review of Resident #20's Progress Notes revealed the following: On 1/3/26 at 7:20 a.m., Pantoprazole tablet- drug unavailable. On 2/6/26 at 8:06 a.m., Lactulose solution- drug not available. Reordered. On 2/6/26 at 8:06 a.m., Famotidine tablet- drug not available. Reordered. On 2/11/26 at 11:41 a.m., Duloxetine capsule- medication unavailable. On 3/10/26 at 11:17 a.m., Lactulose solution- on order. Review of Resident #20's EHR failed to indicate physician notification for omitted administrations. 3. The MDS assessment dated [DATE] for Resident #35 documented diagnoses of acute pain due to trauma, muscle spasm, femur fracture. The MDS showed the BIMS score of 11, indicating moderate cognitive impairment. Review of the facility provided document titled Order Summary Report signed by the physician dated 1/9/26 revealed the following orders: Lidocaine patches for pain with an order date of 1/9/26 Sitagliptin Phosphate with an order date of 1/9/26 Review of Resident #35's Progress Notes revealed the following: On 1/19/26 at 7:26 a.m., Sitagliptin Phosphate- awaiting medication arrival. On 2/12/26 at 11:16 a.m., Lidocaine patch- medication not available. On 3/3/26 at 10:08 a.m., Lidocaine patch- patch not available. On 3/4/26 at 6:57 a.m., Lidocaine patch- medication not available. On 3/16/26 at 7:46 a.m., Lidocaine patch- medication not available. On 3/18/26 at 9:11 a.m., Lidocaine patch- not available. On 3/19/26 at 11:06 a.m., Lidocaine patch- no patches available. On 3/23/26 at 7:18 a.m., Lidocaine patch- on order. Review of Resident #35's EHR failed to indicate physician notification for omitted administrations. Review of facility provided policy titled Physician Orders with a revised date of 5/2007 revealed it is the policy of this facility that drugs shall be administered only upon the written order of a person duly (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	licensed and authorized to prescribe such drugs. The charge nurse or the director of nursing services shall place the order for all prescribed medications. Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to assure that refills are on hand. Interview on 3/24/2026 at 2:12 p.m., with the Director of Nursing revealed if a medication is missed the facility should be notifying the physician the medication had been missed. 4. The MDS dated [DATE] documented Resident #10 had a BIMS of 9 indicating moderate cognitive impairment. On 3/17/26 at 10:57 AM Resident #10's Daughter stated Resident #10 had a weight loss of 27%. Resident #10's Daughter stated Resident #10's weight had fluctuated a little bit in the past but as of right now he is 136 lbs in the hospital. Resident #10's Daughter stated a few weeks ago before the hospital visit the facility had a sheet printed out that said Resident #10 weighed 207 lbs on 2/25/26. Resident #10's Daughter stated Resident #10 did not look 200 lbs at the facility at that time. Review of Resident #10's documented weights: -Resident #10's weight at the facility: Weight at the facility on 8/15/25 was 191 lbs. Weight at the facility on 10/7/25 was 202 lbs. Weight at the facility on 1/23/26 was 176 lbs. Weight at the facility 2/1/26 was 174.2 lbs. went to hospital on 2/10/26 Weight at the facility 2/25/26 was 207.4 lbs. -Resident #10's weight at the hospitals: Review of Hospital discharge documented on admission [DATE] Resident #10 weighed 201 lbs. Review of Hospital discharge documented weight on 1/10/26 of 181. Review of Hospital discharge documented a weight of 141 on 2/16/26. An oral nutritional supplement ordered TID at the hospital for poor intake documented on discharge summary from 2/25/26. Review of hospital discharge documented a weight of 136.6 lbs from 3/16/26. -Resident #10's Dialysis Clinic weight: Weight at dialysis 1/31/26 weight of 178.5 lbs. Review of Resident #10 MAR-TAR documented a physician's order with a start date of 8/14/26 to notify the provider if Resident #10 had signs or symptoms of fluid overload every shift for weight gain. (continued on next page)

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Hillcrest Health Care Center	2121 Avenue L Hawarden, IA 51023

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/25/26 at 2:18 PM the Director of Nursing (DON) stated 134 lbs. was reported as a dry weight from the dialysis clinic. The DON explained she did not feel that 207 appropriately identified the weight of Resident #10 when obtained at the facility on 2/25/26. The DON stated the staff may not have taken the wheelchair weight off. The DON stated she would expect the physician would have been notified of the weight difference between the weights at the facility. The DON stated Resident #10 should have been reweighed when he returned from the hospital on 2/25/26. On 3/26/26 at 10:26 AM Staff D, Licensed Practical Nurse (LPN)/Admissions stated she had not noticed the difference in weight from the facility to the hospital on 2/25/26 for Resident #10. Staff D acknowledged when the weight of 207 was obtained at the facility another weight should have been obtained and the physician should have been notified. Staff D said she did not see the discharge order for an oral nutritional supplement for Resident #10. Staff D acknowledged she should have notified Resident #10's physician of the oral nutritional supplement and did not. On 3/26/26 at 8:22 AM the DON stated she had spoke to the dialysis clinical manager and Resident #10 weighed 169 lbs. on 2/3/26. The DON stated the dialysis clinic manager stated Resident #10 weighed 138 lbs. on 3/3/26. The DON stated if the hospital had ordered supplements then the supplements would have been reported to Resident #10's primary physician and would have requested for Resident #10 to have them at the facility. The DON stated with the weight loss she would have expected the staff to re-weigh Resident #10 and for the physician to have been notified of the difference since returning from the hospital. On 3/26/26 at 9:07 AM Staff O, Nurse Practitioner (NP) stated she had Resident #10 on her case load. Staff O stated the facility had explained in the past that they were having problems with their scales. Staff O explained with any drastic weight loss the facility was obligated to notify her. Staff O explained that a consideration would have to be taken for the amount of food and medications Resident #10 had refused. Staff O explained if she was notified of Resident #10's weight change she would have started him on the supplement. Staff O explained Resident #10 was already deteriorating and did not feel it would have made a difference in his outcome. Review of a policy provided by the facility reviewed 7/23 titled, Documentation and Charting documented it was the policy of the facility to provide A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., as well as the progress of the resident's care. Guidance to the physician in prescribing appropriate medications and treatments. The facility, as well as other interested parties, with a tool for measuring the quality of care provided to the resident. Nursing service personnel with a record of the physical and mental status of the resident. Assistant in the development of a Plan of Care for each resident. The elements of quality medical nursing care. Review of a policy provided by the facility reviewed 7/24 titled, Change of Condition Reporting documented a licensed nurse will inform the physician and family/responsible party of change of condition and document notification. All attempts to reach the physician and responsible party will be documented in the nursing progress notes. Documentation will include time and response.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, electronic health record (EHR) review, resident interview and staff interview the facility failed to provide nursing staff to assure residents safety by not responding to call lights in a timely manner for 3 of 16 resident reviewed (Resident #30, #32 and #33). The facility reported a census of 57 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #30 had a Brief Interview for Mental Status (BIMS) of 14 indicating no cognitive impairment. The MDS indicated Resident #30 had diagnoses of Dysphagia, hemiplegia and hemiparesis following cerebral infarction, and stiffness of right shoulder. The MDS also indicated Resident #30 required partial/moderate assistance with oral hygiene, substantial/maximal assistance with toileting hygiene, partial/moderate assistance with upper body dressing, substantial/maximal assistance with lower body dressing and substantial/maximal assistance with personal hygiene. On 3/18/26 at 10:21 AM Resident #30 stated last night on overnights before 12:00 AM she looked for her call light and it was not in bed with her. Stated she could not get any help and urinated on herself two times. Resident #30 explained last week she sat in the bathroom on the toilet for 45 minutes waiting for help and she timed the response on her phone. 2. The MDS dated [DATE] for Resident #32 documented a BIMS of 13 indicating no cognitive impairment. The MDS documented Resident #32 required partial/moderate assistance with eating, oral hygiene, upper body dressing and personal hygiene. The MDS also documented Resident #32 was dependent on staff for toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear.On 3/18/26 at 11:31 AM Resident #32 stated she has to wait longer than 30 minutes at times when she turns the call light on and she needs to use the restroom. Resident #32 stated the facility is severely understaffed. 3. The MDS dated [DATE] for Resident #33 documented a BIMS of 15 indicating no cognitive impairment. The MDS documented Resident #33 required setup or clean-up assistance for eating, oral hygiene, toileting hygiene, upper body dressing and personal hygiene. The MDS also documented Resident #33 partial/moderate assistance with lower body dressing and putting on/taking off footwear. On 3/18/26 at 8:02 AM Resident #33 stated the staff tell her they are short on the floor frequently. Resident #33 explained the facility was short 3/17/26 last week there was only one person working this side and her hall. Resident #33 stated it could take up to an hour to answer her call light. Resident #33 stated last night it was much longer than 15 minutes for staff to respond to her call light. Review of a document provided by the facility titled, January Grievance Log documented call light times were reported on 1/7/26, 1/13/26 and 1/21/26.Review of a document provided by the facility titled, February Resident Council 2026 documented the residents reported call light response had been slower lately.On 3/25/26 at 10:08 AM Staff P, Licensed Practical Nurse (LPN) stated she worked the evening of 3/8/26 and that night there was only one Certified Nurse Assistant (CNA) and two nurses. Staff P stated Staff N, LPN also called the Director of Nursing (DON) about the situation. Staff P stated no CNA came into help until 12:00 AM or 12:30 AM. Staff P stated she worked with Staff M that night. Staff P stated she was sure there were call lights that were not responded to within 15 minutes simply because they just did not have enough staff.On 3/18/26 at 3:06 PM Staff F, Certified Nurse Assistant (CNA) stated she had heard residents complain about call lights taking a long time to respond to daily. Staff F stated Hall 4/G is a busy hall and has a lot of complaints from that hall. Staff F stated she has been at the facility when it has taken call lights longer than 15 minutes to answer. Staff F stated she has seen times for call light responses that took up to 45 minutes. Acknowledged there were call lights that lasted longer than 15 minutes that morning. Staff F stated the facility was short this morning. On 3/19/26 at 8:24 AM Staff K, CNA stated she typically worked overnight shifts from 6:00 PM - 6:00 AM. Staff K stated they always work short. Staff K stated she was the only CNA in the building until 2:00 AM last night on 3/18/26. Staff K stated there were 2 nurses last night, but (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sometimes they are short as well and there is only one nurse. Staff K stated the nurses do not help when she works by herself on overnights. Staff K stated frequently the call lights take longer than 15 minutes to respond to. Staff K acknowledged the residents frequently seem upset that it takes so long to answer their call lights. On 3/23/26 at 11:48 AM Staff L, CNA stated some nights there are only 2 CNA's and 2 nurses and there had been times when there was only one CNA and 2 nurses. Staff L stated the nurses would help because there was no choice. Staff L explained a lot of things are not completed because of the lack of staff. Review of a document provided by the facility titled, Payroll documented Staff M was the only CNA present in the facility from 6:00 PM on 3/8/26 - 12:00 AM on 3/9/26.On 3/23/26 at 5:48 PM Staff M, CNA stated he worked the overnight shift 6:00 PM - 6:00 AM. Staff M explained at times there are only 2 CNA's. Staff M said there was a time when he was the only CNA as well. Staff M stated that day was 3/8/26. Staff M stated when he entered the building at 6:00 PM on 3/8/26 he was by himself until 12:30 AM. Staff M stated then a CNA came in and then around 1:00 AM another CNA entered the facility. Staff M stated he had to put around 50 residents to bed that evening. Staff M stated on nights like that call light response is much longer than 15 minutes. Staff M acknowledged that night call lights were on for 45 minutes. Staff M explained the charge nurse called the Director of Nursing (DON) and she said she tried to call CNA's to come in but there was none to come in. Staff M stated the charge nurse asked if the DON was going to come in and she said she was busy. Staff M stated the charge nurse called the corporate compliance hotline and told them how short they were. Staff M stated there were 2 nurses that night. Staff M explained the nurses were Staff N, Licensed Practical Nurse (LPN) and another nurse that was her 2nd time working. Stated that night the nurses did not help him put the residents to bed.On 3/23/26 at 6:42 PM Staff I, Registered Nurse (RN) stated she worked on 3/8/26 and Staff M was the only CNA working that evening. On 3/24/26 at 1:35 PM Staff D, Licensed Practical Nurse (LPN) stated the residents had voiced concerns about the call light response being very long. Staff D stated she did not know how the staff ratio is determined. Staff D stated she had seen pm shift only have one CNA and 2 nurses. Staff D stated she had frequently seen the call light response take longer than 15 minutes and it has been noticed. Staff D explained the facility was trying to address the concern. On 3/24/26 at 2:58 PM Staff N, LPN stated she worked 6:00 PM - 6:00 AM. Staff N acknowledged she frequently heard complaints from residents about the length of time it takes to respond to call lights at the facility. Staff N stated it can be a daily thing sometimes. Staff N stated on 3/8/26 she had worked with one CNA and two nurses. Staff N stated she spoke with the Director of Nursing (DON) and the Administrator about the concern. Staff N stated the DON stated they would not come in to work that night. Staff N stated the DON and the Administrator stated they are working on the issue. Staff N explained she told the DON and the Administrator it really puts the residents and on the staff's licenses at risk. Staff N stated Staff M was working and both the nurses were running. Staff N explained 2 CNA's came in at about 12:30 am or 1:00 AM. Staff N stated there had been an evening when she was the only nurse. Staff N explained she had to put her foot down and tell the management she was uncomfortable doing that. Staff N stated the management would not send a staff in until she said she was going to clock out and go home. ON 3/25/26 at 6:10 PM Staff E, LPN stated she works 6:00 PM - 6:00 AM. Staff E stated she felt there was an unsafe staff to resident ratio. Staff E stated the facility did not have that many of their own staff. Staff E stated residents frequently complained about the call light response being lengthy. On 3/25/26 at 2:18 PM the DON stated she expected the 6:00 PM - 6:00 AM shift to have 3 CNA's and 2 nurses and 6:00 AM - 6:00 PM shift to have 4 CNA, a bath aide and 2 nurses. The DON stated staffing was based on the facility census and that was at the 85% occupancy. The DON explained if the census increased additional staff can be added. The DON stated she oversees the staff but another staff completed the staffing. The DON acknowledged there was concerns with staffing at the facility and dependability with the agency staff. The DON stated she would want the call light response time less than 15 minutes. The DON stated they review the call light information as they can review and there had been grievances related to excessive call light (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	times. The DON stated she did not get any calls about the staffing on 3/8/26. The DON stated she had not been aware there was one CNA present in the building on that day. The DON stated she felt that staff should have called her if there was only one CNA present in the building. The DON acknowledged that Staff M was the only CNA until 12:00 AM on 3/9/26. Review of a policy provided by the facility revised 05/07 documented it was the policy of this facility to provide the resident a means of communication with nursing staff. Answer the light/bell within a reasonable time (~ 15 minutes).

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews and policy review the facility failed to ensure proper temperatures for foods served to residents. The facility reported a census of 57 residents.1. The Minimum Data Set (MDS) dated [DATE] documented Resident #30 had a Brief Interview for Mental Status (BIMS) of 14 indicating no cognitive impairment. On 3/18/26 at 10:36 AM Resident #30 stated dinner meals are served cool. Resident #30 stated she does not ask the staff to reheat the food she just does not eat the food. Resident #30 explained the staff would not reheat the food if she asked. 2. The MDS dated [DATE] for Resident #33 documented a BIMS of 15 indicating no cognitive impairment. On 3/18/26 at 7:58 AM Resident #33 stated most meals are served cold. Resident #33 stated she eats most meals in her room. Resident #33 stated she would like the meals to be served warmer. Resident #33 stated she would ask the staff to warm the food up but it depends on who the Certified Nurse Assistant (CNA) working if they will warm it up. Review of a policy provided by the facility revised 8/18 titled, Checking Food Temperatures documented meals will be served at appropriate temperatures to ensure food safety and cross contamination. Temperatures should be taken periodically to assure hot foods stay above 135 degrees F and cold foods stay below 41 degrees F during the portioning, transporting and serving process until received by the customer. 3. Observation on 3/19/26 at 12:11 p.m., of a room tray delivered. The meal arrived on a tray with a metal cover over the food. The meal consisted of enchilada, lettuce salad with salad dressing on the top of lettuce, apple crisp and juice. The dietary staff checked the temperature of the enchilada and the food temperature read 129.6 degrees. Review of the facility provided policy titled Checking Food Temperatures revised 8/2018 revealed meals will be served at appropriate temperatures to ensure food safety and cross contamination. Hot foods should be held at or above 135 degrees F. Interview on 3/25/2026 at 2:11 p.m., with the Administrator revealed the food should be served at safe temperatures.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and staff interview, the facility failed to implement proper hand hygiene protocols to prevent the spread of infection during the administration of oral medication, insulin administration, and enteral tube medication administration for 4 of 4 resident observed for medication administration (Residents #2, #16, #19 and #48). Additionally, the facility failed to adhere to current Centers for Disease Control and Prevention (CDC) guidelines by not utilizing Enhanced Barrier Precautions (EBP) during enteral tube medication administration to prevent the spread of multidrug-resistant organisms (MDROs) for 1 of 1 resident reviewed (Resident #2). The facility reported a census of 58 residents. Findings include: 1.Observation on 3/19/26 at 8:16 AM, showed Staff J, Licensed Practical Nurse (LPN) accessed Resident #48's medication record via computer, obtained medication from the medication cart, and prepared the dose in a medication cup. Staff J approached Resident #48, grasped the resident's drinking glass by the top rim, and assisted with medication ingestion. Staff J then provided the drink, returned to the medication cart, doffed gloves and discarded the medication cup. Staff J failed to perform hand hygiene immediately before or immediately after medication administration then initiated medication administration for Resident #16. Staff J accessed Resident #16's medication record via computer, obtained medication from the medication cart, and prepared the dose in a medication cup. Staff J then prepared Resident #16's insulin pen and approached Resident #16. Staff J assisted Resident #16 to ingest the medications using applesauce, entered the bathroom to perform hand hygiene, returned, and discarded the medication cup. Staff J donned gloves, lifted the resident's shirt, applied an alcohol wipe to the skin, and administered the insulin subcutaneously in the right flank area. With soiled gloves, Staff J returned to the medication cart, discarded the insulin tip, and doffed the gloves. Staff J failed to perform hand hygiene, accessed the computer, entered the medication cart to retrieve medications, and subsequently prepared Resident #19's medications without performing hand hygiene. During an interview on 3/19/26 at 2:25 PM, the Director of Nursing (DON) reported that staff were required to perform hand hygiene immediately before and after medication administration for each resident. The DON also reported that staff were required to perform hand hygiene immediately before donning gloves and immediately after doffing gloves. When informed of the observation, the DON identified Staff J as an agency staff member and stated that follow-up education for hand hygiene would occur immediately. During an interview on 3/19/26 at 2:28 PM, the Administrator reported that she expected staff to follow infection control guidelines for hand hygiene. 2. The MDS dated [DATE] for Resident #2 documented a BIMS of 11 indicating moderate cognitive impairment. The MDS also documented placement of a feeding tube on admission and while as a resident. Observation on 3/18/26 outside of Resident #2 room revealed a sign for Enhanced Barrier Precautions for Resident #2 requiring gown and gloves for direct resident care. Observation on 3/19/26 at 9:04 AM of Resident #2's enteral medication administration by Staff C, Licensed Practical Nurse (LPN) revealed Staff C unlocked the medication cart, opened the computer to check medications, removed medications from medication packages, crushed medications (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	individually, poured water poured a cup, opened a new syringe and dated, drew up 10cc of water for each medication, mixed each medications with a spoon, knocked on door, entered room, applied gloves, (no hand hygiene completed), did not don gown, checked residual, completed an auscultation of air bolus for placement, flushed 30cc H20, pushed water through syringe with palm of hand, drew up medication separately, pushed forcefully with palm of hand, Staff C explained she had to use force because the syringe itself is difficult to push, flushed with 10cc h20 between medications, obtained new syringe, obtained fresh water about 4 0z, removed gloves, no hand hygiene completed, applied gloves, flushed enteral tube with remaining water, removed gloves, picked up trash, completed hand hygiene, left room, obtained 81mg low dose from other cart, returned to medication cart, crushed medication, completed hand hygiene, applied gloves, flushed with 30cc, administered medication, flushed with 70cc H20, removed gloves and completed hand hygiene. Review of Resident #2's EHR titled, Care Plan documented Resident #2 required bolus feeding through the Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube entering the stomach for nutrition and or medication administration). On 3/25/26 at 2:18 PM the DON stated Resident #2 required Enhanced Barrier Precautions (EBP) because of the placement of a PEG tube. The DON explained the nurse should have worn a gown when administering medications through Resident #2's enteral tube. The DON stated the nurse should have completed hand hygiene when entering or leaving the room or at the medication cart. Review of a policy provided by the facility dated 6/25 titled, Enhanced Barrier Precautions Policy and Procedure documented it was the policy of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDROs). CMS notes that facilities have some discretion when implementing EBP and balancing the need to maintain a homelike environment for residents. This policy aims to mitigate the risk of transmission of Multidrug-Resistant Organisms (MDROs) within the facility by implementing Enhanced Barrier Precautions (EBP). This policy seeks to prevent the spread of MDROs among residents and staff members by expanding the use of personal protective equipment (PPE) during high-contact resident care activities for certain residents. High-contact resident care activities are activities that have been demonstrated to result in the transfer of MDROs to hands or clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. Examples of high-contact resident care activities requiring gown and glove use for residents on EBP include, but are not limited to dressing, bathing/showering, changing briefs or assisting with toileting (including ostomy care), device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, and wound care: any skin opening requiring a dressing.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and policy review the facility failed to ensure residents had the proper supplies for urinary independence for 1 of 1 residents reviewed (Resident #17). The facility reported a census of 57 residents.Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #17 documented diagnoses of morbid obesity and heart failure. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment Interview on 3/18/2026 at 11:29 a.m., with Resident #17 revealed she uses a female urinal and she uses it on a daily basis. Observation of her urinal was noted to have brown areas on the outside and noted to have a urine scale in the bottom of the urinal. She explained the brown areas on the outside of the urinal is feces that has been there awhile. She explained the facility has not changed the urinal for approximately 3 months and does not clean it weekly. Observation of the urinal top also showed a bend in the top of the urinal and she stated that it does not work as well when it has the bend. The facility did not provide a policy on urinal care. Interview on 3/25/2026 at 3:23 p.m., with the Director of Nursing (DON) revealed she doesn't know what the facility staff does with Resident #17's urinal. The DON revealed the male urinals are changed monthly so hers should be as well. She is unsure if the facility has any new urinals for her in the facility at this time but they should.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the Electronic Health Record (EHR) review, resident family interview, family interview, staff interview and policy review the facility failed to provide access to personal funds managed by the facility or manage personal funds deposited at the facility for 2 of 3 residents reviewed (Resident #11 and #30). The facility reported a census of 57 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #11 had a Brief Interview for Mental Status (BIMS) of 10 indicating moderate cognitive impairment.On 3/17/26 at 6:39 PM Resident #11's Nephew, financial and care Power of Attorney (POA) stated he was not sure if Resident #11 could get his money on the weekend or in the evening. 2. The MDS dated [DATE] for Resident #30 documented a BIMS of 14 indicating no cognitive impairment.On 3/18/26 at 10:33 AM Resident #30 stated she was unable to get her personal funds in the evening or on the weekends so she had to keep money in her purse to ensure she had money when she wanted it. Resident #30 stated she had personal items come up missing from her room so it did worry her to keep her money in her purse in her room.On 3/24/26 at 2:05 PM Staff A, Social Services Director/Social Worker stated she takes care of the resident trust fund. Staff A stated the residents can ask any staff and she would get the money. Staff A explained the facility kept petty cash on hand. Staff A explained the facility kept about $400.00 on hand and would be replaced when it ran out. Staff A acknowledged her position was Monday - Friday 8:00 AM - 4:30 PM. Staff A stated the residents would be able to call her or the administrator in the evenings. Staff A explained if she needed to she could come in on the weekend or in the evening. Staff A stated she would be able to arrange something to get the money. Staff A stated it would be her or the Administrator that would have to come in and get the money for the residents in the evening or on the weekend. Staff A stated she was the only staff member with a key to the petty cash box. Staff A acknowledged the residents did not have access to their funds 24 hours a day or 7 days a week. On 3/24/26 at 2:22 PM Staff B, Certified Nurse Assistant (CNA) stated she does not know if the residents can get their money at night or on the weekend. On 3/24/26 at 2:26 PM Staff C, Licensed Practical Nurse (LPN) stated she would have to call Staff A and ask her what to do. Staff C explained she did not have access to any money for the resident. Staff C said only Staff A had access to money for the residents.On 3/24/26 at 2:33 PM the Administrator stated the residents would have to contact Staff A to get money when she was not at the facility. Staff A stated the residents can have access to money when they need it and Staff A made sure the residents had money on Friday before she left. The Administrator acknowledged the residents who have money in the resident trust do not have access to the money 24 hours a day or 7 days a week. The Administrator explained the residents only had access when Staff Staff A was at the facility.Review of a policy provided by the facility dated 6/16 titled, Resident Funds documented it was the policy of the facility to ensure resident funds maintained or managed by the facility are protected. The objectives of our resident fund policies are to provide a means for protecting resident funds managed by the facility, provide for an individual accounting of funds received and disbursed on the resident's behalf and establish uniform guidelines to follow in implementing policies and procedures to protect the residents funds. A separate record is maintained for each resident's personal funds account, including receipts and expenditure. It shall be the responsibility of the Administrator to inform all residents, prior to or upon admission, of the facility's policy and procedure governing the management of resident funds.

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	165245	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Health Care Center	2121 Avenue L Hawarden, IA 51023

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Records (EHR) review, staff interview, family interview and policy review the facility failed to notify the resident's representative / family / Power of Attorney (POA) when a resident had a change in condition that lead to a transfer to the Emergency Department (ED) for 1 of 3 residents (Residents #10) reviewed. The facility reported a census of 57 residents.Findings included:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #10 had a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. Review of Resident #10's EHR titled, Census documented Resident #10 was transferred to the hospital 1/7/26 and returned 1/22/26.Review of Resident #10's EHR titled, Progress Note documented an entry at 5:40 AM on 1/7/26 by Staff E, Licensed Practical Nurse (LPN) on-call provider gave orders to send Resident #10 to the ED via ambulance for evaluation and supply oxygen, updated resident on orders as resident is own POA.Review of Resident #10's EHR titled, Progress Note documented an entry at 11:31 AM on 1/7/26 by Staff D, LPN had spoken with ED nurse with report that Resident #10 was transferred to another hospital in Sioux Falls because of urosepsis and kidney failure. Staff D documented she called and notified Resident #10's Daughter.Review of Resident #10's EHR titled, Profile documented Daughter as emergency contact #1, POA, care conference person. On 3/17/26 at 10:56 AM Resident #10 Daughter/POA stated when Resident #10 went to the ED on 1/7/26 she was not notified till he went to the second hospital. Resident #10's Daughter/POA explained Resident #10 was life flighted to second hospital and she was not notified until after Resident #10 was in second hospital. Resident #10's Daughter/POA stated she was called by the nursing home about 30 minutes before the second hospital notified her. Resident #10's Daughter/POA stated she spoke to Staff D, Licensed Practical Nurse. Resident #10's Daughter/POA stated she told Staff D she was not notified her father was sent to the hospital and Staff D apologized. On 3/24/26 at 1:35 PM Staff D, LPN stated she called Resident #10's daughter / POA and notified her that Resident #10 was transferred to the ED. Staff D stated when she arrived the previous nurse Staff E, LPN had not notified the Resident #10's Daughter and Resident #10's daughter was upset. Staff D stated if the resident was their own POA Staff D would ask to notify the emergency contact. Staff D explained if the ambulance was called it would be an emergency and the emergency contact should be notified. On 3/25/26 at 6:10 PM Staff E, LPN stated she was familiar with Resident #10. Staff E explained Resident #10 was his own POA. Staff E stated if Resident #10 was not his own POA; she would notify the emergency contact. Staff E explained she did not notify Resident #10's POA when transferred to the hospital on 1/7/26. Staff E acknowledged she sent Resident #10 out right at 6:00 AM. Staff E said she texted Staff D to let Resident #10's daughter know Resident #10 was transferred. Staff E acknowledged that she should have let the daughter know but she did not at that time. On 3/18/26 at 10:54 AM the Director of Nursing (DON) stated Resident #10 was transferred to the hospital via emergency ambulance on 1/7/26. The DON stated Resident #10 was his own POA at the time but Resident #10's daughter was emergency contact #1 and should have been notified of the transfer to the ED and was not.Review of policy with review date of 7/24 titled, Change of Condition Reporting documented a licensed nurse will inform family/responsible party of change of condition and document notification. All attempts to reach the physician and responsible party will be documented in the nursing progress notes. Documentation will include time and response.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. The facility failed to properly complete the Centers of Medicare & Medicaid form #10123 for 1 of 3 sampled residents. (Residents #4). The facility reported a census of 58 residents.Findings Include: The ABN form #10123 dated 12/23/25 for Resident #4 revealed the Social Worker documented a 48 hour notice waived. During an interview on 3/18/26 at 1:14 PM, the Social Worker reported that she had completed form #10123 and documented that Resident #4 waived a 48-hour notice. She further stated she could not recall the rationale for the waiver and indicated she would investigate the matter. During an interview on 3/18/26 at 2:51 PM, the Social Worker reported that she had been unable to locate documentation or rationale regarding the resident's waiver of the 48-hour notice on form #10123. When asked if a 48-hour notice should be documented as waived by the resident because the facility failed to provide the proper 48 hour advance notice, the Social Worker stated no. The undated Advance Beneficiary Notice of Non Coverage Part A failed to address form #10123 or the required 48 hour notice of Medicare Provider Non-Coverage. The Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 instructed when to deliver the NOMNC A Medicare provider or health plan (Medicare Advantage plans and cost plans, collectively referred to as plans) must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services. The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. During an interview on 3/19/26 at 2:25 PM, the Director of Nursing (DON) reported that she was not familiar with the requirements of ABNs. During an interview on 3/19/26 at 2:28 PM, the Administrator reported she was not fully educated regarding Advanced Beneficiary Notices (ABN's) and expected the Social Worker to adhere to ABN guidelines.

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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 review, facility policy review and staff interview the facility failed to discontinue antipsychotic medication when ordered to be stopped therefore the medication was continued to be administered for 1 out of 5 residents (Resident #20) for unnecessary medication. The facility reported a census of 57 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #20 documented diagnoses of anxiety disorder and depression. The MDS showed the Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Review of order signed by the physician on 10/16/25 revealed discontinue quetiapine. Review of October Medication Administration Record (MAR) revealed quetiapine was administered daily from October 17- 31, 2025. Review of November MAR revealed quetiapine was administered daily from November 1- 30, 2025. Review of December MAR revealed quetiapine was administered daily from December 1-11, 16, 18, 27-30 with a discontinue date of 12/31/25. Review of facility provided policy titled Unnecessary Drugs with a revised date of 7/2025 revealed each resident's entire drug/medication regimen be managed and monitored to promote or maintain the resident's highest practicable mental, psychical, and psychosocial well-being. Residents receive only those medications, in doses and for the duration clinically indicated to treat the resident's assessed condition(s). Interview on 3/24/2026 at 2:12 p.m., with the Director of Nursing revealed the quetiapine should have been discontinued in October when the order was signed.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 2 of 4 residents reviewed for abuse (Resident #3 and #50). The facility reported a census of 57 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 documented diagnoses of coronary artery disease, diabetes mellitus and muscle weakness. The MDS showed the Brief Interview for Mental Status (BIMS) score of 12 indicating no cognitive impairment. Review of facility provided Incident Report dated 3/8/26 at 3:21 p.m., revealed Staff I, Registered Nurse (RN) was at the nursing station paging at about 3:21 p.m., to get update on another resident when caregiver came up to nurse and stated, just letting you know Resident #2 was in this resident room attempting to get in bed with her. This writer hung up and immediately rushed down the hall with a care giver. Staff I met Resident #3 in her bed, resting in bed, and call light within reach. Resident #3 stated, I was in bed, my door was halfway closed when this man came in and just kept coming towards me. He touched my leg and I told him to stop immediately. He moved my bedside table away from me and I thought he wanted to take my dentures on the table, but he had this weird look you know, placed his hand under my blanket and tried to touch me. I pushed my call light and screamed twice. My neighbor heard me and pushed his call light as well, and he took off then the aide came in and I told them. Interview on 3/17/2026 at 11:08 a.m., with Resident #3 revealed she had been laying in bed and her door opened and a guy in a wheelchair came into her room and touched her feet. He then moved her tray over that was next to the bed and all of a sudden his wheelchair was going up the side of my bed and his hand was going up my leg. She stated she screamed and pushed the call like. After she screamed he scooted out of my room. 2. The MDS assessment dated [DATE] for Resident #50 documented diagnoses of need for assistance with personal care, lack of coordination and hypertension. The MDS showed the BIMS score of 6 indicating severe cognitive impairment. Review of facility provided Incident Report dated 3/8/26 at 3:22 p.m., revealed Staff I, RN was at the nursing station paging at about 3:21 p.m., to get update on another resident when caregiver came up to nurse and stated just letting you know, Resident #2 was in Resident #3's room attempting to get in bed with her. Staff I immediately rushed down the hallway to make sure the resident was safe. Staff I and caregiver check rooms to make sure Resident #2 is out of the hallway and is safe. At about 3:22 p.m., Staff I and caregivers found Resident #2 in bed with Resident #50 with her pant and brief halfway down and Resident #2's left hand was in this resident's pants on her buttocks. Resident #2's wheelchair was parked in front of Resident #50's bed and door was locked. Resident #50 was lying in bed on her right side facing the window half asleep and Resident #2 was on bed and not moving. Review of Resident #50's Progress Notes revealed revealed Staff I, RN was at the nursing station paging at about 3:21 p.m., to get update on another resident when caregiver came up to nurse and stated just letting you know, Resident #2 was in Resident #3's room attempting to get in bed with her. Staff I immediately rushed down the hallway to make sure the resident was safe. Staff I and caregiver check rooms to make sure Resident #2 is out of the hallway and is safe. At about 3:22 p.m., Staff I and caregivers found Resident #2 in bed with Resident #50 with her pant and brief halfway down and Resident #2's left hand was in this resident's pants on her buttocks. Resident #2's wheelchair was parked in front of Resident #50's bed and door were locked. Resident #50 was lying in bed on her right side facing the window half asleep and Resident #2 was on bed and not moving. Resident #50 was unable to state or describe what happened. Both residents were separated immediately. Notified Director of Nursing (DON) immediately via phone call. Review of the facility provided policy titled Abuse: Prevention of and Prohibition Against with a reviewed date of 1/2022 revealed the following:a. All allegations of abuse, neglect, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	misappropriation of resident property, or exploitation should be reported immediately to the Administrator. b. Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the Facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations. Interview on 3/24/2026 at 2:11 p.m., with the Administrator revealed once she became aware of the situation that evening she immediately reported it to the state. It should have been reported sooner. Interview on 3/24/2026 at 2:26 p.m., with the DON revealed she did not know about the incident until later in the evening about the touching or being in bed with another resident. The DON confirmed she had been called around 3:00 p.m., but the staff never told her about the incident.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview the facility failed to complete a recapitulation of stay after discharge for 2 of 3 residents reviewed for discharges (Resident #61 and #63). The facility reported a census of 57 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #61 documented diagnoses of hypertension, Bell's Palsy and prediabetes. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. Review of the Census tab revealed stop billing on 1/12/26. Review of the January 2026 notice to the Long Term Care Ombudsman revealed the resident was discharged to home on 1/12/26. Review of the medical record lacked a recapitulation of stay. 2. The MDS assessment dated [DATE] for Resident #63 documented diagnoses of hypertension, muscle weakness and cardiac murmur. The MDS showed the BIMS score of 14 indicating no cognitive impairment. Review of the Census tab revealed stop billing 1/15/26. Review of the Progress Notes revealed on 1/14/26 at 2:38 p.m., Resident will be returning to assisted living upon discharge from skilled services. Review of the medical record lacked a recapitulation of stay. Review of facility provided policy titled Discharge Summary with a revision date of 12/2023 revealed It is the policy of this facility that a discharge summary shall be prepared when a resident is expected to be discharged . A recapitulation of the resident's stay that includes, but is not limited to: diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. Interview on 3/25/2026 at 11:28 a.m., with the Director of Nursing revealed if it is not in the assessments then it was not completed.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Medication Administration Records - Treatment Administration Records (MAR-TAR) Electronic Health Records (EHR) review, document review, policy review and staff interviews the facility failed to incorporate the required recommendations from the Preadmission Screening and Resident Review (PASRR) level II determination and failed to refer a resident with a later identified with newly evident or possible serious MD or ID related condition to the appropriate state-designated authority for a level II evaluation for 3 out of 4 residents (Resident #4, #5, and #15) reviewed for PASRR requirements. The facility reported a census of 57 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #4 had a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. MDS also documented diagnoses of major depressive disorder and schizophrenia. Review of Resident #4's document dated 11/19/25 titled, Notice of PASRR Level II outcome documented ongoing psychiatric medication management by a psychiatrist or psychiatric ARNP (to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services) as a required behavioral health support for Resident #4. Review of Resident #4's MAR-TAR documented physician's order with a start date of 11/24/25 for clozapine (a second generation antipsychotic used for the treatment of schizophrenia) oral tablet to give 100 mg by mouth at bedtime for mood Review of Resident #4's EHR titled, Care Plan documented an intervention with an initiation date of 12/13/25 Resident #4 would receive ongoing psychiatric medication management once a month by a psychiatrist, once a month to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services. Review of Resident #4's EHR titled, Progress Note dated 12/9/25 at 1:44 PM by Staff A, Social Worker documented a referral for psychiatric medication management has been submitted. Initial consultation pending scheduling. Progress Note dated 3/6/26 at 12:54 PM by Staff A documented Due to resident's current payer status, resident will need to complete a payment agreement prior to being seen for an initial psychiatric evaluation. Efforts to reach resident's current payee have been unsuccessful resulting in inability to render services. Frustration from her current payee situation has led Resident #4 to refuse services as well due to her current financial situation. Rep Payee appointment was held with SSA on 2/27/26. Rep Payee determination is currently pending determination. Progress Note dated 3/9/25 at 9:48 AM by Staff A documented neuropsychiatric evaluation cannot be completed until Resident#4 agreed to complete the initial psychiatric evaluation. Continued efforts will be made to engage Resident #4 in initial psychiatric evaluation. Staff A met with Resident #4 today to clarify if Resident #4 would be willing to meet for initial psychiatric evaluation, ongoing medication management, and neuropsychiatric evaluation. Resident #4 stated I don't think so. I don't think I can pay. Staff A reminded Resident #4 the facility was working on financials and had applied for rep payee. Resident #4 stated maybe later then and propelled away in a wheelchair. Review of document dated 3/12/26 titled, Notice of PASRR Level II Outcome documented on (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/28/26- A ServiceMatters review was completed to see if all identified PASRR services and supports noted in the PASRR report from December 2025 were being care planned and delivered. The ServiceMatters review found the nursing facility was not compliant because it had not developed your care plan according to state standards and/or had not incorporated PASRR-identified specialized and rehabilitative services. Technical assistance was provided by Maximus to help the facility become compliant. Document further documented on 3/9/26-A ServiceMatters review was completed to see if all identified PASRR services and supports noted in the PASRR report from December 2025 were being care planned and delivered. The ServiceMatters review found the nursing facility was not compliant because it had not developed your care plan according to state standards and/or had not incorporated PASRR-identified specialized and rehabilitative services. Technical assistance was provided by Maximus to help the facility become compliant. On 3/19/26 at 1:44 PM Staff A acknowledged the initial PASRR completed on 11/19/25 had recommended for Resident #4 to have ongoing psychiatric medication management by a psychiatrist or psychiatric ARNP (to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services). Staff A stated there was a Progress Note completed on 12/9/25 that they had reached out and then again on 3/6/26 something saying that there was a billing issue that needed to be resolved. On 3/26/26 at 10:27 AM Staff A stated Resident #4 has a rep payee that they do not have great communication with. Staff A stated they could not have the payment agreement by the rep payee. Staff A stated the facility that would have completed the psychiatric evaluation explained they would have to have a payment agreement signed prior to the evaluation of Resident #4. Staff A stated when she spoke with Resident #4 she would get upset because she was going to have to pay out of pocket for the services. Staff A stated she came under skilled care with Medicare and just applied for Medicaid 3/25/26 because they finally got a bank statement. Staff A acknowledged she had tried initially when Resident #4 had entered the facility. Staff A acknowledged she did not make any other attempts. Staff A stated applying for the rep payee and Medicaid in the state of Iowa to pay for the psychiatric services was probably dropped for this resident. On 3/25/26 at 2:18 PM the Director of Nursing (DON) stated in regards to Resident #4 PASSR stated she would like to have seen the financial aspect taken care of faster to ensure the meeting with the psychiatrist could have occurred per the PASSR recommendations. Review of a policy provided by the facility reviewed 5/22 titled, PASRR documented it was the policy of the facility to ensure that each resident is properly screened using the PASRR specified by the State. The purpose was to determine if the resident had a mental disorder as defined in paragraph (k)(3)(1), of the SOM unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority prior to admission: That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility and; If the individual requires such level of services, whether the individual requires specialized services. 2. The MDS assessment dated [DATE] for Resident #5 documented diagnoses of anxiety disorder, depression and hallucinations. The MDS included a Brief Interview for Mental Status (BIMS) score of 11 indicating moderate cognitive impairment. Review of the MDS dated [DATE] included current diagnosis of anxiety disorder, depression and hallucinations. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the current diagnosis list revealed major depressive disorder, recurrent moderate, hallucinations and generalized anxiety disorder. Review of the PASARR dated 10/21/24 lacked inclusion of anxiety disorder, depression and hallucinations. The clinical record lacked an updated PASARR to include anxiety disorder, depression and hallucinations. . 3. The MDS assessment dated [DATE] for Resident #15 documented diagnoses of schizophrenia. The MDS included a Brief Interview for Mental Status (BIMS) score of 14 indicating moderate cognitive impairment. Review of the MDS dated [DATE] included current diagnosis of schizophrenia. Review of the current diagnosis list revealed schizophrenia, unspecified. Review of the PASARR dated 2/26/26 listed diagnosis of psychotic delusional disorder. The clinical record lacked an updated PASARR to include schizophrenia. Review of the facility provided policy titled PASRR with a reviewed date of 5/2022 revealed it is the policy of this facility to ensure that each resident is properly screened using the PASRR specified by the stated. Interview on 3/23/26 at 10:37 a.m., with the Social Worker revealed the PASARR should have been updated with proper diagnosis and to include all mental health diagnosis.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, document review, staff interviews and policy review the facility failed to revise a comprehensive care plan to include updated recommendations when a Preadmission Screening and Resident Review (PASRR) Level II Outcome was completed for 1 of 3 residents reviewed (Resident #4). The facility reported a census of 57 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #4 had a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. MDS also documented diagnoses of major depressive disorder and schizophrenia.Review on of Resident #4's EHR titled Care Plan on 3/18/26 documented you will receive this service for one year through 3/13/2027. Continued need will be assessed by the case manager once a year through 12/21/2030. Behavioral Health would provide case management services and the social worker at the NF will be responsible for arranging for these services prior to discharge on [DATE]. You will have home cleaning service once a week for one year through 3/13/2027. Continued need will be assessed by the home health agency once a year through 3/13/2027. A home care service will provide home cleaning services and the social worker at the NF will be responsible for arranging for this service prior to discharge on [DATE]. You will have help from your children with transportation for one year and continue as needed through the next five years. Your daughter and son will help with transportation and the social worker/director of nursing at the NF will be responsible for coordinating this support with your family prior to discharge on [DATE].Review of document dated 3/12/26 titled, Notice of PASRR Level II Outcome documented on 1/28/26- A Service Matters review was completed to see if all identified PASRR services and supports noted in the PASRR report from December 2025 were being care planned and delivered. The Service Matters review found the nursing facility was not compliant because it had not developed your care plan according to state standards and/or had not incorporated PASRR-identified specialized and rehabilitative services. Technical assistance was provided by Maximus to help the facility become compliant. Document further documented on 3/9/26-A Service Matters review was completed to see if all identified PASRR services and supports noted in the PASRR report from December 2025 were being care planned and delivered. The Service Matters review found the nursing facility was not compliant because it had not developed your care plan according to state standards and/or had not incorporated PASRR-identified specialized and rehabilitative services. Technical assistance was provided by Maximus to help the facility become compliant.On 3/26/26 at 10:27 AM Staff A, Social Service Director acknowledged that she had updated the care plans on 3/19/26. Staff A stated she had got the updated PASSR on 3/12/26. Staff A stated updated the care plan on 3/19/26 and had changed the duration dates to match the new PASSR as well as the appointment expectations and things like that. Staff A explained on 3/18/26 she was told by management after the surveyor revealed concerns to make sure that the Resident #4's Care Plan was updated. Staff A explained Resident #4's Care plan should have been changed immediately when she received the PASSR.On 3/25/26 at 2:18 PM the Director of Nursing (DON) stated she would have liked to see Resident #4's Care Plans updated after the PASSR was completed in a timely manner and in this situation that did not occur. Review of a policy provided by the facility reviewed on 11/22 titled, Care Planning it was the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The Care Plan would be revised as needed, and interventions will be implemented. The comprehensive care plan would be developed by the IDT within seven (7) days of completion of the Resident Minimum Data Set (MDS) and will include resident's needs identified in the comprehensive assessment, any specialized services as a result of PASARR recommendation, and (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's goals and desired outcomes, preferences for future discharge and discharge plans. The resident's comprehensive plan of care would be reviewed and/or revised by the IDT after each assessment and updated as appropriate. The Care Plan would be revised as needed for order changes or Resident changes in condition, and interventions would be implemented as appropriate.

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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 clinical record review, resident interview, staff interview and facility policy review the facility failed to provide bathing assistance twice weekly for 2 of 3 residents reviewed for bathing (Resident #20 and #50). The facility reported a census of 57 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #20 documented diagnoses of anxiety disorder and depression. The MDS showed the Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Review of facility provided documentation titled Follow Up Question Report dated 1/19/26-3/19/26 revealed the following information:2/7/26- bathing was documented as refused. Resident received a bath on 2/4/26 and again on 2/11/26. Resident went 6 days without a bath. 3/11/26- bathing was documented as not applicable. Resident received a bath on 3/7/26 and again on 3/14/26. Resident went 6 days without a bath. Review of Care Plan with a revision date of 2/7/25 revealed resident is totally dependent on staff to provide a bath as necessary. 2. The MDS assessment dated [DATE] for Resident #50 documented diagnoses of need for assistance with personal care, lack of coordination and hypertension. The MDS showed the BIMS score of 6 indicating severe cognitive impairment. Review of facility provided documentation titled Follow Up Question Report dated 1/19/26-3/19/26 revealed the following information:1/24/26- bathing was documented as resident refused. Resident received a bath on 1/21/26 and again on 1/27/26. Resident went 6 days with no bath. 2/9/26- bathing was documented as not applicable2/12/26- bathing was documented as not applicable. Resident had a bath on 2/6/26 and again on 2/13/26. Resident went 6 days with no bath. 3/2/26- bathing was documented as not applicable. Resident had a bath on 2/23/26 and again on 3/3/36. Resident went 7 days with no bath. 3/10/26- bathing was documented as resident refused. 3/11/26- bathing was documented as not applicable3/12/26- bathing was documented as not applicable3/13/26- bathing was documented as not applicable3/14/26- bathing was documented as not applicable3/16/26- bathing was documented as not applicable. Resident received a bath on 3/6/26 and received a bath again on 3/17/26. Resident went 11 days with no bath. Review of the facility provided policy titled Bath, Shower with a revised date of 5/2007 revealed It is the policy of this facility to promote cleanliness, stimulate circulation and assist in relaxation. Clinical staff members will offer residents a shower at minimum of 2 times per week. If a resident is unable to shower on a specific day, the resident will be offered a shower on the next available day. Interview on 3/24/2026 at 2:23 p.m., with the Director of Nursing revealed when the resident refused their shower the staff need to continue to offer. They need to try multiple times and try a different person. If they still do not take it that day the staff need to continue to try the next day until they bathe.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, Medication Administration Record - Treatment Administration Record (MAR-TAR) review, policy review and staff interviews the facility failed to provide appropriate interventions for the urinary catheter to provide appropriate services to prevent urinary tract infections to 1 of 3 residents reviewed (Resident #10). The facility reported a census of 57 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #10 had a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. The MDS documented Resident #10 had a diagnosis of neuropathic bladder.Review of document dated 2/25/26 titled, Hospital Discharge Summary documented Resident #10 had a chronic indwelling foley catheter placed on 2/11/26-present and a urinary tract infection associated with indwelling urethral catheter noted on 2/20/26-present. Hospital Discharge Summary documented Resident #10 had the catheter last changed on 2/21/26 prior to discharge and care and management per facility guidelines/protocol.Review of Resident #10's EHR titled, Care Plan documented no focus, goal, or interventions related to placement of a catheter.Review of Resident #10's EHR titled, Tasks documented no tasks related to the placement of a catheter.Review of Resident #10's EHR titled, MAR-TAR documented no orders related to the placement of a catheter.Review of Resident #10's EHR titled, Progress Note documented Resident #10 did have a catheter on 2/25/26 and 3/1/26.On 3/26/26 at 10:26 AM Staff D, Licensed Practical Nurse (LPN)/Admissions stated Resident #10 did have a catheter when he returned from the hospital on 2/25/26 and had the catheter until sent to the hospital on 3/5/26. Staff D acknowledged there were no orders documented at the facility for Resident #10's catheter after discharge from the hospital on 2/25/26. Staff D acknowledged there were no task for nursing staff to empty Resident #10's catheter or to record the output from Resident #10's catheter. Staff D acknowledged there were no treatments, tasks or cares for cleaning Resident #10's catheter in place after Resident #10 was discharged from the hospital on 2/25/26. Staff D acknowledged there was not a care plan developed for Resident #10 for the placement of the catheter. Staff D acknowledged she did not notify the physician of the presence of a catheter upon return and she completed the return assessment. Staff D explained that orders, care plan, tasks, cares, and urine output should have all been initiated upon return from the hospital on 2/25/26.On 3/26/25 at 11:10 AM the Director of Nursing (DON) acknowledged Resident #10 did not have an order, care plan, task, treatment / care of catheter in his EHR from his discharge on [DATE]. The DON stated she expected all of these would have been discussed with the resident and resident's physician to obtain orders. The DON explained Resident #10's output should have been documented as well. Review of a policy provided by the facility reviewed 7/23 titled, Documentation and Charting documented it was the policy of the facility to provide A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., as well as the progress of the resident's care. Guidance to the physician in prescribing appropriate medications and treatments. The facility, as well as other interested parties, with a tool for measuring the quality of care provided to the resident. Nursing service personnel with a record of the physical and mental status of the resident. Assistant in the development of a Plan of Care for each resident. The elements of quality medical nursing care.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on Electronic Health Records (EHR), staff interview, observation and policy review the facility failed to implement policies and procedures regarding the technical aspect of feeding tubes by pushing enteral formula with a piston syringe into feeding tube for 1 of 1 residents (Resident #2). The facility reported a census of 57 residents.Findings include:Observation on 3/19/26 at 9:04 AM of Resident #2's enteral medication administration by Staff C, Licensed Practical Nurse (LPN) revealed Staff C checked residual, completed an auscultation of air bolus for placement, flushed 30cc H20, pushed water through syringe with palm of hand, drew up medication separately, pushed forcefully with palm of hand, Staff C explained she had to use force because the syringe itself is difficult to push, flushed with 10cc h20 between medications, obtained new syringe, obtained fresh water about 4 oz, left room, obtained 81mg low dose from other cart, returned to medication cart, crushed medication, completed hand hygiene, applied gloves, flushed with 30cc, administered medication and flushed with 70cc H20.Review of Resident #2's EHR titled, Care Plan documented Resident #2 required bolus feeding through the Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube entering the stomach for nutrition and or medication administration).On 3/25/26 at 2:18 PM the Director of Nursing (DON) stated she did not have any concerns with pushing the syringe piston. Review of a policy provided by the facility reviewed on 7/25 titled, Gastrostomy Tube Care and Management documented during the administration of medication elevate the head of bed to at least 30 degrees unless contraindicated. Flush the tube with 15-30 mL of water before, between, and after medications. Administer medications one at a time or as approved by provider/pharmacist, administer medications via gravity or gentle pressure via syringe and resume feeding per order.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview the facility failed to address dementia care for 2 out of 3 residents reviewed (Resident #7 and #28). The facility reported a census of 57 residents.Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #7 documented diagnoses of Non-Alzheimer's Dementia, Multiple Sclerosis and cognitive communication deficit. The MDS showed the Brief Interview for Mental Status (BIMS) score of 9, which indicated moderate cognitive impairment. Review of the MDS dated [DATE] revealed active diagnosis of Non-Alzheimer's Dementia. Review of Resident #7's active diagnosis list revealed dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance with a date of 10/18/23. Review of Resident #7's Care Plan with a revision date of 1/15/26 lacked information regarding dementia care. Review of facility provided policy titled Dementia Care with a revised date of 7/2025 revealed the facility is to develop and implement person-centered care plans that include and support the dementia care needs, identified in the comprehensive assessment. Interview on 3/23/26 at 10:40 a.m., with the Director of Nursing (DON) revealed dementia should be addressed on the care plan. 2. The Minimum Data Set (MDS) dated [DATE] documented Resident #28 had a Brief Interview for Mental Status (BIMS) of 7 indicating severe cognitive impairment. The MDS also documented a diagnosis of moderate vascular dementia with anxiety. Review of Resident #28's active diagnosis list revealed moderate vascular dementia with anxiety with a date of 1/11/26. Review of Resident #28's Electronic Health Record (EHR) titled, Care Plan documented no individualized interventions related to Resident #28's diagnosis of dementia such as verbal, behavioral, or environmental prompts to assist Resident #28 in completion of specific tasks or activities.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record review, manufacturer's guidelines and staff interview, the facility failed to assure residents insulin pen was primed by performing a safety check prior to insulin administration preventing a significant medication error for 1 of 1 resident reviewed (Resident #16). The facility reported a census of 58 residents.Findings include:Observation on 3/19/26 at 8:25 AM, showed that Staff J, Licensed Practical Nurse (LPN) accessed Resident #16's medication record via computer, retrieved Resident #16's insulin pen, attached the pen needle, and dialed the dosage to the prescribed 10 units of insulin. Staff J failed to perform a safety test dose of 2 units of insulin as required by the manufacturer's instruction. Staff J donned gloves, lifted Resident #16's shirt, applied an alcohol wipe to the skin, and administered the insulin to the right flank area. Review of the Injections, Insulin policy last reviewed July 2022 failed to provide information or instruction regarding use of an insulin pen. Review of the manufacturer's guidelines dated 2022 showed to perform a safety test:Dial a test dose of 2 Units.Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose.Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test.If no insulin comes out, repeat the test 2 more times. If there is still no insulin coming out, use a new needle and do the safety test again.During an interview on 3/19/26 at 2:25 PM, the Director of Nursing (DON) reported that staff were required to perform hand hygiene immediately before and after medication administration for each resident. The DON also reported that staff were required to perform hand hygiene immediately before donning gloves and immediately after doffing gloves. When informed of the observation, the DON identified Staff J as an agency staff member and stated that follow-up education for hand hygiene and insulin administration would occur immediately.During an interview on 3/19/26 at 2:28 PM, the Administrator reported that she expected staff to follow infection control guidelines for hand hygiene and expected staff to follow the manufacturer's instructions for priming insulin pens.

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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 accurately record residents weights in the facility for 1 of 3 residents (Residents #35). The facility reported a census of 57 residents.Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #35 documented diagnoses of heart failure, atrial fibrillations and hypertension. The MDS showed the Brief Interview for Mental Status (BIMS) score of 11 indicating moderate cognitive impairment. Review of residents weights revealed the following information:On 1/9/26- 200 pounds (lbs) hospital weight.On 1/18/26- 177.2 lbs - wheelchair.On 1/24/26- 176.0 lbs - mechanical lift.On 1/31/26- 259.5 lbs - wheelchair.On 2/1/26- 257.3 lbs - wheelchair.On 3/1/26- 168.4 lbs - standing. Review of the clinical records lacked documentation of the weight fluctuations. Interview on 3/24/2026 at 2:19 p.m., with the Director of Nursing (DON) revealed when looking at the weights she stated the staff should have been questioning the weights as there is a significant weight gain and loss recorded and should have been followed up on. She stated she would have questioned the 1/18/26 weight as there was a significant weight loss and the 1/31/26 weight as there was a significant weight gain. There should have been some kind of follow up or re-weight taken at that time. She also stated she would have questioned the weight on 3/1/26 as there was another significant weight loss. The DON explained it would be hard to monitor the resident for a significant weight loss or gain as the weights are not accurate.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on previous CMS-2567 review, staff interview and facility policy review the facility failed to ensure a comprehensive, effective Quality Assessment and Performance Improvement (QAPI) program. The facility reported a census of 57 residents. Findings include: Review of the Department of Inspections, Appeals and Licensing (DIAL) website under the facility's visit history revealed repeated deficient practices identified during the facility's annual survey and the previous annual survey conducted 3/11/25. The repeat deficiencies cited included: F582- Medicaid/Medicare Coverage/Liability notice cited on 3/11/25 and cited during the current survey. F584- Safe/Clean/Comfortable/Homelike Environment cited on 3/11/25 and cited during the current survey. F677- ADL Care provided for Dependent Residents cited on 3/11/25 and cited during the current survey. F684- Quality of Care cited on 3/11/25 and cited during the current survey. F880- Infection Prevention & Control cited on 3/11/25 and cited during the current survey. Review of the facility provided policy titled QAPI with a revised date of 10/2022 revealed the purpose of the QAPI Plan and processes is to continually assess the facility's performance in all service areas, so that systems and processes achieve the delivery of person-centered care, and which maximizes the individual's highest practicable physical, mental, and social well-being.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review, interview, and facility policy the facility failed to have a Infection Preventionist present for their quarterly Quality Assessment and Assurance (QAA) meetings. The facility reported a census of 57.Findings include: Review of facility documentation titled QAPI attendance dated 12/18/2025 lacked a trained infection preventionist (IP) present at the meeting. Review of facility provided policy titled Quality Assessment Performance Improvement (QAPI) with a revised date of 10/2022 revealed the committee will maintain a record of the dates of all meetings and the names/titles of those attending each meeting. Interview on 3/26/2026 at 9:45 a.m., with the Administrator revealed there was no IP with training present from October 2025 until the current IP got her training at the QAPI meetings.