STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165253	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Panora Specialty Care	805 East Main Panora, IA 50216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 49628 Based on clinical record reviews, staff interviews, and policy review the facility failed to review and revise the Care Plan for 3 of 4 residents reviewed (Resident #1, Resident #3, Resident #4). The facility failed to revise the Care Plan to include recommendations from the PASRR Level II (Resident #1, Resident #3, Resident #4). The facility reported a census of 35 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #1 had an unscorable Brief Interview for Mental Status (BIMS) assessment indicating severe cognitive impairment. The document revealed diagnoses of diabetes mellitus, anxiety, depression, schizophrenia, Post Traumatic Stress Disorder (PTSD), drug induced akathasia, and insomnia. The document disclosed the resident took antianxiety and antidepressant medications. The facility provided document, Preadmission Screening and Resident Resident Review (PASRR) Level II Outcome dated 3/9/25 identified Resident #1 had a time limited approval beginning on 3/9/25 and ending on 9/5/25. The document identified the resident had a diagnosis of a mental health condition that the PASRR program was designed to assess. The document revealed Resident #1 needed to be provided the following specialized services: A. Ongoing psychiatric medication management by a psychiatrist or psychiatric Advanced Registered Nurse Practitioner (ARNP) to monitor mental health symptoms and manage psychiatric medications. B. Individual therapy by a licensed behavioral health profession. C. Rehabilitative services and/or supports: including evaluation for a diagnosis of neurocognitive disorder/dementia, or other organic mental disorder, community living skills, facilitation of family involvement in the resident's Care Plan, obtaining archived psychiatric/behavioral health treatment records, and supportive counseling from the nursing facility staff. D. Community placement supports including home health aide services, home health nurse services, access to community resources, shopping, meal preparation, and behavioral health supports. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The document further revealed ServiceMatters reviews dated 2/6/25 and 3/8/25 had been completed and found the December 2024 PASRR report identifying PASRR services and support services had not been included in the resident's Care Plan. Resident #1's Care Plan dated 4/25/25 revealed a PASRR focus area initiated on 11/7/24. The interventions identified following PASRR recommendations and contact any agencies recommended. The Care Plan failed to identify the resident's specific recommendations made from the PASRR Level II dated 3/9/25. 2. According to the MDS dated [DATE] Resident #3 had a BIMS score of 15/15 indicating normal cognitive function. The document revealed diagnoses of anxiety, depression, and schizoaffective disorder. The document disclosed the resident took antipsychotic, antianxiety, and antidepressant medications. The facility provided document, PASRR Level II Outcome dated 1/15/25 identified Resident #3 had a time limited approval beginning on 1/15/25 and ending on 7/14/25. The document identified the resident had a diagnosis of a mental health condition that the PASRR program was designed to assess. The document revealed Resident #3 needed to be provided the following specialized services: A. Ongoing psychiatric medication management by a psychiatrist or psychiatric Advanced Registered Nurse Practitioner (ARNP) due to long-standing history of schizoaffective disorder, major depression, anxiety and alcohol abuse in remission, and prescribed multiple medications to treat mental health symptoms. B. Rehabilitative services and/or supports including designation of [NAME] of Attorney for Healthcare and Financial matters, services to pursue community living, referral to Integrated Health Home (IHH), self-health care management training, referral for eligibility determination for Medicaid coverage including Home and Community Based (HCBS) waivers, and facilitation of family involvement in the Care Plan process. C. Community placement supports including home health aide services, home health nurse services, referral to HCBS waivers, access to community resources (transportation), shopping, meal preparation, and behavioral health supports. Resident #3's Care Plan dated 4/14/25 revealed a PASRR focus area identifying need for specialized services due to mental illness with a revision of 2/1/24. The goal area for the intervention was last revised on 4/14/25 with a target date of 7/31/25. The interventions included psychiatric medication management initiated 8/27/24 with a duration of 12 months and staff members to make appointments with a revision date of 8/15/23. The document further revealed rehabilitative services to be implemented to address rehabilitation with an initiation date of 8/27/24. The goal area was revised on 4/14/25 with a target date of 7/31/25. The interventions included the resident's goal of discharge to the community with a tentative discharge date of [DATE], and discharge planning with the resident with a tentative discharge date of [DATE] with implementation dates of 8/27/24. The Care Plan contained 3 additional focus areas related to rehabilitation with initiation dates for 8/27/24 with specific goal areas of referral for HCBS waivers, IHH/referrals to Managed Care Organizations, and designation of [NAME] of Attorney for Health and Financial matters. With each of the 3 focus areas the interventions/tasks were not completed to identify Resident #3's specific needs. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan failed to identify the resident's specific recommendations made from the PASRR Level II dated 4/14/25 and identify specific complete interventions for each of the focus areas. 3. According to the MDS dated [DATE] Resident #4 had a BIMS score of 15/15 indicating normal cognitive function. The document revealed diagnoses of anxiety disorder, depression, schizophrenia, and PTSD. The document disclosed the resident took antipsychotic, antianxiety, antidepressant, anticoagulant, antibiotic, opioid, hypoglycemic, and anticonvulsant medications. The facility provided document, PASRR Level II Outcome dated 3/7/25 identified Resident #4 had a time limited approval beginning on 3/7/25 and ending on 8/4/25. The document identified the resident had a diagnosis of a mental health condition that the PASRR program was designed to assess. The document revealed Resident #4 needed to be provided the following specialized services: A. Ongoing psychiatric medication management by a psychiatrist or psychiatric Advanced Registered Nurse Practitioner (ARNP) due to a longstanding history of major mental illness, past and recent symptoms that can impact daily functioning, and prescribed multiple medications to treat mental health symptoms. B. Individual therapy. C. Rehabilitative services and/or supports including services pursue community living, referral for eligibility for HCBS waivers, and work with the case manager through the MCO to assist with discharge planning. D. Community placement supports including environmental management, home health aide services, home health nurse services, referral to HCBS waivers, access to community resources (transportation), shopping, meal preparation, and behavioral health supports. Resident #4's Care Plan dated 4/11/25 revealed a PASRR focus area initiated on 1/8/25. The interventions identified following PASRR recommendations and contact any agencies recommended with an initiation date of 1/8/25. The Care Plan failed to identify the resident's specific recommendations made from the PASRR Level II dated 3/7/25. On 5/14/25 at 2:53 PM Staff F, Licensed Practical Nurse (LPN) MDS/Care Plan Coordinator, stated if the PASRR Level II had recommendations for a resident they should be reflected on the Care Plan. The staff acknowledged Resident #1's was not complete as she was needing to do research for it to be completed. On 5/14/25 at 3:00 PM Staff G, Registered Nurse (RN), Sr. Director of Nursing (DON) stated she did not know a lot about implementing the recommendations from the PASRR Level II into the Care Plan, and she relied on Staff F. The DON did further state that she thought there had been recent training that specifics regarding the Level II recommendations were not required on the Care Plan, but could not immediately find that training. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 10:36 AM Staff H, Interim Administrator, expected that the Care Plan would have the information and the recommendations from the PASRR Level II, and the interventions be centered to a specific resident. The Administrator stated the Care Plan should not have a general statement to follow PASRR recommendations. The facility's Care Plans - Comprehensive Person-Centered Policy, revised 12/16, revealed Care Plans include measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. The document further revealed the Care Plan should describe the services needed for the resident to attain the highest level of practicable physical, mental and psychosocial well-being. The document revealed care plans were to be revised as information about the residents and residents' conditions changed. The facility's Behavioral Assessment, Intervention and Monitoring Policy, revised 3/19, revealed the Level II evaluation report will be used when conducting the resident assessment and developing the care plan. The document indicated current Level II residents will be referred for an additional PASARR Level II evaluation upon a significant change in status assessment. It disclosed the Care Plan will incorporate findings from the comprehensive assessment and PASARR Level II determinations (as appropriate), and be consistent with current standards of practice.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on clinical record reviews, staff interviews, and policy review the facility failed to identify and document target behaviors and/or side effects of medications prescribed to promote or maintain a resident's highest practical mental and psychosocial well-being for 4 of 4 residents reviewed (Resident #1, Resident #2, Resident #3, Resident #4). The facility failed to identify the target behaviors and/or the side effects of medications on either the Electronic Medical Administration Record (EMAR) or the Care Plan. The facility reported a census of 35 residents. 1. According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #1 had an unscorable Brief Interview for Mental Status (BIMS) assessment indicating severe cognitive impairment. The document revealed diagnoses of diabetes mellitus, anxiety, depression, schizophrenia, Post Traumatic Stress Disorder (PTSD), drug induced akathasia, and insomnia. The document disclosed the resident took antianxiety and antidepressant medications. Resident #1's Care Plan dated 4/25/25 failed to identify target behaviors associated with taking an antianxiety medication. Resident #1's EMAR for 5/25 failed to identify target behaviors for the antianxiety medication, and side effects for the antidepressant medication. 2. According to the MDS assessment dated [DATE] Resident #2 had a BIMS score indicating severe cognitive impairment and required staff input for completion. The staff identified the resident had moderately impaired cognitive functioning for daily decision making. The document revealed diagnoses of anxiety disorder, depression, bipolar disorder, and obsessive compulsive disorder (OCD). The document disclosed the resident took antipsychotic, antianxiety, antidepressant, diuretic, and anticonvulsant medications. Resident #2's Care Plan dated 11/14/24 failed to identify target behaviors associated with the antidepressant and antipsychotic medications. Resident #2's EMAR for 5/25 failed to identify the side effects for the antidepressant and antianxiety medications. 3. According to the MDS dated [DATE] Resident #3 had a BIMS score of 15/15 indicating normal cognitive function. The document revealed diagnoses of anxiety, depression, and schizoaffective disorder. The document disclosed the resident took antipsychotic, antianxiety, and antidepressant medications. Resident #3's Care Plan dated 4/14/25 failed to identify target behaviors for the antianxiety, antipsychotic, and antidepressant medications. Resident #3's EMAR for 5/25 failed to identify side effects for the antidepressant and antianxiety medications. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. According to the MDS dated [DATE] Resident #4 had a BIMS score of 15/15 indicating normal cognitive function. The document revealed diagnoses of anxiety disorder, depression, schizophrenia, and PTSD. The document disclosed the resident took antipsychotic, antianxiety, antidepressant, anticoagulant, antibiotic, opioid, hypoglycemic, and anticonvulsant medications. Resident #4's Care Plan dated 4/11/25 failed to identify target behaviors for the antianxiety and antipsychotic medications. Resident #4's EMAR for 5/25 failed to identify the target behaviors and side effects for antianxiety, antidepressant, and antipsychotic medications. On 5/13/25 at 1:40 PM Staff A, Certified Medication Aide (CMA), stated documentation for behaviors would be completed on the EMAR if they were observed or if reported by a Certified Nursing Assistant (CNA). On 5/13/25 at 1:52 PM, Staff B, CNA/CMA, stated when behaviors were observed she would document them and notify the nurse. On 5/14/25 at 1:50 PM Staff C, CNA, stated they were unaware of where to locate a resident's individualized target behaviors or medication side effects. The staff stated they learned new things about residents by word of mouth or possibly the dashboard of the electronic medical record. On 5/14/25 at 2:00 PM Staff D, CNA, stated she wasn't a nurse therefore didn't know about target behaviors or medication side effects for residents. The staff stated if a resident appeared off notification would be made to the nurse. Staff D stated the Care Plan might contain information about medications. On 5/14/25 at 2:10 PM Staff E, CNA, stated she would recognize medication size effects by a resident not acting right, but could not identify where that information about a resident acting right would be available. The staff stated target behaviors for a specific resident would be known by knowing how the resident behaves. On 5/15/25 at 2:53 PM Staff F, Licensed Practical Nurse (LPN) MDS/Care Plan Coordinator, stated CNAs should be aware of any behaviors a resident is having and report them to the nurse. Staff F stated behaviors were being added to the Care Plans, but not specifically relating a behavior to a medication. The staff further stated the nurse should know if a medication was effective and be aware of the side effects of the medication. On 5/15/25 at 3:00 PM Staff G, Registered Nurse (RN), Sr. Director of Nursing (DON), stated target behaviors and side effects should be the same on the EMAR and the Care Plan. The DON acknowledged that not all the Care Plans may reflect the target behaviors for a medication as it was a work in progress. The staff stated when a resident was admitted to the facility a general order was placed on the EMAR for documentation of side effects and general behaviors, but then the EMAR and Care Plan should be updated to specify side effects and target behaviors for each appropriate medication. The DON acknowledged Resident #4's EMAR contained the general order from admittance and was not updated to reflect individualized side effects and behaviors for medications. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/25 at 3:40 PM, Staff H, Interim Administrator, expected the EMAR and Care Plan have the resident's target behaviors and side effects related to each identified antidepressant/ antipsychotic/ antianxiety medication, and the documentation would be completed on the EMAR. The facility's Behavioral Assessment, Intervention and Monitoring Policy, revised 3/19, revealed the facility identify and document onset, intensity and frequency of behaviors, It disclosed the facility will comply with regulatory requirements related to the use of medications to manage behavioral changes. The document indicated the Care Plan at a minimum would include a description of the behavioral symptoms (frequency, intensity, duration, outcomes, location, environment and precipitating factors), individualized interventions, rationale for interventions, measurable goals, and how to monitor for effectiveness of the interventions. The policy reported documentation for medications prescribed for behavioral symptoms include rationale, underlying causes of behavior, other interventions tried prior to use of antipsychotic medications, risks and benefits discussed with resident/family, dosage, duration, monitoring for efficacy and adverse effects, and gradual dose reductions.