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	01/05/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, policy review, and Resident Assessment Instrument (RAI) Manual, the facility failed to ensure proper Minimum Data Set (MDS) coding for three of fifteen residents reviewed for MDS assessments by not coding resident's diagnoses when indicated, and improperly coded medication and tobacco use (Resident #1, #3, and #4). The facility reported a census of 38 residents. Findings include: 1.The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 had diagnoses of chronic obstructive pulmonary disease (COPD). The MDS failed to indicate the resident had a multi-drug resistant organism (MDRO). The Care Plan initiated 12/18/24 revealed the resident had a risk for potential infection related to a MDRO. The Care Plan directed staff to assess for signs and symptoms of infection, administer antibiotics per the physician orders, and use enhanced barrier precautions (EBP) when performing high-contact care activities. The Treatment Administration Record dated 12/1/25 to 12/31/25 revealed to use enhanced barrier precautions due to a MDRO like resistant organism ESBL (extended spectrum beta-lactamase) (an infection caused by bacteria producing enzymes that destroy many antibiotics making the infection harder to treat). In an interview on 12/31/25 at 12:25 PM, the MDS Coordinator reported she completed the residents MDS assessments at least quarterly. She reported she got information to complete MDS assessments and care plans from the medical records and an interview with the resident. She reviewed the resident's diagnoses, and then she marked the applicable diagnoses under section I. She had a goal to try to be as accurate as possible when she filled out the MDS. The Director of Nursing reviewed the assessment and signed off on everything indicating the MDS completion and accuracy. The MDS Coordinator confirmed if a resident had an MDRO, the MDS assessment needed coded to indicate a MDRO. The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual updated 10/2025 revealed the disease conditions in section I require a physician-documented diagnosis in the past 60 days. Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. 2. The MDS completed on 12/11/25 listed Resident #3's facility admission date of 12/3/25. Resident #3 was coded for the use of an anticoagulant, which slows down the body's ability to clot blood. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Physicians Orders noted an order for aspirin extended delayed release 81mg one time daily. This was initiated on 12/4/25. Aspirin is classified as an antiplatelet, a medication that stops platelets from sticking together to form blood clots. No anticoagulant medications, like Coumadin, were identified in Physician Orders either in current or discontinued medications since resident admission. In an interview on 12/31/25 at 12:25 PM, the MDS Coordinator explained they were directed to code aspirin as an anticoagulant by staff associated with a facility mock survey. The MDS Coordinator was unable to recall a timeframe when they were informed of this coding procedure. The Long-Term Care Facility RAI User's Manual updated 10/2025 (page N-9) noted antiplatelet medications, like aspirin/extended release, should not be coded as an anticoagulant. 3. The admission MDS completed on 6/9/25 listed Resident #10's facility admission date as 6/2/25 from another nursing home. Under Section J Health Conditions, item number J1300 Current Tobacco Use was checked as no. On 6/2/25 a diagnosis of cigarette nicotine dependence was documented. A copy of the previous nursing home's Care Plan for Resident #10 indicated they were actively smoking up until the resident was discharged . Interventions included the ability to smoke unsupervised. The Progress Note dated 6/2/25 at 9:59 PM documented Resident #10 taking themselves in/out of the building to smoke. In an interview on 12/31/25 at 12:25 PM, the MDS Coordinator explained Resident #10's smoking status was not well known upon admission and thus coded as no on the MDS for tobacco use. The Long-Term Care Facility RAI User's Manual updated 10/2025 (page J-27) noted tobacco information can be obtained from the resident themselves or with information from the medical record. If there are indications of tobacco use, in any form, question J1300 should be marked yes for tobacco use.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, electronic health record (EHR) review, staff interview, and policy review, the facility failed to complete an admission smoking evaluation for 1 of 2 residents reviewed for smoking (Resident #1). The facility reported a census of 38. Findings include: The EHR census tab for Resident #1 showed the current admission date of 12/5/25. Resident #1 had previously been admitted from 2/5/25 to 3/11/25.The Minimum Data Set (MDS) assessment completed on 12/8/25 revealed Resident #1 with a Brief Interview for Mental Status score of 9, indicating moderate cognitive impairment. Diagnoses included a recent pneumonia diagnosis, dyspnea (shortness of breath), anxiety, bipolar disorder, and depression. Resident #1 noted to use a manual wheelchair independently but requiring staff assistance for transfers. The MDS indicated the use of tobacco products.The Care Plan, last updated 12/26/25, documented Resident #1 smokes. Interventions included completing a Smoking Evaluation on admission and as needed. During an observation on 12/31/25 at 8:00 AM, Resident #1 seen smoking a cigarette outside the facility unsupervised. A smoking evaluation for this current admission was not identified in the EHR.During an interview on 12/31/25 at 9:00 AM, the Director of Nursing (DON) indicated smoking evaluations are completed upon admission and quarterly. The DON or the MDS Coordinator both collaborate to complete the evaluations. The policy Smoking-Residents (version 2.0 H5MAPL0828) documented the following: 1. Residents will be evaluated upon admission to determine if they are a smoker or non-smoker; 2. If a smoker, staff will evaluate the ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation); 3. A resident's ability to smoke safely will be reevaluated quarterly, upon a significant change (physical or cognitive) and as determined by staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, electronic record review, staff interviews, and policy review, the facility failed to follow infection control practices to prevent cross contamination by not completing hand hygiene and glove change during resident cares (Resident #15). The facility reported a census of 38. Findings include: The Minimum Data Set (MDS) Assessment completed on 11/13/25 revealed Resident #15 with Brief Interview for Metal Status score of 15, indicating intact cognition. Diagnoses include multidrug-resistant organism, neurogenic bladder (nerve damage causing poor bladder control), and paraplegia. The MDS indicated the presence of a urinary catheter. The Care Plan, last updated 11/26/25, included a focus area related to the risk of infection due to the presence of a drug-resistant microorganism. Interventions included the use of enhanced barrier precautions (EBP) when performing high-contact care activities. EBP included the use of gowns and gloves. During an observation on 12/29/25 at 4:00 PM, Staff A, Certified Nursing Assistant (CNA) and Staff B, CNA, completed catheter and personal cares on Resident #15. Both staff members put on gowns and gloves and completed hand hygiene. Staff A proceeded to empty the resident's catheter drainage bag and disposed of the collected urine. After this was completed, Staff A transitioned to cleaning around the resident's suprapubic catheter (tube inserted through a small opening in the low abdomen directly into the bladder) site. No hand hygiene or glove change observed prior to initiating catheter cares. After catheter site cares completed, Staff A transitioned to providing perineal cares, which included cleaning of the genital and anal areas. No hand hygiene or glove change observed prior to initiating the perineal cares. Once completed Staff B assisted Staff A in repositioning Resident #15 in bed, placed pillows on the bed, and rearranged blankets. No hand hygiene or glove change observed when perineal cares was completed. During an interview on 12/31/25 at 9:00 AM, the Director of Nursing (DON) noted hand hygiene and glove change should be completed at the end of a specific task or care. If staff completing multiple cares during a single visit, gloves should be changed after each different task or cares. Staff should not wear the same pair of gloves when completing multiple or different types of cares. The policy Catheter Care, Urinary (version 1.1 H5MAPR0048) documented the following: 1. Use standard precautions when handling or manipulating the catheter drainage systems; 2. Wash and hands thoroughly and put on clean gloves before initiating catheter site cares as well as perineal cares; 3. Wash and dry hands thoroughly upon completion of catheter site cares as well as perineal cares.