STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165270	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stratford Specialty Care	1200 Highway 175 East Stratford, IA 50249

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interviews, staff interviews and policy review, the facility failed to provide care for 2 out of 8 residents reviewed (Resident #5 and #7) in a manner to promote dignity and respect. The facility reported a census of 37 residents. Findings include:1. Resident #5's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition.On 12/1/25 at 12:42 PM, Staff A, Certified Nursing Assistant (CNA), reported Staff C, Registered Nurse (RN), told Resident #5 he needed to follow the rules, so he didn't fall. She said Resident #5 would say that Staff C was a bitch. On 12/1/25 at 1:12 PM, Staff B, CNA, reported he didn't like the way Staff C talked to and treated some of the residents. He reported Resident #5 liked to stand and stretch his legs in the mornings, but he was not supposed to stand unless staff were present. He said Resident #5 liked to stand in the morning when the staff were busy. He said Staff C would yell at Resident #5 and they would get into screaming matches. He said Staff C belittled Resident #5 to his face and called him dumb on many occasions. He said Staff C told Resident #5 that she would not feel sorry for him when he fell and broke his hip, as it would be his own fault. On 12/2/25 at 8:23 AM, Staff D, CNA, reported Staff C liked to agitate Resident #5 by some of the questions she asked him, which would escalate his behaviors. She said Staff C liked to put a lot of wet floor signs around the nurses' station to prevent Resident #5 from standing up at the nurses' station. She said Resident #5 required staff assistance with standing. She said Resident #5 would then go down the hallway and use the rail to stand up. Staff D reported Staff C on one occasion took a memory blanket and tied the blanket to Resident #5's wheelchair pedals behind his legs so when he put his feet down, they would not touch the floor preventing him from standing up.On 12/2/25 at 9:07 AM, Staff E, CNA, reported she was in the memory care unit and heard Staff C arguing with Resident #5 and telling him to sit down. She said she looked out the window in the memory care unit door and saw the wet floor signs around the nurses' station. 2. Resident #7's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition.On 12/2/25 at 8:23 AM, Staff D reported Staff C would keep Resident #7 from going back to his room due to his attempts to take himself to the bathroom. She said she would tell Resident #7 she was going to move his bed into the hallway. On 12/2/25 at 12:50 PM, Resident #7 described Staff C as loud and smart-alecky. He said Staff C would yell at him all the time, but he didn't think she meant to. He said Staff C was afraid that he was going to fall. He said Staff C would tell him to watch what he was doing. He said it would make him feel rough, but he could give it right back. When asked if anyone told him they were going to move his bed in the hallway, he said yes, Staff C had. When asked why she would do that, he stated because he didn't obey and was getting up by himself. On 12/2/25 at 1:40 PM, the Administrator reported he would expect the staff to treat residents with the utmost respect and dignity. The facility policy titled Dignity revised February 2021 documented each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The policy documented the following:Residents are treated with dignity and respect at all times.Residents may exercise their rights without interference, coercion, discrimination or reprisal from any person or entity associated with the facility. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents.

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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. Based on interviews, clinical record reviews, and policy review, the facility failed to notify the physician following an allegation of abuse for 1 of 1 resident reviewed for abuse (Resident #1). The facility reported a census of 37 residents.Findings include:The Minimum Data Set (MDS) for Resident #1 dated 11/10/25 assessment identified a Brief Interview for Mental Status (BIMS) score was a 6, indicating severe cognitive impairment. The MDS identified Resident #1 required substantial/maximal assistance with bed mobility and transfers. The MDS documented Resident #1 was non-ambulatory and was dependent on staff for locomotion in a manual wheelchair. Resident #1's MDS included diagnoses of anemia, hypertension (high blood pressure), diabetes mellitus, thyroid disorder, traumatic brain injury (TBI) and alcohol abuse with alcohol induced mood disorder.An Incident Report (IR) titled Allegation of Abuse dated 11/20/25 documented it was reported to the Administrator that Resident #1 sat with two dining room chairs placed behind his wheelchair in the common area. The nurse stated that it was, so he did not tip backwards in his wheelchair. The IR lacked documentation of the facility notifying the Physician of the allegation of abuse.Resident #1's Clinical Record lacked documentation of the facility notifying the Physician of the allegations of abuse. On 12/1/25 at 1:28 PM, the Director of Nursing (DON) reported no one notified the Physician of the incident until the morning of 12/1/25. The DON reported she called the ARNP (Advanced Registered Nurse Practitioner) and the ARNP reported no one notified her of the incident. The DON said there was some miscommunication with the Assistant Director of Nursing (ADON) regarding the Physician notification. The DON reported the ARNP knew of the incident as of 12/1/25 and she documented the notification in the progress notes. On 12/2/25 at 11:20 AM, the Administrator reported he would expect the Physician to be notified of any incident. He said with the ADON being suspended the facility missed notifying the physician. The facility policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating revised April 2021 documented the Administrator or the individual making the allegation should immediately report to the resident's attending physician and the facility medical director.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and facility policy review the facility failed to protect a resident from the use of physical restraints for 1 of 1 residents reviewed (Resident #1). The facility reported a census of 37 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score was a 6, indicating severe cognitive impairment. The MDS identified Resident #1 required substantial/maximal assistance with bed mobility and transfers. The MDS documented Resident #1 was non-ambulatory and was dependent on staff for locomotion in a manual wheelchair. Resident #1's MDS included diagnoses of anemia, hypertension (high blood pressure), diabetes mellitus, thyroid disorder, traumatic brain injury (TBI) and alcohol abuse with alcohol induced mood disorder. The Care Plan with a target date of 2/5/25 revealed Resident #1 had a risk for falls. The Care Plan directed to have Resident #1 within line of sight of staff at all times for his safety. The Care Plan documented Resident #1 didn't ambulate and used a mechanical stand with assistance of one staff member for transfers. An Incident Report (IR) titled Allegation of Abuse dated 11/20/25 documented the Administrator received a report of Resident #1 sitting with two dining room chairs placed behind his wheelchair in the common area. The nurse stated it was so Resident #1 didn't tip backwards in his wheelchair. The IR documented the immediate removal of the chairs from behind Resident #1 and suspension of the nurse. The facility form titled Internal Investigation Witness Statement dated 11/20/25 for Staff C, Registered Nurse (RN), documented they placed a dining room chair sideways behind Resident #1's wheelchair at the dining room table, with several inches between the resident, the dining room chair and the wall. The statement documented Resident #1 could freely move his wheelchair forward and he moved the table with his hands several feet in front of him. Staff C reported she didn't wedge the chair behind him. Staff C reported she just didn't want Resident #1 to wheel his wheelchair back too far so that he'd fall forward out of it as he constantly stood up and walked. On 12/1/25 at 10:30 AM, Staff F, Maintenance Supervisor, reported on Wednesday, November 19th at 6:59 AM, he arrived at work and observed Resident #1 sitting in his wheelchair in the front dining room. He said there were two chairs behind Resident #1's wheelchair, keeping him behind the table so he could not back up. He said he moved the chairs and notified the Dietary Manager. Staff F reported at the daily quality assurance (QA) meeting on 11/19/25 around 9:15 AM, he reported the concern to the Assistant Director of Nursing (ADON). He said the Administrator was not at the meeting. He said the ADON said she would take care of it. He said the next day around 3:30 PM he sent the Administrator a text and a picture regarding the concern. Staff F reported he had taken a picture of Resident #1 the morning of 11/19/25 to show the Administrator what had occurred.On 12/1/25 at 11:42 AM, the Regional Director of Clinical Services provided the photo that Staff F had taken of Resident #1 on 11/19/25. The photo showed Resident #1 sitting in a wheelchair at the dining room table in the front common area with two dining room chairs lined up (one in front of the other) behind his wheelchair in between the wheels of the wheelchair with the second chair touching the wall.On 12/1/25 at 12:50 PM, Staff G, Certified Nursing Assistant (CNA), reported the weekend before 11/19/25 she saw a chair behind Resident #1's wheelchair a few times in the common area. She said he was sitting at a table facing the nurses' station with a wall behind him. She said she believed Staff C did it. She said the staff were busy and didn't have time to sit with Resident #1. She said she removed the chair from behind his wheelchair each time she saw it. She said she thought the chair was put there to prevent Resident #1 from pushing himself back so he couldn't stand up.On 12/1/25 at 1:12 PM, Staff B, CNA, reported on the morning of 11/19/25 Resident #1 was being himself and trying to stand up. He said Staff C sat Resident #1 over at the far table in the common room and put two chairs behind him. He said the chairs were stopping Resident #1 from backing up so he would not stand up. He said the wheelchair was locked and Resident #1 was pushed up to the table with his chest almost touching the table. Staff B said he asked Staff C why it was okay and she said that was all she could do at the time. Staff B said there was no one to sit with Resident #1. Staff B reported he told Staff C he thought the chairs should be removed and she walked off. He said he was headed over to remove the chairs but got called into another resident's room. He said when he came out of the room, the chairs had been removed. He said it happened during breakfast time. He said when he came to work at 6:00 AM Resident #1 sat at the table but didn't have chairs behind him. He said he thought maybe Resident #1 had the chairs placed behind there for about 45 minutes to an hour. He said Staff C reported she put the chair there and Resident #1 hadn't moved since. He said he didn't

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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. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on staff interviews, personnel record review, facility investigation review, and policy review the facility failed to notify DIAL (Department of Inspection, Appeals and Licensing) of an allegation of abuse for Resident #1 that occurred on 11/19/25 at 6:59 AM in a timely manner. In addition, the facility failed to notify the police of the allegation of abuse. The Maintenance Supervisor reported he told the ADON (Assistant Director of Nursing) of the allegations of abuse on the morning of 11/19/25 at 9:15 AM. The facility investigation for the alleged abuse was initiated on 11/20/25 after the Maintenance Supervisor reported it to the Administrator. The facility reported the incident to DIAL on 11/20/25 at 8:16 PM. The facility reported a census of 37 residents. Findings include:An Incident Report (IR) titled Allegation of Abuse dated 11/20/25 at 4:30 PM documented the Administrator received report of Resident #1 sitting with two dining room chairs placed behind his wheelchair in the common area. The nurse stated that it was so Resident #1 didn't tip backwards in his wheelchair. The IR documented the staff immediately removed the chairs from behind Resident #1 and suspended the nurse. Review of document titled Self Report Summary revealed the facility filed the allegation of abuse with DIAL for Resident #1 on 11/20/25 at 8:16 PM. On 12/1/25 at 10:30 AM, Staff F, Maintenance Supervisor, reported on Wednesday, November 19th at 6:59 AM, he arrived at work and observed Resident #1 sitting in his wheelchair in the front dining room. He said there were two chairs behind Resident #1's wheelchair, keeping him behind the table so he could not back up. He said he moved the chairs and notified the Dietary Manager as she was another department head at the facility at the time. Staff F reported at the daily quality assurance (QA) meeting on 11/19/25 around 9:15 AM, he reported the concern to the Assistant Director of Nursing (ADON). He said the ADON reported she was aware and would take care of the concern. He said the Administrator was not at the meeting. He said the next day around 3:30 PM he sent the Administrator a text and a picture regarding the concern. He said the Administrator reported it should not have happened and would start the process of a self-report. He said he didn't think the self-report process/investigation had been started before then.On 12/1/25 at 12:29 PM, the Administrator reported he didn't notify the police of the allegations of abuse. He said normally he did but didn't know why he didn't, but he should have.On 12/1/25 at 11:50 AM, Staff H, Dietary Manager, reported she walked into the facility between 7:10-7:15 AM. She said Staff F showed her a picture of Resident #1 and told her what was going on. She said the picture showed Resident #1 in his wheelchair up against the table with two chairs behind him. She said the chairs had been removed by the time she got to work. When asked what her reaction was to the picture, she said you can't do that. When asked if she gave any direction to Staff F, she said no. She said Staff F had already done what he was supposed to do by moving the chairs. She said Resident #1 was not being harmed. She said she thought it was a restraint and didn't think it was abuse. When asked if she reported it to anyone, she said no. She said Staff F brought it up that day at the QA meeting at 9 AM. She said there really was not a lot of comment or a whole lot of discussion around it. She said the Administrator was not at the meeting and could not recall where he was.On 12/2/25 at 11:20 AM, the Administrator reported he was out of the facility on 11/19/25. He said he was back in the office on 11/20/25 until 10 AM. He said on 11/20/25 around 3:48 PM he got a text message from Staff F with a picture. He said he didn't read the text message until around 4:30 PM. He said he called the ADON to see what was going on and instructed her to call the Regional Nurse to figure out the next steps since the facility was already late with reporting to DIAL. He said in the text message Staff F reported he brought up the concerns to the team on 11/19/25 and he didn't feel the concerns were being addressed. The Administrator reported he got home around 4:45 PM and the Regional Nurse called him at 5:00 PM. He said there was a rapid response call with the regional team. He said approximately 8 PM he suspended Staff C, Registered Nurse, the ADON and Staff F. He reported he completed the self-report to DIAL at 8:16 PM. A facility form titled Disciplinary Action Form dated 11/21/25 for the ADON documented a written warning given due to the failure to notify the Administrator of an allegation of abuse. The facility policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating revised April 2021 documented the Administrator or the individual making the allegation immediately reports to the state licensing/certification agency responsible for surveying/licensing the facility within two hours of an allegation involving abuse or result in serious bodily injury or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. In addition, the policy directed to notify Law enforcement officials of the allegations.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on staff interviews, personnel record review, facility investigation review, and policy review the facility failed to separate a staff member from dependent residents accused of alleged abuse that occurred on 11/19/25 at 6:59 AM for Resident #1. The Maintenance Supervisor told the Assistant Director of Nursing (ADON) of the allegations of abuse on 11/19/25 at 9:15 AM. The ADON did not inform the Administrator of the allegations, did not start an investigation and did not separate the staff member from the resident. On 11/20/25 around 3:48 PM, the Maintenance Supervisor reported the allegations of abuse to the Administrator via text. The staff member worked full shifts on 11/19 and 11/20. The facility reported a census of 37 residents. Findings include: An Incident Report (IR) titled Allegation of Abuse dated 11/20/25 at 4:30 PM documented it was reported to the Administrator that Resident #1 had been sitting with two dining room chairs placed behind his wheelchair in the common area. The nurse stated that it was so Resident #1 did not tip backwards in his wheelchair. The IR documented the chairs were immediately removed from behind Resident #1 and the nurse was suspended. The facility form titled Internal Investigation Witness Statement dated 11/20/25 for Staff C, Registered Nurse (RN) documented Staff C placed a dining room chair sideways behind Resident #1's wheelchair at the dining room table, there were several inches between the resident, the dining room chair and the wall. The statement documented Resident #1 was able to freely move his wheelchair forward and he was also moving the table with his hands several feet in front of him. Staff C reported she did not wedge the chair behind him. Staff C reported she just didn't want Resident #1 to wheel his wheelchair back too far so that he'd fall forward out of it as he was constantly standing up and walking. Review of the Employee Time Entry Report from 11/15/25 to 11/20/25 revealed Staff C worked full shifts on 11/19/25 (14.25 hours) and 11/20/25 (13.63 hours). On 12/1/25 at 10:30 AM, Staff F, Maintenance Supervisor reported on Wednesday, November 19th at 6:59 AM, he arrived at work and observed Resident #1 sitting in his wheelchair in the front dining room. He said there were two chairs behind Resident #1's wheelchair, keeping him behind the table so he could not back up. He said he moved the chairs and notified the Dietary Manager as she was another department head at the facility at the time. Staff F reported the concern to the Assistant Director of Nursing (ADON) at the daily Quality Assurance (QA) meeting on 11/19/25 around 9:15 AM. He said the ADON reported she knew and would take care of the concern. He said the Administrator was not at the meeting. He said the next day around 3:30 PM he sent the Administrator a text and a picture regarding the concern. On 12/2/25 at 11:20 AM, the Administrator reported he was out of the facility on 11/19/25. He said he was back in the office on 11/20/25 until 10 AM. He said on 11/20/25 around 3:48 PM he got a text message from Staff F with a picture. He said he did not read the text message until around 4:30 PM. He said he called the ADON to see what was going on and instructed her to call the Regional Nurse to figure out the next steps since the facility was already late with reporting to DIAL. He said in the text message Staff F reported that he brought up the concerns to the team on 11/19/25 and he did not feel the concerns were being addressed. The Administrator reported he got home around 4:45 PM and the Regional Nurse called him at 5:00 PM. He said there was a rapid response call with the regional team. He said approximately 8 PM he suspended Staff C, Registered Nurse, the ADON and Staff F. He reported he completed the self-report to DIAL at 8:16 PM. He reported with any allegation of abuse he would expect the staff member to be separated/suspended right away. He verified the facility should have suspended/separated Staff C on 11/19/25.A facility form titled Disciplinary Action Form dated 11/21/25 for the ADON documented a written warning given due to the failure to notify the Administrator of an allegation of abuse. The facility policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating revised April 2021 documented any employee accused of resident abuse will be placed on leave with no resident contact until the investigation is complete. If the investigation reveals that the allegations of abuse are founded, the employee will be terminated.