

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Stratford Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on personnel record review, staff interview and policy review the facility failed to provide appropriate screening prior to employment for 1 of 5 employees reviewed for background checks. The facility reported a census of 39 residents. Findings include: The personnel file for Staff D, (Registered Nurse) documented a start date of 6/24/25. The personnel file lacked documentation that a Single Contact License and Background Check (SING) was completed prior to hire. Review of current nursing schedules revealed Staff D was an active RN at the facility and was working during the survey. On 7/8/26 at 4:30 PM, the Administrator reported the facility could not locate the SING for Staff D. He said he sent Staff D home as a precautionary. The facility policy titled Background Screening Investigations revised March 2019 documented the facility would conduct employment background screening checks, reference checks and criminal conviction investigation checks on all applicants for positions with direct access to residents. The policy documented background and criminal checks are initiated two days of an offer of employment or contract agreement, and completed prior to employment.		

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on clinical record review, facility investigative file review, staff interviews, and facility policy review the facility failed to document on the Controlled Drug Count Record and the electronic Medication Administration Record (MAR) when liquid Morphine (opioid medication) was administered for 1 of 1 resident reviewed for controlled substance use (Resident #1). The facility also failed to consistently and accurately reconcile controlled medications. The facility reported a census of 39 residents. Findings include: The Facility Self Report to the Department of Inspections, Appeals and Licensing (DIAL) by the Administrator on 5/15/26 revealed Resident #1 lacked Morphine (strong pain medicine). The report documented a staff member notifying the Director of Nursing (DON) and the Administrator at shift change about the liquid Morphine (strong liquid pain medicine) count differing from the record, with the time of the last correct count remaining unknown. The Facility 5-day Investigation documented on 5/15/26 revealed a report to the DON showing a shortage of 6.75 milliliters (ml) in Resident #1's liquid Morphine count. The Care Plan with a target date of 8/13/26 documented Resident #1's use of opioid (strong pain reliever) medications for chronic pain and metastatic cancer (cancer spreading). The Care Plan directed staff to administer opioid medication as the physician ordered and monitor Resident #1 for side effects. The May 2026 Medication Administration Record (MAR) directed staff to administer Morphine Sulfate Concentrate Oral Solution 20 milligrams/milliliter (mg/ml), 0.25 ml every 2 hours as needed for pain. Resident #1's Individual Narcotic Records from March 28, 2026 to June 30, 2026 revealed: Staff signed out Morphine Sulfate on the Individual Narcotic Record but failed to record the administration on the MAR on 4/16/26, 4/20/26, 4/21/26, 4/30/26 twice, 5/3/26, 5/15/26, 5/31/26, 6/5/26, 6/6/26 twice, 6/7/26, 6/8/26, 6/20/26, and 6/30/26 (15 times). Staff documented Morphine Sulfate on the MAR as administered on 4/18/26 but failed to record it on the Individual Narcotic Record. Staff documented a subtraction error on 4/15/26. On 4/14/26 at 12:46 PM, staff administered 0.25 ml, leaving 18.75 ml. On 4/15/26 at 4:54 AM, staff administered 0.25 ml and recorded 18 ml remaining, creating a 0.5 ml discrepancy. Staff documented a subtraction error on 5/1/26. On 4/30/26 at 1:41 PM, staff administered 0.25 ml, leaving 14 ml. On 5/1/26 at 8:15 AM, staff administered 0.25 ml and recorded 14 ml remaining. Staff documented a medication discrepancy on 5/15/26. On 5/14/26 at 4:29 PM, staff administered 0.25 ml, leaving 7.5 ml. On 5/15/26 at 12:30 PM, staff administered 0.25 ml and recorded 0.25 ml remaining, creating a 7.25 ml discrepancy. On 5/15/26 at 5:00 PM, staff administered 0.25 ml, leaving zero remaining. The facility document titled Controlled Drugs- Count Record required staff signatures to acknowledge counting the controlled drugs on hand and verifying agreement with the quantity stated on the Controlled Drug Administration Record. Review of the count record for both medication carts revealed a lack of staff signatures, indicating staff failed to reconcile controlled medications on the following dates and shifts: 6 AM - On: 4/14/26, 4/17/26, 4/27/26, 5/12/26, 5/28/26, 5/31/26, 7/2/26, and 7/4/26. 6 AM - Off: 4/29/26. 2 PM - On: 4/16/26 and 4/20/26. 2 PM - Off: 5/1/26. 6 PM - Off: 4/14/26, 4/16/26, 4/20/26, 5/3/26, 5/4/26, 5/7/26, 5/11/26, 5/12/26, 5/23/26, 5/24/26, 5/28/26, 5/31/26, 6/8/26, 7/2/26, and 7/4/26. 5 PM - Off: 5/5/26. 10 AM - Off: 7/5/26. 4:47 PM - Off: 7/5/26. On 7/6/26 at 9:49 AM, the DON expected staff to document completion of the narcotic count. On 7/7/26 at 12:49 PM, Staff C, Registered Nurse (RN), reported Resident #1's liquid Morphine count differed from the records since her employment began around 5/5/26. Staff C stated other staff reported the count as correct. Other nurses informed Staff C of potential liquid medication volume fluctuations causing discrepancies. Staff C couldn't recall the exact shortage, estimating a difference (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of 3 to 4 milliliters. Staff C admitted failing to report the discrepancy to the DON. Staff C reported completing the count with another person but acknowledged failing to sign the form in the back of the book, noting if it wasn't documented it wasn't done. On 7/7/26 at 2:13 PM, Staff D, RN, reported Staff C approached her the Sunday prior to 5/15/26 regarding concerns Resident #1's Morphine bottle appeared short compared to the narcotic record log. Staff D inspected the bottle and found it acceptable, attributing a minor discrepancy to observed leakage around the bottle. Staff D didn't recall the exact shortage amount. Staff D recalled a telephone call 3 to 4 days later from the DON inquiring about Staff C's report. Staff D informed the DON the discrepancy appeared minor and non-urgent, noting bottle leakage. Staff D reported completing the count at shift change, acknowledging the expectation to sign the back of the book. Staff D admitted occasionally forgetting to sign or signing during the subsequent count. Staff D stated the facility expected staff to sign the MAR and narcotic record immediately following medication administration. On 7/7/26 at 2:02 PM, Staff F, Certified Medication Aide (CMA), reported Resident #1's liquid Morphine bottle felt damp and the box showed pink markings. Staff F noted a missing stopper under the lid and wet residue trickling from the bottle. Staff F didn't recall whether she discovered the discrepancy during administration or the count. Staff F didn't recall the exact shortage amount but reported finding the bottle nearly empty. On 7/7/26 at 6:51 PM, Staff E, RN, reported the narcotic count required two nurses. Staff E stated staff compared medication cards to the narcotic record and signed the back of the book to verify accuracy. Staff E reported attempting to count at shift change, admitting she occasionally forgot or skipped the count when the other nurse remained busy, though she denied habitual omissions. Staff E stated the facility expected staff to sign the narcotic log and MAR immediately after administering medication. Staff E reported the subsequent narcotic count would catch any undocumented doses. On 7/8/26 at 3:41 PM, the DON expected staff to notify her of any narcotic count discrepancies. The Controlled Substance Record Book (Protocol) policy effective 2/14/22 directed: Conducting a Controlled Substance Count: Begin the narcotic count with the oncoming shift by counting the cards, ensuring the count matches the non-yellowed lines on the index sheet. Verify each medication card against the proper page number, counting each card bubble and the actual medication. Signing out a Controlled Substance: When administering a controlled substance, staff must document the date, time, dose, signature, and remaining quantity on the Individual Narcotic Sheet in the Controlled Substance Book. Staff must sign the MAR in the electronic medication record with the administration date and time to match the entry in the Controlled Substance Record Book.		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on review of the facility's Quality Assurance Performance Improvement (QAPI) plan, the facility's past 2 surveys, and staff interview, the facility failed to correct their own deficiencies for 3 of 3 areas of concern. The facility reported a census of 39 residents. Findings include: The facility had the following concerns identified at the current recertification survey, which matched citations from the previous complaint survey and the previous recertification survey: Infection Prevention and Control Reporting of Alleged Violations Investigate/Prevent/Correct Alleged Violation The Quality Assurance and Performance Improvement (QAPI) Program policy revised March 2020 directed the QAPI committee to: Collect and analyze performance indicator data and other information; Identify, evaluate, monitor and improve facility systems and processes supporting the delivery of care and services; Identify and help resolve negative outcomes or care quality problems identified during the QAPI process; Utilize root cause analysis to help identify where identified problems point to underlying systematic problems; Help departments, consultants and ancillary services implement systems to correct potential and actual issues in quality of care; Establish benchmarks and goals to measure performance improvement; Coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals; and Communicate all phases of the QAPI process to the Administrator and governing body through sharing meeting minutes, committee activities and results of QAPI activities. On 7/9/26 at 2:30 PM the Administrator stated the QAPI committee reviews prior surveys and prior deficiencies to determine root cause and develop a plan to address and correct prior and repeat deficiencies. The Administrator acknowledged the repeat concerns with the repeat deficiencies during this survey and prior surveys and advised the QAPI committee must complete more extensive audits to address them.		

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F 0600 Level of Harm - Minimal harm or potential for 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 observation, interview, and record review, the facility failed to ensure a safe environment and protect residents from inappropriate sexual behaviors for 2 of 2 residents reviewed (Residents #3 and #31). The facility reported a census of 39 residents. Findings include: 1. Resident #3's Minimum Data Set (MDS; clinical assessment) admission assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS; cognitive test) score of 3, indicating severely cognitively impaired. Resident #3 displayed physical behavioral symptoms, including hitting, kicking, pushing, scratching, grabbing, and sexually abusing others, and verbal behavioral symptoms, including threatening, screaming, and cursing, directed toward others for 1 to 3 days during the lookback period. Resident #3 had diagnoses of metabolic encephalopathy (temporary brain malfunction), Alzheimer's disease (progressive brain disorder causing memory loss) with late onset, and a psychotic disorder (mental illness causing detachment from reality) other than schizophrenia. The Care Area Assessment (CAA; care review area) Summary indicated Resident #3 triggered care areas for cognitive loss or dementia and behavioral symptoms. Resident #3's MDS assessment dated [DATE] showed a score of 3, indicating severely cognitively impaired. Resident #3's MDS significant change in condition assessment dated [DATE] showed a score of 0, indicating severely cognitively impaired. Staff rarely or never understood Resident #3. The Staff Assessment for Mental Status showed short-term and long-term memory problems. Resident #3 couldn't recall the current season, room location, staff names and faces, or the nursing home setting. Resident #3 possessed severely impaired cognitive skills for daily decision-making. Resident #3 exhibited physical behavioral symptoms directed toward others for 1 to 3 days during the lookback period. The CAA Summary indicated Resident #3 triggered care areas for delirium (sudden severe confusion), cognitive loss or dementia, and behavioral symptoms. Resident #3's Care Plan Focus revised 5/22/26 and 7/7/26 stated that Resident #3 had a behavior problem, could act sexually inappropriate due to dementia, and experienced a resident-to-resident altercation. Resident #3's Care Plan Focus revised 3/10/26 and 7/6/26 stated that Resident #3 had impaired cognitive function or thought processes related to dementia, an involvement in a resident-to-resident altercation, and an involvement in inappropriate sexual behavior with another resident. A care plan intervention dated 5/26/26 directed that Resident #3 would engage with another male resident at times with affectionate behavior. A progress note dated 7/6/26 at 5:14 PM indicated staff noted Resident #3 in a consensual relationship with another resident in the CCDI (memory care) unit, which progressed to an intimate touch. Staff spoke with Resident #3 Representative, who maintained awareness, stated the relationship fell within Resident #3's rights, and lacked concerns or questions. A progress note dated 7/6/26 at 5:32 PM stated that both residents experienced cognitive impairment and fluctuating behaviors related to Alzheimer's disease. 2. Resident #31's MDS assessment dated [DATE] showed a score of 11, indicating moderately impaired cognition. Resident #31 exhibited physical behavioral symptoms directed toward others for 4 to 6 days during the lookback period. Resident #31 displayed verbal and other behavioral symptoms not directed toward others, including hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, and throwing or smearing food or bodily wastes, for 1 to 3 days during the lookback period. Diagnoses included other sexual disorders, adjustment disorder with depressed mood, and anxiety. Resident #31 received an antidepressant medication during the lookback period. Resident #31's Care Plan Focus revised 5/22/26 stated that Resident #31 had a behavior problem involving sexually inappropriate actions (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	related to dementia. A care plan intervention dated 5/26/26 stated Resident #31 would engage with another male resident at times with affectionate behavior. A care plan intervention dated 6/3/26 stated Resident #31 took medication to help decrease sexual inhibition, which carried a black box warning (strict safety alert). An incident, accident, and unusual occurrence note late entry dated 5/3/26 at 7:15 PM summarized that staff reported finding Resident #31 and another resident kissing lip-to-lip in the dining area. Resident #31 sat in a chair at the table while the other resident stood and leaned toward Resident #31 with a walker nearby. Staff separated both residents. The facility Director of Nursing (DON; chief nursing executive) and Administrator (facility manager) received notification. Staff called the sheriff and updated Resident #31 Representative. Staff sent notifications on 5/3/26 at 7:23 PM to the DON, 5/3/26 at 7:25 PM to the Administrator, 5/3/26 at 8:01 PM to the sheriff, and 5/3/26 at 8:20 PM to Resident #31 Representative. A nurses note dated 5/4/26 at 11:29 AM indicated the facility received orders from the medical provider for a psychiatry (mental health) consultation, with consideration for Depo-Provera (hormone medication) use to regulate sexual behaviors. Staff planned to call Resident #31 Representative to obtain permission for the consultation while the plan of care remained ongoing. A psychiatry encounter note dated 5/4/26 at 6:00 PM for a date of service on 5/5/26 detailed an initial psychiatric evaluation. Resident #31, a [AGE] year-old male with a history of dementia with mood disturbance and major depressive disorder, sat in a wheelchair during the evaluation. Resident #31 appeared calm and lacked acute distress. Due to cognitive impairment, Resident #31 experienced difficulty focusing and answering questions, stating life felt terrible because Resident #31 didn't get Cheerios. Staff reported consistent verbal aggression consisting of yelling and screaming, but denied sleep concerns, recent depression, or anxiety symptoms. Current psychiatric medications included Paroxetine 20 milligrams daily and Trazodone 50 milligrams nightly. Resident #31 Representative signed a consent form for evaluation and treatment. The clinician noted poor impulse control, impaired cognition, impaired attention, impaired concentration, impaired memory, minimal insight, and poor judgment. Diagnoses included major depressive disorder, unspecified dementia with mood disturbance, psychophysiological insomnia (sleep disorder), and inappropriate sexual behavior. The plan directed continuing Paroxetine to monitor depression, noted Resident #31 resided in the memory care unit with verbal but not physical aggression, and addressed the inappropriate sexual behavior toward staff and other residents by increasing Paroxetine to 30 milligrams daily to see if it helps, with future consideration for a Trazodone increase. An alert note dated 5/17/26 at 7:28 AM documented sexually inappropriate behavior where Resident #31 asked another resident if he had a gay orientation. Resident #31 sat at the far table in the dining room when the other male resident walked over. Staff heard the comment, turned from the medication cart, and witnessed the two men kiss. Staff immediately called the other resident over, and he cooperated. Staff reported neither resident displayed anger, and both appeared to enjoy themselves. Staff assisted Resident #31 to a bedroom via wheelchair for care and bed placement per request, leaving the call light within reach. On 7/9/26 at 9:12 AM Staff H, Certified Nursing Assistant (CNA), stated during an interview that Resident #3 and Resident #31 liked each other and held hands, which represented the extent of the witnessed behavior. On 7/9/26 at 9:15 AM Staff I, Certified Medication Aide (CMA), stated during an interview that Resident #3 and Resident #31 kissed and expressed mutual love. Staff I once found Resident #3 fondling Resident #31 through clothing. Staff I kept them separated to prevent this behavior in the dining room. Staff I noted Resident #3 declined recently, experienced episodes of unresponsiveness, and staff previously thought Resident #3 faced active death. On 7/9/26 at 10:45 AM Resident #31 stated during an interview that Resident #31 lacked friends but recognized Resident #3 as a friend. Resident #31 (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	denied a romantic relationship or any instances of inappropriate touching or kissing. On 7/9/26 at 10:48 AM Resident #3 rested in bed during an observation with eyes closed, and Resident #3 didn't awaken when staff called Resident #3's name. On 7/9/26 at 10:45 AM Staff J, Program Coordinator, stated during an interview that reports indicated Resident #3 and Resident #31 kissed and engaged in mutual touching in the dining room. Staff J never witnessed the behavior directly but heard about it, noting Resident #3 usually initiated the encounters. Staff J reported management instructed staff they couldn't keep the residents separate anymore, though groin touching in the dining room or entry into each other's rooms remained restricted. Staff J believed management held awareness of the reports. Staff J noted Resident #3 experienced a significant decline recently and could hardly speak. On 7/9/26 at 11:10 AM the DON stated during an interview that awareness existed regarding Resident #3 and Resident #31 kissing and holding hands. The DON noted only a physician could determine Resident #3's capacity to consent. The DON stated Resident #31 had a Power of Attorney (POA) that remained un-enacted because the primary care provider hadn't declared Resident #31 incompetent. The DON contacted the primary care provider and Resident #3 Representative about the relationship; the provider didn't state Resident #3 lacked the capacity to consent, and Resident #3 Representative stated Resident #3 had the right to do what he wanted. The DON held awareness that Resident #3 placed a hand on Resident #31's inner thigh recently, and that Resident #31 pulled his pants down while Resident #3 touched Resident #31's penis in the dining room before staff intervened. The DON stated reporting would only occur for true sexual contact or if either resident demonstrated resistance. The facility restricted contact to common areas and disallowed anything beyond holding hands in those spaces. On 7/9/26 at 12:45 PM Staff K, Registered Nurse (RN), stated during an interview that although she didn't work in the locked unit often, she heard reports about sexually inappropriate behaviors between Resident #3 and Resident #31. The interactions didn't appear nonconsensual, though both residents had Alzheimer's disease. Staff K witnessed kissing and heard of fondling. Resident #3 and Resident #31 only interacted with each other. On 7/9/26 at 12:55 PM the DON stated during an interview that she charted the behavior as consensual because no reports indicated otherwise. The DON and the Administrator decided the residents could make their own decisions, and they didn't request capacity evaluations, though they reported the relationship to the primary care provider. The DON recognized regulatory changes occurred and didn't know if future consent evaluations would take place, noting she would seek higher guidance today. The facility allowed the relationship to naturally evolve without intervention. The DON added that Resident #31 walked independently for the first time on Monday. On 7/8/26 at 1:27 PM the DON stated during an interview that corporate communication indicated consent for residents with dementia relies on body language and visible pleasure, based on a presentation by the Iowa Departments of Inspections, Appeals, and Licensing (DIAL) Bureau Chief. On 7/9/26 at 1:30 PM the Administrator stated during an interview that he functioned as the abuse coordinator. The Administrator determined consent occurred because the interactions progressed from light kissing to a hand on the thigh, and staff intervened when Resident #31 pulled his pants down or when Resident #3 touched Resident #31's penis in the dining room to ensure decency. The Administrator referenced a corporate presentation on F600 on May 12th of this year, which indicated that residents with lower capacity could engage in sexual contact without reporting if they showed signs of enjoyment. Because both residents showed enjoyment, the facility categorized the behavior as consensual and didn't report it as abuse. The Chief Nursing Officer informed them of the presentation by the DIAL Bureau Chief. The Administrator lacked handouts or knowledge of capacity assessments, focusing only on whether the behavior appeared enjoyable. The Abuse and Neglect - Clinical Protocol revised March 2018 defined sexual abuse as (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	non-consensual sexual contact of any type with a resident. The Identifying Types of Abuse dated April 2021 directed as part of the abuse prevention strategy volunteers, employees, and contracts hired by the facility are expected to be able to identify the different types of abuse that may occur against residents. The policy defined sexual abuse as non-consensual sexual conduct of any type with a resident. The policy listed the following:Sexual contact with a resident who lacked the cognitive ability to consent is considered non-consensual and therefore, constitutes abuse.The resident's capacity to consent to sexual conduct is carefully evaluated as part of the initial assessment and care planning process.The interdisciplinary team consults with the ethics committee or legal counsel whenever there is a question of capacity to consent.The resident's capacity to consent is monitored and re-evaluated over time, as needed, based on changes to his or her physical, mental, and/or psychosocial status.		

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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 observations, interviews, clinical record reviews, and facility policy review the facility failed to report an allegation of sexual abuse for a resident with an unknown capacity to consent for 2 of 2 residents reviewed (Residents #3 and #31). The facility failed to report the allegation of sexual abuse after the residents progressed to fondling each other over clothing and then to touching without clothing. The facility reported a census of 39 residents. Findings include: 1. Resident #3's Minimum Data Set (MDS; clinical assessment) admission assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS; cognitive test) score of 3, indicating severely cognitively impaired. Resident #3 displayed physical behavioral symptoms, including hitting, kicking, pushing, scratching, grabbing, and sexually abusing others, and verbal behavioral symptoms, including threatening, screaming, and cursing, directed toward others for 1 to 3 days during the lookback period. Resident #3 had diagnoses of metabolic encephalopathy (temporary brain malfunction), Alzheimer's disease (progressive brain disorder causing memory loss) with late onset, and a psychotic disorder (mental illness causing detachment from reality) other than schizophrenia. The Care Area Assessment (CAA; care review area) Summary indicated Resident #3 triggered care areas for cognitive loss or dementia and behavioral symptoms. Resident #3's MDS assessment dated [DATE] showed a score of 3, indicating severely cognitively impaired. Resident #3's MDS significant change in condition assessment dated [DATE] showed a score of 0, indicating severely cognitively impaired. Staff rarely or never understood Resident #3. The Staff Assessment for Mental Status showed short-term and long-term memory problems. Resident #3 couldn't recall the current season, room location, staff names and faces, or the nursing home setting. Resident #3 possessed severely impaired cognitive skills for daily decision-making. Resident #3 exhibited physical behavioral symptoms directed toward others for 1 to 3 days during the lookback period. The CAA Summary indicated Resident #3 triggered care areas for delirium (sudden severe confusion), cognitive loss or dementia, and behavioral symptoms. Resident #3's Care Plan Focus revised 5/22/26 and 7/7/26 stated that Resident #3 had a behavior problem, could act sexually inappropriate due to dementia, and experienced a resident-to-resident altercation. Resident #3's Care Plan Focus revised 3/10/26 and 7/6/26 stated that Resident #3 had impaired cognitive function or thought processes related to dementia, an involvement in a resident-to-resident altercation, and an involvement in inappropriate sexual behavior with another resident. A care plan intervention dated 5/26/26 directed that Resident #3 would engage with another male resident at times with affectionate behavior. A progress note dated 7/6/26 at 5:14 PM indicated staff noted Resident #3 in a consensual relationship with another resident in the CCDI (memory care) unit, which progressed to an intimate touch. Staff spoke with Resident #3 Representative, who maintained awareness, stated the relationship fell within Resident #3's rights, and lacked concerns or questions. A progress note dated 7/6/26 at 5:32 PM stated that both residents experienced cognitive impairment and fluctuating behaviors related to Alzheimer's disease. 2. Resident #31's MDS assessment dated [DATE] showed a score of 11, indicating moderately impaired cognition. Resident #31 exhibited physical behavioral symptoms directed toward others for 4 to 6 days during the lookback period. Resident #31 displayed verbal and other behavioral symptoms not directed toward others, including hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, and throwing or smearing food or bodily wastes, for 1 to 3 days during the lookback period. Diagnoses included other sexual disorders, adjustment disorder with depressed mood, and anxiety. Resident #31 received an (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Stratford Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	antidepressant medication during the lookback period. Resident #31's Care Plan Focus revised 5/22/26 stated that Resident #31 had a behavior problem involving sexually inappropriate actions related to dementia. A care plan intervention dated 5/26/26 stated Resident #31 would engage with another male resident at times with affectionate behavior. A care plan intervention dated 6/3/26 stated Resident #31 took medication to help decrease sexual inhibition, which carried a black box warning (strict safety alert). A psychiatry encounter note dated 5/4/26 at 6:00 PM for a date of service on 5/5/26 detailed an initial psychiatric evaluation. The plan directed continuing Paroxetine to monitor depression, noted Resident #31 resided in the memory care unit with verbal but not physical aggression, and addressed the inappropriate sexual behavior toward staff and other residents by increasing Paroxetine to 30 milligrams daily to see if it helps, with future consideration for a Trazodone increase. On 7/9/26 at 9:15 AM Staff I, Certified Medication Aide (CMA), stated during an interview that Resident #3 and Resident #31 kissed and expressed mutual love. Staff I once found Resident #3 fondling Resident #31 through clothing. Staff I kept them separated to prevent this behavior in the dining room. Staff I noted Resident #3 declined recently, experienced episodes of unresponsiveness, and staff previously thought Resident #3 faced active death. On 7/9/26 at 11:10 AM the DON stated during an interview that awareness existed regarding Resident #3 and Resident #31 kissing and holding hands. The DON noted only a physician could determine Resident #3's capacity to consent. The DON stated Resident #31 had a Power of Attorney (POA) that remained un-enacted because the primary care provider hadn't declared Resident #31 incompetent. The DON contacted the primary care provider and Resident #3 Representative about the relationship; the provider didn't state Resident #3 lacked the capacity to consent, and Resident #3 Representative stated Resident #3 had the right to do what he wanted. The DON held awareness that Resident #3 placed a hand on Resident #31's inner thigh recently, and that Resident #31 pulled his pants down while Resident #3 touched Resident #31's penis in the dining room before staff intervened. The DON stated reporting would only occur for true sexual contact or if either resident demonstrated resistance. The facility restricted contact to common areas and disallowed anything beyond holding hands in those spaces. On 7/9/26 at 12:45 PM Staff K, Registered Nurse (RN), stated during an interview that although she didn't work in the locked unit often, she heard reports about sexually inappropriate behaviors between Resident #3 and Resident #31. The interactions didn't appear nonconsensual, though both residents had Alzheimer's disease. Staff K witnessed kissing and heard of fondling. Resident #3 and Resident #31 only interacted with each other. On 7/9/26 at 12:55 PM the DON stated during an interview that she charted the behavior as consensual because no reports indicated otherwise. The DON and the Administrator decided the residents could make their own decisions, and they didn't request capacity evaluations, though they reported the relationship to the primary care provider. The DON recognized regulatory changes occurred and didn't know if future consent evaluations would take place, noting she would seek higher guidance today. The facility allowed the relationship to naturally evolve without intervention. The DON added that Resident #31 walked independently for the first time on Monday. On 7/8/26 at 1:27 PM the DON stated during an interview that corporate communication indicated consent for residents with dementia relies on body language and visible pleasure, based on a presentation by the Iowa Departments of Inspections, Appeals, and Licensing (DIAL) Bureau Chief. On 7/9/26 at 1:30 PM the Administrator stated during an interview that he functioned as the abuse coordinator. The Administrator determined consent occurred because the interactions progressed from light kissing to a hand on the thigh, and staff intervened when Resident #31 pulled his pants down or when Resident #3 touched Resident #31's penis in the dining room to ensure decency. The Administrator referenced a corporate presentation on (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F600 on May 12th of this year, which indicated that residents with lower capacity could engage in sexual contact without reporting if they showed signs of enjoyment. Because both residents showed enjoyment, the facility categorized the behavior as consensual and didn't report it as abuse. The Chief Nursing Officer informed them of the presentation by the DIAL Bureau Chief. The Administrator lacked handouts or knowledge of capacity assessments, focusing only on whether the behavior appeared enjoyable. The Abuse and Neglect - Clinical Protocol revised March 2018 defined sexual abuse as non-consensual sexual contact of any type with a resident. The Identifying Types of Abuse dated April 2021 directed as part of the abuse prevention strategy volunteers, employees, and contracts hired by the facility are expected to be able to identify the different types of abuse that may occur against residents. The policy defined sexual abuse as non-consensual sexual conduct of any type with a resident. The policy listed the following: Sexual contact with a resident who lacked the cognitive ability to consent is considered non-consensual and therefore, constitutes abuse. The resident's capacity to consent to sexual conduct is carefully evaluated as part of the initial assessment and care planning process. The interdisciplinary team consults with the ethics committee or legal counsel whenever there is a question of capacity to consent. The resident's capacity to consent is monitored and re-evaluated over time, as needed, based on changes to his or her physical, mental, and/or psychosocial status. The Abuse, Neglect, Exploitation, or Misappropriation - Reporting and Investigating policy revised April 2021 directed all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. The administrator or the individual making the allegation immediately reports his or her suspicion to the state licensing/certification agency responsible for surveying/licensing the facility. The policy defined immediately as within 2 hours of an allegation of abuse.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, interviews, and policy review the facility failed to separate residents with the unknown capacity to consent in sexual relations for 2 of 2 residents reviewed (Residents #3 and #31). See F600 for additional information regarding Resident #3 and #31. The facility reported a census of 39 residents. Findings include: 1. Resident #3's Minimum Data Set (MDS; clinical assessment) admission assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS; cognitive test) score of 3, indicating severely cognitively impaired. Resident #3 displayed physical behavioral symptoms, including hitting, kicking, pushing, scratching, grabbing, and sexually abusing others, and verbal behavioral symptoms, including threatening, screaming, and cursing, directed toward others for 1 to 3 days during the lookback period. Resident #3 had diagnoses of metabolic encephalopathy (temporary brain malfunction), Alzheimer's disease (progressive brain disorder causing memory loss) with late onset, and a psychotic disorder (mental illness causing detachment from reality) other than schizophrenia. The Care Area Assessment (CAA; care review area) Summary indicated Resident #3 triggered care areas for cognitive loss or dementia and behavioral symptoms. Resident #3's MDS assessment dated [DATE] showed a score of 3, indicating severely cognitively impaired. Resident #3's MDS significant change in condition assessment dated [DATE] showed a score of 0, indicating severely cognitively impaired. Staff rarely or never understood Resident #3. The Staff Assessment for Mental Status showed short-term and long-term memory problems. Resident #3 couldn't recall the current season, room location, staff names and faces, or the nursing home setting. Resident #3 possessed severely impaired cognitive skills for daily decision-making. Resident #3 exhibited physical behavioral symptoms directed toward others for 1 to 3 days during the lookback period. The CAA Summary indicated Resident #3 triggered care areas for delirium (sudden severe confusion), cognitive loss or dementia, and behavioral symptoms. Resident #3's Care Plan Focus revised 5/22/26 and 7/7/26 stated that Resident #3 had a behavior problem, could act sexually inappropriate due to dementia, and experienced a resident-to-resident altercation. Resident #3's Care Plan Focus revised 3/10/26 and 7/6/26 stated that Resident #3 had impaired cognitive function or thought processes related to dementia, an involvement in a resident-to-resident altercation, and an involvement in inappropriate sexual behavior with another resident. A care plan intervention dated 5/26/26 directed that Resident #3 would engage with another male resident at times with affectionate behavior. A progress note dated 7/6/26 at 5:14 PM indicated staff noted Resident #3 in a consensual relationship with another resident in the CCDI (memory care) unit, which progressed to an intimate touch. Staff spoke with Resident #3 Representative, who maintained awareness, stated the relationship fell within Resident #3's rights, and lacked concerns or questions. A progress note dated 7/6/26 at 5:32 PM stated that both residents experienced cognitive impairment and fluctuating behaviors related to Alzheimer's disease. 2. Resident #31's MDS assessment dated [DATE] showed a score of 11, indicating moderately impaired cognition. Resident #31 exhibited physical behavioral symptoms directed toward others for 4 to 6 days during the lookback period. Resident #31 displayed verbal and other behavioral symptoms not directed toward others, including hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, and throwing or smearing food or bodily wastes, for 1 to 3 days during the lookback period. Diagnoses included other sexual disorders, adjustment disorder with depressed mood, and anxiety. Resident #31 received an antidepressant medication during the lookback period. Resident #31's Care Plan Focus revised 5/22/26 stated that Resident #31 had a behavior problem involving sexually inappropriate actions (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	related to dementia. A care plan intervention dated 5/26/26 stated Resident #31 would engage with another male resident at times with affectionate behavior. A care plan intervention dated 6/3/26 stated Resident #31 took medication to help decrease sexual inhibition, which carried a black box warning (strict safety alert). An incident, accident, and unusual occurrence note late entry dated 5/3/26 at 7:15 PM summarized that staff reported finding Resident #31 and another resident kissing lip-to-lip in the dining area. Resident #31 sat in a chair at the table while the other resident stood and leaned toward Resident #31 with a walker nearby. Staff separated both residents. The facility Director of Nursing (DON; chief nursing executive) and Administrator (facility manager) received notification. Staff called the sheriff and updated Resident #31 Representative. Staff sent notifications on 5/3/26 at 7:23 PM to the DON, 5/3/26 at 7:25 PM to the Administrator, 5/3/26 at 8:01 PM to the sheriff, and 5/3/26 at 8:20 PM to Resident #31 Representative. The Facility's Self Report submitted 5/3/26 identified the staff found Resident #3 and Resident #31 sitting at the table kissing. The facility immediately separated the residents. The Intervention directed the facility would have the residents sit at separate tables while in the dining room. On 7/9/26 at 9:15 AM Staff I, Certified Medication Aide (CMA), stated during an interview that Resident #3 and Resident #31 kissed and expressed mutual love. Staff I once found Resident #3 fondling Resident #31 through clothing. Staff I kept them separated to prevent this behavior in the dining room. Staff I noted Resident #3 declined recently, experienced episodes of unresponsiveness, and staff previously thought Resident #3 faced active death. On 7/9/26 at 10:45 AM Staff J, Program Coordinator, stated during an interview that reports indicated Resident #3 and Resident #31 kissed and engaged in mutual touching in the dining room. Staff J never witnessed the behavior directly but heard about it, noting Resident #3 usually initiated the encounters. Staff J reported management instructed staff they couldn't keep the residents separate anymore, though groin touching in the dining room or entry into each other's rooms remained restricted. Staff J believed management held awareness of the reports. Staff J noted Resident #3 experienced a significant decline recently and could hardly speak. On 7/9/26 at 11:10 AM the DON stated during an interview that awareness existed regarding Resident #3 and Resident #31 kissing and holding hands. The DON noted only a physician could determine Resident #3's capacity to consent. The DON stated Resident #31 had a Power of Attorney (POA) that remained un-enacted because the primary care provider hadn't declared Resident #31 incompetent. The DON contacted the primary care provider and Resident #3 Representative about the relationship; the provider didn't state Resident #3 lacked the capacity to consent, and Resident #3 Representative stated Resident #3 had the right to do what he wanted. The DON held awareness that Resident #3 placed a hand on Resident #31's inner thigh recently, and that Resident #31 pulled his pants down while Resident #3 touched Resident #31's penis in the dining room before staff intervened. The DON stated reporting would only occur for true sexual contact or if either resident demonstrated resistance. The facility restricted contact to common areas and disallowed anything beyond holding hands in those spaces. On 7/9/26 at 12:55 PM the DON stated during an interview that she charted the behavior as consensual because no reports indicated otherwise. The DON and the Administrator decided the residents could make their own decisions, and they didn't request capacity evaluations, though they reported the relationship to the primary care provider. The DON recognized regulatory changes occurred and didn't know if future consent evaluations would take place, noting she would seek higher guidance today. The facility allowed the relationship to naturally evolve without intervention. The DON added that Resident #31 walked independently for the first time on Monday. On 7/9/26 at 1:30 PM the Administrator stated during an interview that he functioned as the abuse coordinator. The Administrator determined consent occurred because the interactions progressed from light kissing to a hand on the thigh, and (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff intervened when Resident #31 pulled his pants down or when Resident #3 touched Resident #31's penis in the dining room to ensure decency. The Administrator referenced a corporate presentation on F600 on May 12th of this year, which indicated that residents with lower capacity could engage in sexual contact without reporting if they showed signs of enjoyment. Because both residents showed enjoyment, the facility categorized the behavior as consensual and didn't report it as abuse. The Chief Nursing Officer informed them of the presentation by the Department of Inspections, Appeals, and Licensing (DIAL) Bureau Chief. The Administrator lacked handouts or knowledge of capacity assessments, focusing only on whether the behavior appeared enjoyable. The Abuse, Neglect, Exploitation, or Misappropriation - Reporting and Investigating policy revised April 2021 directed all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for initiating a thorough investigation and determining what actions (if any) are needed for the protection of residents.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure staff administered medications in accordance with physician orders for 1 of 2 residents reviewed for skin conditions (Resident #9). The facility reported a census of 39. Findings include:Resident #9's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 6, indicating severely cognitively impaired. The MDS listed diagnoses of hypertension (high blood pressure), diabetes mellitus (high blood sugar), and non-Alzheimer's dementia (brain decline). Resident #9 had moisture associated skin damage (skin irritation from moisture) and received applications of ointments or medications other than to feet. The Care Plan Focus dated 5/5/26 identified Resident #9's potential or actual skin impairment. Resident #9 had a rash to the scrotum and buttocks. The Nurses Note dated 6/10/26 at 12:09 PM indicated the facility received new orders from Advanced Registered Nurse Practitioner (ARNP) 2 to discontinue Nystatin cream, start miconazole 2% cream twice a day for 2 weeks, and apply a thin layer over affected areas. The orders instructed staff to apply Triad paste three times a day and as needed after incontinence (loss of bowel or bladder control) episodes, reassess after 14 days, and consider an oral antifungal if not effective. The Orders - Administration Note Text dated 6/12/26 at 7:49 PM specified instructions to apply Micatin Cream 2% topically two times a day for a rash for 14 days per additional directions. The Communication - with Physician Note Text dated 6/15/26 at 9:50 AM detailed verbal orders ARNP3 to start Resident #9 on Nystatin Cream, discontinue Micatin, start 10 mg prednisone PO (by mouth) daily in the AM for 5 days, and provided an order for a dermatology referral. The Nurses Note Text dated 6/18/26 at 5:08 PM documented a new order for Nystatin cream BID (twice daily) and Triad paste. The note indicated Resident #9's appointment with a dermatologist on the 24th for skin issues, noting the rash spread to Resident #9's face, eyelid, and ears. The Dermatology Visit Note dated 6/24/26 included the following orders:a. Fluconazole 150 mg tablet by mouth, give one and may repeat up to 2 additional doses for a total of 3 days.b. Econazole Nitrate 1% topical cream apply to rash in groin, on thighs, and buttocks twice a day until areas resolve. Resume application for an additional 1 week thereafter to minimize reoccurrence.c. Nystatin-Triamcinolone 100,000 units/gram - 0.1% topical ointment. Apply to rash in groin, buttocks, and thighs twice daily for up to 2 weeks. Take a 2 week break from applications, then resume course as directed until areas resolve.d. Follow-up rash and medication progress in 1 month. The Order Note Text dated 6/25/26 at 5:11 PM noted a new order for Nystatin-Triamcinolone 100,000 unit/gram 0.1% topical ointment to apply to the rash on the groin, buttocks, and thighs BID for 2 weeks, take a 2-week break, then resume the cycle until healed. The Nurses Note Text dated 7/2/26 at 1:55 PM indicated a provider saw Resident #9 that morning. New orders changed the duration of Fluconazole to once daily, updating the order to read as 150 mg daily for 14 days total. Staff administered the first dose on 6/28/26 and updated the order to include doses for the next 10 days to reach the 14-day duration. Resident #9's July 2026 MAR included the following orders:a. Fluconazole Oral Tablet 150 MG (Fluconazole) Give 1 tablet by mouth one time a day for rash for 10 administrations with a start date of 7/3/26 at 7:00 AM.b. Nystatin-Triamcinolone External Ointment 100000-0.1 UNIT/GM-% (Nystatin-Triamcinolone) Apply to groin, buttocks, and thigh topically every shift for rash for 2 weeks, apply up to 2 weeks then take a 2-week break then continue cycle until healed with a start date of 6/29/26 at 5:00 AM.c. Triad Hydrophilic Wound Dress External Paste (Wound Dressings) Apply to buttocks and groin topically three times a day for incontinence episodes, reassess after 14 days, and consider an oral antifungal if not effective with a start date of 6/10/26 at (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4:00 PM.d. Triad Hydrophilic Wound Dress External Paste (Wound Dressings) Apply to groin and buttocks topically every 3 hours as needed for affected areas with a start date of 6/10/26 at 12:15 PM. On 7/7/26 at 9:12 AM, Staff L, Certified Medication Assistant (CMA), and the Director of Nursing (DON) completed incontinence care and ointment application to Resident #9. Staff L removed the brief, cleansed the front area, and applied ointment and powder. Staff L applied the ointment to the backside as well, utilizing Econazole Nitrate 1% and Nystatin powder. On 7/7/26 at 11:47 AM, the Pharmacist stated during a telephone call the pharmacy held orders for two ointments for Resident #9, specifically Nystatin/Triamcinolone 100,000/0.1 Unit/GM every shift and Econazole 1% topical. The Pharmacist noted the medications differ and the Electronic Medication Administration Record (eMAR) lacked the Econazole 1% order. The Pharmacist also stated orders from the nurse practitioner discontinued the Nystatin powder on 6/1/26. On 7/7/26 at 11:55 AM, the DON stated the facility received no paperwork or orders when Resident #9 returned from the dermatology clinic. The DON noted the Assistant Director of Nursing (ADON) called the clinic and verified the order for Nystatin/Triamcinolone ointment but not for the Econazole ointment. On 7/7/26 at 12:15 PM, Staff L stated she shouldn't have administered the Econazole without an order but thought she held the Nystatin ointment. Staff L noted she shouldn't have documented the Nystatin ointment since she administered the other ointment, and she shouldn't have administered the Nystatin powder since the provider discontinued it. On 7/7/26 at 12:22 PM, the ADON stated she received paperwork from the dermatology clinic ordering oral Fluconazole for 3 days and a topical antifungal. The ADON noted Resident #9 showed no improvement, leading to an extension of the Fluconazole duration, though she couldn't remember if the clinic prescribed two ointments. Following a review of the morning observation, the ADON stated Staff L shouldn't have administered the Econazole without an order, shouldn't have signed for the Nystatin ointment since she didn't administer it, and shouldn't have administered the Nystatin powder since the provider discontinued it. On 7/7/26 at 1:40 PM, ARNP2 stated she routinely evaluated Resident #9 for a groin rash. She noted Resident #9 previously received Nystatin, but it failed to work, prompting a change to a different topical antifungal medication. She didn't start Diflucan due to a potential reaction with Eliquis increasing bleeding risks. ARNP2 stated another provider evaluated Resident #9 when the rash still showed no improvement and restarted Nystatin despite its previous failure. She noted the dermatology clinic started Diflucan for 3 days, and the physician subsequently extended the Diflucan to 14 days. The dermatologist attributed the condition to poor perineal care (cleansing the genital area), but ARNP2 disagreed because the rash spread to Resident #9's face as well. She believed the medication failed to work, noting moisture didn't help. On 7/8/26 at 2:20 PM, Advanced Registered Nurse Practitioner (ARNP) 1 stated she provided orders for Diflucan and two ointments. The orders specified Nystatin/Triamcinolone as the first ointment and Econazole as the second ointment.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, staff interviews, and policy review the facility failed to prepare and serve pureed food to meet the nutritional needs of 2 of 3 residents reviewed (Residents #17 and #28). The facility reported a census of 39 residents. Findings include: A facility form titled Diet Type Report dated 7/7/26 identified three residents (Residents #6, #17 and #28) who received a pureed texture diet. During an observation on 7/8/26 at 10:57 AM Staff A, Cook, prepared 4 servings of puree. She placed 4 servings (2 scoops with a 4 ounce number #8 scoop) of beef and bean casserole into the blender with 2 buns and blended to pureed texture. She then put the mixture into a container for service without measuring and stated that the serving size would be 2 #8 scoops for service. Next, she put 4 servings (1 scoop of 4 ounce #8 scoop) of green beans with 2 buns and blended to pureed texture. She then put the mixture into a container for service without measuring and stated that the serving size would be 1 #8 scoop for service. Finally, she placed 4 servings (1 scoop of 4 ounce #8 scoop) of rice and added tomato juice and blended to puree texture. She then put the mixture into a container for service without measuring and stated that the serving size would be 1 #8 scoop for service. In an observation 7/8/26 at 12:15 PM Staff A, [NAME] used a #8 scoop to serve the pureed meat, vegetables and rice to 2 of the 3 residents who received a pureed diet. Resident #6 declined to eat lunch. In an interview on 7/8/26 at 1:22 PM Staff B, Dietary Manager stated that when doing puree they always do an extra serving. They add butter or sauce to the food when blending. They should measure the final blend and use the chart to find out the final scoop to use for service. She stated that Staff A, [NAME] should have measured the puree after blending to get the correct serving size but she did not. When she noticed it was too late. In an undated document titled Care Initiatives Puree Process hanging on the wall next to the steamer indicated the steps in the puree process. Measure out desired number of servings into container for pureeing. Puree the food. Add any necessary thickener or appropriate liquid of nutritive value and flavor to obtain desired consistency. Measure the total volume of the food after it is pureed. Measure the total volume of the pureed food by the original number or portions. See the Puree Scoop Chart for reference. Heat or chill the puree food to safe serving temperatures. In a policy titled Kitchen Weights and Measures revised April 2007 it indicated that Cooks and Food Services staff will be trained in weights and measures, volume and weights, appropriate utensil use, and food can sizes. It also indicated that staff will be trained in the appropriate measurement and type of serving utensil to use for each food. Signs or posters explaining coded measurement indicators (e.g., color-coded) on utensils will be prominently displayed for reference and the Food Service Supervisor will ensure cooks prepare the appropriate amount of food for the number of servings required.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Stratford Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation and interview, the facility failed to ensure staff followed dietary orders for Resident #27. The facility reported a census of 39 residents. Findings include: The Diet Type Report printed 7/7/26 listed Resident #27 had a diet order for a mechanical soft texture. The Diet Spreadsheet for Cycle Day 32 included a vegetable of corn relish. The spreadsheet directed to give regular texture diets 1/2 cup corn relish, but directed to give 1 each puree corn to mechanical soft texture. On 7/8/26 at 12:30 PM watched Staff A, Cook, serve corn relish to Resident #27 and sent the item with other meal trays to the locked unit. On 7/8/26 at 12:40 PM Dietary Manager (facility nutritional services director) clarified Resident #27's dietary restrictions regarding a mechanical soft diet (foods altered to a soft texture for easier chewing). She stated Resident #27 could not consume corn relish. Following notification regarding the delivery of the corn relish to Resident #27, she walked to the locked unit to inspect the meal. On 7/8/26 at 12:42 PM witnessed the staff distribute meal trays to the residents. The meal tray for Resident #27 contained corn relish. Dietary Manager removed the item prior to delivery to Resident #27. She obtained another tray and provided the correct diet. On 7/8/26 at 12:43 PM the Dietary Manager acknowledged the improper delivery of corn relish to Resident #27 and termed the occurrence a mistake. On 7/8/26 at 1:22 PM the Dietary Manager explained the standard food preparation protocol of producing an extra serving during the pureeing process. Kitchen staff members add butter or sauce to the food during blending. The protocol required measuring the final blend and utilizing a reference chart to determine the correct scoop size for meal service. She noted Staff A failed to measure the pureed food after blending to ensure the correct serving size. She discovered the omission too late for correction.		

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NAME OF PROVIDER OR SUPPLIER Stratford Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 Highway 175 East Stratford, IA 50249	
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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 clinical record review, staff interviews and policy review, the facility failed to have a complete and accurately documented medical record for 2 of 13 residents reviewed (Residents #33 and #4). The facility reported a census of 39 residents. Findings include: Resident #33's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS included diagnoses of diabetes mellitus (high blood sugar). The July 2026 Medication Administration Record (MAR) directed staff to administer Pregabalin (nerve pain medicine) 100 milligrams (mg), 1 capsule three times a day for fibromyalgia (chronic pain disorder). Resident #33's Individual Narcotic Record revealed a late entry on 6/30/26 at 1:11 PM documenting Staff D, Registered Nurse (RN) administered 1 capsule of Pregabalin. On 7/7/26 at 12:49 PM Staff C, RN reported witnessing Staff E, RN sign another nurse's name, Staff D, on Resident #33's individual narcotic record to correct the count for the Pregabalin medication a few days prior. Staff C reported notifying the Director of Nursing (DON), who promised to handle the situation. Staff C didn't know what steps the facility took to address the matter. Staff C reported saying nothing directly to Staff E to avoid an argument. Staff C stated the forgery bothered her. Staff C felt the facility dismissed the concern and didn't feel Staff E should continue working at the facility. Staff C questioned what other records Staff E signed out. Staff C didn't know the facility policy on forging. On 7/7/26 at 6:51 PM Staff E acknowledged signing Staff D's signature on Resident #33's individual narcotic record. Staff E stated the MAR documented the Pregabalin dose as given. Staff E reported checking with Staff D before leaving the shift, and Staff D confirmed administering the medication and instructed her to log it on the narcotic record. Staff E stated the DON provided verbal counseling and warned further actions would result in a written warning and increased supervision. On 7/8/26 at 10:30 AM Staff D verified the signature on Resident #33's Individual Narcotic Record for the Pregabalin medication on 6/30/26 at 1:11 PM didn't match her handwriting. Staff D stated she administered the medication to Resident #33. Staff D didn't recall any issues with the narcotic count that day. Staff D reported she didn't give consent or instruct Staff E to log the medication. Staff D stated she'd never ask another nurse to document for her. The Disciplinary Action Form dated 7/1/26 documented a written warning for Staff E. The form revealed Staff E noted an unsigned narcotic medication, verified its administration on the MAR by a previous nurse, and logged it out for that nurse. The DON signed the form on 7/1/26, and Staff E signed it on 7/8/26. On 7/8/26 at 3:41 PM the DON stated she expected staff to notify her regarding any narcotic count discrepancies. The DON reported Staff E should've notified her when the medication lacked recording on the narcotic log. The Charting and Documentation policy revised July 2017 directed documentation in the medical record to be objective, complete, and accurate. Resident #4's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of diabetes mellitus (high blood sugar), heart failure (poor heart pumping), and peripheral vascular disease (poor blood flow). The MDS documented Resident #4 had a stage three pressure ulcer (deep skin sore) and received treatments. The Care Plan with a target date of 9/23/26 documented Resident #4 had a history of diabetic foot ulcers (foot sores) and wounds to his buttocks. The Care Plan directed staff to complete treatments as ordered. Review of the May 2026 Treatment Administration Record (TAR) revealed missing documentation for the following treatment orders: Betadine (antiseptic medicine) and offloading bandage (pressure-relieving (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Stratford Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 Highway 175 East Stratford, IA 50249	
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wrap) to left foot daily - 4 timesDiabetic foot checks daily - 5 timesResident #4 to wear post-op (after surgery) shoe to left foot until obtaining diabetic shoes - 4 timesApply Triad cream (skin barrier ointment) to wound on right buttocks three times a day and as needed until healed - 10 times Review of the June 2026 TAR revealed missing documentation for the following treatment orders:Betadine and offloading bandage to left foot daily - 7 timesDiabetic foot checks daily - 6 timesResident #4 to wear post-op shoe to left foot until obtaining diabetic shoes - 6 timesApply Triad cream to wound on right buttocks three times a day and as needed until healed - 10 times On 7/8/26 at 2:00 PM the DON reported nurses didn't click over to the TAR from the MAR to complete documentation based on similar experiences at a previous facility. The DON stated Resident #4 had a history of occasionally refusing treatments but expected staff to document refusals in the electronic medical record (EMR). On 7/8/26 at 11:35 AM the DON acknowledged the missing documentation on Resident #4's TARs. The DON stated she expected staff to complete and document treatments on the TAR or MAR.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews, and policy review, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 2 of 4 resident reviewed (Resident #33 and #18) during medication administration. The facility reported a census of 39 residents. Findings include: 1. Resident #33's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS included diagnoses of diabetes mellitus (high blood sugar). The July 2026 Medication Administration Record (MAR) directed staff to administer Lantus (long-acting insulin), inject 25 units subcutaneously (under the skin) every morning and at bedtime due to type two diabetes mellitus (high blood sugar). The MAR instructed staff to notify the physician if blood sugar fell below 60 or rose over 400. On 7/8/26 at 8:15 AM Staff D, Registered Nurse (RN), entered Resident #33's room to complete a blood sugar test. Staff D wore gloves and cleansed Resident #33's finger with an alcohol swab. Staff D poked Resident #33's finger with an Assure lancet and then threw the lancet into the garbage can. Staff D stated that another nurse told her she could throw the lancets into the garbage can because they're single-use devices. On 7/8/26 at 8:22 AM Staff G, Licensed Practical Nurse (LPN), put on gloves without performing hand hygiene and prepared Resident #33's Lantus insulin at the medication cart, touching multiple surfaces. After preparing the insulin, Staff G entered Resident #33's room wearing the same pair of gloves and administered the insulin into Resident #33's abdomen. Review of the Assure Lance Safety Lancets box instructions directed staff to dispose of used lancets in approved sharps containers in accordance with state or local biohazard regulations. On 7/8/26 at 8:35 AM Staff D acknowledged the directions on the lancet box. Staff D stated that another nurse told her that staff could throw lancets in the garbage can to avoid using up space in the sharp containers. Staff D stated she'd start reading the boxes. On 7/8/26 at 9:00 AM the Director of Nursing (DON) reported she expected staff to discard lancets in a sharp's container. The DON walked to Resident #33's room and removed the lancet from the garbage can. Additionally, the DON stated she expected staff to perform hand hygiene when putting on, removing, or changing gloves. 2. Resident #18's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of diabetes mellitus (high blood sugar) and anemia (low red blood cells). On 7/8/26 at 8:40 AM Staff G put on gloves to prepare Resident #18's morning medications and eye drops. During the preparation, Staff G touched multiple surfaces on the medication cart, including the computer, medication cards, eye drop box, and pill cup. After preparing the medication, Staff G entered Resident #18's room and administered the medication and eye drops while wearing the same gloves. Staff G then exited the room, removed the gloves, and performed no hand hygiene. Staff G pushed the medication cart down the hallway to another resident's room and documented the medication administration on the computer. The Handwashing/Hand Hygiene policy dated August 2019 directed staff to perform hand hygiene as the primary means to prevent the spread of infection. The policy instructed staff to perform hand hygiene before applying non-sterile gloves and after removing gloves. Additionally, the policy specified that glove use doesn't replace handwashing or hand hygiene. The policy identified the integration of glove use with routine hand hygiene as the best practice for preventing healthcare-associated infections.		