

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165295	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/23/2026
NAME OF PROVIDER OR SUPPLIER  Montezuma Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE  316 Meadow Lane Drive Montezuma, IA 50171	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, clinical record review, policy review, and staff interview, the facility failed to maintain adequate kitchen sanitation for 2 of 2 observations of the kitchen. The facility reported a census of 31 residents. Findings: Observations on 4/21/2026 at 10:29 a.m. revealed the following concerns:a. Small plates and dishes placed face down in a cupboard covered with heavy crumbs.b. Cabinets on the left side and back wall of the kitchen sticky to the touch. The cabinets were partially covered with red and dark colored splatters and food debris.c. Styrofoam plates sat in a cupboard on a coating of heavy dust.d. Twelve large serving scoops sat in a layer of heavy crumbs and food debris in the 3rd drawer on the right of the entry door.e. Seven serving scoops sat in a layer of heavy crumbs and food debris in the 4th drawer on the right of the entry door.f. Multiple serving scoops sat in a layer of heavy crumbs in the 5th drawer on the right of the entry door.g. Fifteen plus slotted serving spoons sat in crumbs and red droplets in the 7th drawer on the right of the entry door. h. Eight serving ladles sat in a layer of crumbs in the bottom right drawer of the row of cabinets. i. Three muffin tins, 2 cookie sheets and other pans sat in a layer of crumbs and black debris in a cupboard below and to the right of the microwave. A small, dead, winged insect also sat on the floor of the cupboard near the cookie sheets.j. Various kitchen tools including a pizza cutter, egg slicer, and a basting brush sat in a layer of crumbs and what appeared to be a black human hair in a drawer to the right of the coffee maker. k. Multiple pitchers sat on bare wood in a cupboard below the coffee maker. The wood was stained black.On 4/22/2026 at 9:50 a.m., the drawers and cupboards remained unchanged from the previous observation.The facility policy Sanitation, revised October 2008, stated staff would maintain a clean and sanitary food service area. The policy directed staff to clean surfaces such as shelves frequently enough to prevent the accumulation of grime. On 4/23/26 at 9:20 a.m., the Dietary Manager (DM) stated she expected staff to wipe down drawers and cupboards. When asked if she thought that the staff had cleaned the cupboards and drawers recently, she stated she guessed not. She stated they were supposed to do this daily.</p>		

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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on clinical record review, policy review, and staff and resident interviews, the facility failed to update the care plan to reflect a resident's exit seeking behavior for 1 of 12 residents reviewed for care plans (Resident #6). The facility reported a census of 31 residents. Findings included: The Minimum Data Set (MDS) assessment tool, dated 12/19/25, listed diagnoses for Resident #6 which included non-Alzheimer's dementia, bipolar disorder, and depression. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 11 out of 15, indicating moderately impaired cognition. The facility policy Care Plans, Comprehensive Person-Centered, revised December 2016, stated the care plan would incorporate risk factors associated with identified problems. An 8/8/25 Encounter Note stated the resident expressed a strong desire to leave the care facility. A 2/17/26 Nurses Note stated the resident reported to a family member that she tried to remove the window in her room so she could get out. Inspection of the window revealed the resident removed a screw from the window track in order to open the window fully. A 3/2/26 Encounter Note stated the resident's family reported her cognition was worsening. The resident recently removed screws from the screen in her room because she wanted to try to climb out her window. On 4/20/26 at 12:56 p.m., the resident stated that she wanted to be released from the facility. She stated she wanted to leave and maybe she would just go out the window. As of 4/21/26, the resident's Care Plan did not include information regarding the resident's desire to leave the facility nor her history of removing a part of the window. On 4/21/26 at 3:28 p.m., the Maintenance Director stated he received a report that Resident #6 attempted to take a screw out of the window. He stated he replaced the screw with a torx screw (a screw that offered superior durability and required a specialized tool to remove). The Maintenance Director then pointed out the screw that he installed in the resident's room. The resident was present at the time and stated don't take that screw out, I got in trouble for taking it out. On 4/22/26 at 10:10 a.m., the Director of Nursing (DON) stated the resident did not make an attempt to leave but had told multiple staff members she would like to leave. She stated the resident removed the screw to her window but the screen was intact. She stated she was surprised this information was not on the care plan but she would have staff add this.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, clinical record review, staff interviews and policy review, the facility staff failed to administer oxygen in accordance with physician orders for 1 of 2 residents reviewed (Resident #5). The facility reported a census of 31 residents. The Minimum Data Set (MDS) dated [DATE] for Resident #5 revealed a diagnosis of an irregular heart beat and identified the use of continuous oxygen therapy. Resident #5 had a Brief Interview for Mental Status score of 15 out of 15, which indicated intact cognition. During an observation on 4/20/2026 at 2:18 pm, Resident #5 was in her recliner with oxygen (O2) tube in her nose, the oxygen concentrator was set on 1-liter, and she took deep breaths while relaxing in her recliner. During an observation on 4/21/2026 at 9:05 am, Resident #5 sat in the dining room for breakfast and the portable oxygen tank level indicator not to be in red area, which indicated the tank had an inadequate to no supply of oxygen. Resident #5 was unaware that the O2 tank was not administering oxygen. On 4/21/26 at 9:26 am, the Director of Nursing (DON) notified by the State Agency that Resident #5 did not appear to be receiving oxygen per the portable oxygen tank. The DON assessed Resident #5's oxygen saturation at 91%. The Administrator checked the portable oxygen tank and stated it looked pressurized. Staff C, Certified Medication Aide (CMA) responded with an O2 Key used to open the portable oxygen tank to the valve to deliver oxygen through the valve and meter. Staff C placed the key on top of the O2 tank and turned it and the O2 pressure released O2 around the connection to the valve that caused a high hiss sound and quickly turned it closed. The DON educated Staff C that the valve seal was not lined up with the tank correctly and demonstrated how to connect it properly. When it was connected correctly, then the DON turned the key, the valve dial moved into the green and O2 was being delivered through the meter and tubing cannula to Resident #5's nose. The DON stated she will provide education for the nursing staff. During an interview on 4/21/26 at 9:35 am, Staff C, Certified Nursing Assistant (CNA) stated she put Resident #5's portable O2 on, turned it on to 1 Liter and she felt that it was working. Staff C stated the nurse regulated the oxygen. During an interview on 4/21/2026 at 12:24 pm, Staff A, Registered Nurse (RN) stated the CNA's had not brought any residents who used portable O2 to her. When asked who adjusted oxygen, Staff A stated the nurses regulate and administer O2. The Policy titled Oxygen Administration provided guidelines for the procedure to deliver safe oxygen to the resident, adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on observation, clinical record review, resident and staff interviews, the facility staff failed to hold the anticoagulant (blood thinning) medication as ordered by the surgeon that resulted in the delay of a scheduled surgery for 1 of 1 resident's reviewed (Resident #31). The facility reported a census of 31 residents. The Minimum Data Set (MDS) for Resident #31 revealed a diagnosis of atrial fibrillation (a dysrhythmia of the heart) and received an anticoagulant. The Physician Orders for Resident #31 revealed an order for Apixaban (Eliquis) 5 milligram (mg) twice a day, Obtain X-ray of right knee and a referral to orthopedic doctor for a follow up on right knee pain and swelling. The X-ray results dated 3/30/26 for Resident #31 revealed a dislocation of the knee joint and a bone fragment concerning for a fracture. A document titled Orthopedic Surgeons dated 4/3/26 for Resident #31 revealed the following: a. A surgical intervention would be necessary for the right dislocated knee. b. The blood thinner must be stopped five days before surgery or the patient can't have anesthesia. c. The surgery scheduled date was 4/22/26. The Medication Administration Record (MAR) for Resident #31 revealed: a. Apixaban 5mg (blood thinner) 1 tablet two times a day initiated on 3/21/26, with a hold date 4/19/26 to 4/21/26. b. Apixaban administered twice a day every day and on the morning of 4/19/26. A review of Progress Notes in the electronic health record revealed: a. On 4/3/26, Resident #31 had an appointment with the Orthopedic (bone) doctor. A surgery date was scheduled for 4/22/26. Resident #31 to be evaluated by the Cardiologist (heart doctor) on 4/14/26 prior to surgery. b. On 4/14/26, the Pharmacist requested to place a note on Resident #31's medication to hold the blood thinner for 3 days prior to surgery date on 4/22/26. c. On 4/21/26 at 2:44 pm, Staff A, Registered Nurse (RN) documented the night shift nurse Staff B, Licensed Practical Nurse (LPN) gave 6 am report that Resident #31 was to have surgery for knee on 4/21/26. Resident #31 was administered the morning dose of her blood thinner on 4/20/26 and the evening dose from 4/19/26 was not in the medication card. Resident #31 was to have the blood thinner held for 3 days prior to surgery on 4/22/26. Staff A notified the surgical team. d. On 4/21/26 at 3:02 pm Staff A, RN received an order to reschedule Resident #31's right knee surgery for April 27th and to hold the blood thinner after the evening dose on 4/23/26. The Director of Nursing (DON) notified the daughter. During an interview on 4/22/26 at 1:12 pm, the Medical Director stated he was not aware Resident #31's surgery was delayed but was not aware of the reason. The Medical Director stated he did not feel that due to holding the blood thinner, then restart and hold again would increase Resident #31's risk for an adverse outcome in the surgical area. During an interview on 4/22/26 at 1:50 pm, Staff C, Certified Medication Aide (CMA) stated she was aware that Resident #31 was to have a surgery to her right knee as she was applying an ordered wash to her leg. Staff C stated she was not aware that the blood thinner was to be held and the MAR on the computer would have lite up red if it was held or cancelled and it was yellow on 4/19/26. Staff C stated the medication card was in the medication cart without a note but today it had an H on it and she had to clarify with the nurse on duty if it was to be administered. Staff C stated she was informed the surgical date was changed but was unaware of the reason. During an interview on 4/22/26 at 2 pm, Staff D, RN stated she had received the order to hold Resident #31's blood thinner on 4/15/26 and place the order into the computer which should have turned red on 4/19/26 to 4/22/26. Staff D stated the DON made her aware of the medication error on 4/21/26 and notified the surgical team. Staff D stated the procedure was for the nurse to immediately notify the DON if they discover a medication error, even over the night shift and notify the provider on call. Staff D stated that did not occur. Staff D stated the surgery for Resident #31 was postponed until 4/27/26 due to the error. During an interview on 4/23/2026 at 8:04 am, The DON stated a medication error occurred for Resident #31 on 4/19/26 as her blood thinner was on hold on 4/19/26 to 4/22/26 due to the scheduled surgery for her right knee. The DON stated she was made aware of the medication error on 4/21/26 in the afternoon and immediately contacted the surgical team to notify the surgeon who rescheduled the surgery. The DON stated Staff A, RN reported that the night nurse Staff B, LPN discovered the error on 4/20/26. (continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON stated her expectation was that the nurses remove a medication from the medication cart if it was on hold and if an error was found, to report it immediately. The DON stated there was a scheduled care plan conference today, 4/23/26, that the resident and family would attend. They would be notified of the medication error.</p>		