STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165305	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chariton Specialty Care	1214 North Seventh Street Chariton, IA 50049

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 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 observations, clinical record review, provider interview and staff interviews, the facility failed to follow physician orders while administering medications through a feeding tube for 1 of 1 residents reviewed for tube feeding (Resident #38). The facility reported a census of 33 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #38 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS indicated medical diagnosis of traumatic subdural hemorrhage with loss of consciousness of unspecified duration. The MDS revealed the resident utilized a feeding tube.The Care Plan revealed a focus area dated 7/15/25 for tube feeding osmolyte 1.2 calorie. The Electronic Medical Record (EMR) revealed the following Physician Orders: Enteral Feed- dated 9/22/25- three times a day Flush feeding tube with at 60 ML of water before and after administration of medicationsThe January Medication Administration Record (MAR) revealed hydralazine 25 mg given on 1/12/26 at mid morning and qualified oral liquid 20 ml given on 1/12/26 at midmorning. The Orders Administration Note revealed the qualified oral liquid give 20 ml via PEG (percutaneous endoscopic gastrostomy) tube three times a day for congestion x 14 days. Called [name redacted] to verify Tussin of 20 ml is correct dosage. During an observation on 1/12/26 at 1:06 PM, Staff E, Licensed Practical Nurse (LPN) mixed a crushed hydralazine (blood pressure medication) with warm water and liquid Tussin (cough suppressant). During an observation on 1/12/26 at 1:11 PM, Staff E shut off the continuous feeding tube, flushed the feeding tube with 30 milliliters (ml) of warm and then administered the mixed medications into the feeding tube. Staff E then again flushed the feeding tube with 30 ml of water before turning the continuous feeding tube back on. During an interview on 1/13/26 at 3:31 PM, Staff E queried on the order to flush with 60 ml before and after medication administration and Staff E confirmed the order indicated 60 ml before and after medication administration. Staff E asked if she needed an order to be able to mix Resident #38 medications prior to giving them through the feeding tube and Staff E stated she would have to look at Resident #38 orders. During an interview on 1/14/26 at 8:21 AM, the Nurse Practitioner (NP) confirmed the order revealed to flush with 60 ml of water before medication administration and then 60 ml of water after medication administration. The NP stated the facility needed an order to slurry Resident #38 medications together so they could give the medications all at the same time. During an interview on 1/13/26 at 3:49 PM, Staff E stated the facility was going to get an order for a crushed cocktail for Resident #38. During an interview on 1/14/25 at 1:18 PM, the Director of Nursing (DON) queried on Resident #38 order for flushing with 60 ml of water before and after medication administration and the DON stated the nurse was new and read the order wrong and thought it was 60 ml total. The DON stated that was not an excuse, but her assumption. The DON stated she expected the orders to be read thoroughly and carried out efficiently and orders were written for a reason. The DON stated the facility received an order for a crushed cocktail, but the pharmacy did review Resident #38 medications and after today, the facility will not do crushed cocktail with Resident #38 because he has too many medication changes. The Facility Enteral Tube Feeding via Continuous Pump dated November 2018 did not address flushing the feeding tube before or after medication administration or mixing medications prior to administration into a feeding tube.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165305	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chariton Specialty Care	1214 North Seventh Street Chariton, IA 50049

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on clinical record review, observations, facility policy review, resident and staff interviews, the facility failed to ensure staff provided therapy prescribed restorative nursing services to maintain a resident's ability to walk and transfer for 1 of 1 sampled residents (Resident #20). The facility reported a census of 33.Findings include:Review of the Minimum Data Set (MDS) assessment for Resident #20, dated 10/30/25, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which was indicative of a mild cognitive impairment. The MDS assessment revealed the resident utilized a walker and wheelchair for mobility, required substantial/maximum assistance for transfers and had not attempted to walk during the assessment period. Resident #20 had diagnoses of stroke, abnormalities of gait and mobility, muscle weakness, lack of coordination, and a history of falls. Review of the Care Plan for Resident #20, last revised 12/29/25, revealed the resident required assistance with Activities of Daily Living (ADLs) including an intervention for the assistance of one staff with transfers, dated 3/15/24, and the assistance of two staff with ambulation (walking) 20 to 30 feet with a FWW (front wheeled walker) and wheelchair to follow to meals, dated 10/31/25.Review of Physical Therapy (PT) Evaluation and Plan of Treatment notes, dated 8/28/25 through 11/18/25, revealed Resident #20 received PT services to, in part, safely ambulate 20 feet using two-wheeled walker on level surfaces with Partial/Moderate Assistance in order to prepare for walk to dine for meals and safely perform functional transfers with Partial/Moderate Assistance for safe maneuvering in small spaces in the presence of high sensory demand situations in order to decrease level of assistance from caregivers. The notes identified the resident discharged from PT services on 11/18/25 due to meeting all therapy goals, and in part, included, Pts (patient's) primary mobility is in WC (wheelchair) and is safe and indep (independent). Pt (patient) needs 1 assist for safe transfers and short distance walks with FWW. The physical therapist recommended the following: Dc (discharge) with RNP (restorative nursing program) in place; Restorative Ambulation Program, Restorative Range of Motion Program. The physical therapist documented, in part, Ambulation Program Established / Trained: walk to dine. Range of Motion Program Established / Trained: Omnicycle (type of leg exercise machine) and standing with Ad. The physical therapist documented, in part, Prognosis to Maintain CLOF (Current level of functioning) = Excellent.A progress note for Resident #20, titled Nursing/Therapy Communication, dated 11/4/25, revealed the patient was to amb (ambulate) 20 to 30 feet with FWW and wheelchair to follow to meals. Assist x 2 (assist of two staff).A progress note for Resident #20, titled Nurses Note, dated 11/18/25, revealed the following note: Communication received from therapy for New Restorative Program. pt (patient) to complete 3-5x/week (3 to 5 times per week) or as tolerated: STS (sit to stand) from w/c (wheelchair) to FWW (front wheeled walker) x 5 (5 times) with use of UEs (upper extremities). Omnicycle L4 10-15 mins (minutes) (;) standing: heel raises, hip abd (abductions), marching, x 10-15 reps, continue with walk to dine program. Care plan updated and resident aware.On 1/11/26 at 11:18 AM, during an interview in Resident #20's room, Resident #20 reported staff were supposed to help him walk to the dining room for meals. The resident reported staff had not helped him walk since before Thanksgiving. He reported having to go to the dining room in his wheelchair. The resident reported staff was not doing any leg exercises with him and he had not used the Omnicycle since working with therapy. The resident was unsure if he had a recent decline in his ability to walk. An observation, during the same interview with Resident #20 revealed a sign posted on the wall by the resident's room door that read to walk with resident to each meal. On 1/11/26 at 11:45 AM, observation revealed Staff F, Certified Nurses Aide (CNA), enter Resident #20's room, close the door, and then exited the room at 11:49 AM. Resident #20 exited his room and self propelled his wheelchair to the dining room for lunch.On 1/12/26, review of the clinical record for Resident #20 revealed a lack of documentation regarding the task completion of the restorative program by facility nursing staff. The clinical record lacked documentation of the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165305	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chariton Specialty Care	1214 North Seventh Street Chariton, IA 50049

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's inability to walk to dine and the need for the assistance of two staff with transfers. The clinical record lacked documentation staff had performed restorative exercises including the Omnicycle, sit to stand exercises, heel raises, hip abductions and marching exercises. On 1/13/26 at 8:03 AM, observation revealed Resident #20 to be self-propelling his wheelchair down the hall towards the dining room. Resident #20 stopped his wheelchair by the nurses station. At 8:05 AM, Staff C, Licensed Practical Nurse (LPN), asked the resident if he wanted a boost. Staff C then helped to wheel resident around nurses station toward dining room. The Laundry/Housekeeping Supervisor assisted the resident with donning a clothing protector, and Resident #20 continued to propel himself to a table in the dining room for breakfast. On 1/13/26 at 9:06 AM, observation revealed Resident #20 self propelled his wheelchair from the dining room to his room independently. On 1/13/26 at 9:45 AM, during an interview with Staff A, CNA, and Staff B, CNA, Staff A thought nursing staff had discontinued Resident #20's walk to dine due to unsteadiness. Both Staff A and Staff B reported it was now taking two staff to assist the resident with transfers.On 1/13/26 at 9:55 AM, during an interview, the Director of Rehabilitation reported she had worked with Resident #20 on transfers and walking the last time he had received PT services, dated 8/28/25 to 11/18/25. She reported at the completion of therapy, therapy determined the resident was appropriate for walk to dine and recommended that the resident ambulate 20 to 30 feet with a FWW, w/c to follow. The Director of Rehabilitation explained therapy staff had been walking with the resident and he was doing wonderful. She reported she had not seen the resident since he completed therapy and no one had reported to her that he was struggling with transfers and not able to do the walk to dine restorative program. On 1/13/26 at 10:06 AM, during an interview, Staff C, LPN, reported Resident #20 was in the walk to dine restorative program, but the resident was not standing the best, so staff was not doing the walk to dine with him. Staff C, LPN, reported she had spoken with the Director of Rehabilitation this morning (1/13/26) and told therapy that the resident was not walking, because he was unsteady with transfers. Staff C, LPN, reviewed the resident's electronic health record (EHR), and reported the record lacked documentation of staff walking with the resident in December 2025 and January 2026.On 1/13/26 at 10:13 AM, during an interview, the Director of Nursing (DON) explained the Kardex (CNA assignment of tasks) for Resident #20 included an intervention for the CNAs to do walk to dine. The DON reported the walk to dine restorative program was on the resident's care plan, as well. The DON reported that for some reason the tasks related to restorative were not triggering under the assigned tasks for the CNAs to document on. The DON confirmed staff had not documented the walk to dine restorative program November 2025 through present date. A Visual/Bedside Kardex Report for Resident #20, dated 1/13/26, revealed the following, in part, for restorative: a. Omnicycle L4 10-15 mins (minutes).b. standing: heel raises, hip abd (abduction), marching, x 10-15 reps, STS (sit to stand) from w/c (wheelchair) to FWW (front wheeled walker) x 5 with use of UEs (upper extremities).c. Walk to Dine: Ambulate 20-30' (feet) with FWW and wheelchair to follow to meals. Assist x 2.On 1/13/26 at 12:06 PM, during an interview, with Staff A, CNA, and Staff B, CNA, both staff reported they were unsure of the last time they had walked with Resident #20. Staff B reported the resident had required the assistance of two staff for transfers intermittently for the last couple weeks. Staff B reported Resident #20 had refused to walk with her frequently. Staff B was unsure if she was documenting the resident's refusals. Staff A reported the resident had been sick with a bad respiratory infection three to four weeks ago, and she had not walked with him since then. Staff A reported the walk to dine restorative program was not in the computer for the CNAs to document on it. Both Staff A and Staff B reported they were responsible for completing the restorative program with residents.Review of a progress note, titled Encounter Note, dated 11/11/25, revealed a note completed by Resident #20's healthcare practitioner which identified the resident had been diagnoses with pneumonia (the respiratory infection occurred prior to the resident's successful completion of physical therapy on 11/18/25).On 1/13/26 at 12:12 PM, observation revealed the DON and Staff D, CNA, both assisted Resident #20 to stand from his wheelchair to a FWW. Staff A, CNA, stood behind the resident's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165305	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chariton Specialty Care	1214 North Seventh Street Chariton, IA 50049

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair. The resident's were legs shaky per the DON. The DON and Staff D assisted the resident to sit. Staff D then moved the resident's catheter from the wheelchair to the walker. The DON and Staff A assisted the resident to stand to the walker while Staff D followed with the wheelchair. The resident walked approximately 10 feet before having to sit down. The resident reported being too tired and weak to walk further. On 1/13/26 at 12:17 PM, during an interview, Staff A, CNA, reported she had been doing range of motion with Resident #20; she denied performing any other restorative exercises. On 1/13/26 at 12:18 PM, the Regional Director of Clinical Services reported the DON was responsible to ensure staff completed restorative exercises with the residents. The Regional Director reported there was no documentation that staff completed restorative exercises with Resident #20 and the exercises were not getting done. Review of the facility policy, titled Restorative Nursing Services, dated 7/2017, revealed, in part, restorative goals and objectives were individualized and resident-centered, and were outlined in the resident's plan of care.