STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165323	A. Building B. Wing	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Correctionville Specialty Care	1116 East Highway 20 Correctionville, IA 51016

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, and policy review the facility failed to provide food at an appetizing temperature to 3 of 5 residents (Residents #3, #9, and #12) reviewed. The facility reported a census of 35 residents.Findings include: 1. Review of Resident #9's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. Interview 12/29/2025 at 10:56 AM with Resident #9 revealed that the food is not always hot when it is delivered on the meal tray. 2. Review of Resident #12's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. Interview 12/29/2025 at 1:00 PM with Resident #12 revealed that food is absolute garbage at the facility, and is always cold. Continuous observation 12/30/25 from 11:19 AM until 12:14 PM dining service was completed in the dining room. Pre-temp meal temperature on the food items in the steam table revealed gravy was 161 degrees, mashed potatoes were 170.9 degrees, spinach with mushrooms were 164.4 degrees, and the chicken dijon was 152 degrees. During observations on 12/30/25 at 12:15 PM the first of the 10 room trays were prepared and placed on the meal cart for room service. These trays were then sent from the kitchen to the rooms at 12:23 PM. A sample tray was obtained at 12:28 PM with a temperature check completed revealing chicken was 131.7 degrees, and the mashed potatoes were 139 degrees. Interview 12/30/2025 at 12:36 PM with the Certified Dietary Manager (CDM) revealed that she would expect temps of food to be appropriate at the time of service. The CDM then confirmed the temp of the chicken from the room tray was low. 3. The Quarterly MDS dated [DATE] for Resident #3 revealed a BIMS score of 15/15 indicating normal cognitive impairment. The MDS included diagnoses of neurogenic bladder, paraplegia and post polio syndrome. The document revealed the resident was independent with eating and had gained weight during the past reporting period due to a physician prescribed weight gaining program The resident's Care Plan updated 12/18/25 identified an activities of daily living (ADL) focus dated 11/3/24 and the intervention for eating was independent. A focus related to nutrition identified the resident consumed a regular diet/regular texture and thin liquid consistency revised 12/16/24 with interventions of providing diet within her consistencies, meal preferences and reviewing/monitoring (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	her diet. On 12/29/25 at 1:27 PM Resident #3 stated the hot food was served cold. The resident stated she frequently receives room trays and the food will be cold or not be what she ordered. The facility's Food Preparation and Service Policy, revised 4/19, revealed the danger zone for rapid growth of pathogenic microorganisms that cause foodborne illness was 41 degrees and 135 degrees Fahrenheit (F). The document further indicated those food items included meats, poultry, seafood, milk, yogurt and cottage cheese. The document included those items must be maintained below 41 degrees and above 135 degrees F.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical document review, staff interview, and policy review the facility failed to provide a comprehensive care plan related to oxygen use for 1 of 5 residents (Resident #9) reviewed. The facility reported a census of 35 residents.Findings include: Review of Resident #9's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS further revealed diagnoses of hypertension (high blood pressure), renal insufficiency, and anxiety disorder. Review of a facility provided document titled, Order Summary Report with a date of 12/17/25 revealed a physician's order with a start date of 11/13/25 for oxygen continuously at 2 liters to keep oxygen saturation above 90% every shift for shortness of breath, and hypoxemia (a medical condition with abnormally low oxygen levels in the blood). Review of Resident #9's Care Plan with a revision date of 11/13/25 revealed no focus, goals, or interventions for oxygen utilization.Interview 12/30/25 at 10:18 AM with the Director of Nursing (DON) revealed that her expectation would be for oxygen use to be involved on the care plan. Review of a facility provided policy titled, Care Plans, Comprehensive Person-Centered with a revision date of 12/2016 revealed:a. The comprehensive, person-centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide thorough and timely assessment and intervention for 1 of 16 residents reviewed. Resident #24 was diagnosed with Covid-19 and was admitted to the hospital with pneumonia. The resident returned to the facility on 11/25 and the staff failed to assess the resident's Vital Signs (VS; heart rate, oxygen saturation, blood pressure and respirations) until 12/4/25 when she was found to have a change in condition, including low blood pressures. The resident was sent back to the hospital on [DATE]. The facility reported a census of 35 residents. Findings include:According to the Minimum Data Set (MDS), Resident #24 was admitted to the facility on [DATE]. She had a Brief Interview for Mental Status (BIMS) score of 14 (intact cognitive ability.) Resident #24 required substantial assistance with sit to stand transfers, and was totally dependent on staff for dressing, toileting and showering. The resident was on oxygen therapy as needed. Her diagnoses included: anemia, coronary artery disease, heart failure, pneumonia, diabetes mellitus and chronic respiratory failure. The Care Plan for Resident #24, updated on 11/13/25, showed that she had oxygen therapy related to respiratory illness and hypertension (high blood pressure.) Staff were to monitor for unsteady gait. The Census tab in the electronic chart, showed that Resident #24 went to the hospital on [DATE] and returned on 11/25/25. She was sent back in the hospital on [DATE].The following was found in the Nursing Progress Notes:a. On 11/20/25 at 11:50 AM. Resident #24 tested positive for Covid-19 on 11/12/25, had increased confusion and several falls with an intervention to increased monitoring. A chest x-ray showed that she was positive for pneumonia and placed on antibiotic. b. On 11/20/25 at 1:06 PM, Resident #24 was having difficulty with breathing and was using supplemental oxygen at 2 liters (L). The oxygen saturations (O2 sats) came up to 92% but dropped to 66% without supplemental oxygen (normal oxygen levels are between 95%-100%, drops below 80%-85% may affect brain function.) The resident's Blood Pressure (BP) reading was 70/48 (American Heart Association describes hypotension, or low blood pressure, as less than 90/60.) The Nurse Practitioner (NP) was called Resident #24 was sent to the hospital. c. On 11/25/25, the NP Encounter note included vital signs; Heart Rate (HR) 100 beats per minute, BP; 126/82, and oxygen level; 94% on room air. Resident #24 was admitted to the hospital on [DATE] with diagnoses of respiratory failure with hypoxia, and she returned back to the facility on [DATE]. The plan included continued supplemental oxygen at 2 L to keep sats greater than 90%. Encourage the resident to cough and take deep breaths, monitor heart rate and rhythm.d. On 12/1/25, NP Encounter note showed the HR, BP, O2 sats and respirations were the same as documented on 11/25/25. The plan included continued monitoring of heart rate and rhythm, O2 to keep sats greater than 90%. e. On 12/3/25 at 3:05 PM, nursing received orders to check vital signs daily for 7 days and notify provider if BP was less than 90 systolic (upper number) or great than 160 systolic. The clinical records lacked vital signs for Resident #24 from 11/26/25 through 12/3/25.A written Physician Order Form, dated 12/1/25, showed that the NP wrote an order to take daily BP readings. The order was signed by the NP on 12/1/25, and it was noted by nursing on 12/2/25. A Nursing Note (NN) dated 12/4/25 at 2:56 PM, showed that the nurse had checked the BP for Resident #24 multiple times, but each pressure continued to drop. The resident was weak with increased confusion, the NP was called and the resident was sent to the emergency room. An Emergency Department (ED) report dated 12/4/25 at 3:44 PM, showed that Resident #24 presented to the ED for hypotension as low as 76/46. The resident had a history of hypertension, septic shock, and atrial fibrillation. The physician documented that the hypotension was secondary to her hypertension medication. The resident was admitted to the hospital for monitoring. On 12/30/2025 at 1:57 PM, Staff D, Assistant Director of Nursing (ADON) said that Resident #24 had a significant change in condition when she had Covid. She was moving around less and had low oxygen saturations. She thought the nurses were monitoring her more closely during that time. On 12/30/25 at 3:30 PM, the Administrator said that Resident #24 had (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been very sick with Covid, she was unsteady and had a couple of falls. She agreed that on-going vital signs would have been important during that time. On 12/30/25 at 2:26 PM, Staff E, NP, said that she had noticed that there weren't any vitals in the chart from 11/25 - 12/4. When she came in to see the resident on 12/1/25, she had asked the nurses where the vitals were, they responded that they thought they were getting done and it was just a case of them not getting them documented. According to the facility policy titled: Resident Examination and Assessment, dated February 2014, the purpose of the procedure was to examine and assess resident for any abnormalities in health status. Documentation of information that should be recorded in the resident medical record: all assessment data obtained during procedure, and how the resident tolerated the procedure.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, staff interview, and policy review the facility failed to provide a professional standard of quality of care by not completing catheter cares for 1 of 2 residents reviewed (Resident #3). The facility reported a census of 33 residents. Findings include:Review of Resident #3's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating normal cognition. The document provided resident diagnoses of Post polio syndrome, neuromuscular dysfunction of bladder and Raynaud's Syndrome. The document disclosed the resident had an indwelling catheter and ostomy.Resident #3's Care Plan dated 12/18/25 revealed a focus of urinary catheter suprapubic 16fr with 10cc bulb initiated 12/16/24 and revised 6/9/25. Interventions dated 12/16/24 and 4/11/25 included monitoring kinks, encouraging fluids, enhanced barrier precautions (EBP) An additional focus area identified risk for urinary tract infection (UTI) related to suprapubic catheterization initiated 7/24/25 and revised 12/18/25. Interventions dated 7/25 included administration of antibiotics as ordered, EBP, education, fluids, monitor urine for color, clarity, odor and quality, signs and symptoms of UTI. A focus area disclosed a risk for potential UTI, chronic bladder infections initiated 7/22/25 and revised 7/31/25. Interventions included monitoring for signs/symptoms of UTIs revised 7/31/25.On 12/29/25 at 11:39 AM Resident #3 stated staff were supposed to empty her catheter every shift and it did not always happen. The resident stated staff do not consistently clean her catheter with alcohol swab after emptying or wear personal protective equipment (PPE). The resident stated she has had UTI's and bladder infections. Review of the Electronic Health Record (EHR) Clinical Physician Notes found Resident #3 had a history of UTIs and bladder infections. The EHR revealed the following:7/10/25 Resident was prescribed Cephalexin 1 tablet twice daily (BID) x 7 days, discontinued 7/15/25.7/24/25 Doxycycline Hyclate 100 mg x 10 days, 1 tablet by mouth two times a day for UTI for 10 Days per emergency room (ER) visit, end date 8/3/25.7/31/25 Cefpodoxime Proxetil 200 mg x10 days, give 1 tablet by mouth BID for cystitis, end date 7/31/25.8/1/25 Cefpodoxime Proxetil 200 mg x10 days, give 1 tablet by mouth BID for cystitis, end date 8/11/25. 10/15/25 report of low output, dark urine.The EHR Point of Care (POC) Response History for bowel and bladder, catheter care - cleanse with soap and water every shift; use alcohol swabs for past 29 days revealed 3 days of care provided twice in a single day:12/3/25 5:59 AM, 1:38 PM12/14/25 5:59 AM, 11:43 AM12/19/25 5:43 AM, 9:39 PMThe EHR POC Response History for monitoring of urine output revealed 3 days of care provided emptying of catheter twice in a single day. 12/3/25 5:59 AM 1100 cc, 1:39 PM 650 cc.The next documented emptying of the catheter on 12/4/25 at 5:55 AM output was 1800 cc.12/14/25 5:59 AM 675 cc, 8:35 AM 400 cc.The next documented emptying of the catheter on 12/15/25 at 5:59 AM output was 300 cc. 12/19/25 5:43 AM 550 cc, 9:40 PM 2200 cc.On the date of the document review, 12/30/25 at 12:40 PM it was noted that the emptying of the catheter had not been documented for the first shift. Observation of Resident #3's catheter bag at 2:30 PM revealed the catheter bag with 1500 cc of urine with sediment in the tubing. The Resident stated the first shift had not emptied her catheter bag. Observed Staff A, Certified Nurse Assistant (CNA), on 12/30/25 at 2:40 PM complete emptying of Resident #3's catheter. The staff utilized proper techniques and drained 1500 cc of urine from the resident's bag. The staff stated she was concerned the resident's catheter bag was leaking and was going to notify the nurse.Observed Staff B, Licensed Practical Nurse (LPN), on 12/30/25 at 2:48 PM assess Resident #3's catheter and determined there was no leakage. The staff did state the resident had sediment in the tubing and needed to monitor the catheter. On 12/30/25 at 2:01 PM the Director of Nursing (DON) stated catheter care and emptying should occur every shift and PRN. The DON stated documentation would be in the POC for catheter care and catheter emptying. The staff stated if the document(s) did not contain documentation for a specific shift, she could not state with certainty the task had been completed as required. On (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/30/25 at 2:10 PM the Administrator stated catheter bags should be emptied every shift and documented. On 12/30/25 at 2:33 PM when asked about shift exchange, the DON indicated a shift typically ended at 2:00 PM with an occasional CNA working past that time. When provided with a photo of Resident #3's catheter bag taken at 2:30 PM the DON stated the bag should not be that way and needed to be emptied. On 12/30/25 at 2:35 PM the Administrator when provided with the photo of Resident #3's catheter bag stated the drainage bag should have been emptied. On 12/31/25 at 7:55 AM the DON stated she had spoken with the staff responsible for Resident #3 on the previous date during the day shift; the staff had been working past 2:00 and had planned to empty the catheter. The DON acknowledged the catheter drainage bag was full and should have been emptied prior to that time. The DON concurred the resident had a history of UTI's and the bag being that full was concerning. On 12/31/25 at 8:00 AM the Administrator indicated understanding the concern of the catheter drainage bag having 1500 cc of urine. The Administrator stated staff should be checking throughout the day. On 12/31/25 at 8:20 AM Staff B stated catheters should be emptied at least once a shift and as needed. The staff stated if a catheter drainage bag appeared full it needed to be emptied.On 12/31/25 at 8:40 AM Staff C, CNA, stated catheters should be emptied at least once per shift and those residents who have frequent urination their catheters need to be emptied more frequently. The facility's Catheter Care, Urinary Policy, revised 9/14, revealed the resident's level of urine required monitoring of noticeable increases or decreases and physician notification if necessary. The document revealed the collection bag should be emptied at least every 8 hours.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, resident interviews, staff interviews, and policy review the facility failed to provide respiratory care and services in accordance with professional standards of practice for 1 of 4 residents reviewed (Residents #9) requiring the use of oxygen. The facility reported a census of 35 residents.Findings include: Review of Resident #9's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS further revealed diagnoses of hypertension (high blood pressure), renal insufficiency, and anxiety disorder. Observation on 12/29/2025 10:58 AM Resident #9 was observed to be utilizing oxygen via a concentrator at 2 liters by nasal cannula at that time. It was also observed that the oxygen tubing was not dated. Interview on 12/29/25 at 10:58 AM with Resident #9 revealed that Resident #9 was unsure as to when the staff last changed the oxygen tubing. Review of Resident #9's Electronic Healthcare Record (EHR) page titled, Clinical Physician Orders revealed an order for oxygen continuously at 2 liters to keep oxygen saturation above 90% every shift for shortness of breath, and hypoxemia (a medical condition with abnormally low oxygen levels in the blood) with a start date of 11/13/25. Further review revealed an order for oxygen tubing and nebulizer mask to be changed every Tuesday with a start date of 12/24/25. Interview 12/30/2025 10:18 AM with the Director of Nursing (DON) revealed that oxygen tubing should be dated when changed, and changed per the orders.Review of a facility provided policy titled, Oxygen Administration with a revision date of 10/2010 revealed:a. After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record. The date and time that the procedure was performed.