STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165326	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bloomfield Care Center	800 North Davis Street Bloomfield, IA 52537

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff and resident interviews, the facility failed to ensure nursing staff administered the right medications to the right resident for 1 of 3 (Resident #2) residents reviewed for significant medication error. The error caused Resident #2 to become unresponsive and required hospitalization. The facility reported a census of 40 residents.Findings include:The Minimum Data Set (MDS), dated [DATE], list of diagnoses for Resident #2 included heart failure, diabetes (a disease which caused abnormalities in blood sugar), and non-Alzheimer's dementia. The MDS listed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. A 2/10/26 11:53 a.m. Health Status Note documented the resident sat in her wheelchair at the table with her eyes closed and staff was unable to arouse her. The resident did not respond to the nurse. Staff C, Nurse Practitioner (NP) attempted to arouse her with no response and gave an order to send the resident to the ER (emergency room). A 2/10/26 12:20 p.m. Communication with Physician Note stated the resident received another resident's medication in error: amoxicillin (an antibiotic) 500-125 milligrams (mg), quetiapine (an antipsychotic) 400 mg, and levetiracetam (an anti-seizure medication) 750 mg. The facility reported the medication error to the hospital. A 2/11/26 11:39 a.m. Communication with the Outside Vendor Note stated the hospital called and reported the resident admitted around 9:30 a.m. and that she was more alert today and talked. The hospital stated they would keep her one more day to make sure her blood pressure was stable. A hospital History and Physical, dated 2/14/26, stated the resident presented to the ER due to becoming unresponsive at her care facility. In the ER, the resident was able to be aroused and awakened and follow commands but would then quickly drift back to sleep. Due to the resident being significantly sedated, the hospital decided to place her in observation for monitoring. The next morning the resident was still quite sleepy, sitting upright with her eyes closed and mouth open and sedated. The resident reported that she felt groggy. In the afternoon, the resident ate soup and because of her poor mental status, began coughing and sputtering and had some gurgling that followed that episode. The note stated over the last 3 days, she slowly improved but due to her inability to move due to the medication error her strength diminished to the point where she needed significant assistance to move around as she would at her facility. The decision was made to place the resident in the hospital's skilled nursing unit for continued strengthening and medication adjustments until they could get her to the point where she was prior to the recent incident. The note listed significant findings as encephalopathy (disease or damage to the brain)/sedation secondary to a medication error and low blood pressure, and low heart rate, presumably due to the medication error as well.A 2/26/26 admission Note stated the resident readmitted to the facility. During an interview on 6/10/26 at 2:00 p.m., Resident #2 stated she was in the dining room and became drowsy. The staff was saying her name and she could hear them. After that, for 2 days she didn't know anything. She stated her daughter was at her bedside the whole time but she didn't know she was there. Her daughter later said by the way she looked, she thought she was going to die. She stated she still didn't feel like she was back to baseline after the incident. She stated she still can't do things like she did prior to the incident and stated she cannot carry out therapy per normal.On 6/1/26 at 8:59 a.m., Staff D, Certified Nursing Assistant (CNA) stated (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 0760 Level of Harm - Actual harm Residents Affected - Few	at the time of the incident, the resident was in the dining room and had a hard time waking up. Staff D described her as druggy. She stated staff took her out of the dining room and to her room and subsequently the ambulance arrived. On 6/11/26 at 9:06 a.m. Staff B, Registered Nurse (RN) stated the resident was in the dining room and she had her eyes closed and this was not like her. She stated the resident wouldn't wake up so she rubbed her chest. The resident opened her eyes but closed them again. She stated Staff C was present and directed to call an ambulance. She stated later on, she found out the resident received the wrong medication from Staff A, Certified Medication Aide (CMA). On 6/11/26 at 10:46 a.m. via phone, Staff A, CMA stated on the day of the incident, she passed morning medications and everyone came at her so she was not focused. She stated at the time of the noon medication pass, she realized she gave the resident the wrong medications and went right to the Assistant Director of Nursing (ADON) and told her what happened. She stated during the medication pass, she received multiple questions and could not safely administer the medications while this happened. She stated that day was horrible. Residents were trying to get up and it was not safe for one person to complete all of the medications. She stated she did not refer to the MAR while she prepared the resident's medications but rather went by memory. Staff A stated she should have stopped and double checked. She stated after the incident, the facility disciplined her and observed all of her medication passes for a week. On 6/11/26 at 11:06 a.m., Staff C, NP stated on the day of the incident she saw the resident earlier and then an hour later she was unresponsive. Staff C stated she was afraid it was a stroke. She stated she then found out the CMA administered the wrong medication and said that two of the medications, levetiracetam and quetiapine were sedating. She stated the resident subsequently admitted to the hospital. On 6/11/26 at 12:05 p.m., the Director of Nursing (DON) stated that the resident had a change in status and they determined she received medications intended for another resident. She stated Staff A went through the medication cards without following the MAR. The DON stated staff could not do this from memory and had to follow along with the MAR in order to check the correct dose, order, and medication. The facility policy Medication Administration-Medication Pass, revised 5/2023, stated the purpose of the policy was to ensure safe and accurate preparation and administration of medications. The policy directed staff to compare the Medication Administration Record (MAR) with the medication label for accuracy.