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	11/20/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of kitchen dishwasher checklists, U.S. Food and Drug Administration Food Code 2017, and staff interviews the facility failed to monitor the dishwasher to ensure proper sanitization of resident dishes and utensils. The facility reported a census of 42. Findings include: During an observation on 11/17/25 at 10:55 AM, the dish washer noted to have a low temperature. Review of the Dishwasher Temperature/Sanitizer Checklist revealed the following: a. For the month of September 2025, 15/90 entries were made documenting the wash temperature, rinse temperature, and the sanitizer parts per million (PPM)b. For the month of October 2025, 13/93 entries were made documenting the wash temperature, rinse temperature, and the sanitizer PPMc. For the month of November 2025, 4/48 entries were made documenting the wash temperature, rinse temperature, and the sanitizer PPMDuring an interview on 11/17/25 at 11:00 AM, the Dietary Manager acknowledged the incomplete dish machine temperature logs. During an interview on 11/19/25 at 11:15 AM, Staff C, Dietary Aide, explained the dish machine sanitizer is tested three times per day, correlating with meal times. The ideal range is 50 ppm. This along with the dish machine temperatures are written in the log book. The Dishwasher Temperature/Sanitizer Checklist directed staff to record the temperature or test strip results prior to washing dishes for each meal. Wash and rinse water temperatures should both be 120 degrees or above. The chlorine sanitizer test strip should test at 50ppm or above. The U.S. FDA Food Code 2017 section 4-703.11 Hot Water and Chemical noted equipment food-contact surfaces and utensils shall be sanitized by the following: a. Chemical mechanical operations using a solution b. Contact time of at least seven seconds for a chlorine sanitizing solution with a minimum temperature of 120 degrees

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review and staff interviews, the facility failed to update and personalize resident Care Plans for 3 of 17 resident Care Plans reviewed (Resident #1, #21, and #30). The facility reported a census of 42.Findings include: 1.The Minimum Data Set (MDS) Assessment completed on 10/3/25 revealed Resident #1 with Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Diagnoses include anemia, cancer, muscle wasting, pain and rheumatoid arthritis. The MDS documented no pressure injuries a the time of the assessment and noted Resident #1 was a risk for the development of pressure injuries. Interventions listed on the MDS for skin treatment include pressure reducing device for chair and bed, turning/positioning program, nutrition/hydration interventions, and application of ointment/medications. The MDS documented Resident #1 with a significant weight loss. The Skin Evaluation Pressure Wound Assessment for Resident #1 completed on 11/2/25 identified a Stage II pressure injury to the right lower buttock. The EHR revealed the following Physician Orders for Resident #1: a. Apply 40% Zinc and xeroform secure with additional smaller comfort foam border line with soft silicone adhesive due to a right lower buttock Stage II pressure injury initiated 11/5/25.b. Mighty Shake two times per day for diet supplementation initiated on 11/6/25.The EHR Census tab noted Resident #1 transitioned to Hospice services on 11/12/25. The Care Plan obtained on 11/19/25 listed Resident #1 at risk for alterations in skin integrity related to poor oral intake. It did not include an update for the newly identified Stage II pressure injury. Interventions included administer treatment as ordered, encourage good nutrition, encourage repositioning, provide preventative skin care, and use pillows, positioning devices as needed. It did not include specific resident-centered interventions as noted in the MDS Assessment. The Care Plan also listed Resident #1 with altered nutritional status but did not notate the significant weight loss. Interventions included providing diet as ordered, offer snacks/meal substitute as appropriate, monitor weights, and for signs/symptoms of aspiration. It did not include resident-centered interventions related to significant weight loss or the Stage II pressure injury. The Care Plan did not include an update for Resident #1 transition to hospice. 2.The MDS Assessment completed 9/10/25 revealed Resident #21 with a BIMS score of 15 indicating intact cognition. Diagnoses include chronic obstructive pulmonary disease, chronic respiratory failure, diabetes, and seizure disorder. The MDS documented the presence of 2 unstageable pressure injuries. Interventions include pressure reducing devices for chair and bed, nutrition interventions, pressure injury care, application of non-surgical dressings and ointments/medications. The Skin Evaluation Pressure Wound Assessment for Resident #21 completed on 11/12/25 documented the following: a. Stage II pressure injury to the left heel (date of onset 10/22/25).b. Stage II pressure injury to left second toe (date of onset 7/30/25).c. Vascular wound to left third toe (date of onset 10/22/25).d. Vascular wound to left outer heel (date of onset 10/27/25).The Care Plan obtained on 11/19/25 listed Resident #21 at risk for alterations in skin integrity. It did not include an update for the Stage II pressure injuries nor the vascular wounds. Interventions include administer treatment as ordered, encourage good nutrition, encourage repositioning, observe skin condition with cares, and provide preventative skin cares. It did not include specific resident-centered interventions as noted in the MDS Assessment, including wound care consult with podiatry and wound care clinic. 3.The MDS Assessment completed on 8/6/25 revealed Resident #30 with a BIMS score of 3 indicating severe cognitive impairment. Diagnoses include cerebrovascular accident (CVA), chronic kidney disease, hemiplegia, and non-Alzheimer's dementia. The MDS documented Resident #30 with a significant weight loss. Physician Orders listed a Mighty Shake mixed with iced cream (one time per day) for weight loss. This was initiated on 10/22/25.Dietary Progress Notes, written by the Registered Dietitian (RD), revealed the following: a. On 11/10/25 at 7:48 PM, a significant weight loss of 10.2% (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified. Resident receiving daily Might Shake mixed with ice creamb. On 8/11/25 at 2:38 PM, a significant weight loss of 5% identified. History of weight fluctuations. No changes recommended at this timec. On 3/31/25 at 11:15 PM, a significant weight loss of 6.7% identified. Resident receiving [NAME] Breeze supplement as ordered. No changes recommended at this timeThe Care Plan obtained on 11/19/25 listed Resident #30 at potential risk for altered nutritional status. Interventions included to provide diet as ordered, offer snacks/meal substitutions as appropriate, monitor weights, and assess for signs/symptoms of aspiration or swallowing difficulty. The Care Plan did not include updates regarding on-going weight loss, which were assessed as significant. The Care Plan did not include specific resident-centered interventions regarding changes to nutritional status. During an interview on 11/19/25 at 420 PM, the MDS Coordinator explained that Care Plans are coordinated with the MDS Assessments. The Director of Nursing (DON), Assistant Director of Nursing (ADON), or the MDS Coordinator can update resident Care Plans at any time. Discipline-specific staff, such as Activities or Dietary, complete their own updates. During an interview on 11/19/25 at 4:35 PM, the DON noted that all of the interdisciplinary team members have a responsibility to update Care Plans. During a follow-up interview on 11/20/25 at 12:00 PM, the DON explained specific pressure injuries, regardless of staging or timeframe, are not typically added to resident Care Plans. The DON noted transitions to Hospice are usually added to Care Plans. This was an oversight for Resident #1. During an interview on 11/20/25 at 12:30 PM, Staff B, Regional RD, indicated nutritional components of the Care Plan should be updated to reflect changes to a resident's nutritional status. This would include significant weight changes. Specific supplement regimens typically are not listed on a resident's Care Plan. Instead a generic statement identifying the use of a nutrition supplement can be used. The Care Plan Policy, revised 3/25, noted the following: a. After the comprehensive assessment is completed, the facility will put in place person-centered Care Plans outlining care for the residentb. These will be reviewed and revised by the interdisciplinary team after the completion of the MDS assessments when applicable and with changes that warrant a Care Plan revision

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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 clinical record review, facility policy review and staff interviews, the facility failed to follow professional standards of care for 2 of 17 residents reviewed. Staff did not update the clinical record to add an identified medication allergy (R#21) and did not notify the physician with blood sugar results (Resident #6) as ordered. The facility reported a census of 42.Findings include: 1.The Minimum Data Set (MDS) Assessment completed on 9/10/25 revealed Resident #21 with Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The electronic health record (HER) revealed the following Physician Orders for Resident #21 on 11/2/25: a. Discontinue Cefepime intravenously every 12 hours. b. Add medication to list of possible allergies. c. Watch resident closely for further signs of allergic reaction, such as difficulty breathing or swallowing, hives, etc, for the next three days. Orders were noted and acknowledged by facility nursing staff on 11/2/25. Orders were also reprinted for the Medical Provider signature with the comment allergic reaction changing antibiotic. The Allergy tab of the EHR, obtained on 11/18/25, documented the following allergies: Gabapentin, Metformin, and Sulfa antibiotics. Cefepime was not listed. During an interview on 11/18/25 at 5:05 PM, the Assistant Director of Nursing (ADON), noted Resident #21's possible allergic reaction to Cefepime and the need to change antibiotics. During an interview on 11/20/25 at 12:00 PM, the Director of Nursing (DON) explained allergies are reviewed and entered into the EHR upon resident admission. New allergies which are identified afterwards do not happen that often. Newly identified allergies should be entered into the EHR once identified. This information can then be relayed during morning meetings or in the staff communication book. The DON was not aware of Resident #21's Cefepime allergy. The facility did not have a policy addressing resident allergy documentation. 2. The MDS assessment dated [DATE] revealed Resident #6 scored a 10 out of 15 on the BIMS, which indicated cognition moderately impaired. The MDS revealed a diagnoses list which included diabetes mellitus (DM). The Care Plan revealed a Focus area dated 2/26/25 for resident at risk for complications related to diabetes mellitus. The interventions dated 2/26/25 indicated to monitor glucose levels as ordered and report to practitioner per parameters Review of the EHR revealed a Physician Order, dated 1/20/19 to Check fasting blood glucose level weekly on Tuesday. Notify physician if BS <60 or >150. one time a day every Tue related to Type 2 DM without complications (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Blood Sugar Summary in the EHR revealed the following blood sugar levels a. On 8/5/25 at 7:55 AM: 169 mg/dl (milligrams per deciliter) b. On 8/12/25 at 7:53 AM: 196 mg/dl c. On 8/19/25 at 7:34 AM: 196 mg/dl d. On 8/20/25 at 8:52 AM: 154 mg/dl e. On 9/9/25 at 7:46 AM: 195 mg/dl f. On 10/28/25 at 8:21 AM: 162 mg/dl g. On 11/4/25 at 7:28 AM: 238 mg/dl Review of the EHR revealed a lack of documentation to indicate the physician notified of the blood glucose readings above 150 mg/dl as ordered. During an interview on 11/20/25 at 11:22 AM, Staff A, Registered Nurse (RN) queried on Resident #6 blood glucose order and she stated she didn't believe there was anything specific to the order, like having to notify the provider but Staff A would need to look. Staff A reviewed Resident #6 order and Staff A stated the order indicated blood glucose checks once a week and notify provider if not within the parameters. Staff A stated they faxed the provider for day-to-day things and called them for emergent issues. Staff stated the notification should be in the progress notes. During an interview on 11/20/25 at 12:32 PM, the DON queried on Resident #6 blood glucose order and she stated it seemed like an odd order and was put in before she worked at the facility. The DON stated the nurses were supposed to notify the provider if the blood sugars not within the parameters. The Facility Physician Orders/Transcription of Orders revised on 7/2023 revealed the following: a. Physician's orders will be received by a licensed nurse, therapist, or dietician b. The order should be entered into the resident's medical record exactly as it was stated/written by MD (Medical Doctor)/ NP (Nurse Practitioner)/ PA (Physician Assistant) c. Active orders should be followed and carried out as written/transcribed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, facility policy review and family and staff interviews, the facility failed to evaluate effectiveness and revise fall interventions in an effort to prevent future falls for 1 of 3 residents (Resident #25) reviewed for falls. The facility reported a census of 42 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 scored an 8 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition moderately impaired. The MDS indicated resident needed partial/moderate assistance with chair/bed to chair transfers, and used a manual wheelchair for mobility which he could propel independently. The MDS list of diagnoses included Parkinson's disease and non-Alzheimer's dementia. The MDS documented Resident #25 had 2 or more falls with no injury and 2 or more falls with injury (not major injury) since the last assessment.The Care Plan revealed a Focus area revised on 9/17/25 for resident at risk for falls, and when in wheelchair remove pedals to decrease tripping hazard. The interventions dated 2/26/25 indicated assistance with ambulation and transfers as needed.During an interview on 11/18/25 at 2:27 PM, Resident #25 wife stated Resident #25 had multiple falls and would trip over his foot pedals, so the facility implemented to removal of the foot pedals when Resident #25 sat in his wheelchair. During an observation at 11/19/25 at 3:14 PM, Resident #25 sat in his room and stood up by his recliner. The Administrator came into his room and handed Resident #25 his walker and the Administrator helped him sit down.Review of an Incident Report Note dated 8/30/25 at 10:43 AM revealed Describe Situation: Reported to this nurse by [name redacted] Registered Nurse (RN). Resident found on floor in B hall hallway. Resident was in front of his wheelchair, with his knees on his foot pedals and hands on the found in front of him. Assessment completed and no signs of injuries noted. Resident assisted back into wheelchair. This nurse asked resident if he fell, resident stated yes. This nurse asked resident how he fell and he stated he was reaching for something. Neuros started since fall was unwitnessed.Preliminary Recommendations, if any, for consideration as further preventative measures: Resident not to have foot pedals on wheelchair while he is sitting, will educate staff.Review of an Incident Report Note dated 8/31/25 at 6:45 PM, revealed Describe Situation: Resident found on the floor with wheelchair pedals under buttocks, leaning to the left side, resting head on nurse's cart. No marks to left side of head. Resident was sitting at nurse's station in wheelchair for frequent visual checks. Staff had seen Resident within last 5 minutes.List Relevant Interventions That Were In Place At The Time of The Incident: Resident was in wheelchair, had skid socks on, sitting at nurse's station for frequent visual checks. Preliminary Recommendations, if any, for consideration as further preventative measures: NONEReview of an Incident Report Note dated 9/1/25 at 6:30 PM, revealed Describe Situation: This nurse called from report d/t (due to) Resident having a witnessed fall in dining room. Resident stood up et (and) went to step over pedal et fell, landing on a foot pedal on the left buttock. All extremities move per baseline. Denies pain. Smiling et talking with staff. Assisted x 3 with mechanical lift transferred from the floor to the wheelchair et brought to nurse's station.List Relevant Interventions That Were In Place At The Time of The Incident: Was in dining room with staff/ frequent visual checks. Preliminary Recommendations, if any, for consideration as further preventative measures: Educating staff et placing sign in Resident's room stating wheelchair pedals only to be on during transfers.Review of an Incident Report Note dated 9/17/25 at 6:20 PM, revealed Describe Situation: Aides was pushing another resident to edge of dining room when this nurse entered dining hall. Resident is laying on floor on left side with feet towards wheelchair. Wheelchair right foot pedal is caught on table leg. When staff asks resident what happened he states he does not know he fell on the floor. Resident denies hitting head.List Relevant Interventions That Were In Place At The Time of The Incident: resident was sitting in wheelchair with nonskid socks on.During an interview on 11/20/25 at 9:51 AM, Staff D, RN queried on Resident #25 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fall interventions like foot pedals and Staff D stated when Resident #25 was pushed in the wheelchair he needed foot pedals, but anytime Resident #25 at the nurse's station, the foot pedals needed to be removed. Staff D stated the intervention was on the fall report and on a note on Resident #25 door in his room and staff educated on the foot pedals. Staff D did not recall when the intervention was put in place.During an interview on 11/20/25 at 10:12 AM, Staff E, RN queried on Resident #25 fall interventions and Staff E stated staff took off Resident #25-foot pedals at times when Resident #25 sat in his wheelchair. Staff E stated the staff didn't remove the foot pedals unless Resident #25 messed with them, but the foot pedals were usually off because Resident #25 leaned forward and messed with them. During an interview on 11/20/2025 at 10:43 AM, Staff F, Certified Nurse Aide (CNA) queried on fall interventions for Resident #25 and Staff F stated Resident #25 was supposed to have his foot pedals on unless Resident #25 was moving because it was a fall hazard. During an interview on 11/20/25 at 10:50 AM, Staff G, CNA asked about Resident #25 fall interventions and Staff G stated when Resident #25 in his wheelchair, his foot pedals needed to be off so he didn't hurt his feet or trip over them when Resident #25 tried to stand up.During an interview on 11/20/25 at 12:37 PM, the Director of Nursing (DON) queried on the process of evaluating falls and the DON stated the management team discussed falls every morning and reviewed the when, why, and where the fall occurred. The DON stated they evaluate what happened and how to fix it. The DON queried on the interventions for the fall on 8/30/25 and the DON stated they did a medication evaluation. The DON asked about the interventions for the falls on 8/31 and 9/1/25 and the DON stated the intervention was to remove Resident #25-foot pedals for both of those falls. The DON queried on the fall on 9/17/25 and the DON confirmed the foot pedals on the wheelchair when Resident #25 fell and the foot pedals needed to be off when the resident sitting. The DON stated she put communication for Resident #25-foot pedals to be removed on 9/15/25. The DON stated the intervention for Resident #25 fall on 9/17/25 was to reeducate staff and told them Resident #25 pedals should be off.Review of the facility policy titled, Fall Occurrence, dated 2/2024 revealed a Purpose statement which declared: It is the policy of the facility to ensure that residents are evaluated for falls risks and implement interventions to minimize risk for falls and/or risk for injury from falls. The Procedure step #6 directed Additional intervention(s) will be implemented post fall. IDT may change the intervention(s) if IDT (Interdisciplinary Team) investigation identifies a more appropriate intervention for the individual fall