STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165329	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingsley Specialty Care	305 West Third Kingsley, IA 51028

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to notify physician of blood sugars not within parameters and when medication not given as ordered for 1 of 4 residents reviewed, (Resident#1). The facility reported a census of 37 residents. Findings include:According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident's diagnoses included heart failure, hypertension, renal failure, diabetes, and chronic obstructive pulmonary disease.The Care Plan dated 4/16/26 identified Resident #1 used insulin/hypoglycemic medications related to diabetes. The interventions included administering insulin medications as ordered by the physician and monitor blood glucose as ordered. a. The Medication Administration Record (MAR) for March 2026 included Insulin Lispro 10 units 3 times a day with a start date of 3/24/26, hold if insulin less than 100. The MAR lacked a blood sugar readings or insulin administration on 3/27/26.On 5/19/26 at 12:10 p.m. the Director of Nursing (DON) showed the resident received long acting insulin at bedtime on 3/27/26. She was unable to find BS's, or why she did not receive the Insulin Lispro. She said physician's orders should be followed. If something was not done, the physician should be notified. b. The Medication Administration Record (MAR) for May 2026 included accuchecks (blood sugar checks) before meals and at bedtime with no results in the p.m. 5/4 and 5/6/26. The order included if the blood sugar was less than 70 or greater than 350, notify the physician. The blood sugar result was outside the parameters on 5/2/26 before lunch at 67, 5/4/26 at bedtime, 405, 5/6/26 before breakfast 377 and before lunch at 379, and 5/7/26 before breakfast at 434.The MAR included Insulin Lispro per a sliding scale with nothing documented 5/4 or 5/6/26 in the p.m. The clinical record lacked documentation why the blood sugars and Insulin Lispro 10 units were not completed as ordered. The clinical record lacked documentation the facility notified the physician of the blood sugars that were not within the parameters.On 5/20/26 at 11:01 a.m. the Administer stated they had found nothing to indicate they had completed the insulin as ordered, or of notification of the physician of the blood sugars not within the parameters. On 5/21/26 at 11:48 a.m. Resident #1's physician stated she would expect to be notified of the blood sugars not within the parameters, and if not receiving her insulin per order.

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
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review, the facility failed to report misappropriation of medication for 1 resident (Resident #6) to the Department of Inspections, Appeals and Licensing (DIAL) (the state survey and licensing agency). The facility reported a census of 37 residents. Findings include:According to the Minimum Data Set assessment dated [DATE], Resident #6 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident's diagnoses included heart failure, chronic obstructive pulmonary disease and respiratory failure.The Medication Administration Record (MAR) for December 2025 showed Resident #6 had the order for Ondansetron disintegrating oral tablet every 8 hours as needed (PRN) for nausea.On 5/19/26 at 9:41 p.m. Staff D Licensed Practical Nurse (LPN) stated she started mid-December last year and was training with Staff E LPN. Staff D said at 1 point Staff E took a Zofran pill out, and took it herself. Staff D was shocked Staff E would take a resident's medicine in front of her. The next morning Staff D called the Administrator and told her.In an email 5/20/26 at 1:44 p.m. the Administrator identified Staff E took Resident #6's Zofran tablet.A Disciplinary Action Form dated 12/24/25 documented Staff E received a documented verbal warning for a performance/conduct infraction. It was reported and confirmed that Staff E became physically ill while on duty and subsequently self-administered a resident's prescribed PRN Zofran medication. The medication was the personal property of of the resident and prescribed solely for that resident's use. Administering or consuming resident medication for personal use was strictly prohibited and violated facility policy regarding medication administration and handling, resident's rights and property, and professional standards of conduct. As a Charge nurse Staff E was expected to demonstrate leadership and adherence to all facility policies at all times. A documented verbal warning was issued to the employee, and she was advised that any further violations may result in additional disciplinary action, up to and including termination.On 5/20/26 11:01 a.m. the Administrator stated she did not self-report (to DIAL) Staff E taking the Zofran because it was not a controlled substance.The facility Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy revised April 2021 documented if resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source was suspected, the suspicion must be reported immediately to the administrator and other officials according to state law, including the state licensing/certification agency responsible for surveying/licensing the facility.

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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 record review and staff interview, the facility failed to follow the physician's orders for medication administration and blood sugars falling outside the identified parameters for 1 of 4 residents reviewed for medications (Resident #1). The facility reported a census of 37 residents.Findings include:According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident's diagnoses included heart failure, hypertension, renal failure, diabetes, and chronic obstructive pulmonary disease.The Care Plan dated 4/16/26 identified Resident #1 used insulin/hypoglycemic medications related to diabetes. The interventions included administering insulin medications as ordered by the physician and monitoring blood glucose as ordered. a. The Medication Administration Record (MAR) for March 2026 included Insulin Lispro 10 units 3 times a day with a start date of 3/24/26, hold if blood sugar less than 100. The MAR lacked blood sugar readings or insulin administration on 3/27/26.On 5/19/26 at 12:10 p.m. the Director of Nursing (DON) showed Resident #1 received long acting insulin at bedtime on 3/27/26. She was unable to find blood sugars, or why she did not receive the Insulin Lispro. She said physician's orders should be followed. If something was not done, the physician should be notified. b. The MAR for May 2026 included Accuchecks (blood sugar checks) before meals and at bedtime, with no results in the p.m. 5/4 and 5/6/26. The order included if the blood sugar was less than 70 or greater than 350, notify the physician. The blood sugar result was outside the parameters on 5/2/26 before lunch at 67, 5/4/26 at 405, 5/6/26 before breakfast 377 and before lunch at 379, and 5/7/26 before breakfast at 434.The MAR included Insulin Lispro per a sliding scale with nothing documented 5/5 or 5/6/26.The clinical record lacked documentation why the blood sugars and Insulin Lispro 10 units were not completed as ordered. The clinical record lacked documentation the facility notified the physician of the blood sugars that were not within the parameters.On 5/20/26 at 11:01 a.m. the Administer stated they had found nothing to indicate they had completed the insulin as ordered, or of notification of the physician of the blood sugars not within the parameters. On 5/21/26 at 11:48 a.m. Resident #1's physician stated she would expect to be notified of the blood sugars not within the parameters, and if not receiving her insulin per order.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to provide adequate Cardiopulmonary Resuscitation (CPR), to a resident requiring CPR prior to the arrival of Emergency Medical Services (EMS) personnel for 1 resident (Resident #1). Resident #1 had requested CPR and was not breathing and had no pulse. Staff performed some compressions, but failed to perform airway resuscitation, and failed to continue the compressions until EMS took over. The facility had a crash cart and back board to perform CPR, but staff failed to utilize the available resources. EMS started CPR when they arrived and transported the resident to the hospital. This failure resulted in Immediate Jeopardy to the health, safety, and security of the resident. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of [DATE] on [DATE] at 2:35 PM. The facility staff removed the Immediate Jeopardy on [DATE] through the following actions: staff education on CPR policy and need to continue CPR until EMS arrives, conducting mock code drills to ensure staff is aware of resources to utilize, staff educated on team lead assigning roles during a code and staff involved in a code will have debriefing after the code to discuss events and determine opportunities for improvement. The scope lowered from a J to a D at the time of survey after ensuring the facility implemented education and their policy and procedures.The facility identified a census of 37 residents.Findings include:According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident's diagnoses included heart failure, hypertension, renal failure, diabetes, and chronic obstructive pulmonary disease.A Cardiopulmonary Resuscitation (CPR)and Do Not Resuscitate (DNR) order declaration form, documented it was the policy of the facility to provide CPR. Basic CPR referred to a means of opening and maintaining an airway, providing ventilation through rescue breathing, and providing circulation through the use of external cardiac compression. The resident understand that if they wished for the facility to start CPR to prolong life when biological death was not imminent, (i.e.: no signs of irreversible death), the facility would initiate CPR until emergency responders arrived. They also understood the type of CPR provided would consist only of chest compressions and breathing techniques taught in basic CPR training. They also understand the facility may utilize an automatic external defibrillator (AED) in conjunction with CPR. On [DATE], Resident #1 electronically signed that she wanted CPR initiated and/or the AED used to prolong the life of the resident when biological death was not imminent.The Progress Notes dated [DATE] at 12:50 a.m. documented Resident #1 had difficulty getting settled for the night. Her bowels were moving and she needed cleaned up several times. She stated she wanted to go to the hospital because she could not breath. Resident #1's vital signs were attempted and could not be read. The nurse went to obtain oxygen (O2) for the resident. A Certified Nursing Assistant (CNA) was in the room. The resident's Head of the Bed (HOB) was elevated and the CNA noticed her breathing slow down, and she couldn't respond. The CNA summoned the nurse. At 12:35 a.m. they began chest compressions. The resident had no pulse present. The other CNA called 911. The ambulance arrived at 12:40 a.m. and began CPR. The resident transported on a stretcher to the hospital at 12:55 a.m. At 2:25 a.m. a hospital nurse called to inform her of the resident's death.On [DATE] at 1:35 p.m. Staff A Registered (RN) stated the resident had loose stools, and the CNA's cleaned her up. They did not tell her she complained of SOB, and when they did she intended to get her oxygen (O2). She couldn't find all the working parts so she had gone to the basement to find them. She said then they called her urgently to her room. She had no respirations or pulse. The CNA said he had done some chest compressions, but she didn't know if he had. One CNA left to call 911 and the other to help other residents. She stayed in the room and did chest compressions. When she heard the ambulance come in she stopped compressions. They came in and started CPR.On [DATE] at 1:50 p.m. Staff B CNA (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stated she had not worked at the facility very long. She wasn't even sure what the other CNA's name was. She said Resident #1 had loose stools and said she couldn't breathe. She said they told the nurse, and she went to get her some O2. Staff C CNA thought they should call the hospital. Staff C called for help because Resident #1 was unresponsive. They were all in the room and Staff B asked if she should call 911, and she went to do that. Staff C tried to do CPR. She didn't know if Staff A did CPR. She said it all happened very quickly.On [DATE] at 2:08 p.m. an Emergency Medical Technician (EMT) on the Ambulance crew stated when they arrived to the resident's room, someone stood at the foot of the bed. She said they asked why they were not doing CPR, and the person she thought was the nurse said she was giving Resident #1 some air. She said the other EMT on the ambulance started CPR. Resident #1 was cyanotic from lack of oxygen. They did put her on the floor, but they started while she was in bed. She said it was 10 minutes from the time they received the call and entered the facility. She said the family had a question for them. They wanted to know if they had started CPR at the facility. She reiterated when they asked why they were not doing CPR the person said she was giving her some air. There was no O2 in the room.On [DATE] at 2:37 p.m. Staff C stated Resident #1 had loose stools and wanted cleaned up, but did not want to get up to the bathroom. She wanted to go to the hospital, she had difficulty breathing. Staff A went to get her O2, and had to go to the basement. Resident #1 became unresponsive and he radioed Staff A several times and she didn't respond. They had to yell for her. Staff A then looked for her code status and found on the computer the resident wanted CPR, and he started compressions. On [DATE] at 7:46 a.m. Staff B stated she helped Resident #1 earlier in the evening to the bathroom. She did not have complaints. Staff C said she had trouble breathing and Staff A went to get oxygen. Staff A went to the basement for something. She heard Staff C screaming Resident #1 wasn't breathing. It took a minute or 2 to find Staff A. They all went to the room and she was not breathing. Staff A didn't know if Resident #1 was a code. Staff B and Staff A went to the nurse's station and looked for the book with code status. They could not find it, so Staff A looked on the computer and found she was a full code. Staff C started chest compressions. Staff A checked a pulse and said she was gone, and it basically stopped. Staff C stopped compressions. She said then they left the room. She expected the nurse to take charge, but she kind of acted like she was in shock.On [DATE] at 11:10 a.m. the Director of Nursing (DON) showed the crash cart which sat across from the nurse's station. The crash cart contained an Ambu bag (to administer respiratory support) and oxygen. A backboard hung next to it. There were pads for the AED that hung on the wall. She did not know if the crash cart was used for the code for Resident #1.On [DATE] at 12:59 p.m. The other EMT on the ambulance department said when she went in the room there was a male CNA outside the room in the hall. There was not a crash cart or Ambu bag in the room, and she didn't know if the facility had those items. She said the nurse said she thought Resident #1 was gone, but the resident was warm, so they initiated CPR. Compressions to start and breathing when they were set up. They did move her to the floor. They put pads on for the AED, and they did shock her 1 time when prompted to.On [DATE] at 9:44 a.m. Staff A stated when she found the code status she went to the resident's room. She said Staff C said he had been doing CPR, but she didn't know if he had. Staff A was left alone in the room. She was flustered and hadn't thought to grab the crash cart and take it to the room. She did chest compressions until she heard the ambulance come in. She did not do rescue breathing because she didn't have a barrier. On [DATE] at 9:59 a.m. Staff C stated he learned the basics of CPR in the military and again in CNA training. He said he stayed with Resident #1 while Staff A and Staff B went to find Resident #1's code status. He said when Staff A yelled the resident was a full code he started chest compressions, and did them until Staff A came back to the room. Staff A checked a pulse and said Resident #1 was gone. Staff A told Staff C to grab a gown and wait for the ambulance and let them in. He said he did not do rescue breathing.On [DATE] at 9:57 a.m. the DON stated if a resident who wanted CPR had no respirations or pulse they should start CPR right away. She said they could do compressions only until they were able to get the crash cart. She said they would get some oxygen with the compressions alone, but the (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	crash cart should be obtained as soon as possible so they could administer respirations. She said CPR should continue until one staff person took over for another or EMS took over. She said they had not done code drills that she knew of since she had been there (since after Thanksgiving). The DON stated she was unaware there may be a problem until the surveyor asked if the crash cart was used for the code. They had done some interviews with staff and identified some issues.The facility Cardiopulmonary Resuscitation and Do Not Resuscitate Orders procedure effective [DATE] documented it was the policy of the facility that residents have the choice to receive basic CPR, which included maintaining an airway, rescue breathing, and external cardiac compressions. Facilities must ensure residents understand that basic CPR would be initiated until paramedics arrived.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure a resident on dialysis had needed equipment to facilitate treatment for 1 resident (Resident #1). The facility reported a census of 37 residents.Findings include:According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident's diagnoses included heart failure, hypertension, renal failure, diabetes, and chronic obstructive pulmonary disease. The resident received dialysis.The Care Plan dated 4/16/26 identified Resident #6 used insulin/hypoglycemic medications related to diabetes. Interventions included administering insulin medications as ordered by the physician, monitoring blood glucose as ordered, and monitoring for side effects (low blood sugar, headache, weakness, sweating and fainting) and effectiveness. The Care Plan identified the resident received hemodialysis on Monday, Tuesday, Wednesday and Fridays each week at the dialysis center. Interventions included encouraging the resident to go for the scheduled dialysis appointments.On 5/19/26 at 11:49 a.m. Resident #1's family member stated they were concerned about her care at the facility. The family member said Resident #1 did not have dialysis on 5/8/26.A facility form for Dialysis dated 5/6/26 contained the note Resident #1 needed to be in a hoyer (total mechanical lift) sling. She was unable to transfer or shift position in their chair.A Facility form for Dialysis dated 5/8/26 contained the note to please make sure Resident #1 had a lift sling.In an email on 5/20/26 at 1:50 p.m. the Dialysis Facility Administrator documented Resident #1's treatment orders were for 4x/week. (Mon, Tues, Wed, and Fri). The resident attended 5/4 (Mon) - and left over on fluid. She missed 5/5 (Tues) due to a doctor appointment. She received treatment 5/6 (Wed) - and left over on fluid. She missed 5/8 (Fri). In a follow up email on 5/20/26 at 2:38 p.m. the Dialysis Facility Administrator documented Resident #1 leaving over on fluid, meant she left above her estimated dry weight so she had extra fluid on board. They could only pull so much each treatment which is why it was very important to not miss treatment. On 5/8/26 Resident #1 arrived without a sling under her in her wheelchair, and she could not transfer on her own. They called the nursing home to bring a sling so they could transfer Resident #1 to the treatment chair to begin treatment. It took the nursing home over a hour to return, and by that point the patient no longer wanted to treat due to sitting and waiting so long, she was in pain and uncomfortable. They rescheduled the patient to have dialysis 5/9/26. On 5/20/26 at 3:45 p.m. the Director of Nursing (DON) said the resident could transfer with assistance, but did acknowledge the dialysis centers note about her needing a lift sling when she went for her dialysis treatment.A Long Term Care Facility Outpatient Dialysis Services Care Coordination Agreement between the facility and the dialysis center dated 5/4/26 included the long term care facility should ensure that each resident was prepared to spend an extended length of time at the dialysis facility, as necessary for the administration of the resident's prescribed treatment.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure an accurate account of controlled medications for 1 of 3 residents reviewed (Resident #3). The facility reported a census of 37 residents. Findings include:According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #3 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident's diagnoses included heart failure, pneumonia, diabetes, and pain in right and left knees.The Care Plan dated 1/7/25 identified Resident #3 had pain related to his diagnosis. Interventions included monitoring and documenting side effects of pain medication. The resident used opioid medications. Interventions included administering opioid medication per physician order and monitoring for side effects.A facility report documented on 4/8/26 during the administration of Resident #3's scheduled morning dose of Oxycodone/APAP (narcotic/acetaminophen (Tylenol), the administering nurse identified a discrepancy in the resident's narcotic record sheet. Review revealed 5 doses of the medication were removed on 4/7/26, when only 3 doses were prescribed. They identified 2 nurses having access to the medication cart at the time these medications were signed out, Staff A Registered Nurse (RN) and Staff E Licensed Practical Nurse (LPN). The discrepancy raised concern for potential medication diversion, and an internal investigation immediately initiated.The investigation identified documentation irregularities, including an attempted forged nurse signature on the individual narcotic record. It appeared Staff E attempted to sign as Staff A on the narcotic record. Staff A stated it was not her signature. Staff E said she hit the ground running and thought Staff A had not given the medications since she said she had several medications left to give that night when Staff E reported for work.On 4/8/26 Staff A stated they did not do a narcotic count. She had to get to the 100 cart and start those medications. Staff E verified they did not do a narcotic count.A review of Resident #3's Individual Narcotic Record for Oxycodone/APAP revealed on 4/7/26 at 3:10 p.m. Staff A signed out an oxycodone for the resident. The record further showed an Oxycodone/APAP signed out at 4 p.m. 7 p.m. and 8 p.m. The final 2 signed out were dated 4/8/26, however on 4/8/26, 3 tabs were signed out as ordered. The 4 p.m. and 7 p.m. signatures were not legible. The 8 p.m. signature was Staff E.The Schedule for April showed on the 7th Staff A would work 2-10 p.m. and Staff E would work 6 p.m. to 6 a.m.The 300 hall Controlled Drugs-Count Record revealed Staff A did not sign on or off of the count sheet 4/7/26. Staff E signed as the on nurse at 2 p.m. (though she didn't come to work until 6 p.m.).Review of Controlled Drugs-Count Record revealed the following gaps in counts when keys were exchanged:On 2/1/26 at 6 a.m. no nurse on signature,On 2/1/26 at 6 p.m. no on or off nurse signature,On 2/3/26 at 6 p.m. no off nurse signature,On 3/8/26 with no time identified, no on nurse signature.On 3/23/26 at 4 p.m. with no on nurse signature,On 3/26/26 2 p.m. no nurse on signature,On 3/30/26 at an illegible time with no off nurse signature,On 4/2/26 2 lines with 6 a.m. with no sign on nurse signature on the 2nd,On 4/5/26 at 10 p.m. with no sign off nurse signature.On 5/19/26 at 4:15 p.m. the DON confirmed both staff counting the meds when exchanging keys, needed to sign the Controlled Drug Count Record, confirming the narcotic counts were correct.The facility policy Conducting a Controlled Substance Count effective February 14, 2022 directed beginning the narcotic count with the on-coming shift by counting the number of cards, then verifying each medication card to proper page number for actual count. Actually, count each card bubble and the actual medication. If the Controlled Substance Count was off, the off going medication passer must stay in the facility until direction was provided by the Director of Nursing (DON)/Administrator.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, the facility failed to ensure accurate and complete record of 1 resident missing dialysis for 1 resident reviewed (Resident #1). The facility reported a census of 37 residents.Findings include:According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident's diagnoses included heart failure, hypertension, renal failure, diabetes, and chronic obstructive pulmonary disease. The resident received dialysis.The Care Plan dated 4/20/26 identified Resident #1 received hemodialysis on Monday, Tuesday, Wednesday and Fridays each week at the dialysis center. Interventions included encouraging to go for the scheduled dialysis appointments.The Progress Notes dated 5/9/26 documented Resident #1 sent by ambulance to the hospital.On 5/19/26 at 11:49 a.m. Resident #1's family member stated they were concerned about her care at the facility. The family member said Resident #1 did not have dialysis on 5/8/26.The clinical record lacked documentation Resident #1 did not receive dialysis on 5/8/26.On 5/19/26 at 12:10 p.m. the Director of Nursing (DON) said it should be documented if the resident did not have dialysis on her scheduled day.