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	08/07/2025

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on the Center for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report from Fiscal Quarter 2, 2025 (January 1 through March 31) review, facility staffing review, and staff interviews, the facility failed to meet staffing requirements in all three metrics. The facility reported a census of 31 residents.Findings include:The PBJ Staffing Data Report with a run date of 7/29/25 triggered submitted weekend staffing data excessively low within the quarter.Review of staffing for Nurses and Certified Nursing Assistants (CNAs) scheduled similarly for weekdays and weekends. In an interview on 8/7/25 at 3:34 PM, the Administrator reported recently being hired and not aware of how incorrect data was reported to CMS. The Administrator reported she expected data to be reported correctly and would look into the matter. The Reporting Direct-Care Staffing Information (Payroll-Based Journal) policy last revised October 2017 identified staffing and census information will be reported electronically to CMS through the Payroll-Based Journal system in compliance with 6106 of the Affordable Care Act.Policy Interpretation and Implementation1. Beginning with the fiscal quarter of 2016 (beginning July 1, 2016), direct-care staffing and census information will be reported electronically to CMS through the Payroll-Based Journal (PBJ) system.2. Direct-care staffing information includes staff hired directly by the facility, those hired through an agency, and contract employees.3. Providers who are employed by the facility (including physicians) are included in direct-care staffing information; providers who bill Medicare directly are not included.4. For auditing purposes, reported staffing information is based on payroll records, or other verifiable information.5. Information may be uploaded to the PBJ system manually, or through a payroll time and attendance system, or a combination of both.6. The PBJ system is accessed through the QIES at https://www.qtso.com/.7. Manual entries are made only by designated personnel with training on the PBJ user interface.8. Technical specifications for uploading data directly from a payroll or time and attendance system will be accessed through: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/S Staffing information is collected daily and reported for each fiscal quarter no later than 45 days after the end of the reporting quarter. Dates are as follows:Fiscal Quarter Date Range Submission Deadline1 October 1- December 31 February 142 January 1- March 31 May 153 April 1 - June 30 August 144 July 1 - September 30 November 1410. Staffing data includes the number of hours worked each day by each staff member.11. Census data is reported each fiscal quarter and includes resident census on the last day of each month of the quarter.12. Definitions, instructions and examples of the PBJ user interface can be found in CMS' Electronic Staffing Data Submission Payroll-Based Journal Long-Term Care Facility Policy Manual. A current copy of this manual can be accessed at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html.13. A manual log is available to record information should the facility experience temporary internet outage and cannot record staffing data directly to the PBJ system. This log may also serve as a tool to record data that will be manually uploaded quarterly.

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
	165329	A. Building B. Wing	08/07/2025

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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 4 of 20 residents reviewed (Resident #3, #5, #8 and #25). The facility reported a census of 31 residents.Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #3 documented a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. On 8/4/25 at 1:03 PM Resident #3 stated the food is delivered cold to her room every day. Resident #3 stated all meals not a particular time. Resident #3 stated the meal came cold at lunch today. 2. The MDS dated [DATE] for Resident #5 documented a BIMS of 14 indicating no cognitive impairment. On 8/5/25 at 9:33 AM Resident #5 stated he told the Administrator that the food was cold and then the evening meal started to get hotter but lunch is almost always cold. 3. The MDS dated [DATE] for Resident #25 documented a BIMS of 15 indicating no cognitive impairment. On 8/5/25 at 7:55 AM Resident #25 stated nearly all the meals are served cool. Stated she does not ask the staff to reheat the food. Resident #25 stated she would like it if the food was served warmer. On 8/6/25 at 12:05 PM during a continuous observation of lunch service revealed Staff G, Lead [NAME] remove 6 servings of ham from the steam table, ham placed in food processor, ham blended to ground consistency, ham removed from food processor, 4oz scoop utilized to place ham on 4 plates, Staff G acknowledged his intent to serve the plate once all food was on the plates, surveyor requested temperature of mechanical ham, Staff G obtained a temperature of 114 degrees, Staff G removed mechanically altered ham from the plated into container with the other 2 servings of ham, ham placed in microwave, ham removed from the microwave, temperature of 170 obtained. On 8/6/2025 at 12:15 PM Staff G stated residents with room trays had complained about food being cold so the facility ordered warming pellets and received the warming pellets for the plates yesterday. On 8/6/2025 at 12:47 PM Staff H, Dietary Manager acknowledged the mechanical soft ham should not have been served at a temp of 114. Staff H stated her expectation was the serving / holding temperature for the food would be a minimum of 135 degrees. On 8/6/25 at 1:01 PM the Administrator expected all food would have been served at a minimum of 135 degrees. 8/6/25 at 3:18 PM Staff I, Registered Dietitian stated she expected food to have a holding temperature of at least 135 degrees. Staff I stated the mechanical soft should have had the temperature taken prior to serving and then reheated. Staff I stated her expectation was the mechanically soft ham would have been reheated to 135 degrees in the microwave because it was not considered leftover. (continued on next page)

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	165329	A. Building B. Wing	08/07/2025

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of policy revised 4/19 titled, Food Preparation and Service documented the danger zone for food temperatures was between 41 degrees and 135 degrees. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. The longer food remains in the danger zone the greater the risk for growth of harmful pathogens. Therefore, potentially hazardous foods must be maintained below 41 degrees or above 135 degrees. Mechanically altered hot foods prepared for modified consistency diets remain above 135 degrees during preparation or they are reheated to 165 degrees for at least 15 seconds. 4. Observation on 08/06/2025 at 8:12 AM showed the kitchen staff knocked on Resident # 8’s door, during resident care, and reported the breakfast tray would be outside of the room. At 8:49 AM resident care ended, staff retrieved the tray from an uninsulated cart and served the breakfast tray to the resident. At 8:51 AM Resident #8 reported the breakfast to be cold. When asked how many days of the week meals are cold, the resident replied, six out of seven. When asked how many meals were cold in the six days, the resident replied, all three. Resident #8 consumes all meals in her room. In an interview on 8/7/25 at 3:34 PM, the Administrator reported staff should have provided a new breakfast tray for the resident. When asked if she had knowledge of the resident's concerns of cold food, the Administrator stated, we have ordered warming pellets for room trays. The Food Preparation and Service Policy last revised April 2019 identified the services employees prepare and serve food in a manner that complies with safe food handling practices. Policy Interpretation and Implementation Food Preparation, Cooking and Holding Time/Temperatures The “danger zone” for food temperatures is between 41°F and 135°F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. Potentially hazardous foods include meats, poultry, seafood, cut melon, eggs, milk, yogurt and cottage cheese. The longer foods remain in the “danger zone” the greater the risk for growth of harmful pathogens. Therefore, PHF must be maintained below 41°F or above 135°F. Potentially hazardous foods held in the danger zone for more than 4 hours (if being prepared from ingredients at room temperature) or 6 hours (if cooked and then cooled) may cause foodborne illness. Food thermometers used to check food temperatures are clean, sanitized and calibrated for accuracy. The following internal cooking temperatures/times for specific foods are reached to kill or sufficiently inactivate pathogenic microorganisms: Internal Cooking Temperature Raw Animal Foods 145°F for 15 seconds (continued on next page)

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	165329	A. Building B. Wing	08/07/2025

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	• Raw eggs cooked for immediate service • Fish (except as listed below) • Meat (except as listed below) • Commercially raised game animals, rabbits 155°F for 15 seconds • Ground meat (beef, pork) • Ground fish • Raw eggs held for service • Comminuted meat, fish, or commercially raised game animals • Injected or mechanically tenderized meats • Ratites (ostrich, [NAME] and emu) 165°F for 15 seconds • Wild game animals • Poultry • Stuffed fish, meat, pork, pasta, ratites & poultry • Stuffing containing fish, meat, ratites & poultry Fresh, frozen or canned fruits and vegetables are cooked to a holding temperature of 135°F. Raw food cooked in a microwave reach 165°F in all parts of the food. The item is rotated and stirred during the cooking process so that all parts of the food reached 165°F, and allowed to stand covered for at least two (2) minutes after cooking. Previously cooked food is reheated to an internal temperature of 165°F for at least 15 seconds. Reheated foods that are not consumed within 2 hours are discarded. Ready to eat foods that require reheating are taken directly from the sealed container or intact package from the food processing source and cooked to at least 135°F. Mechanically altered hot foods prepared for a modified consistency diet remain above 135°F during preparation or they are reheated to 165°F for at least 15 seconds. continues on next page (continued on next page)

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	165329	A. Building B. Wing	08/07/2025

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Only pasteurized shell eggs are cooked and served when: Residents request undercooked, soft-served or sunny side up eggs; and Preparing foods that will not be thoroughly cooked (e.g., hollandaise sauce, French toast, ice cream, etc.). Unpasteurized eggs are cooked until all parts of the egg (yolk and whites) are completely firm. Only the number of eggs necessary for immediate service or baking are cracked and pooled (combined together). Eggs are not cracked and pooled for later use. Raw eggs with damaged shells are discarded. All raw fruits are washed thoroughly before serving. Food served once is not served again. Residents are discouraged from saving anything from their meals for later consumption. Residents are strongly discouraged from keeping potentially hazardous food in their rooms. Food Service/Distribution Proper hot and cold temperatures are maintained during food service. Foods that are held in the temperature “danger zone” are discarded after 4 hours. The temperatures of foods held in steam tables are monitored throughout the meal by food and nutrition services staff. Steam tables are never used to reheat foods.

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	165329	A. Building B. Wing	08/07/2025

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Records (EHR) review, observation, document review, and staff interviews the facility failed to prepare food in a form designed to meet individual needs by sending incorrect consistency for modified diet ordered for 6 of 6 residents reviewed (Resident #7, #9, #10, #11, #13 and #22). The facility reported a census of 31 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] for Resident #7 documented a Brief Interview for Mental Status (BIMS) of 12 indicating moderate cognitive impairment. The MDS also documented diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, unsteadiness on feet and generalized muscle weakness. Review of Resident #7's EHR titled, Orders documented an order for regular / no added salt diet with mechanical soft texture.Review or Resident #7's lunch meal ticket from 8/6/25 documented a mechanical soft diet with 1/2 cup of chopped brussels sprouts.2. The MDS dated [DATE] for Resident #9 documented a BIMS of 13 indicating no cognitive impairment. Review of Resident #9's EHR titled, Orders documented an order for regular / no added salt diet with mechanical soft texture.Review or Resident #9's lunch meal ticket from 8/6/25 documented a mechanical soft diet with 1/2 cup of chopped brussels sprouts.3. The MDS dated [DATE] for Resident #10 documented a BIMS of 0 indicating Resident #10 was rarely / never understood. Review of Resident #10's EHR titled, Orders documented an order for regular / no added salt diet with mechanical soft texture.Review or Resident #10's lunch meal ticket from 8/6/25 documented a mechanical soft diet with 1/2 cup of chopped brussels sprouts.4. The MDS dated [DATE] for Resident #11 documented a BIMS of 7 indicating severe cognitive impairment. Review of Resident #11's EHR titled, Orders documented an order for regular / no added salt diet with mechanical soft texture.Review or Resident #11's lunch meal ticket from 8/6/25 documented a mechanical soft diet with 1/2 cup of chopped brussels sprouts.5. The MDS dated [DATE] for Resident #13 documented a BIMS of 10 indicating moderate cognitive impairment. Review of Resident #13's EHR titled, Orders documented an order for regular / no added salt diet with mechanical soft texture.Review or Resident #13's lunch meal ticket from 8/6/25 documented a mechanical soft diet with 1/2 cup of chopped brussels sprouts.6. The MDS dated [DATE] for Resident #22 documented a BIMS of 12 indicating moderate cognitive impairment. Review of Resident #22's EHR titled, Orders documented an order for regular / no added salt diet with mechanical soft texture.Review or Resident #22's lunch meal ticket from 8/6/25 documented a mechanical soft diet with 1/2 cup of chopped brussels sprouts.On 8/6/25 at 12:05 PM a continuous observation of lunch service revealed Staff G, Lead [NAME] remove 6 servings of ham from the steam table, ham placed in food processor, ham blended to ground consistency, ham removed from food processor, 4oz scoop utilized to place ham on 4 plates and 1/2 cup spoodle utilized for whole brussels sprouts. Observation revealed all 6 mechanically soft diets received regular brussels sprouts on the plate for lunch. No mechanical soft brussels sprouts prepared for the lunch meal. Review of document titled, Therapeutic Spread Report Summer / Spring Menu 25 for Week 4 Wednesday Lunch documented mechanical soft diets were to receive 1/2 cup of chopped brussels sprouts.Review of document dated 8/6/25 titled Diet Type Report documented Resident #7, #9, #10, #11, #13, and #22 received mechanical soft diets.On 8/6/2025 at 12:47 PM Staff H Dietary Manager acknowledged the brussels sprouts served on 8/6/25 at the lunch service to the residents on a mechanically soft diet were not chopped and should have been. On 8/6/25 at 1:01 PM the Administrator stated her expectation was the brussels sprouts would have been chopped if that was how the menu read. On 8/6/25 at 1:24 PM Staff J, Dietary Aide acknowledged the mechanical soft diets had regular brussels spouts served to them during lunch on 8/6/25. Staff J stated he depended on the cook to serve the right consistency for residents on a mechanical soft diet. Staff J stated the dietary slips have the diets that should be served to the resident but only sees the dietary slips when (continued on next page)

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	165329	A. Building B. Wing	08/07/2025

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Kingsley Specialty Care	305 West Third Kingsley, IA 51028

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the plates are not taken to the residents fast enough and the plated food gets backed up on the steam table.On 8/6/25 2:22 PM Staff G, Lead [NAME] acknowledged the brussels sprouts should have been chopped for the lunch meal on 8/6/25. Staff G acknowledged none of the residents that were on a mechanical diet received chopped brussels sports. Staff G explained that chopped brussels sprouts were on the menu and the residents did not receive them. Staff G explained he utilized the menu to determine what to prepare for the mechanically altered diets. Staff G stated he thought the brussels spouts were soft enough for the mechanical diets. Staff G stated Resident #10 ate too fast and was changed to a mechanical diet because he choked. Stated Resident #13 choked and was changed to a mechanical soft diet as a result as well.On 8/6/25 at 3:18 PM Staff I, Registered Dietitian stated mechanical soft brussels sprouts should be chopped or fork tender. Staff I stated the cooks should be following the menu if the menu stated the brussels spouts are chopped then they should be chopped.

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	165329	A. Building B. Wing	08/07/2025

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Kingsley Specialty Care	305 West Third Kingsley, IA 51028

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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, staff interview, and policy review the facility failed to store food in accordance with professional standards by not dating open food items and not disposing of expired food items. The facility reported a census of 31 residents.Findings include:The initial kitchen observation on 8/4/25 at 10:50 AM revealed the refrigerator in the dish machine room had broccoli dated 7/25/25. The 3 door refrigerator had an open and undated bag of shredded cheese. The Dry storage had an open and undated 5lbs bag of egg noodles and an open undated 5lbs bag of tri color spiral noodles. The 2 door freezer had an open and undated bag of hush puppies. The [NAME] freezer chest had an open and undated bag of frozen chicken breasts. The 2 door stand up freezer had an open undated bag of pork chops and a bag of pork sausages that were dated but were not covered.On 8/4/25 at 11:00 AM Staff H, Dietary Manager stated all open food items should have the date the item was opened. Staff H stated the broccoli dated 7/25/25 should have been thrown away. Staff H explained her expectation was that all leftovers would be thrown out after 3 days. Staff H acknowledged all the food items in the kitchen without open dates. Staff H explained all of the food items without open dates would be thrown away immediately. On 8/6/25 at 1:01 PM the Administrator stated her expectation was all open food would be covered and labeled with an open date.Review of policy revised 10/17 titled, Food Receiving and Storage documented dry foods that are not stored in bins will be removed from original packaging, labeled and dated (use bydate). All foods stored in the refrigerator or freezer will be covered, labeled and dated.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, Electronic Health Record (EHR) review, policy review, resident interviews and staff interviews the facility failed to provide dignity and respect to 1 of 8 residents reviewed (Resident #7). The facility reported a census of 31 residents.Finding include:1. The Minimum Data Set (MDS) dated [DATE] for Resident #7 documented a Brief Interview for Mental Status (BIMS) of 12 indicating moderate cognitive impairment. The MDS also documented diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, unsteadiness on feet and generalized muscle weakness. The MDS indicated Resident #7 required substantial / maximal assistance for transfers on and off the toilet and Resident #7 was completely dependent on staff for toileting hygiene.An observation on 8/4/25 at 1:15 PM revealed Staff A, Non Certified Aide (NA) entered Resident #7's room and shut the call light off. Resident #7 stated to Staff A he needed to go to the bathroom. Staff A told Resident #7 she could not take him to the bathroom on her own and would get someone to help. On 8/4/25 at 1:16 PM Resident #7 stated he needed to use the restroom that was the reason he turned the call light on. Resident #7 explained he told the staff he needed to use the restroom. An observation on 8/4/25 1:48 PM revealed Staff B, Activities Director turned Resident 7's call light on because the resident stated he needed to be changed and needed a staff to change him. On 8/4/25 at 1:49 PM Staff B, acknowledged Resident #7 stated he would come to the activity as soon as he got his brief changed. Staff B stated she turned the call light on so that a staff member would come and provide him personal care.An observation on 8/4/25 at 1:49 PM revealed Staff C, Certified Nursing Assistant (CNA) / Certified Medication Assistant (CMA) entered Resident #7's room and shut the light off. Staff C explained to Resident #7 she would have to have another staff to help provide personal care.An observation on 8/4/25 at 1:53 PM revealed Resident #7 audibly and visually sobbing.An observation on 8/4/25 at 1:55 PM revealed the DON enter Resident #7's room and speak to him about why he was crying.On 8/4/25 at 1:56 PM the DON stated Resident #7 was upset because he wanted to be changed and have personal care completed. The DON acknowledged Resident #7 stated he had been waiting. The DON stated Resident #7 wanted to go down to the activity.On 8/4/25 at 2:06 PM staff entered the room to assist Resident #7 after DON requested staff to help Resident #7.On 8/4/25 at 2:08 PM Staff A stated she entered Resident #7's room and shut the call light off in his room. Staff A stated she told Staff C that Resident #7 needed to be changed. Staff A stated staff did not go into the room because the surveyor was in the room when the staff came back down. On 8/4/25 at 2:18 PM Resident #7 stated he felt the staff had not provided him with dignity and was very upset the light was turned off 2 times without changing his wet brief. Resident #7 acknowledged the reason he was sobbing when the DON spoke with him was because he wanted to be changed and no staff had the time to change him. Resident #7 explained that was very upsetting to him.On 8/4/25 at 2:24 PM Staff C stated she was working on hall 3 and she cared for Resident #7 that day. Staff C stated Resident #7 had his light on and she shut it off and said she was busy with a 2 assist and she would be right back. Staff C explained Resident #7 told her that would be fine. Staff C stated Staff B did not tell her that Resident #7 needed help prior to when she entered Resident #7's room at 1:49 PM. Staff C stated the expectation was that call lights would be answered within 15 minutes and if they can't get to it will ask if it was an emergency or if it was something that could wait. On 8/6/25 at 4:16 PM the DON stated the lack of communication had led to the delay of care and Resident #7 being upset. The DON stated she had already spoken to staff about the situation once she had talked to Resident #7. The DON stated she could understand if Resident #7 felt he did not receive the appropriate respect or dignity in that situation.On 8/6/25 at 4:35 PM the Administrator stated she would have expected no delay in care and understood Resident #7 was upset. The Administrator acknowledged anyone in a similar situation would feel appropriate dignity and respect was not (continued on next page)

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	165329	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided. Review of policy revised 12/16 titled, Resident Rights documented employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of that facility. These rights include the resident's right to be treated with respect, kindness and dignity.

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	165329	A. Building B. Wing	08/07/2025

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy and interviews the facility failed to permit a resident to return to the facility after hospitalization for 1 of 1 residents reviewed (Resident #39). The facility reported a census of 31 residents. Findings include:The Minimum Data Set (MDS) assessment dated [DATE] for Resident #39 documented a discharge assessment with return anticipated for an unplanned short-term general hospital stay.The Clinical Progress Notes for Resident #39 showed on 3/10/25 at 9:01 PM showed the resident admitted to the hospital. The notes showed no documentation for readmission.In an interview on 8/4/25 at 1:32 PM, the locally assigned Office of the State Long-Term Care Ombudsman (OSLTCO) reported on March 7, 2025 the facility's Business Office Manager (BOM) called to discuss Resident #39's Medicare coverage ended and that he owed a substantial outstanding balance. The BOM reported Resident #32 wanted to remain at the facility until he had the strength to go home, but refused to pay. The BOM told the Ombudsman the OSLTCO needed to tell the resident he had to pay for services. The BOM stated to the Ombudsman, he cannot just stay here without paying. On 3/18/25 at 1:00 PM the Ombudsman arrived at the facility, talked with the Administrator, and discovered the resident no longer resided at the facility after hospitalization. The Ombudsman inquired if the resident's goal was to return to the facility, whether he received a bed hold notice, and if an involuntary discharge notice was served. The Administrator, uncertain about the details, brought the Ombudsman to speak to the BOM. The BOM reported bed hold notices are not provided to residents if outstanding debt to the facility is owed upon hospitalization per policy, and as per the facility's admission agreement. In an interview on 8/6/25 at 11:37 AM, the BOM reported Resident #39 was transferred to the emergency room and did not return. When asked if the resident wanted to return to the facility, the BOM reported per the facility's admission agreement residents are not allowed to hold open a bed if a balance is owed. When asked if the resident was not permitted to return to the facility because he owed money, the BOM stated, I wasn't the one who would talk to him about returning, that would have been the social worker or corporate. In an interview on 8/6/25 at 12:11 PM, the Nurse Consultant reported she had no knowledge of the discharge of Resident #39, and would find the intake specialist for more information. The Administrator reported being recently hired, and also had no knowledge of the discharge.In an interview on 8/7/25 at 11:11 AM, Staff L, Central Intake reported Resident #39 transferred to the hospital and signed a Bed Hold form but due to an extended stay at the hospital the bed hold was stopped to prevent further billing. Staff L stated, Resident #39 agreed to a payment plan, he wanted to stop the bed hold charge because he wasn't going to be ready for discharge for quite awhile. In an interview on 8/7/25 at 11:44 AM, when asked if Resident #39 was allowed to return to the facility after hospitalization, Staff M, Regional Finances stated a bed hold was allowed even with a past due amount. Staff M reported she worked with the case manager at the hospital, Resident #39 wanted to let the bed hold go to prevent further billing. The hospital Case Manager notes for Resident #39 dated 3/12/25 at 10:52 AM documented the following:Social Worker called from Facility, Care Liaison, Staff L. States patient did not do a bed hold and has other issues with the facility (Care Liaison did not elaborate). The Patient can't return to the facility or other facilities owned by the company.In an interview on 8/7/25 at 3:34 PM, the current Administrator reported if a resident's account is past due they should be permitted to return from the hospital to the facility. The undated admission Agreement dated 8/20/24 documented the resident shall have the option to hold the bed indefinitely; however, Resident will not be allowed to hold open a bed during a temporary absence if the account is past due. The Bed Hold Policy/Authorization date effective 3/10/25 showed to be signed by Resident #39 on 3/12/25. The Discharge Summary and Plan dated December 2016 failed to address readmissions to the facility.

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	165329	A. Building B. Wing	08/07/2025

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Medication Administration Record (MAR) - Treatment Administration record (TAR), Electronic Health Records (EHR) review, resident interviews and staff interviews the facility failed to represent an accurate assessment of the resident's status during the observation period of the MDS by not accurately assessing the use of insulin for 1 of 10 residents reviewed (Resident #7). The facility reported a census of 31 residents. Finding include:1. The Minimum Data Set (MDS) dated [DATE] for Resident #7 documented a Brief Interview for Mental Status (BIMS) of 12 indicating moderate cognitive impairment. On 8/4/25 at 1:21 PM Resident #7 stated he was not on insulin. Review of Resident #7's MDS dated [DATE] documented 7 days insulin injections were received during the last 7 days and no order for insulin.Review of Resident #7's EHR titled, Orders documented no current order for insulin.Review of Resident #7's EHR titled, Orders documented basaglar kwik pen started 2/3/23 and discontinued 3/22/24 and insulin glargine started 4/29/22 and discontinued 7/6/22.Review of Resident #7's MAR - TAR for the month of May, June and July revealed no orders for insulin.On 8/6/25 at 4:03 PM Staff D, MDS Coordinator / Infection preventionist (IP) / Registered Nurse (RN) acknowledged the MDS that was completed for Resident #7 on 5/15/25 was entered in error when documenting the use of insulin. Staff D stated the MDS would be updated immediately. Staff D acknowledged Resident #7 did not have an order for insulin at the time of the MDS and was not receiving insulin at the time of the completion of the MDS on 5/15/25.On 8/7/25 at 4:00 PM the DON explained that her expectation was that the MDS would be completed accurately. The DON acknowledged Resident #7's MDS dated [DATE] was not accurately completed. The DON acknowledged that Resident #7 did not take insulin and did not have an order for insulin at that time. Email request for policy on accurate MDS assessment documented a response that the facility does not have a policy. The facility followed the Resident Assessment Instrument (RAI) guidelines.

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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. Based on observation, Electronic Health Record (EHR) review, staff interview, policy, and Medication Administration Records - Treatment Administration Records (MAR-TAR) review the facility failed to provide needed services in accordance with professional standards by administering a medication that should have been held related to parameters for 1 of 3 residents (Resident #8). The facility reported a census of 31 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #8, dated 7/7/25 did not document a Brief Interview for Mental Status (BIMS). Review of EHR titled, Progress Notes dated 8/5/25 revealed a BIMS evaluation with a BIMS of 15 documented. The MDS documented diagnoses of essential hypertension and unspecified hypotension. An observation on 8/6/25 at 7:24 AM with Staff D, MDS Coordinator / Infection Preventionist (IP) / Registered Nurse (RN) present of Staff E, Registered Nurse (RN) prepare medications for Resident #8, blood pressure obtained 140/70, midodrine 10mg removed from the drawer, midodrine reviewed with the MAR, midodrine 10mg removed from the bubble pack, the rest of Resident #8's medications removed from bubble pack, Staff E knocked on Resident #8's door, Staff E presented Resident #8 with medications, Resident #8 self administered medications with sips of water mixed with Miralax.Review of Resident #8 EHR titled, Orders documented an order for midodrine HCl Oral Tablet 10mg to give 10mg by mouth three times a day related to hypotension hold if the Systolic Blood Pressure (SBP) >110. Review of Resident #8's MAR - TAR documented a Physician's Order for midodrine HCl Oral Tablet 10mg to give 10mg by mouth three times a day related to hypotension hold if the Systolic Blood Pressure (SBP) >110. Review of Resident #8's EHR titled, Vitals / Blood Pressure Summary documented a blood pressure on 8/6/25 at 7:41 AM of 140/70. On 8/6/25 at 8:48 AM Staff D stated other than the parameters for Resident #8's midodrine not being followed she did not see any concerns. Staff D explained Resident #8's midodrine was given outside of the physician's parameters. Staff D stated the physician would be notified and would complete follow up blood pressures throughout the day. Staff D acknowledged Resident #8's midodrine should have been held because the systolic blood pressure was above 110. Staff D acknowledged Resident #8's systolic blood pressure was 140. On 8/7/25 at 4:00 PM the DON stated her expectation was that Resident #8's midodrine would have been held with a systolic blood pressure of 140 according to the physician's orders. The DON stated she expected the nurse to follow the medication checks prior to medication administration. Review of policy revised 4/19 titled, Administering Medications documented medications were to be administered in a safe and timely manner, and as prescribed. The individual administering the medication checks the label 3 times to verify the right resident, right medication, right dosage, right time, and right method of administration before giving the medication.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review and staff interviews the facility failed to provide 2 of 37 medications as ordered resulting in a medication error rate of 5.41. The facility reported a census of 31 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #8, dated 7/7/25 did not document a Brief Interview for Mental Status (BIMS). Review of EHR titled, Progress Notes dated 8/5/25 revealed a BIMS evaluation with a BIMS of 15 documented. The MDS documented diagnoses of essential hypertension and unspecified hypotension. An observation on 8/6/25 at 7:24 AM with Staff D, MDS Coordinator / Infection Preventionist (IP) / Registered Nurse (RN) present of Staff E, Registered nurse (RN) prepare medications for Resident #8, blood pressure obtained 140/70, midodrine 10mg removed from the drawer, midodrine reviewed with the MAR, midodrine 10mg removed from the bubble pack, the rest of Resident #8's medications removed from bubble pack, Staff E knocked on Resident #8's door, Staff E presented Resident #8 with medications, Resident #8 self administered medications with sips of water.Review of Resident #8 EHR titled, Orders documented an order for midodrine HCl Oral Tablet 10mg to give 10mg by mouth three times a day related to hypotension hold if the Systolic Blood Pressure (SBP) >110. Review of Resident #8's MAR - TAR documented a Physician's Order for midodrine HCl Oral Tablet 10mg to give 10mg by mouth three times a day related to hypotension hold if the Systolic Blood Pressure (SBP) >110. Review of Resident #8's EHR titled, Vitals / Blood Pressure Summary documented a blood pressure on 8/6/25 at 7:41 AM of 140/70. On 8/6/25 at 8:48 AM Staff D stated other than the parameters for Resident #8's midodrine not being followed she did not see any concerns. Staff D explained Resident #8's midodrine was given outside of the physician's parameters. Staff D stated the physician would be notified and would complete follow up blood pressures throughout the day. Staff D acknowledged Resident #8's midodrine should have been held because the systolic blood pressure was above 110. Staff D acknowledged Resident #8's systolic blood pressure was 140. On 8/7/25 at 4:00 PM the DON stated her expectation was that Resident #8's midodrine would have been held with a systolic blood pressure of 140 according to the physician's orders. The DON stated she expected the nurse to follow the medication checks prior to medication administration. 2. The MDS dated [DATE] for Resident #26 documented a BIMS of 2 indicating severe cognitive impairment. The MDS documented Resident #26 had a diagnosis of type 2 diabetes mellitus with other specified complications.Review of Resident #26's MAR-TAR documented a Physician's Order for NovoLog solution 100 UNIT/ML (insulin aspart). Inject 6 units subcutaneously three times a day with a start date of 7/25/25.Review of Resident #26's EHR titled, Orders documented a Physician's Order for NovoLog solution 100 UNIT/ML (insulin aspart). Inject 6 units subcutaneously three times a day with a start date of 7/25/25.An observation on 8/6/25 at 8:38 AM with Staff D, MDS Coordinator / Infection Preventionist (IP) / Registered Nurse (RN) revealed Staff F, Licensed Practical Nurse (LPN) draw up 2 units of NovoLog insulin, 2 units primed to check patency, 6 units drawn up, cleansed Resident #26's back upper arm with an alcohol wipe, NovoLog given in the back of the right upper arm, visual and audio observation of turning insulin pen down 2 clicks, insulin pen needle removed from Resident #26's arm clicking continued 2 times outside of the arm, Staff F acknowledged she had completed the insulin administration, surveyor requested to see the insulin pen and 2 units remained in the insulin pen. Staff A stated she would administer the rest with another needle in the left side abdomen. Staff A obtained a new needle for insulin pen, cleansed Resident #26's left abdomen with an alcohol wipe and injected the remaining 2 units of NovoLog insulin.On 8/6/25 at 8:48 AM Staff D acknowledged during the observation of insulin administration to Resident #26 it appeared the insulin was not administered appropriately. Staff D explained that it appeared the insulin was being administered after the needle had been removed from Resident #26's arm. Staff D stated her expectation was the insulin would have been administered appropriately. On 8/7/25 at 4:00 PM the DON stated the facility's expectation was medication would (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be administered appropriately according to the physician's orders. The DON stated in the incident with Resident #26's insulin administration she expected all 6 units would have been administered to Resident #26 in one dose and all in the upper right arm at once. The DON explained when Staff F had not given all 6 units at once she would have expected with a second needle being applied to the insulin pen that 2 more units would have been primed to ensure patency of the needle. The DON explained the facility's expectation was medication errors would not occur and all appropriate administration steps would be followed.Review of policy revised 4/19 titled, Administering Medications documented medications were to be administered in a safe and timely manner, and as prescribed. The individual administering the medication checks the label 3 times to verify the right resident, right medication, right dosage, right time, and right method of administration before giving the medication. Insulin pens are clearly labeled with the resident's name or other identifying information. Prior to administering insulin with an insulin pen, the nurse verifies that the correct pen is used for that resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews and policy reviews, the facility failed to provide proper hand hygiene after resident care for 2 of 2 residents reviewed (Resident #8 and #26). The facility reported a census of 31 residents.Findings include: 1. Observation on 08/06/2025 at 8:02 AM showed Staff K, Certified Nursing Assistant, (CNA) and Staff C, CNA performed hand hygiene, donned personal protective equipment (PPE) of a gown and gloves then provided care for a catheter and bowel movement incontinence. When finished Staff K removed the soiled gown and gloves, used the left hand to hold the trash receptacle, then used the right hand to place soiled PPE into the trash. Staff K next placed her right hand on top of the soiled PPE, and pushed the soiled PPE down further into the trash receptacle. Without performing hand hygiene Staff K arranged the resident’s sheet and bedside table. In an interview on 8/7/25 at 3:34 PM, the Administrator reported she expected staff to complete hand hygiene immediately after removing solid gloves. 2. The Minimum Data Set (MDS) dated [DATE] for Resident #26 documented a Brief Interview for Mental Status (BIMS) of 2 indicating severe cognitive impairment. The MDS documented Resident #26 had a diagnosis of type 2 diabetes mellitus with other specified complications. An observation on 8/6/25 at 8:38 AM with Staff D, MDS Coordinator / Infection Preventionist (IP) / Registered Nurse (RN) revealed Staff F, Licensed Practical Nurse (LPN) complete hand hygiene, apply gloves, draw up 2 units of NovoLog insulin, 2 units primed to check patency, 6 units drawn up, cleansed Resident #26’s back upper arm with an alcohol wipe, NovoLog given, Staff F removed gloves picked up insulin supplies, placed hands on the handles of Resident #26’s wheelchair, wheeled Resident #26 down the hall to the medication cart, retrieved keys, unlocked the medication cart, placed supplies in the medication cart, completed hand hygiene and wheeled Resident #26 to the dining room table. On 8/6/25 at 8:48 AM Staff D stated her expectation was hand hygiene would have been completed after gloves were removed before contamination of any surfaces, pushing Resident #26 up the hall and prior to returning supplies to the medication cart. On 6/7/25 at 4:00 PM the DON stated the facility’s expectation was hand hygiene would be completed after gloves were removed before contamination of any surfaces, pushing Resident #26 up the hall and prior to returning supplies to the medication cart. Review of policy revised 8/19 titled, Handwashing / Hand Hygiene documented This facility considers hand hygiene the primary means to prevent the spread of infections. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations before and after direct contact with residents, after contact with a resident’s intact skin, after contact with blood or bodily fluids and after removing gloves.