STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165333	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmark Care Center	215 Highway 30 SW Mount Vernon, IA 52314

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. Based on clinical record reviews and staff interview, the facility failed to ensure residents were provided with education regarding the risks and benefits of psychotropic medications 4 of 5 residents reviewed for unnecessary medications (Resident #8, #18, #33, #38) . Additionally, the facility failed to offer alternative treatment options prior to the administration of the medications. The facility reported a census of 42 residents. Findings include:1. The admission Minimum Data Set (MDS) Assessment for Resident #8 dated 7/30/25 documented diagnoses that included: Non Alzheimer's dementia, anxiety disorder, and depression. The MDS recorded an admission date to the facility of 7/23/25. The resident's Medication Administration Record (MAR) dated July of 2025 reflected the resident had orders for Escitalopram, an antidepressant medication, start date 7/24/25; Buspirone, an antianxiety medication, start date 7/24/25 and Quetiapine, an antipsychotic medication, start date of 7/23/25. A clinical record review of the Resident's Electronic Health Record (EHR) failed to reveal consent obtained for any of the medications prior to administration. Additionally, no progress notes or assessments revealed education was provided of the side effects, risk versus benefits of psychotropic medications, or that alternative treatments were offered. On 4/7/26 at 1:00 pm, the Administrator stated the Director of Nursing (DON) started employment in October of 2025 and had been catching up the assessments for psychotropic medications since that time as they previously had been completed. 2. The admission MDS Assessment for Resident #18 dated 10/29/25 documented diagnoses that included: Anxiety disorder, post traumatic stress disorder (PTSD) and insomnia. The MDS recorded an admission date to the facility of 10/22/25. Resident #18's MAR for October 2025 reflected that the resident had orders for Sertraline, and Trazodone, antidepressant medications. The MAR of Resident #18 for March of 2026 reflected the resident was ordered Abilify, an antipsychotic medication in December of 2025, as well as Doxepin, an antidepressant/hypnotic used for insomnia, ordered in February of 2026. A clinical record review of Resident #18's EHR failed to reveal consent being obtained for any of the medications prior to administration. Additionally, no progress notes or assessments revealed education was provided of the side effects, risk versus benefits of psychotropic medications, or that alternative treatments were offered. 3. The Quarterly MDS Assessment for Resident #33 dated 3/19/26 documented diagnoses that included: anxiety disorder, depression, bipolar disorder and post traumatic stress disorder (PTSD). The MDS recorded an admission date to the facility of 9/25/25.The MAR for Resident #33 dated March 2026 reflected the resident was ordered bupropion, duloxetine and trazodone, all antidepressant medications, ordered September and November of 2025 and buspirone, an antianxiety medication ordered in September 2025.A clinical record review of Resident #33's EHR failed to reveal consent obtained for any of the medications prior to administration. Additionally, no progress notes or assessments revealed education was provided of the side effects, risk versus benefits of psychotropic medications, or that alternative treatments were offered. 4. The Quarterly MDS Assessment for Resident #38 dated 3/10/26 documented diagnoses that included: anxiety disorder and PTSD. The MDS recorded an admission date to the facility of 9/3/25. The MAR for Resident #38 dated March 2026 reflected the resident was ordered Abilify in February 2026, trazodone in December 2025, buspirone in December 2025, and duloxetine in September 2025.A clinical record review of Resident #38's EHR failed to (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reveal consent obtained for any of the medications prior to administration. Additionally, no progress notes or assessments revealed education was provided of the side effects, risk versus benefits of psychotropic medications or that any alternative treatments were offered. On 4/8/26 at 2:15 pm, the Administrator voiced she had just started her position at the facility a month earlier. She stated she would speak with the Director of Nursing regarding education and consents for psychotropic medications.The facility did not have a policy for use of psychotropic medications.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, Center for Medicare and Medicaid (CMS) Long-Term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User Manual, and staff interview the facility failed to accurately code resident falls with major injury, medications, smoking, and restraints on the Minimum Data Set (MDS) Assessment for 5 of 15 reviewed (Resident #8, #13, #18, #28 and #31). The facility identified a census of 42 residents. Findings include:1.Resident #13's Electronic Healthcare Record (EHR) Census showed he admitted to the facility on [DATE]. A 2/12/26 Hospital Discharge Summary documented Resident #13 with a diagnosis of a stroke and to discharge on aspirin (antiplatelet medication) 81 Milligrams (MG) chewable tablet daily and clopidogrel (antiplatelet medication) 75 MG, take 1 tablet daily. A 2/16/26 Provider Encounter Visit Progress Note documented Resident #13 on dual antiplatelet therapy for secondary stroke prevention. Resident #13's 2/19/26 MDS Assessment showed a Brief Interview for Mental Status (BIMS) score of 11/15, indicating a moderate cognitive impairment. The MDS included diagnoses of stroke with hemiplegia/hemiparesis (one-sided body weakness or paralysis due to nervous system injury (e.g., stroke) and documented Resident #13 received anticoagulant and antiplatelet medications. A Review of the February, March and April 2026 Electronic Medication Administration Records (EMAR's) documented the administration of aspirin 81 mg daily and Clopidogrel 75 MG daily. The records lacked documentation an anticoagulant was administered. On 4/08/26 at 3:06 PM the Director Of Nursing (DON) reported she would check to see if Resident #13 had taken any anticoagulant medications and check with corporate on the accuracy of all the MDS Assessments. On 4/09/26 at 10:13 AM the DON reported she reached out to the Corporate MDS Coordinator to review the MDS Assessments. The Corporate MDS Coordinator reported the MDS Assessments were not accurate. On 4/09/26 at 10:14 AM the Regional Nurse Consultant explained the facility used the CMS LTC RAI manual for coding the MDS Assessment. The CMS LTC RAI Manual, Chapter 3, Page N-9 directed do not code antiplatelet medications such as aspirin/extended release, or clopidogrel as anticoagulant (medications). 2. Resident #31's 1/06/26 MDS Assessment showed a BIMS Score of 15/15 indicating intact cognition. Resident #31 had no functional limitations in range of motion to the upper/lower extremities and required the use of a walker. Resident #31 was independent with dressing, personal hygiene, positioning in bed, getting in/out of bed, transferring and walking. The MDS documented Resident #31 utilized a bed rail daily. A 3/17/25 Bed Rail/Other Device Evaluation documented Resident #31 utilized one grab bar outer rail on the bed. Resident #31 was oriented to self, time, environment/situation and able to make her needs known. The Evaluation documented the grab bar device was an assistive device to turn and reposition (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in bed to maintain the resident's highest level of independence. The Device Evaluation Risk versus Benefit explained the grab bar was to remain in place per the resident's preference to maximize independence with bed mobility, and assist with getting in and out of bed. The Care Plan dated 5/11/23 documented Resident #31 wanted a grab bar on one side of her bed, and was able to utilize the grab bar to safely get in/out of the bed. On 4/06/26 at 2:10 PM, Resident #31 sat in the wheelchair in her room. Observation at this time revealed a loop style grab bar on the resident's upper left side of the bed. Resident #31 explained the grab bar really helped her to be independent in repositioning and getting in/out of bed. The grab bar did not restrict her from any movement or accessing her body in any way. It really helped her. Review of Resident #31's EHR Assessments, Progress Notes, miscellaneous(documents) on 4/8/26 lacked documentation of a physician order for a restraint. The CMS LTC RAI Manual documented the following definition for a Physical Restraint: any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. On 4/08/26 at 9:50 AM Staff A, Certified Medication Aide (CMA) voiced Resident #31 did not use restraints. She was up independent. The grab bar on her bed allowed her to reposition in the bed on her own and didn't restrain her in anyway. On 4/08/26 at 10:56 AM Staff B, Certified Nursing Assistant (CNA) reported there were no residents in the facility using restraints that she was aware of. On 4/08/26 at 2:05 PM Staff C, Licensed Practical Nurse (LPN) reported there were no residents using restraints in the facility. During an interview on 4/08/26 at 2:42 PM, the DON stated she noticed that the grab bars were being coded as restraints and she was trying to go through and change the care plans to reflect they were not restraints. There were no residents using grab bars that met the definition of a physical restraint. The grab bars were utilized for body positioning. The facility MDS Coordinator resigned from the facility in early March 2026 and she was covering the MDS in the interim. She had not done MDS for 12 years, and would have to defer to the corporate office if the MDS Assessment were coded accurately. The CMS LTC RAI defined a Physical Restraint as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. The Steps to Assessment included:1. Review the resident's medical record (e.g., physician orders, nurses' notes, nursing assistant documentation) to determine if physical restraints were used during the 7-day look-back period.2. Consult the nursing staff to determine the resident's cognitive and physical status/limitations.3. Considering the physical restraint definition as well as the clarifications listed below, observe the resident to determine the effect the restraint has on the resident's normal function. Do not focus on the type, intent, or reason behind its use.4. Evaluate whether the resident can easily and voluntarily remove any manual method or physical or mechanical device, material, or (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	equipment attached or adjacent to their body. If the resident cannot easily and voluntarily do this, continue with the assessment to determine whether or not the manual method or physical or mechanical device, material or equipment restrict freedom of movement or restrict the resident's access to their own body.5. Any manual method or physical or mechanical device, material or equipment should be classified as a restraint only when it meets the criteria of the physical restraint definition. This can only be determined on a case-by-case basis by individually assessing each and every manual method or physical or mechanical device, material or equipment (whether or not it is listed specifically on the MDS) attached or adjacent to the resident's body, and the effect it has on the resident.6. Determine if the manual method or physical or mechanical device, material, or equipment meets the definition of a physical restraint as clarified below. Remember, the decision about coding any manual method or physical or mechanical device, material, equipment as a restraint depends on the effect it has on the resident.7. Any manual method or physical or mechanical device, material, or equipment that meets the definition of a physical restraint must have: physician documentation of a medical symptom that supports the use of the restraint, a physician's order for the type of restraint and parameters of use, and a care plan and a process in place for systematic and gradual restraint reduction (and/or elimination, if possible), as appropriate. Current Tobacco Use: 1.Ask the resident if they used tobacco in any form during the 7-day look-back period.2.If the resident states that they used tobacco in some form during the 7-day look-back period, code 1, yes. Fall with Major Injury: Includes, but is not limited to, traumatic bone fractures, joint dislocations/ subluxations, internal organ injuries, amputations, spinal cord injuries, head injuries, and crush injuries. Coding Instructions: Code 0, none: if the resident had no major injurious fall since admission/entry or reentry or prior assessment. Code 1, one: if the resident had one major injurious fall since admission/entry or reentry or prior assessment. Code 2, two or more: if the resident had two or more major injurious falls since admission/entry or reentry or prior assessment. 3. The Medication Administration Record (MAR) of Resident #8 for July 2025 reflected an order for Buspirone (an antianxiety medication), 10 milligram tablets, give two tablets three times daily for anxiety, with a start date of 7/24/25. This order was discontinued on 9/9/25. The MAR additionally reflected the resident had an order for Seroquel, an antipsychotic medication with a start date of 7/23/25. The MAR of Resident #8 for September 2025 reflected a new order started on 9/10/25 of the same dosage, with a minor scheduling change. This order remained active through the survey dates. The MDS for Resident #8 dated 7/30/25 failed to document the use of an antianxiety and antipsychotic medication. The resident's MDS dated [DATE] failed to document the use of an antianxiety medication. The MDS dated [DATE] failed to document the use of an antianxiety medication. The 2025 RAI Manual directed: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review the resident's medical record for documentation that any of these (high risk) medications were received by the resident and for the indication of their use during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Column 1: Check if the resident is taking any medications by pharmacological classification during the 7-day observation period (or since admission/entry or reentry if less than 7 days). On 4/8/26 at 4:12 pm, the Administrator stated the facility had no policy regarding the use of psychotropic medications. The Minimum Data Set (MDS) Assessment for Resident #8, dated 1/1/26, documented that he used bed rails daily as a restraint. An observation of Resident #8's bed on 4/7/2026 at 9:41 AM revealed two (2) grab bars on each side, though they did not appear to limit his ability to get out of bed. The current Care Plan for Resident #8 on 4/9/26 instructed him to use bed grab bars to help with repositioning in bed. 4. The MDS dated [DATE] for Resident #18 documented that she did not use tobacco. The 10/22/26 Admission/readmission Assessment documented that she was a smoker and will continue to smoke at the facility. On 4/6/26 at 12:02 PM, Resident #18 revealed she was a current smoker and had been since living at the facility. The current Care Plan for Resident #18 on 4/9/26 revealed starting on 10/22/25, she would smoke cigarettes. 5. A review of Resident #28's MDS logs in her EHR documented an admission MDS on 11/10/25 and a discharge MDS on 1/23/26. A Progress Note dated 1/19/26 documented that Resident #28 received a follow-up evaluation at the facility from her provider following a 1/16/26 emergency department visit, where she was diagnosed with a sacral fracture. The MDS dated [DATE] documented that Resident #28 had not sustained any falls with major injury. On 4/8/26 at 2:38 PM, the Director of Nursing (DON) revealed that staff should have coded tobacco use for Resident #18 on her admission MDS and a fall with major injury on Resident #28's discharge MDS. She also clarified that Resident #8 does not use a bed rail restraint; instead, the bars assist him with bed mobility.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of records, staff interviews, and facility policy, the facility failed to provide education and obtain informed consent for 4 of 4 residents regarding eligibility for influenza vaccination (Resident #7, #12, #18, and #24) and 3 of 3 residents for pneumococcal vaccination (Resident #7, #18, and #24). The facility reported a census of 42 residents.Findings include:Review of the Census List on 4/9/26 for Resident #7 documented she was admitted to the facility on [DATE] and was a current resident. A review of her Electronic Health Record (EHR) on 4/9/26 revealed she had not received her influenza or pneumococcal vaccinations.Review of the Census List on 4/9/26 for Resident #12 documented he was admitted to the facility on [DATE] and was a current resident. A review of his EHR on 4/9/26 revealed he had not received the influenza vaccination.Review of the Census List on 4/9/26 for Resident #18 documented she was admitted to the facility on [DATE] and was a current resident. A review of her EHR on 4/9/26 revealed she had not received her influenza or pneumococcal vaccinations.Review of the Census List on 4/9/26 for Resident #24 documented she was admitted to the facility on [DATE] and was a current resident. A review of her EHR on 4/9/26 revealed she had not received her influenza or pneumococcal vaccinations.In an interview on 4/9/26 at 10:29 AM, the Director of Nursing stated the current Infection Preventionist was on leave. After reviewing past immunization records, the Director was unable to find documentation that Resident #7, #12, #18, and #24 were provided with education. There was also no signed documentation showing the residents refused the vaccinations.The facility's Infection Control Manual, last revised in 10/2025, required staff to educate residents, obtain consent for available vaccines, and document all immunizations in the EHR.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and instructions of CMS form 10123-NOMNC, and 10055-SNF ABN, the facility failed to ensure an accurate and timely Notice of Medicare Non-Coverage (NOMNC) was provided and failed to issue a Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) for 1 of 3 residents reviewed for Beneficiary Notification (Resident #50). The facility reported a census of 42 residents.Findings include: Record review of Resident #50's Minimum Data Set (MDS) assessment dated [DATE] and the Census line of the resident's Electronic Health Record (EHR) revealed the resident received Medicare-covered services from 2/10/26 through 3/3/26. On 3/4/26, the resident's payor source transitioned to private pay until discharge on [DATE]. A review of the facility-provided Notice of Medicare Non Coverage (NOMNC) form for Resident #50, signed by the resident's spouse/representative on 2/18/26, documented that Medicare coverage would end on 2/24/26. On 4/7/26, the facility noted on the SNF Beneficiary Protection Notification Review form that a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) was not provided to Resident #50 because the plan was for her to discharge home the day after skilled care ending. The note also documented that the facility had a staff change over at the same time and the ABN was likely overlooked.The Encounter Note dated 2/20/26, authored by the Medical Provider noted the resident's husband was concerned about the projected discharge date of 2/24. The Encounter Note dated 2/27/26, authored by the Nurse Practitioner, documented that the resident was seen that day for evaluation of therapy follow-up and discharge planning.No notes were found in the resident's chart indicating that the original discharge date was delayed or the reason for the change of discharge. No discharge summary note was found in the resident's chart. The Assessment labeled Instructions for Discharge, dated 3/5/26 was noted as incomplete in the resident chart. On 4/9/26 at 10:44 am, the Administrator stated she was unable to locate an additional NOMNC issued to Resident #50 with the correct end of Medicare coverage date of 3/3/26. The document titled Notice Instructions for the Notice of Medicare Non Coverage (NOMNC) CMS 10123 documented the following: -Insert the actual date coverage of the service will end.The documented titled Form Instructions Advance Beneficiary Notice of Non-coverage (ABN) documented the following: -Deliver the ABN far enough in advance that the patient or representative has time to consider the options and make an informed choice.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review, staff and resident interviews, and policy review, the facility failed to maintain documentation of the information sent to the hospital to ensure that continuity of care and resident needs were maintained during the transfer process for 4 of 4 hospitalizations reviewed (Residents #2 and #6). The facility reported a census of 42 residents.Findings include: 1.The Census List for Resident #2 documented a hospital transfer from 1/19/26 to 1/23/26, and a second transfer from 3/25/26 to 4/2/26.A review of Resident #2's Progress Notes and Assessments revealed a lack of documentation regarding the information sent to the hospital for the 1/19/26 and 3/25/26 hospitalizations2. The Census List for Resident #6 documented hospital transfers from 2/18/26 to 2/27/26 and from 3/29/26 to 4/3/26.A review of Resident #6's Progress Notes and Assessments revealed a lack of documentation regarding the information sent to the hospital for the 2/18/26 and 3/29/26 hospitalizationsDuring an interview on 4/8/26 at 3:17 PM, the Director of Nursing (DON) and Administrator stated the facility did not have a written discharge policy or procedure. The DON noted her expectation that nursing staff send the Medication Administration Record (MAR), the Treatment Administration Record (TAR), and the Iowa Physician Orders for Scope of Treatment (IPOST), along with the Face Sheet and Bed Hold form. She further expected staff to record vital signs, provide a verbal report to the Emergency Medical Technicians (EMTs), and provide a verbal report to the hospital emergency room (ER) to notify them of the transfer. However, they acknowledged the facility was unable to locate the documentation sent with Resident #6 for the 2/18/26 and 3/29/26 hospitalizations, or for Resident #2 for the 1/19/26 and 3/25/26 hospitalizations.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, Pre-admission Screening and Resident Review (PASRR), and resident and staff interviews, the facility failed to ensure a resident's mental health diagnosis and medications were accurately reported to the designated state agency for 1 of 3 residents diagnosed with Post Traumatic Stress Disorder (PTSD) (Resident #38) and failed to implement PASRR level II recommendations into the care plan for 2 of 3 residents (Residents #6 and #18). The facility reported a census of 42 residents.Findings include:The Electronic Healthcare Record (EHR) Census documented Resident #38 admitted to the facility on [DATE]. A Facsimile (fax) Transmission dated 9/3/25 from a local hospital detailed a 9/2/25 PASRR (a federally mandated process for evaluating individuals with serious mental illness (SMI), intellectual disabilities (ID), or related conditions (RC) prior to admission into a Medicaid-certified nursing facility to ensure appropriate placement, and necessary services) which determined Resident #38 did not have SMI, ID, or another RC and a level two was not required. The PASRR listed a diagnosis of a suspected anxiety disorder and the use of antidepressant and a medication used for diagnosis of anxiety in the past 6 months. Further review of the clinical record lacked documentation of an updated PASRR. Resident #38's Hospital Discharge Summary Note dated 9/03/25 documented to follow up with psychiatry in 1-2 months, psychology therapy 1-2 weeks and included an order for trazodone (antidepressant medication) 100 Milligrams (MG) take 0.5 MG by mouth daily for a diagnosis of post-traumatic stress disorder (PTSD). The September 2025 Electronic Medication Administration Record (EMAR) documented Resident #38 received the trazodone medication for PTSD. The Care Plan dated 10/16/25 documented the use of Psychotropic Medication Use related to PTSD. The 11/21/25 Care Plan noted Resident #38 with a behavior problem related to PTSD and Psychosocial complications related to anxiety and PTSD. A 11/21/25 Referral Form for a telehealth psychiatry service documented Resident #38 resided in the nursing home and needed a referral for a diagnosis of, in part, anxiety disorder and PTSD. The Referral also had an Order Summary Report detailing Resident #38 was taking antidepressant medication for PTSD. A Physician Order dated 12/19/25 detailed to start Abilify (antipsychotic medication) 5 MG every morning related to PTSD. Review of the December 2025 EMAR documented Resident #38 started to receive the medication on 12/20/25 and continued to take the antipsychotic medication and Trazodone (antidepressant medication) from that time to current 4/07/06. On 4/07/26 at 4:00 PM the Director of Nursing (DON) reported the facility did not have any updated PASRR Evaluation for Resident #38. She reported the Social Worker was responsible for reviewing and completing the PASRR Evaluations. On 4/07/26 at 4:15 PM the Social Worker reported she was still working on her conditional training for PASRR. She honestly did not know if she would need to rescreen a PASRR for a diagnosis of PTSD or medication changes. (continued on next page)

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	165333	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmark Care Center	215 Highway 30 SW Mount Vernon, IA 52314

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON reported on 4/08/26 at 2:53 PM the PASRR was completed by the Social Worker and everything was a learning curve right now. The DON believed a new PTSD diagnosis and new psychotropic medications would require a new PASRR to be updated. On 4/08/26 at 4:03 PM, the Administrator reported the facility did not have a PASRR Policy. On 4/09/26 at 10:15 AM, the Regional Nurse Consultant reported the facility utilized the [State] PASRR site to comply with completing the PASRRs. 2. Resident #6's 3/16/26 PASRR Level II outcome identified her as Level II and directed the need for specialized and rehabilitative services. On 4/9/26 review of Resident #6's current Care Plan lacked her Level II outcome and the implementation of specialized and rehabilitative services directed in her 3/16/26 PASRR. 3. Resident #18's 1/1/26 PASRR Level II outcome identified her as a Level II and directed the need for specialized and rehabilitative services. Review of Resident #18's Care Plan review on 4/9/26 listed her Level II requirements but did not show who would oversee the services, when they would begin, or if the facility had completed the necessary referrals. In an interview on 4/8/26 at 3:17 PM, the Administrator explained the facility's Social Worker completed the PASRRs for the residents. She had been in the role for nine months; however, she had not had training on how to complete them.

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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. Based on record review, staff and resident interviews, and policy review, the facility failed to implement interventions into the care plans for 2 of 2 residents following their return from hospitalizations (Residents #2 and #6). The facility reported a census of 42 residents.Findings include:1.The Census List for Resident #2 documented hospitalization from 1/19/26 to 1/23/26, and a second hospitalization from 3/25/26 to 4/2/26.Review of Resident #2's Progress Note by his Advanced Registered Nurse Practitioner (ARNP) revealed he was seen on 1/26/26 at the facility for an acute follow-up due to a recent hospitalization from 1/19/26 to 1/23/26. During his hospital stay, he was diagnosed with acute respiratory failure with hypoxia due to Influenza A and was also treated for a Urinary Tract Infection (UTI).Review of Resident #2's Progress Note by his ARNP revealed he was seen on 4/6/26 at the facility for an acute follow up due to a recent hospitalization that he returned from on 4/2/26. During his hospital stay, he was treated for kidney stones and treated for a UTI. He returned to the facility with a peripherally inserted central catheter (PICC) line and is receiving antibioticsIn an interview on 4/8/26 at 1:45 PM, Resident #2 denied having any issues with care at the facility. He stated that his hospitalizations went well and that if he didn't feel well, the nurses took it seriously and took action.Review of Resident #2's current Care Plan Report on 4/9/26 revealed it had not updated to include his recent hospitalization, his current need for antibiotic therapy, kidney stones, or the maintenance of his PICC site. 2. The Census List for Resident #6 documented hospitalizations from 2/18/26 to 2/27/26 and from 3/29/26 to 4/3/26.Review of Resident #6's Progress Note by her ARNP revealed the resident was seen on 3/2/26 at the facility for an acute follow up due to a recent hospitalization that she returned from on 2/27/26. During her hospital stay, she was treated for hypernatremia (too much salt in the blood) causing confusion and diabetes insipidus (kidneys unable to conserve water as they filter the blood). Review of Resident #6's Progress Note by her ARNP revealed the resident was seen on 4/6/26 at the facility for an acute follow up due to a recent hospitalization that she returned from on 4/3/26. During her hospital stay, she was treated for aspiration pneumonia and acute respiratory failure with hypernatremia and hyperkalemia (elevated potassium).Review of Resident #6's current Care Plan Report on 4/9/27 revealed it had not updated to include her recent hospitalization and if signs or symptoms could be monitored in the facility for hypernatremia. During an interview on 4/8/26 at 3:17 PM, the Director of Nursing (DON) confirmed that the Care Plans for Resident #2 and Resident #6 were not updated following their hospitalizations.A review of the facility's Care Plan Policy (last revised 3/2025) revealed a lack of instructions regarding whether care plans need to be reviewed following hospitalizations.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on clinical record review, document review and staff interview the facility failed to follow physician orders to obtain daily weights for 1 of 1 resident sampled on daily weights (Resident #5). The facility reported a census of 42 residents.Findings include:The Electronic Healthcare Record (EHR), last order review 2/09/26 documented a physician order for a daily weight in the morning related to heart failure, start date 11/25/25.The Risk for Altered Cardiovascular Functioning related to Heart Failure and Chronic Kidney Disease, Stage 4 Care Plan dated 10/7/25 directed to monitor weights as ordered. A 4/07/26 review of the 2026 Electronic Treatment Administration Records (ETARs) and the Vital Sign Weight Records revealed the following missing daily weights:a. January 1, 3, 4, 13, 18, 20, 29 and 31b. February 12, 19, and 21c. March 1, 3, 5, 17, 19, and 22d. April 4On 4/08/26 at 10:23 AM, Staff A, Certified Medication Aide (CMA) reported generally the certified nursing assistants (CNAs) got the daily weights first thing in the morning and then gave the weights to the nurses. The nurses documented the weights in the resident's electronic health record. On 4/08/26 at 10:26 AM, Staff D, Licensed Practical Nurse (LPN) explained the CNAs got the daily weights first thing in the morning before breakfast. They had two residents on dialysis which included Resident #5 that required daily weights before and after dialysis treatments. The CNAs reported the weights to the nurses and the nurses documented the daily weights in the ETAR or in the EHR vital signs tab. On 4/08/26 at 10:56 AM, Staff B, CNA reported occasionally the nurses asked her to get a weight, but other than that she was not sure what they did for daily weights. On 4/08/26 at 2:37 PM, the Director of Nursing (DON) reported she had talked with the nurses and the EHR was not marked with a heart to allow the nurses to enter the weight into the ETAR. If the nurse didn't enter the weight into the vital signs weight then the weight was probably not documented. The DON reported she expected the nurses to follow the physician order for daily weights and document the weights in the medication record. On 4/09/26 at 11:07 AM, the Administrator reported ideally the nurse who took the physician order should put the order in the resident's EHR. The nurses may need more education to know there was a supplemental area that prompted for more information to be placed within the order. She stated most likely the weight was taken and the nurse didn't enter the weight into the EHR Vital Sign area. The Physician Orders/Transcription of Orders Policy dated 7/2023 included a Purpose to correctly and safely receive/transcribe physician's orders so the correct order can be followed/administered. The policy further revealed the following per the Procedure section: Medication/Treatment orders would be entered in the EMAR or ETAR accordingly and active orders should be followed and carried out as written.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, CMS 2567 review, and QAPI (Quality Assurance Performance Improvement) Plan review, the facility failed to implement effective quality assurance processes to address Pre-admission Screening and Resident Review (PASRR) deficiencies, resulting in F644 being cited in 2025 as well as the current survey. The facility reported a census of 42 residents.Findings include:A review of the facility CASPER report revealed the facility cited for F644 Coordination of Pre-admission Screening and Resident Review (PASRR) (a federally mandated process for evaluating individuals with serious mental illness (SMI), intellectual disabilities (ID), or related conditions (RC) prior to admission into a Medicaid-certified nursing facility to ensure appropriate placement, and necessary services) and Assessments March 2025.The facility CMS 2567 Plan Of Correction (POC) with a compliance date of 4/19/25 detailed the Administrative Nurses and Social Service Designee would continue to review the PASRR assessments during the referral process to ensure new admissions had all mental health diagnoses included on the PASRR completed prior to admission. The Social Service Coordinator, or Designee, would audit admissions monthly times three months to ensure all diagnosis were listed on the current PASRR. The results of the audits would be reviewed as a part of the facility's ongoing quality assurance process and the frequency of the audits thereafter would be based on the outcomes. A 4/07/26 review of Resident #38's Clinical Record revealed a PASRR completed by a local hospital 9/02/25 prior to admission which listed a suspected diagnosis of anxiety disorder and the use of antidepressant and antianxiety medications. Resident #38 was admitted to the facility on [DATE] with a physician order for antidepressant medication for a diagnosis of post-traumatic stress disorder (PTSD). A 12/19/25 Physician Order detailed to start Abilify (antipsychotic medication) every morning.During an interview on 4/07/26 at 4:00 PM the Director of Nursing (DON) reported the facility did not have any updated PASRR Evaluation for Resident #38 since 9/02/25. Interview on 4/09/26 at 11:09 AM the Administrator explained all audits from any tagged (non-compliance) areas would have proper audits placed, completed, and tracked through the Quality Assurance and Process Improvement (QAPI) program for compliance. The QAPI Plan Policy, effective date 2/18/20 documented the Administrator functioned as the chair of the QAPI Committee and would be responsible and accountable for ensuring the QAPI program defined, implemented, maintained and addressed identified priorities and sustained it during transitions. The Policy further documented regulatory outcomes including licensure survey results would be monitored and trended. Completion of investigations and review of those findings should demonstrate process improvement initiatives implemented in the assessment stage have been sustained and the focus area has not been re-identified in the investigation stage.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on document review, policy review, and staff interview the facility failed to ensure the Infection Preventionist attended the Quality Assurance and Performance Improvement (QAPI) quarterly meetings. The facility identified a census of 42 residents.Findings include:A 4/07/26 review of the Quality Assurance (QA) Sign-in (Attendance) Sheets for 10/24/25 and 1/21/26 lacked documentation the facility Infection Preventionist attended the quarterly QA meetings.On 4/08/26 at 3:00 PM the Director of Nursing (DON) reported the Infection Preventionist had still been an employee of the facility at that time and may have worked the floor so she was unable to attend the QA meetings.On 4/09/26 at 8:35 AM the Administrator reviewed all the QA Sign-In Sheets and verified the Infection Preventionist was not in attendance at the meetings. She reviewed the QAPI meeting notes for 10/24/25 and 1/21/26 to find there wasn't significant information regarding a quarterly review of the infection control program/tracking. The Administrator voiced if the Infection Preventionist had worked the floor, she wouldn't have been able to attend the meetings at those times. She would expect the Infection Preventionist to attend the QAPI meetings. The QAPI Plan Policy effective date 2/18/20 outlined the QA Committee included the Medical Director or Designee, DON, Administrator or other leader, and the Infection Prevention and Control Officer.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of records, staff interviews, and facility policy, the facility failed to provide education and obtain informed consent for 2 of 5 residents regarding eligibility for COVID-19 vaccination (Resident #7 and #12). The facility reported a census of 42 residents.Findings include:1.Review of the Census List on 4/9/26 for Resident #7 documented she was admitted to the facility on [DATE] and was a current resident. A review of her Electronic Health Record (EHR) on 4/9/26 revealed no documentation that she received COVID-19 vaccination education or was provided informed consent.2. Review of the Census List on 4/9/26 for Resident #12 documented he was admitted to the facility on [DATE] and was a current resident. A review of his EHR on 4/9/26 revealed no documentation that he received COVID-19 vaccination education or was provided informed consent.In an interview on 4/9/26 at 10:29 AM, the Director of Nursing stated the current Infection Preventionist was on leave. After reviewing past immunization records, the Director was unable to find documentation that Resident #7 and #12 were provided with education. There was also no signed documentation that showed the residents refused the COVID-19 vaccinations.The facility's Infection Control Manual, last revised 10/2025, required staff to educate residents, obtain consent for available vaccines, and document all immunizations in the EHR.