STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165342	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Dale Wellness Village	404 First Street Battle Creek, IA 51006

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, guidance from the 2025 Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual and facility policy review, the facility failed to update the Comprehensive Care Plan for 1 of 13 residents (Resident #32) reviewed for Care Planning. The facility reported a census of 29 residents. Findings include:The Annual Minimum Data Set (MDS) of Resident #32, dated 8/31/25, documented diagnoses that included atrial fibrillation, heart failure and hypertension. The Quarterly MDS dated [DATE] documented the same above diagnoses as still be active for Resident #32The History and Physical from the community hospital dated 8/18/25 documented Resident #32 arrived to the hospital emergency department on 8/17/25 and was admitted for acute congestive heart failure (a new diagnosis) with hypoxemia (when the heart suddenly gets very weak, failing to pump well, causing fluid to back up into the lungs, which then causes the oxygen levels in the blood to be lowered. This can lead to severe breathlessness). The notes from the community hospital, with a print date of 12/5/25 documented a registration date to the hospital of 12/1/25. The History of Present Illness documented the resident was transported to the emergency department for further evaluation with symptoms of back pain, abdominal pain and refusal to eat. The workup in the emergency department findings were acute on chronic congestive heart failure and hypoxemia, requiring intravenous (IV) diuretic medication (medication to remove excess body fluid). The Medical Administration Record (MAR) of Resident #32 for December of 2025 documented the resident had daily orders for Amlodipine for hypertension (high blood pressure), aspirin for atrial fibrillation (chronic irregular heartbeat), Furosemide (diuretic, water pill for heart failure), Lisinopril for hypertension, and Metoprolol for hypertension.The Comprehensive Care Plan of Resident #32, reviewed on 12/10/25 failed to identify the resident having any cardiac diagnoses or cardiac medications. The Care Plan documented use of diuretic medication related to edema. On 12/11/2025 at 9:45 am, the Director of Nursing (DON) stated the MDS Coordinator is the person who completes the care plans. She stated she was aware certain medications should be care planned and they audit the care plans for particular medications. On 12/11/2025 at 9:46 am, the MDS Coordinator stated the resident primary diagnosis was not required to be on the care plan. On 12/11/2025 at 9:47 am, the Regional Nurse Consultant stated the Corporate Reimbursement Specialist reviews the care plans. She stated they will speak to her regarding primary diagnoses being care planned. She added that any new diagnosis a resident receives should be reviewed and added to the Care Plan. The 2025 RAI manual states the Care Area Assessment (CAA) portion of the MDS for an Annual Assessment must be completed within 14 days of the ARD (the date of the assessment), and the Care Plan must be completed within 7 days of the CAA completion. Resident #32's most recent Annual Assessment was dated 8/31/25. The facility policy titled Care Plan Policy, revision date 7/2023 documented the following:Procedures:1. During admission, the facility will put in place baseline care plans within 48 hours to address resident's care.2. The baseline care plan at a minimum should include initial goals, physician orders, dietary orders, therapy services, social services, and PASARR recommendations if applicable.3. The facility will provide the resident/representative a written summary of the baseline (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plan by the completion of the comprehensive care plan.4. After the comprehensive assessment (state/federal-required MDS) is completed, the facility will put in place person-centered care plans outlining care for the resident.5. These will be reviewed and revised by the interdisciplinary team after completion of MDS assessments when applicable and with changes that warrant a care plan revision.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, staff interview, clinical record review, drug manufacturer guidance, and facility policy review, the facility failed to assure a medication error rate of less than 5%. Medication administration was observed for a total of five residents, with errors being observed for one of five residents (Resident #25). A total of 26 ordered medications were reviewed with two errors, an error rate of 7.7%. The facility reported a census of 29 residents. Findings include:On 12/10/25 at 7:48 am, the observation of the medication pass began. Staff A, Licensed Practical Nurse (LPN) stated Resident #25 was done eating his breakfast so she would start with him. Staff A prepared a total of 12 medications for Resident #25. Among the medications observed, Staff A prepared Breo Ellipta Inhalation (a maintenance inhalation medication used for the treatment of airflow obstruction for asthma or pulmonary disease). Staff A additionally administered Levothyroxine, a thyroid medication. Staff A administered the medications to the resident at 7:59 am. The Medication Administration Record (MAR) for December of 2025 for Resident #25 included the instructions for Breo Ellipta for the resident to rinse mouth after use. Staff A failed to instruct the resident to rinse his mouth after inhaling the medication. The MAR additionally included the instructions for Levothyroxine to administer on an empty stomach. Resident #25 had eaten his entire breakfast prior to medication administration.The Prescribing Information from the Breo Drug Manufacturer documented the following: BREO can cause serious side effects, including: fungal infection in your mouth or throat (thrush). Rinse your mouth with water without swallowing after using BREO to help reduce your chance of getting thrush.The Prescribing Information from the Levothyroxine Drug Manufacturer documented the following: Administer Levothyroxine Sodium Tablets as a single daily dose, on an empty stomach, one-half to one hour before breakfast.On 12/10/25 at 12:54 pm, the Director of Nursing stated after using Breo medication, the resident is to rinse his/her mouth. The DON stated all synthroid medications in the facility are scheduled with the morning medication pass per the Medical Director's approval. She stated she would clarify with the provider to remove the instructions of taking on an empty stomach. On 12/10/25 at 1:59 pm, the DON stated the facility Nurse Practitioner agreed to remove the verbiage from the levothyroxine order for Resident #25 to administer the medication on an empty stomach. The facility policy Medication Administration - Medication Pass, review date 5/2023, documented the following:Procedure Step 6: Read special medication administration instructions