STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165347	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nora Springs Care Center	907 W Congress Nora Springs, IA 50458

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility records, policy review and staff interviews, the facility failed to have competent staff explain the risks of not wearing a physician ordered knee immobilizer prior to transferring a resident from a chair to the bed for 1 of 3 residents (Resident # 3) reviewed resulting in bilateral closed fractures of the condyles of tibial plateau (the two rounded prominences at the top of the shin bone that form the weight-bearing surface, articulating with the thigh bone to create the knee joint) and fibulae (smaller of the two bones between the knee and the ankle). The facility reported a census of 46 residents. Findings include:Resident #3's Minimum Date Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicated intact cognition. The MDS documented Resident #3 had lower extremity impairment on one side. The MDS listed Resident #3 as dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for chair/bed-to-chair transfers. The MDS listed active diagnoses of fractures, osteoporosis, diabetes mellitus, and morbid (severe) obesity. The MDS documented an open wound to the right knee. The MDS documented Resident #3 had received surgical wound care. The Care Plan included the following Focuses with target date of 3/14/26:Resident #3 required assistance with activities of daily living (ADL's). The Interventions directed the following:Right knee immobilizer on during transfers/ambulation. Transferring: dependent with assist of 2 staff member(s) to complete this ADL.Walking: dependent with assist of 2 staff member(s) to complete this ADL.Resident #3 had a risk for falls related to altered gate and balance complicated by osteoporosis, history of previous fracture, obesity, renal (kidney) failure requiring dialysis (external mechanical filtering of the wastes and toxins from the blood) and open wound with delayed healing to the knee. The Interventions directed: Assist resident with ambulation and transfers as needed.Call light within reach.Consult with therapy as needed.Nonskid footwear.Resident #3 had a history of noncompliance with therapy recommendations related to transfers, ambulation and use of assistive devices. The Interventions directed:Educate resident regarding potential risks and adverse effects refusing recommendations.Staff to maintain respect for resident rights to make own lifestyle choice.The Care Plan Report lacked direction of the specific staff competent to provide education regarding potential risks and adverse effects of refusing treatment.Review of the Durable Medical Equipment (DME) Miscellaneous (Free Text Entry) (Non-Medicare Covered): Rehab Facility Orders dated 12/16/25, noted by Staff A, Licensed Practical Nurse (LPN), reflected the Physician saw and evaluated Resident #3 at the clinic on 12/16/25. The orders indicated Resident #3 could start advancing with weight-bearing as tolerated on the right lower extremity with the assistance of Physical Therapy (PT) and should continue with the protective knee immobilizer at all times while ambulating.The Appointment Note dated 12/16/25 at 2:05 PM indicated Resident #3 arrived back to facility from an appointment. Resident #3 received (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an order to start advancing weight bearing status as tolerated but continue with immobilizer at all times when weigh bearing. Follow up visit on 1/6/25. The Communication - with Therapy Note dated 12/19/25 at 2:35 PM directed Resident #3 up with 2 assist with bariatric 2 wheeled walker for pivots and ambulation, must have knee immobilizer on.The Communication - with Therapy Note dated 12/25/25 at 12:21 PM indicated Resident #3 got up with 2 assist and a 2 wheeled walker, knee immobilizer must be on. She can walk to bathroom and in hallway short distances. The Incident Report Note dated 12/31/25 at 5:31 PM indicated a nurse heard a scream down hall 4 around suppertime. The aides called on the walkie talkie for a nurse to come to Resident #3's room immediately. When walking into the room the nurse saw Resident #3 fall backwards with her legs in a backwards W shape. Upon first sight Resident #3's wound appeared split open. The aides had the gait belt placed appropriately on her. Resident #3 wore proper footwear and used her walker. She had her room free of clutter with adequate lighting. After determining Resident #3 as stable, the nurse called 911 for an emergent transfer. The nurse informed both Resident #3's husband and son of the situation in which they agreed to send her out. The nurse went back and did a further assessment in which Resident #3 stated, I did not hit my head the girls caught me, they did nothing wrong. There was nothing they could've done to prevent this my legs just buckled. Resident #3 showed signs and symptoms of severe pain and couldn't move either of her legs. Resident #3's vitals remained within normal limits until taken by ambulance to hospital. The Assessment of Resident including range of motion and pain described Resident #3's leg as bent backwards, with the wound on her knee spread open and actively bleeding. Resident #3 had pain rated as 10/10 (0 no pain, 10 worst pain ever), nearly hyperventilating (breathing too fast taking in too much oxygen and not releasing enough carbon dioxide), she couldn't move either of her legs or wiggle her toes upon her assessment. Resident #3 couldn't move her legs upon assessment and had suspected bilateral broken legs. The nurse completed a head-to-toe assessment, stabilized her legs with pillows, and contacted emergency medical services (EMS). The nurse noted Resident #3 needed educated she needed the immobilizer for safe ambulation per PT recommendations and Care Plan if refused ambulating will be deferred due to safety risks.The Communication - with Physician Note dated 12/31/25 at 6:10 PM reflected the nurse called the Physician and received verbal orders to send Resident #3 to the emergency room (ER) for evaluation.The Communication - with Staff Note dated 1/2/26 at 10:17 AM documented Resident #3's spouse came and took her personal belongings the day before and didn't want to hold her bed.The Progress Notes lacked documentation of Resident #3's refusal to wear the right knee immobilizer or that the staff provided education of the potential risk and adverse effects of the refusal. Staff B, Certified Nurse Aide (CNA)'s, personnel file documented a hire date of 8/20/25. The CNA job description, signed 8/20/25 by Staff B, listed the following essential functions of the position:Provides quality nursing care to guests in an environment that promotes their rights, dignity and freedom of choice.Provides individualized attention, which encourages each guest's ability to maintain or attain the highest practical physical, mental and psychosocial well-being. Attends to individual needs of all guests in regard to incontinent care, transferring, ambulation, range of motion, communication and other needs.Must be knowledgeable of individual care plans and support the care planning process by providing supervisor with specific information and observations of the guests needs, preferences and report any behavioral changes.Follow established safety precautions when preforming tasks and using equipment and supplies.The Skills and Techniques Evaluation, signed by Staff A on 8/20/25 indicating she received orientation in each of the areas identified and she understood her role in the various topics), directed to complete during job specific orientation and re-evaluated annually with performance review and/or as needed. Each task included Staff A's initials with (continued on next page)

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