

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165347	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Nora Springs Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to maintain kitchen equipment and clean dishes in a sanitary condition due to a white residue buildup. The facility reported a census of 39 residents. Finding includes: On 7/20/26 at 9:15 AM, an observation during an initial kitchen walkthrough revealed a buildup of white residue on the dishwasher and clean dishes. On 7/20/26 at 10:50 AM, an observation in the kitchen revealed the white residue remained on the dishes and in the dishwasher. On 7/21/26 at 11:05 AM, Staff E, Cook, reported facility staff attempted weekly descaling (removing mineral buildup) on the dishwasher, but dishes still retained the buildup. Staff E reported the Administrator held awareness of the issue. On 7/21/26 at 11:30 AM, the Dietary Manager (DM) reported facility awareness regarding the dishwasher issues, noting an ordered water softener remains on backorder. On 7/21/26 at 11:45 AM, the Administrator reported contacting the city in June regarding water usage to determine the required softener size, but received no response. The Administrator reported awareness regarding the buildup on the dishes and in the dishwasher. On 7/22/26 at 7:40 AM, Staff F, Dietary Aide (DA), reported the white residue on the dishwasher and dishes persisted for a long time. Staff F reported the Administrator held awareness without resolving the issue, noting several past and current residents disliked the buildup.		

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure staff obtained a completed and signed Iowa Physician Orders for Scope of Treatment (IPOST) (end-of-life care order) from a physician for 1 of 8 residents (Resident #4) reviewed for advance directives. The facility reported a census of 39 residents. Findings include: Resident #4's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] documented a BIMS score of 12, indicating moderately impaired cognition. A progress note dated [DATE] at 1:49 PM by Staff A, Social Worker (SW), documented leaving a message with Resident #4 Representative, asking Resident #4 Representative to call Staff A to sign Resident #4's Iowa Physician Orders for Scope of Treatment (IPOST) (end-of-life care order). The progress note documented Resident #4 maintained a Do Not Resuscitate (DNR) (no CPR) code status and noted the facility didn't have the original IPOST. Resident #4's care plan on [DATE] directed staff of an advance directive of DNR code status. An observation on [DATE] at 1:37 PM of Resident #4's Profile documented a code status of DNR. Resident #4's order summary documented a DNR order dated [DATE]. A progress note dated [DATE] at 1:31 PM documented Staff A reviewed the care plan and code status with Resident #4. Staff A reminded Resident #4 regarding seeking assistance at any time as needed and documented Preadmission Screening and Resident Review (PASRR) (mental health screening) in compliance. The note documented Resident #4's niece would call for a care conference on [DATE] at 11:30 AM to review code status and the care plan with Resident #4's niece. On [DATE] at 10:31 AM Resident #4 indicated she was a DNR. On [DATE] at 10:35 AM Staff A acknowledged the physician hadn't signed the IPOST and stated expecting the physician to sign the IPOST. On [DATE] at 12:33 PM Staff A indicated the Nurse Practitioner (NP) signed Resident #4's IPOST. On [DATE] at 12:34 PM an observation of Resident #4's record revealed the NP signed Resident #4's IPOST on [DATE].		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, the facility failed to provide resident centered activities that incorporated the resident's interests and hobbies for 1 of 13 residents reviewed (Resident #29). The facility reported a census of 39 residents. Findings include:Resident #29's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Resident #29 reported high importance regarding engaging in favorite activities, attending religious practices, keeping up with news, listening to music, and reading books, newspapers, and magazines. Resident #29's MDS documented diagnoses including anxiety (excessive worry) and depression (mood disorder). On 7/21/26 at 9:11 AM Resident #29 reported uncertainty if the facility offers activities. Resident #29 expressed wanting someone to read aloud and assist with a computer tablet to watch movies. Resident #29 stated staff members don't visit or engage in activities with Resident #29. Resident #29 reported lying in bed all day and hasn't gotten out of bed for some time, preventing participation in activities. A record review of Resident #29's Progress Notes and Electronic Health Record (EHR) showed a lack of documentation regarding provided activities beyond verbal encouragement to attend group activities. Resident #29's EHR showed no documentation of one-to-one or in-room activities offered to Resident #29. On 7/22/26 at 9:50 AM Staff A, Activity Director, stated not always having time to conduct one-on-one activities with residents remaining in rooms. Staff A reported not conducting any one-on-one activities with Resident #29. On 7/22/26 at 10:00 AM Staff B, Administrator, stated staff members need to offer one-on-one activities if a resident doesn't leave the room for group activities.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review and staff interviews, the facility failed to follow professional standards for reconciling controlled drugs (medication with a high potential for abuse) for 1 of 3 residents reviewed (Resident #36). The facility reported a census of 39 residents. Findings include:Based on observation, record review, and interview, the facility failed to ensure staff members accurately counted and reconciled controlled medications (narcotics), and failed to immediately report a narcotic count discrepancy for 1 of 1 resident (Resident #36) reviewed for medication administration. Resident #36's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #36's MDS documented diagnoses including malignant neoplasm of the bladder (cancerous growth on the bladder). Resident #36's MDS documented hospice care (end-of-life care). On 7/20/26 at 1:55 PM Staff A, Registered Nurse (RN), and Staff B, Licensed Practical Nurse (LPN), conducted a narcotic count for shift change. Staff B held the narcotic count book, reading the count numbers aloud while Staff A looked at the narcotics. Neither staff member compared the physical narcotic count to the count sheet to verify accuracy. On 7/21/26 at 10:42 AM the Administrator stated nurses or a nurse and a Certified Medication Aide (CMA) count the cart whenever keys transfer. The Administrator stated staff must verify the physical narcotic count matches the narcotic count sheet. A record review of a facility-reported incident summary dated 7/10/26 at 6:06 AM showed staff notified the Director of Nursing (DON) of a narcotic count discrepancy for Resident #36's liquid morphine sulfate (controlled pain medication). The count sheet documented 29.25 milliliters (ml) should remain in the bottle, but staff measured 24 ml. Further incident investigation documented 29 ml should remain in the bottle when staff measured 24 ml. The facility couldn't determine the location of the missing morphine. On 7/22/26 at 9:27 AM Staff B stated working second shift the previous night without Staff G, CMA, reporting a count discrepancy. Staff B reported returning for the 6:00 AM to 2:00 PM shift the next morning and noticing a count discrepancy with Resident #36's morphine. Staff B reported immediately notifying the DON, who investigated the discrepancy. On 7/22/26 at 10:31 AM Staff H, LPN, reported the narcotic count appeared correct upon arriving for shift early morning on 7/9/26. Staff H reported the 2:00 PM count on 7/9/26 measured 29 ml, noting a minor discrepancy might exist due to liquid holding in the syringe insertion area during counting with Staff G. On 7/22/26 at 10:38 AM Staff G stated noticing a count discrepancy of 24 ml in the bottle during a count with Staff H, but felt unsure of the exact volume. Staff G stated Staff H reported the count as correct, so staff continued counting. Staff G stated failing to report the discrepancy to anyone other than Staff H at time of discovery. Staff G reported attempting to administer morphine to Resident #36 using a syringe larger than 1 ml, possibly 5 ml, but couldn't measure 0.25 ml accurately. Staff G reported receiving help from another CMA to obtain a different syringe, noting a small amount of morphine possibly remained in the discarded syringe tip. Staff G reported counting narcotics at 10:00 PM with Staff I, LPN, noting Staff I didn't question the count. Staff G reported Staff B identified the missing morphine on the morning of 7/10/26 and notified the DON. Staff G reported the facility provided instruction regarding the importance of narcotic documentation and reporting. On 7/22/26 at 11:34 AM Staff I reported failing to notice the initial count discrepancy due to incorrectly viewing the bottle. Staff I reported becoming aware of Resident #36's missing morphine on the morning of 7/10/26 while counting with Staff B, and immediately notified the DON. The Controlled Medication Storage and Count Policy dated October 2023 directed staff to immediately report any narcotic count discrepancy to the DON.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure staff administered insulin according to physician orders and failed to notify the physician when holding or altering insulin doses for 2 of 5 residents reviewed (Residents #30 and #22). The facility reported a census of 39 residents. Findings include: 1. Resident #30's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 2, indicating severely cognitively impaired. Resident #30's MDS included a diagnosis of diabetes (high blood sugar). Resident #30's insulin orders as of 4/7/26 documented Lantus (long-acting insulin used to manage blood sugar levels) 35 units in the morning, Novolog (rapid-acting insulin used to control high blood sugars) 10 units at lunch and 8 units at supper. On 6/30/26 a physician order documented Novolog 8 units in the morning. Resident #30's Progress Notes documented the following times nurses held insulin orders without notification or orders from the physician from 5/1/26 through 7/11/26: 5/4/26 at 12:54 PM held Novolog 10 units of insulin 5/10/26 at 5:07 PM held Novolog 8 units of insulin 5/11/26 at 11:35 AM held Novolog 10 units of insulin 5/16/26 at 4:58 PM held Novolog 8 units of insulin 5/18/26 at 1:18 PM held Novolog 10 units of insulin 5/19/26 at 12:27 PM held Novolog 10 units of insulin 5/20/26 at 12:49 PM held Novolog 10 units of insulin 5/28/26 at 5:22 PM held Novolog 8 units of insulin 6/10/26 at 12:37 PM held Novolog 10 units of insulin 6/27/26 at 9:08 AM held Lantus 35 units of insulin 7/8/26 at 8:53 AM held Novolog 8 units of insulin 7/8/26 at 11:35 AM held Novolog 10 units of insulin 7/11/26 at 6:18 PM held Novolog 8 units of insulin On 7/22/26 at 11:25 AM Staff A, Registered Nurse (RN), reported nurses don't adjust insulin doses (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but can hold insulin per nursing judgment per staff discretion. Staff A reported staff should send a fax to the physician and document in progress notes notifying the physician. Staff A reported nurses didn't verify with the doctor at the time, noting facility training instructed this practice. Staff A reported staff don't always notify the physician, but documented notifications in progress notes if completed. On 7/22/26 at 12:23 PM Staff B, Licensed Practical Nurse (LPN), reported nurses can't adjust the dose. Staff B reported a meeting where the former Director of Nursing (DON) told nurses staff could hold insulin per nursing judgment. Staff B reported a few residents had hold orders. On 7/22/26 at 12:29 PM Staff C, LPN, reported the former DON told staff nurses can't adjust dosing but can hold per nursing judgment. Staff C reported receiving instruction staff needed to document reasons for holding insulin without needing to call the physician. On 7/22/26 at 12:56 PM Administrator reported nurses per nursing judgment can hold insulin and should pass information at shift change and notify the physician. On 7/22/26 at 1:05 PM Nurse Consultant reported nurses can hold insulin if parameters exist for holding; otherwise, staff need to contact the doctor for directions. On 7/22/26 at 1:30 PM the DON reported nurses must call the physician if staff feel insulin needs holding or immediate adjusting. The DON reported staff must clarify with the physician what to do for insulin per physician direction. The DON reported some residents have hold parameters with orders from the doctor. On 7/22/26 at 2:20 PM Staff D, LPN, reported holding insulin per nursing judgment. Staff D reported not calling the physician to confirm insulins and receiving instruction nurses don't need to notify the physician. The Medication Administration-Medication Pass policy revised May 2023 directed staff to administer medications according to physician orders. 2. Resident #2's Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Resident #2's MDS documented diagnoses of diabetes (high blood sugar) and adult failure to thrive (unintentional weight loss and functional decline). The Transfer Orders signed by the physician on 1/20/26 documented orders for Basaglar (long-acting insulin) inject 8 units under the skin 1 time each day in the morning and insulin Aspart (rapid-acting insulin) inject 8 units under the skin 3 times a day before meals. Resident #22's Progress Notes documented the following times nurses held insulin orders per nursing judgment without notification to the physician: 1/23/26 at 3:32 PM insulin Aspart 8 units held (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/26/26 at 4:18 PM insulin Aspart 8 units held 1/28/26 at 4:52 PM insulin Aspart 8 units held 1/29/26 at 5:07 PM insulin Aspart 8 units held 1/30/26 at 5:02 PM insulin Aspart 8 units held and administered only 4 units per nursing judgment 1/31/26 at 5:14 PM insulin Aspart 8 units held 2/1/26 at 4:24 PM insulin Aspart 8 units held 3/7/26 at 4:49 PM insulin Aspart 8 units held 3/12/26 at 5:32 PM insulin Aspart 8 units held 3/15/26 at 4:42 PM insulin Aspart 8 units held 3/19/26 at 4:58 PM insulin Aspart 8 units held 3/20/26 at 5:42 PM insulin Aspart 8 units held 3/23/26 at 5:11 PM insulin Aspart 8 units held 3/26/26 at 5:16 PM insulin Aspart 8 units held 3/29/26 at 5:08 PM insulin Aspart 8 units held 4/1/26 at 12:48 PM insulin Aspart 8 units held 4/8/26 at 4:59 PM insulin Aspart 8 units held 4/14/26 at 5:03 PM insulin Aspart 8 units held 4/16/26 at 4:59 PM insulin Aspart 8 units held 4/17/26 at 5:08 PM insulin Aspart 8 units held 5/3/26 at 5:13 PM insulin Aspart 8 units held 5/7/26 at 4:59 PM insulin Aspart 8 units held 5/8/26 at 11:37 AM insulin Aspart 8 units held 5/12/26 at 4:56 AM insulin Aspart 8 units held (continued on next page)		

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