STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165352	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emmetsburg Care Center	2405 21st Street Emmetsburg, IA 50536

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, resident interview, staff interviews, and policy review, the facility failed to provide care and services according to accepted standards of clinical practice for 1 of 3 residents reviewed (Residents #2). The facility reported a census of 39 residents.Findings include: Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS identified Resident #2 required partial/moderate assistance with bed mobility and was dependent on staff for all transfers. Resident #2's MDS's documented diagnoses of cancer, hypertension (high blood pressure), urinary tract infection past 30 days, and chronic kidney disease. The Care Plan with a target date of 3/8/26 revealed Resident #2 was at risk for alteration in skin integrity related to frequent urinary incontinence and the need for bed mobility assistance. The care plan directed staff to administer treatments per physician orders. A Health Status Note dated 12/29/25 documented Resident #2 had a moisture break down on the left inner buttocks measuring 0.6 centimeters (cm) x 0.9 cm. The note documented the area was cleansed and barrier cream was applied. A Physician Order dated 12/29/25 directed staff to apply barrier cream with cares every shift to promote healing. The order lacked direction on where to apply the barrier cream or what type of barrier cream to use. On 1/7/26 at 10:40 AM, Resident #2 reported the staff were in a hurry to get her up this morning. She said she ate breakfast in her room and then went to do exercise. She said her bottom was hurting. She said she did not get any cream put on her bottom this morning as the staff was in a hurry. She said she had [NAME] ointment in her bedside table drawer but that not all the staff had been using it. She said her pants would stick to the cream and then irritate her bottom. She said it is hard to get around when you have a sore butt. Review of the January 2026 Treatment Administration Record revealed the treatment for the barrier cream had been signed off as completed on 1/7/26 morning shift (6 AM to 2 PM).On 01/7/26 at 11:20 AM, Staff A, Certified Medication Aide (CMA) reported he was told the barrier cream was applied with morning cares. He said Staff B, Certified Nursing Assistant (CNA) and Staff C, CNA got Resident #2 up this morning to go to therapy. He said it was around 7 AM. On 1/7/26 at 11:35 AM, Staff B, CNA reported she thought Staff C, CNA applied a cream to Resident #2's bottom when they got her up this morning. She said Staff C took some cream from a white tube and put it on. She said she did not know what the cream was or where Staff C got it from. On 1/7/26 at 11:49 AM, Staff C, CNA reported she did not assist with changing Resident #2's brief this morning. She said she had to step out of the room to assist another resident who was wandering. She reported she did not apply any barrier cream to Resident #2 buttocks.On 1/7/25 at 2:40 PM, the Regional Nurse Consultant reported she would expect staff to follow the physician order and administer the treatment according to the order. She reported the treatment should not be documented as completed if it had not been done.On 1/7/25 at 3:25 PM, observed Staff D, Licensed Practical Nurse (LPN) measured Resident #2's wound to the left buttocks. Staff D reported the wound was (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	round in appearance and measured 1.4 cm x 1.4 cm with two small open areas inside the wound that measure 0.2 cm x 0.3 cm and 0.2 cm x 0.2 cm. Staff D reported she thought the wound looked like it was caused from shearing with the top layer of skin missing. Staff D applied Desitin ointment to the wound. Staff D told Resident #2 she was going to reach out to the doctor to request a patch for padding and to protect the wound from moisture. Resident #2 replied that would be nice. Resident #2 verified she did not receive any cream or treatment for the wound during the morning shift (6 AM to 2 PM).A facility policy titled Physician Orders/Transcription of Orders revised 7/2023 documented active orders should be followed and carried out as written/transcribed.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, family interview, resident interviews, staff interviews and policy review the facility failed to provide bathing assistance for 3 of 3 residents reviewed for bathing (Residents #1, #2, #3). The facility reported a census of 39 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented Resident #1 required partial/moderate assistance for bathing. Resident #1's MDS included diagnoses of cancer, hypertension (high blood pressure), non-alzheimer's dementia, anxiety disorder and schizophrenia. The Care Plan with a target date of 2/8/26 documented staff to assist Resident #1 with shower/bathing per schedule. The Task Form titled Bathing Monday and Thursday for the last 30 days revealed Resident #1 received a bath/shower on 12/12, 12/24, 1/1 and 1/4. The form documented Resident #1 did not receive a bath/shower on 12/11, 12/22, 12/25 and refused a bath/shower on 12/29. Review of the documentation revealed Resident #1 did not have a bath/shower from 12/13 to 12/24 (11 days) and from 12/25 to 1/1 (7 days).The Clinical Record lacked documentation of any other attempts to offer or encourage Resident #1 to shower or bathe.On 1/5/26 at 1:39 PM, Resident #1's sister reported bathing was very infrequent and more likely to happen when she was at the facility. She said she thought a bath for Resident #1 was completed every two weeks. 2. Resident #2's MDS dated [DATE] assessment identified a BIMS score of 14, indicating intact cognition. The MDS documented Resident #2 required setup or clean up assistance for bathing. Resident #2's MDS included diagnoses of cancer, hypertension (high blood pressure), urinary tract infection past 30 days, and chronic kidney disease. The Care Plan with a target date of 3/8/26 documented staff to assist Resident #1 with shower/bathing per schedule. The Task Form titled Bathing Monday and Thursday for the last 30 days revealed Resident #2 received a bath/shower on 12/17, 12/23, 12/31 and 1/4. The form documented Resident #2 did not receive a shower on 12/11, 12/22, 12/25 and on 12/29. Review of the documentation revealed Resident #2 did not have a bath from 12/18 to 12/23 (5 days) and from 12/24 to 12/30 (7 days). The Clinical Record lacked documentation of any other attempts to offer or encourage Resident #2 to shower or bathe.On 1/7/25 at 10:40 AM, Resident #2 reported she thought she had not had a shower/bath for about 2 1/2 weeks. When asked if she had a sponge bath or bed bath, she said staff would use the wipes to clean her bottom but that was it.3. Resident #3's MDS dated [DATE] assessment identified a BIMS score of 10, indicating moderately impaired cognition. The MDS documented Resident #3 required substantial/maximal assistance for bathing. Resident #3's MDS included diagnoses of hypertension (high blood pressure), diabetes mellitus, depression, and overactive bladder. The Care Plan with a target date of 1/15/26 documented Resident #3 preferred showers for bathing and staff to assist with shower/bathing per schedule. The Task Form titled Bathing Tuesday and Friday for the last 30 days revealed Resident #3 received a bath/shower on 12/9, 12/26, 12/30, 1/2 and 1/6. The form documented Resident #3 did not receive a shower on 12/16, 12/19, and on 12/23. Review of the documentation revealed Resident #3 did not have a bath from 12/10 to 12/25 (15 days). The Clinical Record lacked documentation of any other attempts to offer or encourage Resident #3 to shower or bathe.On 1/8/26 at 9 AM, Resident #3 reported that he liked to take a whirlpool bath. He said the shower was gross. He said he gets a bath about once a week but would like to have a bath more often.On 1/6/26 at 2:14 PM, the Director of Nursing (DON) reported baths are scheduled two times a week and could be adjusted per resident preference. The DON reported staff documented baths in the electronic medical record. On 1/7/26 at 11:25 AM, the DON reported she was in the process of giving a written warning to all staff regarding bathing expectations. The DON reported she expected baths to be given (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	according to the schedule and if the bath was not given to have documentation on why it was not done. She said bathing documentation had been a concern and if the bath was not documented then it did not happen. The DON reported if a resident refused to take a bath, she expected the staff to reapproach the resident, if reapproach does not work, then a different staff member was to try and if the resident still refused, the staff member was to tell the nurse and the DON. She reported she did not have any documentation or insight on why the baths were not done.On 1/7/25 at 10 AM, the Administrator reported baths are automatically offered/scheduled two times a week on admission and then adjusted according to resident preferences. A facility policy/procedure titled Hygiene- Bathing/Shower revised 3/2024 documented the purpose was to cleanse skin, promote cleanliness and prevent infection. The procedure directed staff to document the completion of the shower/bath in point of care (electronic charting).