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	05/11/2026

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to develop a comprehensive care plan identifying a resident's needs and describing services to be furnished for a pressure sure and catheter for 1 of 3 residents reviewed (Resident #6). The facility reported a census of 41 residents.According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #5 scored 15 on the Brief Interview for Mental Status indicating no cognitive impairment. The resident's diagnoses included paraplegia, injury of kidney, and chronic kidney disease. Resident #5 had an indwelling urinary catheter. The Care Area Assessment (CAA) documented the resident had a suprapubic catheter in place, and it would be addressed in the care plan to avoid complications, maintain level of functioning, and minimize risks.The current Care Plan with a goal target date of 5/3/26 failed to address the indwelling catheter.A Weekly Pressure Ulcer Progress Report dated 1/13/26 documented Resident #5 had a stage 2 pressure ulcer. The report continued to present.The current Care Plan identified Resident #5 at risk for alteration in skin integrity with the goal not to develop skin alterations outside of the disease process.The Current Care Plan with goal target dates of 5/3/26 failed to address the resident had a pressure ulcer.On 5/7/26 at 7:35 a.m. Staff A MDS Coordinator/Licensed Practical Nurse (LPN) verified the catheter and the pressure ulcer should be addressed on the care plan.The facility Care Plan Policy revised 3/25 documented the purpose to ensure that all care plans including base line care plans were in conjunction with the federal regulations including a comprehensive care plan developed after the comprehensive assessment of a resident. These would be reviewed and revised by the interdisciplinary team after completion of MDS assessments when applicable and with changes that warranted a care plan revision.

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	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 record review and staff interview, the facility failed to update the care plan to reflect a resident on an antipsychotic for 1 of 3 residents reviewed (Resident #8). The facility reported a census of 41 residents.According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #8 scored 7 on the Brief Interview for Mental Status indicating severe cognitive impairment. Resident #8's diagnoses included a stroke and hallucinations. The resident received 0 antipsychotic medications.The Progress Notes dated 3/24/26 at 9:25 a.m. documented a communication with the physician about Resident #8 having increased behaviors and paranoia, and requesting a review of her medication for possible update or review. At 2:27 p.m. received a signed order for Seroquel (antipsychotic) 25 mg 2 times a day.The Medication Administration Record (MAR) for March 2026 showed Resident #8 started Seroquel 25 mg two times a day with a start date of 3/24/26. The MAR showed the Seroquel dose increased to 50 mg two times a day on 3/30/26 related to dementia in other diseases classified elsewhere, unspecified severity with mood disturbance.The Care Plan with a goal target date of 6/21/26 lacked identification of Resident #8 receiving antipsychotic medication.The facility Care Plan Policy revised 3/25 documented the purpose to ensure that all care plans including base line care plans were in conjunction with the federal regulations including a comprehensive care plan developed after the comprehensive assessment of a resident. These would be reviewed and revised by the interdisciplinary team after completion of MDS assessments when applicable and with changes that warranted a care plan revision.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review and staff interview, the facility failed to ensure baths as planned for 3 of 4 residents reviewed (Resident #2, #4 and #5). The facility reported a census of 41 residents.Findings include:1. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #2 scored 14 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident required partial/moderate assistance with bathing. Resident #2's diagnoses included anemia, inflammatory bowel disease, and diabetes.The current Care Plan with goal target dates of 5/31/26 identified Resident #2 required assistance with Activities of Daily Living (ADL's) related to generalized weakness and neuropathy to lower extremities. Interventions included assisting the resident with shower/bathing per schedule.The Tasks tab in Resident #2's Electronic Health Record (EHR) documented bathing 2 times a week and as needed.A report of bathing Tuesday and Friday showed Resident #2 had a bath documented on: a. 2/6/26 and 2/13/26, 7 days between b. 2/13/26 and 2/20/26, 7 days between c. 2/25/26 and 3/3/26, 6 days between d. 3/9/26 and 3/17/26, indicating the resident not available on 3/13/26, e. 3/17/26 and 3/27/26, 10 days between, f. 3/27/26 and 4/3/26 and 4/4/26, 7 days between. 2. According to the MDS dated [DATE], Resident #4 scored 8 on the BIMS indicating moderate cognitive impairment. The resident required supervision/touching assistance with bathing. Resident #4's diagnoses included diabetes and cardiomyopathy.The current Care Plan with a goal target date of 6/15/26 identified Resident #4 required assistance with ADL's related to difficulty in walking, generalized weakness, and obesity. Interventions included assisting the resident with shower/bathing per schedule.The Tasks tab in Resident #4's EHR documented bathing 2 times a week and as needed.A report of bathing Tuesday and Friday showed Resident #4 had a bath documented on: a. 2/8/26 and 2/20/26, 12 days between, b. 2/20/26 and 2/27/26, 7 days between, c. 3/6/26 and 3/17/26, 11 days between, d. 3/17/26 and 3/24/26, 7 days between, e. 3/27/26 and 4/3/26, 7 days between, f. 4/10/26 and 4/21/26 11 days between. 3.According to the MDS dated [DATE], Resident #5 scored 13 on the BIMS indicating no cognitive impairment. The resident required partial/moderate assistance with bathing. Resident #5's diagnoses included cancer and non-Alzheimer's dementia.The Current Care Plan with a goal target date of 6/15/26 identified Resident #4 required assistance with ADL's. Interventions included assisting the resident with shower/bathing per schedule.A report of bathing Tuesday and Friday showed Resident #4 had a bath documented on: a. 3/2/26 and 3/9/26, 7 days between. b. 3/9/26 and 3/15/26, 6 days between. c. 3/15/26 and 3/23/26 resident refused (8 days between), 3/26/26 11 days between, d. 3/26/26 and 4/6/26, 11 days between, e. 4/16/26 and 4/23/26, 7 days between, f. 4/16/26 and 4/23/26, 7 days between, g. 4/23/26 and 4/30/26, 7 days between.On 5/7/26 at 9:28 a.m. Staff B Certified Nursing Assistant (CNA) stated she did baths. She said some days she was pulled to the floor and did not get to do the baths.On 5/7/26 at 4:15 p.m. The Director of Nursing (DON) verified baths did not always get done as planned due to staffing. They were looking at changes to avoid that.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 3 residents reviewed (Resident #4). The facility reported a census of 41 residents.According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #4 scored 8 on the BIMS indicating moderate cognitive impairment. The resident depended on staff for toileting hygiene. The resident was incontinent of urine and frequently incontinent of bowel. Resident #4's diagnoses included diabetes and benign prostatic hyperplasia (enlarged prostate).The current Care Plan with goal target dates of 6/15/26 identified Resident #4 required assistance with Activities of Daily Living (ADL's) related to difficulty in walking, generalized weakness, and obesity. Interventions included assist of 1 for toilet transfers and cares, with the front wheeled walker and belt.On 5/7/26 at 8:08 a.m. Staff C Certified Nursing Assistant (CNA) and Staff D CNA went to do a.m. cares with Resident #4. Staff assisted the resident to stand with a gait belt. After removing the incontinent pad, Staff C stood on the resident's right side and used a premoistened cloth and wiped his anal area with her left gloved hand resulting in bm on the wipe. Staff C asked Staff A LPN to help with wipes. Staff A handed wipes to Staff C and multiple wipes had bm on them. When she no longer found bm, without changing gloves she obtained a washcloth from a basin and with both hands handled the washcloth and wiped in the front genital area with the right hand, turning the cloth with her left gloved hand after each wipe. When finished she assisted in applying the new incontinent pad and shorts wearing the same gloves. When the resident sat in the w/c Staff C removed her gloves and washed her hands.On 5/7/26 at 4:15 p.m. The Director of Nursing (DON) stated when doing incontinent care they should go from front to back. If they started in the back, gloves should be changed with hand hygiene before cleaning the front.The Incontinence Care policy revised 8/2023 identified the purpose to provide perineal care to ensure cleanliness and comfort to the resident, to prevent infection and skin irritation, and to observe the resident's skin condition. If feces present, remove with toilet paper or disposable wipe by wiping from front of perineum to rectum. Discard soiled materials and discard gloves. Wash hands if visibly soiled and apply new gloves. Apply clean brief/incontinent pad/undergarment.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and staff interview, the facility failed to ensure a record of controlled drugs was adequately monitored allowing for the temporary inability to reconcile a controlled medication for 1 resident (Resident #1) and other residents with controlled medications. The facility reported a census of 41 residents.Findings include:According to the Minimum Data Set Assessment (MDS) dated [DATE], Resident #1 scored 14 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. Resident #1's diagnoses included fractures and other multiple traumas. The resident took opioid medication.The Care Plan with a goal target date of 7/2/26 identified Resident #1 had complaints of pain described as Acute- 1 month, related to semitruck accident, with multiple fractures to bilateral lower extremities and left hand. Interventions included administering pain medication per physician orders.The Hospice Medication Orders dated 3/23/26 included Morphine Sulphate 20 mg/ml oral concentrate, quantity 30 ml. Take 0.25 ml (5 mg) by mouth or under tongue every 2 hours as needed for moderate to severe pain or shortness of breath.The Progress Notes dated 4/3/26 at 11 a.m. documented a medication event incident repot. The nurse received notification that a resident's morphine was missing from the narcotic drawer. The facility initiated an immediate investigation, including a search of both medication carts and treatment carts, with no medication located at that time. Further investigation revealed the overnight nurse was contacted and reported that she had inadvertently taken the medication home in the pocket of her scrub jacket. The nurse returned the morphine to the facility upon discovery. The returned medication was reviewed by the nurse in collaboration with hospice staff, and the narcotic count reconciled. The medication was assessed for color, amount, and consistency, with no discrepancies noted. The morphine was subsequently destroyed per facility narcotic destruction protocol with hospice present. Review of facility camera footage confirmed that the nurse exited the resident's room holding the medication and subsequently placed it in her pocket while assisting another resident. Video evidence further confirmed that the medication remained in the nurse's jacket pocket as she left the facility. Additional review indicated that proper narcotic count procedures were not followed by the nurse and medication aide at the time of shift change.The Narcotic and Controlled Substance Shift to Shift Sheet for February 2026 lacked signature for:On coming nurse 2/2/26 1st shift,Off going nurse 2/2/26 2nd shift,On coming nurse 2/10/26 1st shift,Off going nurse 2/10/26 2nd shift,Off going and on coming nurse 2/11/26 1st, 2nd, and 3rd shift,Off going and on coming nurse 2/14/26 3rd shift,Off going nurse 2/15/26 1st shift,On coming nurse 2/17/26 2nd shift,Off going nurse 2/19/26 2nd shift,Off going nurse 2/22/26 2nd shift,Off going nurse 2/23/26 2nd shift,Off going and oncoming nurse 2/23/26 3rd shift,Off going nurse 2/24/26 1st shift,On coming nurse 2/24/26 2nd shift,Off going nurse 2/24/26 3rd shift,On coming nurse 2/27/26 1st shift,Off going nurse 2/27/26 2nd shift.The Narcotic and Controlled Substance Shift to Shift Sheet for March 2026 lacked signature for:Off going and on coming nurse 3/1/26 1st shift,Off going nurse 3/1/26 2nd shift,Off going and on coming nurse 3/26/26 3rd shift,Off going nurse 3/27/26 1st shift.The Narcotic and Controlled Substance Shift to Shift Sheet for April 2026 lacked signature for:Off going nurse 4/3/26 1st shift,On coming nurse 4/4/26 2nd shift,On coming nurse 4/8/26 3rd shift,Off going nurse 4/9/26 1st shift,Off going nurse 4/9/26 2nd shift,Off going nurse and on coming nurse 4/30/26 1st shift,Off going nurse 4/30/26 2nd shift.On 5/4/26 at 3:46 p.m. Staff E CMA said Staff F Registered Nurse (RN) had already signed the narc count off (the day thet could not find the morphine). He found something he thought was off and went to tell the nurse. Staff F, Staff G Licensed Practical Nurse (LPN), and Staff H LPN all said why the patches were off and did not even offer to count with him. Staff F had already signed off the count.On 5/4/26 at 4:25 p.m. Staff H stated she did not recall Staff E saying anything about pain patches being off. She said she was not on the cart that day so she had not done the count. She said she always did count (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with someone, and started late if need be to get that done. On 5/4/26 at 5:18 p.m. Staff G stated Staff E did come and say they only counted boxes not patches and the count was off. They tried to explain on the 1st count they count the # of boxes/cards/etc Then they count the number in the boxes and cards. She said she always counted with the off going nurse, or on-coming nurse. She had seen spaces where the off going or on coming nurse or med aide had not signed off.On 5/5/26 at 9:09 a.m. Staff F RN stated the night she worked and inadvertently took the morphine home, she was multitasking, and put the morphine bottle in her scrub jacket, which she never wore, and she had so many pockets. She had administered the morphine in the resident's room. She drew it up in the plunger and administered it to Resident #1. After that she had a blood sugar and forgot the morphine was there. She said the CMA did the count by himself and said there was a problem with the fentanyl patches. But apparently, they count the box of patches as 1, instead of the number of patches. So, she signed the count even though she didn't do the count. She said if they had done the count together, she would have realized she still had the morphine in her pocket. She said Resident #1 had a lot of pain in his legs. She felt terrible about this, and him possibly needing it and it not being there. She felt not counting narcs together was a common practice. She said she would never do that againOn 5/7/26 at 8:32 a.m. the Director of Nursing (DON) stated Resident #1's morphine went home with a nurse. The nurse and CMA did not count the narcotics. The off going and on coming nurse/cma should count the narcs together to assure all meds were accounted for.The Controlled Medication Storage and Count Policy revised 10/2023 documented narcotic counts were completed at the beginning and end of each shift or at the time when there was an exchange of medication cart keys. The exchange required 2 nurses or 1 nurse and 1 Certified Medication Aide. The oncoming nurse validated the medication count on the med card, and the off going nurse validated medication count on the paper document. Both nurses were required to sign off on the shift to shift count record.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure residents were free of significant med errors for 3 of 4 residents reviewed (Resident #2, #6 and #7). The facility reported a census of 41 residents.Findings include:1. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #2 scored 14 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. Resident #2's diagnoses included diabetes and the resident received insulin daily.The current Care Plan with a goal target date of 5/31/26 identified Resident #2 at risk for complication related to Diabetes Mellitus. Interventions included encouraging compliance with diet and medication regimen, and medication as ordered. The Medication Administration Record (MAR) for April 2026 Showed Resident #2 had an order foe Lantus 20 units 2 times a day with a start date of 4/20/26. The 4/22/26 a.m. dose was blank.The MAR showed the resident had an order for Novolog per sliding scale. The resident had an a.m. blood sugar of 168. Per the sliding scale the resident would receive 17 units of the Novolog. The breakfast insulin was blank.The Progress Notes dated 4/22/26 at 11:31 a.m. documented Resident #2's blood sugar log faxed to the physician. At 12:14 p.m. Resident #2 monitored after a decrease in Lantus to 20 units 2 times a day.On 5/11/26 at 9:34 a.m. Staff I LPN Licensed Practical Nurse (LPN) stated she could not say for sure about the resident's insulin that day. He had been having low blood sugars, so not sure if she may have held the insulin. She could not remember. She said she didn't recall having given insulin and not signing it out. She said she may have written something on the fax with the blood sugars.A Blood Sugar Summary dated 4/22/26 included hand written notes about the a.m. sliding scale Novolog being held due to a blood sugar of 168 and resident only eating 1 bowl of cereal per the resident's normal, and he did receive 20 units of Lantus.On 5/11/26 at 2:34 p.m. Resident #2's Physician stated they had nothing in their record that the Novolog was held on 4/22. She said they could hold until they heard back from the physician and had a discussion. There has been an issue with receiving faxes, and if they didn't hear back timely, they needed to call. 2. According to the MDS assessment dated [DATE], Resident #6 scored 14 on the BIMS indicating no cognitive impairment. Resident #6's diagnoses included a seizure disorder. The resident received anticonvulsant (antiseizure) medication.The MAR for February showed the Resident #6 had an an order for Lacosamide 150 mg 2 times a day with a start date of 9/18/25. The MAR documented the resident received the medication 2 times a day in February.The Controlled Drug Receipt/Record/Disposition Form for Resident #6's Lacosamide 150 mg, take 1 tablet twice daily. The record showed a tab only signed out 1 time on 2/5, 6, 9, and 11/26.The Progress Notes dated 2/16/26 at 10:58 a.m. an agency nurse notified the Director of Nursing (DON) she identified a medication administration error involving omitted doses of Lacosamide 150 mg at bedtime on 2/5, 6, 9, and 11/26. The nurse acknowledged the medication was not administered on those dates but was documented as given in the medical record. Upon discovery, the nurse immediately completed a resident assessment. The resident remained at baseline with vital signs within normal limits, no adverse effects noted, and no seizure activity or seizure-like symptoms observed during the time period of the missed doses. The attending provider and responsible party were notified per facility policy. The medication was administered as ordered moving forward, and the resident will continue to be monitored. The incident will be reviewed per facility policy for follow-up and corrective action. On 5/7/26 at 8:32 a.m. the DON stated the Lacosamide was a controlled medication and an agency nurse did not pull it from the lock box several times when she worked. When the agency nurse realized she had not given it she notified the DON. She said they did education and audits after this occurred. She said the staff was from agency and she had not worked in a while.3. According to the MDS dated [DATE], Resident #7 scored 3 on the BIMS indicating severe cognitive impairment. Resident #7's diagnoses included depression. The resident received antidepressant medication.The current Care Plan with a goal target date of 5/21/26 identified Resident #6 utilized a psychotropic medication in (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the category of antidepressant related to depression. Interventions included administering medications as ordered.The Progress Notes documented the following regarding Resident #7's Escitalopram 5 mg daily:1/22/26 out of these meds,1/23/26 no replacement card from pharmacy,1/24/26 medication not available at this time,On 1/26/26 no medication available at this time,On 1/27/27 still no meds,On 1/28/26 needs to be ordered,On 1/29/26 med not available at this time,On 1/30/26 med not available from pharmacy,On 1/31/26 medication not available at this time,On 2/1/26 medication not available at this time,On 2/2/26 medication to be delivered from pharmacy,On 2/3/26 medication not available at this time,2/4/26 medication not available at this time,2/5/26 med not available,2/6/26 med not available,2/7/26 medication ordered from pharmacy,2/8/26 waiting for pharmacy to deliver,2/9/26 med not available,2/10/26 medication not available.2/11/26 med not available.The Progress Notes dated 3/17/26 at 8 a.m. documented it was brought to office staff attention the resident had not received her Escitalopram Oxalate 5mg and documented in progress notes 01/22/26 - 01/24/26, 01/26/26 - 01/31/26, and 02/01/26 - 02/11/26. Medication was changed from being given at a.m. to bedtime (HS) on 01/21/26 per physician orders. It was subsequently not given on the above dates. Pharmacy did not send a new card, as there should have been a card with the proper dose already. On 5/7/26 at 8:50 a.m. the DON stated they did not have the medication, and staff kept charting awaiting med. Staff should call the pharmacy to question why they didn't have the med. They did staff education, reviewed all the meds in the cart to ensure correct, and conducted audits.The Medication Administration Administration - Medication Pass policy revised 5/2023 directed the purpose to safely and accurately prepare and administer medication according to the physician order and resident needs. The procedure included opening the Electronic Medication Administration Record (EMAR) and reviewing the medication order against the medication label. Read the transcribed physician order on the EMAR, resident name, medication name, dosage, route and interval ordered. Remove medication from the cart, and compare medication to the label for accuracy. If the medication was unfamiliar or the physician order questioned, contact the physician for clarification.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure accurate medication record for 1 of 3 residents reviewed (Resident #2). The facility reported a census of 41 residents. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #2 scored 14 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. Resident #2's diagnoses included diabetes.The Medication Administration Record (MAR) for March 2026 documented Resident #2 took Pregabalin 50 mg 2 times a day. On 3/14/26 the order changed from 50 mg to 75 mg 2 times a day.The Progress Notes dated 4/10/26 at 11:54 a.m. documented during med pass the med aid alerted the nurse of a discrepancy in medication dosage. The Medication card read: Pregabalin 50 mg 2 times a day and the MAR read: 75 mg 2 times a day. Per the nurse, the morning dosage held until further clarification with the provider obtained. Called the pharmacy and the provider to clarify. Per the provider's nurse, Resident #2 to continue on Pregabalin 50 mg BID daily. Transcription error corrected on MAR.A note from the facility to the physician on 4/10/26 at 10:05 a.m. documented a need for clarification on Resident #2's Pregabalin order, citing that a nurse changed the order from 50 mg 2 times a day to 75 mg on 3/13/26. Since 3/13/26 nursing staff had been giving 50 mg 2 times a day even though the MAR stated 75 mg. The nurse sought clarification because the pharmacy never documented for 75 mg, and had the correct dose of 50 mg as ordered by the physician.The physician responded 4/10/26 at 10:18 a.m. that this had been addressed previously. The documentation in the chart on 2/19/26 in the Electronic Health Record (HER) said 50 mg 2 times a day and then clarified with the pharmacy. It had not changed. The dose sent to the pharmacy was 50 mg 2 times a day and was the dose to continue. The dose had not been adjusted since 2/19/26 and had never been 75 mg.On 5/7/26 at 8:32 a.m. the Director of Nursing was unsure how Resident #2's Pregabalin order got changed. She confirmed they continued documenting they were giving the 75 mg dose until the CMA questioned it.The facility Medication Administration-Med Pass policy revised 5/2023 documented the procedure included reading the transcribed physician order on the MAR: resident name, medication name, dosage, route, and interval ordered. If the medication was unfamiliar or physician order questioned, contact the physician for clarification if needed.

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	05/11/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to implement appropriate infection control practices during wound care for 1 resident reviewed (Resident #5). The facility reported a census of 41 residents.Findings include:According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #5 scored 15 on the Brief Interview for Mental Status indicating no cognitive impairment. The resident's diagnoses included paraplegia, injury of kidney, and chronic kidney disease. Resident #5 had a pressure ulcer.On 5/6/26 at 7:04 a.m. Staff J Registered Nurse (RN) and Staff A Licensed Practical Nurse (LPN) to do Resident #5's dressing change. Staff J said the resident had just had a bath. Resident #5 rolled herself to her left side. Staff J used gauze sponges saturated with Vashe cleanser. She used 1 sponge to wipe the anal area. She then used another sponge to clean the ulcer wearing the same gloves and around the ulcer, then wiped over the ulcer again with the same gauze. Staff A measured the area at 2.2 cm by 1.2 cm by 0.3 cm. Staff J washed her hands and changed gloves, then applied the collagen dressing and covered with the silicone dressing. Neither staff wore gowns during the procedure for enhanced barrier precautions.On 5/7/26 at 7:35 a.m. Staff A stated they forgot to use EBP during the wound care the previous day. On 5/7/26 at 7:45 a.m. Resident #5 stated the staff did not wear gowns when they did her dressing changes.On 5/7/26 at 8:45 a.m. the Director of Nursing (DON) stated they should be using EBP with wounds. She said a new pair of gloves would be appropriate when moving from the anal area to a wound. The facility Enhanced Barrier Precautions policy revised 3/2024 documented for residents whom EBP were indicated, gowns and gloves should be used during high contact resident care activities including wound care: any skin opening requiring a dressing.