STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165364	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concord Care Center	490 West Lyons Street Garner, IA 50438

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, resident and staff interviews, along with policy and procedure review, the facility failed to treat a resident with respect and dignity in a manner that promotes maintenance or enhancement of his or her quality of life during morning cares for 1 out of 5 residents reviewed. (Resident #3). The facility identified a census of 40 residents.Findings include:Resident #3's Minimum Data Set (MDS) assessment dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 13 for which indicated intact cognitive decisions, was able to be understood and understand others, with no behaviors present. The MDS addressed the resident with limited range of motion in the upper and lower extremities on one side of the body and required substantial to maximal assistance of staff for toileting hygiene, upper and lower body dressing, and dependent on transfers and once in wheelchair is independent for mobility. The MDS included diagnosis of cerebrovascular accident (CVA), hemiplegia (severe or total paralysis of one side of the body, caused by brain damage, often from strokes) hemiparesis (one side muscle weakness, caused by central nervous system damage such as a stroke) and cataracts. The Care Plan Focus with no date, indicated Resident #3 will be assisted with activities of daily living (ADL) as required. Interventions include: one staff member to assist with dressing/grooming, always transfer toward left side, resident requires assist times two staff for transfers and EZ stand (a powered patient lift designed for transfer, and mobility), assist with toileting per residents' routine.An Abuse Allegation Investigation Report dated 4/10/26, documented Resident #3 reported Staff A, Certified Nursing Assistant (CNA), had entered Resident #3's room at approximately 6:45 AM on 4/2/26 or 4/3/26, and told Resident #3 it was time to get ready for the day and left the room. Resident #3 stated that Staff A, did not come back to her room for 20 minutes. When Staff A returned, Resident #3 asked for help and Staff A told Resident #3 that she was able to do it herself and left the room again. Resident #3 stated she needed assistance getting to the bathroom so Resident #3 got dressed herself and got herself to the bathroom. When Staff A, came back to the room again, Resident #3 was transferring off the toilet by herself and staff A asked what Resident #3 was doing. Resident #3 told Staff A that she needed to use the restroom and asked for help putting on a brief. Staff A, helped her put on the brief while Resident #3 held onto the bar in the bathroom. Resident #3 stated Then Staff A, wheeled me back, well no she didn't. Staff A helped me put on my foot pedal for my bad leg and left again, so Resident #3 went out and started my day. Resident #3 stated that she notified three staff regarding the incident. Resident #3 denies feeling unsafe around Staff A, and in the facility. Resident #3 does not feel that Staff A acted toward her in an abusive fashion. Resident #3 does not wish for Staff A to be prevented from working with Resident #3 in the future. I don't feel unsafe or not want Staff A around me. Staff A can work with me just fine, I just want Staff A to apologize. That is all. Resident #3 confirmed to the Administrator that she did not feel she was a victim of abuse, feels safe in the facility, and does not believe that Staff A intentionally upset Resident #3. The resident described the interaction as rude in nature and expressed a desire for an apology and further stated that no other concerns for receiving cares from Staff A in the future following a sincere apology. Staff (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concord Care Center	490 West Lyons Street Garner, IA 50438

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A was immediately suspended at the time of the incident was reported on 4/10/26.The Trauma Screening Evaluation completed on 4/16/26 at 11:00 AM, documented per resident interview, is the resident a victim of abuse (physical, verbal, mental, in the past)? Response was yes with a response that the resident was a victim of verbal and physical abuse for 11 years by husband.The Plan of Care lacked any documentation of post trauma focus area and interventions for Resident #3.On 4/10/26 at 1:55 PM, observed Resident #3 was lying in bed on her back, call light attached to the left upper side rail and blanket over her.On 4/10/26 at 1:55 PM, Resident #3 stated that she was very upset, and explained on 4/3/26 about 6:40 AM, Staff A, came into my room and said hey, it is time to get up, and then left my room. Resident #3 stated she was puzzled that a staff member would come into my room and tell me that, so I threw my covers from across my legs and tried to move the bedside table away so that I could sit on the edge of the bed and try to reach my wheelchair for which had my clothes in it, I tried to get things moved and arranged so that I could get up and to the bathroom, then about 7:00 AM, Staff A came back into my room and said You are not up and dress, lets go. I asked Staff A if she can help me, Staff A said no I got other people to take care of, I thought to myself, like I am not people to. I was mad by this time and felt worthless, and that I was nothing and a nobody. I then got myself up and thankfully did not have an accident. I got into the bathroom and used the grab bar to stand up, sat down on the toilet. Staff A then came in again and said, what the hell are you doing. I was exhausted by this time from trying to get ready for breakfast. Staff A said let me help you put on your brief since you don't have it on right. I then went down for breakfast and ate. Resident #3 stated that while going down to the dining room, three staff were aware of the incident that happened.Interview on 4/10/26 at 2:20 PM, the facility Administrator stated was not aware of the incident that occurred on 4/3/26 and will start an investigation and visit with Resident #3.Interview on 4/15/26 at 12:15 PM, Staff B, Registered Nurse (RN) explained that Resident #3 came up to her, not sure of the date or time and stated that Resident #3 was upset that the brief was on sideways and if someone would come and assist with getting it changed. Staff B stated that there was no mention about an incident that happened between Resident #3 and Staff A. Staff B, explained that Resident #3 was more upset about the brief not being positioned correctly.Interview on 4/15/26 at 1:30 PM, Staff C, CNA, explained that on 4/4/26, around 12:00 PM, while giving Resident #3 eye drops, Resident #3 asked Staff C, to sit down on the edge of the bed, that Resident #3 wanted to tell Staff C something. Staff C stated that Resident #3 was upset that Staff A came into Resident #3 room, and Resident #3 clothes on the wheelchair and told Resident #3 that it was time to get up and then left the room, about 20 minutes later, Staff A came back into Resident #3 room and said ?what are you doing in the bathroom by yourself, and that Staff A assisted to get finish dressing. Staff C, stated that Resident #3 was visibly upset by crying and Resident #3 hit the top of the bed in frustration that this type of interaction occurred. Staff C stated that they told Staff B about the interaction between Staff A and Resident #3. Staff C, felt that it was more a respect and dignity issue rather that an abuse issue. Staff C, went onto say if it was considered an abuse issues, she would have separated Resident #3 and Staff A immediately. Staff C felt that it was a dignity and respect concern.On 4/15/26 at 1:45 PM, Staff A, CNA, stated that on 4/4/26 before breakfast, Staff A went into Resident #3 room and explained to Resident #3 that it was time to get up and placed Resident #3's leg brace, sock and clothes in Resident #3's wheelchair and that would be back after she answers a call light. Staff A came back into Resident #3 room, not sure of the time, and Resident #3 was already in the bathroom, standing up by using the grab bar and pulling up her brief, Staff A explained that she assisted with putting on the brief and pants and helped Resident #3 to sit in the wheelchair and then Resident #3 propelled herself out to the dining room for breakfast. Staff A explained that she did not mean to be rude and disrespectful to Resident #3.On 4/15/26 at 2:20 PM, the facility Administrator acknowledged that the expectation of all staff is to treat all resident's with dignity and respect, and follow the Resident Rights and Dignity policy and this is a good lesson learned by all.On 4/16/26 at 2:21 PM, Staff D, RN and Staff E, RN, both acknowledge that the expectation of all staff are to treat resident's with dignity (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concord Care Center	490 West Lyons Street Garner, IA 50438

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and respect.The Resident Rights-Dignity and Respect policy dated 4/2024, documented that the purpose it to lay the foundation for treating all residents with dignity and respect and maintaining and enhancing his or her self-esteem and self-worth. Each resident has the right to considerate and respectful care and to be treated with honesty, dignity, respect and with reasonable accommodation of individual needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026
NAME OF PROVIDER OR SUPPLIER Concord Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 490 West Lyons Street Garner, IA 50438	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility investigation, resident and staff interview and review of policy and procedures, the facility failed to ensure all alleged violations of abuse involving mistreatment, verbal, and physical abuse, were reported to the Department of Inspection and Appeals and Licensing (DIAL) within 2 hours for 1 of 5 resident reviewed. (Resident #10). The facility reported a census of 40 residents.Findings include:Resident #10's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate impaired cognitive decisions. Resident #10 could understand others and others understood them. They had adequate vision with glasses and no behaviors or delirium and a schedule pain medication given daily. Resident #10 required partial to moderate assistance with all aspects of daily living (dressing, personal hygiene, transfers, oral hygiene and positioning) and one fall documented. The MDS included diagnoses of Non-Alzheimer's Dementia, hypertension, (a chronic condition where blood force against artery walls is consistently too high), heart failure, anxiety, depression and adult failure to thrive.The Care Plan Focus area with no date, indicated Resident #10 required assistance with activities of daily living, complaints of pain described as chronic due to lower back pain, and impaired cognitive function or impaired thought process such as short term/long term memory, easily confused, disoriented to place, time and situation, and needing assist with decisions. Interventions include: to keep routine and environment consistent, anticipate and meet all resident needs. Resident is impulsive and at times resistive to cares, if resistive with a staff member, switch out and have another staff attempt to assist resident. Substantial to maximal assistance of one staff for bed mobility, administer pain medications as ordered, evaluate pain level and monitor or alleviate activities that precipitate or aggravate pain.The Abuse Allegation Investigation Report dated 4/12/26, with an allegation date 3/10/26, notified on 4/12/26 by Staff F, CNA, that she received a phone call from Staff G, CNA, stating that she knew what current self-report investigation in the building entailed. Staff G, stated that she had witnessed Staff H, CNA, slap Resident #10's hand two times while completing cares. Administrator instructed Staff F, to immediately call Staff G and have her report this directly to the Administrator, per the education all staff had received regarding abuse reporting on 4/10/26. The facility does not have reason to believe the resident was abused by Staff H on 3/10/26. During the investigation, Staff G was not able to provide information as to why she did not immediately report this to a charge nurse or Abuse Coordinator, despite recently completing CNA training and facility education/expectations regarding alleged abuse. When questioned, Staff G, was not able to tell Administrator why she did not report this when she received a phone call for staff education on 4/10/26 regarding who the Abuse Coordinator is in the building and stated she just had not thought about it.The resident confirmed to the Administrator that she did not feel she was a victim of abuse, feels safe in the facility, and does not believe any staff harmed her. Resident was admitted to hospice services on 4/6/26 to assist with comfort and pain management. Staff do report this had been helpful in reducing resistance to cares, as she is more comfortable when they are working with her.On 4/17/26 at 9:55 AM, observed Staff F, CNA, and Staff I, CNA, transfer Resident #10 from the rock-n-go chair to the resident bed, during the transfer Resident #10 would say ow,ow,ow. Staff F explained to the resident that a transfer was being completed between the chair and bed. While Staff F and Staff I removed the hoyer lift sling from underneath Resident #10, while lying in bed, Resident #10 proceeded to keep saying ow,ow,ow.Interview on 4/17/26 at 11:00 AM, Resident #10 stated that no staff members have been mean to her during cares and that she feels safe at the facility.Interview on 4/16/26 at 3:25 PM, Staff G, CNA, stated that on 3/10/26 on the evening shift, Staff H and Staff G, were completing incontinent cares on Resident #10. Staff G felt that Staff H, was very fast and did not take her time with Resident #10. Staff G, felt that Staff H was rough when rolling Resident #10 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026
NAME OF PROVIDER OR SUPPLIER Concord Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 490 West Lyons Street Garner, IA 50438	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from side to side, and Resident #10 was yelling, screaming and crying during the completion of incontinent cares. Staff G, verified that Resident #10 was hitting and swinging at Staff H while attempting to roll Resident #10 from side to side. Staff G, explained that Staff H, would take Resident #10's hands and slap them and explain to Resident #10 that cares needed to be completed. Staff G, stated that she did not know what to do with the situation that she observed and when an all staff education was completed on 4/10/26, Staff G, thought more and more about the incident and decided to call Staff F on 4/11/26. Staff F, informed Staff G, that it needed to be reported to the Administrator as soon as possible. Staff G, acknowledged that she had the Dependent Adult Abuse Reporting training and that from now on, Staff G, will report any allegation/accusation of abuse to the Abuse Coordinator right away. On 4/16/26 at 3:55 PM, Staff F, acknowledged that a phone call was received from Staff G on 4/11/26 and that Staff F, called the facility Administer to inform about an allegation of abuse that occurred on 3/10/26, and the Administrator explained to Staff F, that Staff G needed to call the Administrator right away. Staff F, explained that all allegations/accusations of abuse are to be reported right away to the charge nurse or administrator.On 4/16/26 at 4:22 PM, Staff H, explained that incontinent cares were completed on 3/10/26 about 8:45 PM, for Resident #10. Resident #10 was hitting/swinging while Staff H was rolling Resident #10 from side to side and that Staff H did pat Resident #10's hands to reassure that cares where going to be completed shortly. Staff H denied slapping Resident #10's hand during the incontinent cares that were provided.On 4/17/26 at 10:33 AM, Staff J, Licensed Practical Nurse (LPN), confirmed that on 3/10/26, Staff H and Staff G removed Resident #10 from the lobby area and took into Resident #10's room. Staff J stated that no yelling or screaming was heard coming out of Resident #10's room for which was right across from the nurses station and that Resident #10 will hit/scream/bite at staff members that are attempting to complete cares or do a transfer. Staff J, acknowledged that all staff had the Dependent Adult Abuse education on 4/10/26 and any allegation or accusation of abuse needs to be reported right away.On 4/17/26 at 12:02 PM, the facility Administrator acknowledged that all staff are expected to report any allegations of abuse or accusations to the Abuse Coordinator right away.Review of the Patient Protection Guidelines for Abuse Prevention, Reporting and Investigation dated 9/2025, residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, family members friends or other individuals. All allegations of Resident abuse should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative. Report all allegations of Resident abuse to the Iowa Department of Inspection and Appeals and Licensing immediately and not later than two (2) hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026
NAME OF PROVIDER OR SUPPLIER Concord Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 490 West Lyons Street Garner, IA 50438	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, hospital encounter, and staff interview the facility failed to document on a resident with a change in condition for 1 of 6 residents reviewed. (Resident #2). The facility identified a census of 40 residents. Findings include:Resident #2's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognitive decisions. Resident #2 could understand others and others understood them, had adequate vision and hearing. Resident #2 was dependent with personal and toileting hygiene, dressing, transfers and was independent with oral cares and eating and no shortness of breath documented. The MDS included diagnoses of hypertension, (a chronic condition where blood force against artery walls is consistently too high), heart failure, renal failure, diabetes mellitus and adult failure to thrive.The Care Plan Focus area with a cancel date 3/30/26, indicated Resident #2 was at risk for ineffective breathing pattern related to congestive heart failure, resident becomes short of breath with exertion. Interventions include: to elevate head of bed, encourage participation in coughing, deep breathing and forced expiratory techniques as ordered, evaluate for shortness of breath, respiratory rate and effort and provide a calm and reassuring manner. Monitor and report to practitioner any signs or symptoms of cardiac complications.The Health Status Note documented on these dates and times:On 3/1/26 at 2:09 AM, resident requesting cough medicine at this time for unproductive dry cough.On 3/3/26 at 12:02 PM, upon administering AM medications resident complained of cough. Reports that it is a productive dough, and that her chest hurts from coughing all night long. She reports that she is having a hard time getting comfortable. Decreased appetite, and fatigue. Crackles noted to bilateral lobes. She has been utilizing an as needed albuterol nebulizer (a fast acting bronchodilator used to treat acute breathing issues, by opening up airways with a medication mist).On 3/3/26 at 5:41 PM, resident has not been feeling well this shift. She received new orders from provider and has been in bed resting thought out the shift as she has refused to get out of bed other than to go to the bathroom. Appetite has been poor today. She refused breakfast, but ate soup for lunch. Staff encouraging fluids with each interaction.ON 3/4/26 at 4:55 AM, resident requested to go to hospital. Primary care provider called and gave order to send by ambulance.The clinical record lacked documentation of any further assessment on the resident with a change in condition.The Patient Care Report dated 3/4/26 at 7:48 AM, the chief complaint as upper respiratory infection is declining. Dispatched at 6:50 AM for a patient with respiratory issues. Arrived on scene to find patient in lateral recovery position holding a garbage can off the side of the bed and having a tough time breathing, labored. I asked the nurse how long she had been like this and she said, most of the night. I used a pulse oximeter on finger monitor and received a reading of 83% oxygen saturation.The Encounter form dated 3/4/26 at 1:26 PM, chief complaint: shortness of breath, generalized weakness, patient transferred from care center for shortness of breath requiring more oxygen. It is understood patient has been coughing and requiring more oxygen. Patient have pain coughing up sputum. Patient is currently RSV positive and hypoxic on examination. Principle problems include: acute hypoxic respiratory failure requiring 2 liters of oxygen by high-flow nasal cannula. Suspected aspiration pneumonia, acute bronchitis with bronchospasm and generalized weakness.On 4/17/26 at 1:48 PM, Staff E, Registered Nurse (RN) acknowledged that the clinical record lacked documentation of lung sounds being completed and that it is an expectation of nurses to document abnormal lungs sounds per the standard of practice. The facility has a change of condition policy but no actual policy for assessment to be completed.