STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165366	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Mills Care Center	406 South Tenth Avenue East Lake Mills, IA 50450

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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on direct observation, clinical record review, staff interview, and facility policy review, the facility failed to protect residents from pathogens when they stored food in an unhygienic manner and when they assisted residents with eating using unsanitary practices. The facility reported a census of 39. Findings include: The Minimum Data Set (MDS) for Resident #29, dated 02/07/2026, documented the following relevant diagnoses: Alzheimer's disease, Non-Alzheimer's dementia, Dysphagia Oropharyngeal Phase (difficulty swallowing). It documented the resident required substantial/maximal assistance in eating. The MDS for Resident #33, dated 03/06/2026, documented the following relevant diagnoses: Non-Alzheimer's dementia. It documented the resident required supervision or touch assistance while eating. The MDS for Resident #41, dated 03/10/2026, documented the following relevant diagnoses: Dysphagia Oral Phase (difficulty swallowing). It documented the resident required supervision or touch assistance while eating. The initial kitchen observation on 04/12/2026 at 12:25 PM revealed the following: A container of cheese slices was unsealed and open to the air of the refrigerator. A smell resembling spoiled milk was immediately noted upon entering the refrigerator. A sticky, smelly substance was observed covering a box of sealed yogurt containers. A direct observation of dining service on 04/13/2026 at 08:46 AM documented the following:At 08:59 AM Staff A, Certified Medication Aide (CMA), began assisting two residents with eating, identified as Resident #29 and Resident #33. Both residents were directly fed by Staff A, and no hand sanitation was witnessed leading up to feeding. During the observation starting at 08:59 AM and ending 09:24 AM Staff A frequently alternated from one resident to another, often using the same hand to feed both residents. At no point in time during the observation did Staff A wash or use hand sanitizer. At 09:06 AM Staff A took a straw wrapped in paper, unwrapped the item, and touched both drinking ends of the straw before giving it to a resident. The resident then used the straw to drink. At 09:23 AM Staff A picked up Resident #41's toast with ungloved hands, appeared to butter and jelly the toast, and then allowed Resident #41 to eat it. It was not until after this encounter that Staff A finally sanitized her hands. In an interview on 04/14/2026 at 01:28 PM with Staff A, CMA, she stated she frequently feeds two residents at the same time. She confirmed she is supposed to sanitize her hands between each bite a resident takes before moving on to another resident. She agreed she did not perform hand sanitation during the observation the day before. She was unsure if she could touch feeding surfaces that go directly in the mouth like a straw. She confirmed she used ungloved hands to pick up the resident's food and put jelly on it for the resident, but she was unsure if that was an acceptable practice. In an interview on 04/15/2026 at 10:22 AM with Staff B, CMA, she stated there are a number of things to avoid when assisting residents with eating. She stated it was not appropriate to touch a residents food with ungloved hands, not appropriate to touch the ends of straws or other surfaces a resident would eat or drink off of. She stated she can feed multiple residents at the same time but confirmed she was required to sanitize her hands in between each resident. In an interview on 04/15/2026 at 10:36 AM with Staff C, Licensed Practical Nurse (LPN), she confirmed staff members have to refrain from touching resident's food with their bare hands. She stated staff members should not feed multiple residents at the same time as it can be a hazard. She stated if you are feeding two (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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(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 - Some	residents at the same time you should sanitize your hands in between each bite given to a different resident. In an interview on 04/15/2026 at 10:38 AM with Staff D, Certified Nurses Aide (CNA), she stated it is never acceptable to directly handle a resident's food. If you have to touch a resident's food she stated you should wear gloves. She confirmed that when feeding two residents at the same time staff members must wash or sanitize their hands between each bite if you're alternating between residents. In an interview on 04/14/2026 at 03:15 PM with the Assistant Director of Nursing (ADON), she stated her expectation is that staff members do not directly handle a resident's food, that they use gloves if they have to. She confirmed her expectation is for staff members to sanitize their hands frequently during meal service and between each bite when assisting two residents with feeding. She stated it is her expectation staff members do not directly touch surfaces a resident may eat off of or drink from. Review of a facility provided document titled Food Handling, with a revision date of 10/2023, documented the following: 1. Employees must perform hand hygiene prior to handling food. 2. Ready-to-eat foods must not be touched with bare hands. 3. All foods prepared in operation must be covered and labeled with date of preparation prior to storage in refrigerators and freezers.4. Upon receiving, check products for condition, possible contamination, and temperature.