STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165384	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheffield Care Center	100 Bennett Drive Sheffield, IA 50475

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on facility record review, staff interviews, and policy review, the facility failed to ensure a Registered Nurse (RN) worked 8 consecutive hours a day, 7 days a week. On 2/1/25 and 8/1/25 the facility failed to ensure they had an RN on duty for at least 8 hours for the entire 24 hours. The facility reported a census of 37 residents. Findings include: Review of the Nursing schedules and Timecards lacked a RN on 2/1/25 and 8/1/25.On 8/19/25 at 3:00 PM, the Director of Nursing (DON) verified she didn't work on 8/1/25. She said she didn't think about needing RN coverage. She said if she could get a day off, she takes it. On 8/19/25 at 3:56 PM, the Administrator verified the facility didn't have RN coverage on 8/1/25. She reported the DON did the best she could with RN coverage. She said the facility only had 3 RNs on staff and used agency staff for RN coverage as needed. On 8/19/25 at 6:26 PM, the Administrator reported she expected the facility to have 8 hours of RN coverage, 7 days per week. On 8/20/25 at 8:30 AM, the Administrator verified the facility didn't have RN coverage on 2/1/25. The facility's undated policy titled Registered Nurse defined the purpose of the policy as to ensure the facility had an RN available for supervision in the facility. The policy directed the facility must use the services of a RN for at least 8 consecutive hours a day, 7 days a week.

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on review of the facility's Quality Assurance Performance Improvement (QAPI) plan, the facilities past surveys, and staff interview, the facility failed to correct their own deficiencies for 2 of 2 areas of concern. Findings include: The survey identified the following concerns at the current survey, previously cited at surveys in the past year:a. Abuse, Neglect, and Exploitation Trainingb. Infection Prevention and ControlThe facility's QAPI Plan revised April 2014 instructed the facility shall develop, implement, and maintain an ongoing facility wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems. In addition, the QAPI plan included the following objectives:a. Provide a means to identify and resolve present and potential outcomes related to resident care and services.b. Reinforce and build upon effective systems and processes related to delivery of quality care and services.c. Provide structure and processes to correct identified quality and/or safety deficiencies.d. Establish systems and processes to maintain documentation relative to the QAPI programs, as a basis for demonstrating the facility had an effective ongoing program.On 8/21/25 at 10:30 AM, the Administrator reported she didn't know of the concerns with the repeated deficiencies until identified during this survey. The Administrator reported the facility would review their current process for each area of concern and provide staff education/training. She said the concerns would be reviewed and monitored through the facility's QAPI program.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on personnel file reviews, facility policy review, and staff interviews, the facility failed to provide dependent adult abuse certification training within 6 months of hire for 2 of 5 employees reviewed (Staff C, Dietary Aide, and Staff D, Housekeeper). The facility identified a census of 37 residents.Findings include: 1. Staff C's personnel file documented a hired date of 12/2/24. The personnel file lacked documentation Staff C had completed Dependent Adult Abuse Mandatory Reporter Training within 6 months of hire. 2. Staff D's personnel file documented a hired date of 10/7/24. The personnel file included a Dependent Adult Abuse Mandatory Reporter Training Certificate completed 5/30/25.On 8/19/25 at 1:42 PM, the Business Office Manager (BOM) verified Staff C didn't complete the Dependent Adult Abuse Mandatory Reporter Training and acknowledged Staff D completed their Dependent Adult Abuse Certification late. The BOM said the facility expected new hires to complete Dependent Adult Abuse Mandatory Reporter Training within 6 months of hire. On 8/19/25 at 1:50 PM, the Administrator reported she expected the staff to complete Dependent Adult Abuse Mandatory Reporter Training within 6 months of hire.The facility policy titled Abuse Prevention Policy revised December 2016 documented the facility required staff training/orientation programs that include such topics as abuse prevention, identification and reporting abuse, stress management, and handling verbally or physically aggressive resident behavior. On 8/19/25 at 4:20 PM, the Administrator reported the facility didn't have a specific policy related to dependent adult abuse training. She said they always followed the State mandated within 6 months of hire.

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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 clinical record review, observations and staff interviews the facility failed to implement care plan interventions related to not locking smoking materials for one resident (Resident #27). The facility reported a census of 37 residents.Findings include: 1. Resident #27's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of cerebrovascular accident (CVA or stroke), anxiety and depression. The Care Plan Focus initiated 5/7/24 related to smoking. The Focus reflected Resident #27 smoked for a long-time but recently decided to quit due to the cost of cigarettes however, he did occasionally smoke. Resident #27 had a history of extinguishing his cigarettes on his wheelchair, then keeping the cigarette butts, and storing them in his wheelchair bag. The Interventions directed to store Resident #27's smoking supplies in the north nurses' station. The Smoking - Safety Screen dated 7/26/25 indicated Resident #27 needed the facility to store lighter and cigarettes. On 8/18/25 at 12:03 PM Resident #27 stated he smoked and rolled his own cigarettes in his room. Resident #27 explained he went outside to smoke around 20-30 times a day. He added he could go unsupervised. On 8/20/25 at 9:45 AM observed Resident #27 go outside to smoke. Resident #27 lit his own cigarette and distinguished it in the proper container. Resident #27 didn't stop at the nurses' station to get his smoking materials and didn't drop them off at the nurse's station after he finished smoking. On 8/20/25 at 10:00 AM, Resident #27 stated he kept his cigarettes and lighter in his bag on his wheelchair, so he didn't forget to take them with him when he went outside. On 8/20/25 at 10:40 AM Staff G, Certified Nurse Aide (CNA), reported Resident #27 kept his lighter and cigarettes on him.The Care Plans, Comprehensive Person-Centered policy revised December 2016 instructed to develop and implement a comprehensive, person-centered Care Plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional for each resident. a. The Care Plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 2. Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care. 3. The resident will be informed of his or her right to participate in his other treatment. 4. An explanation will be included in a resident's medical record if the participation of the resident and his/her resident representative for developing the resident's Care Plan is determined to not be practicable. The care plan process will: a. Facilitate resident and/or representative involvement b. Include an assessment of the resident's strengths and needs c. Incorporate the resident's personal and cultural preferences in developing the goals of care.5. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.6. Assessments of residents are ongoing, and Care Plans are revised as information about the residents and the residents' condition change.7. The Interdisciplinary Team must review and update the care plan: a. When a resident had a significant change in their condition b. When the resident didn't meet the desired outcome8. The resident has the right to refuse to participate in the development of his/her Care Plan, medical, and nursing treatments. The nurse would document the refusals in the resident's clinical record in accordance with established policies. An interview on 8/20/25 at 3:30 PM the Director of Nursing (DON) acknowledged she missed updating Resident #27's Care Plan related to locking his smoking materials.

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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 clinical record review, staff interview, and facility policy review the facility failed to update a resident's Care Plan to accurately reflect the resident's needs for 2 of 2 residents reviewed (Residents #8 and #32). The facility reported a census of 37 residents.Findings include:1. Resident #8's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment. The MDS included diagnoses of non-Alzheimer's dementia, depression, and hypertension (high blood pressure). The Nurse Progress Note dated 6/27/25 at 4:44 PM reflected Resident #8 fell and complained of left hip and leg pain. The Intervention listed the facility sent him to the emergency room for evaluation. The Fall Investigation dated 6/27/25 at 4:31 PM indicated Resident #8 had an unwitnessed fall. The facility sent him to the emergency room (ER) for evaluation. The Intervention reflected the facility would update his Care Plan upon return from the hospital.The Skilled Note dated 7/6/25 at 2:38 AM identified Resident #8 used a seat alarm. The Fall Investigation Report dated 7/25/25 at 5:04 AM indicated Resident #8 had an unwitnessed fall in his room. The previous fall interventions in place at the time of the fall listed grippers socks and seat alarm. The Intervention directed to change Resident #8's scenery if he appeared restless, and move him to the north dining room in the recliner to watch TV. The Care Plan Focus revised 5/14/24 reflected the last revised Intervention as 5/14/24. The Care Plan lacked information related to changing his scenery and an Intervention related to the 6/27/25 fall.2. Resident #32's MDS assessment dated [DATE] identified a BIMS score of 2, indicating severe cognitive impairment. The MDS included diagnoses of benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland that commonly occurs in older men), Alzheimer's disease, and Parkinson's disease.On 8/19/25 at 10:30 AM, observed Staff E, Certified Nursing Assistant (CNA), and Staff F, CNA, provide Resident #32 perineal (peri) care and catheter care. The Clinical Physician Orders reviewed 8/20/25 included an order dated 8/4/25 to change his catheter every month and as needed (PRN).Resident #32's Care Plan lacked documentation of use of an indwelling urinary catheter.The Care Plans, Comprehensive Person-Centered policy revised December 2016 instructed to develop and implement a comprehensive, person-centered Care Plan included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. The Policy directed the following:a. The Care Plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. b. Care Plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.c. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change.d. The Interdisciplinary Team must review and update the care plan:i. When a resident had a significant change in condition.iii. When the resident readmitted to the facility from a hospital stay.An interview on 8/20/25 at 3:30 PM the Director of Nursing (DON) acknowledged she missed updating the Care Plan to identify Resident #32's catheter and Resident #8's fall with fracture.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review the facility failed to provide adequate nursing supervision to prevent accidents for 1 of 3 residents reviewed (Resident #13) for falls. The facility failed to complete a thorough root cause analysis (RCA) and failed to implement new and/or effective fall interventions after a fall occurred. The facility reported a census of 37 residents.Findings Include: Resident #13's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 5 indicating severely impaired cognition. Resident #13 required partial/moderate assistance with bed mobility and transfers. The MDS documented Resident #13 used a walker and wheelchair for mobility. The MDS included diagnoses of cerebrovascular accident (CVA) (stroke), non-Alzheimer's dementia, hemiplegia (muscle weakness or partial paralysis on one side of the body), repeated falls, unsteadiness on feet, transient alternation of awareness, dizziness and giddiness, low back pain, and muscle spasm of back. The MDS identified Resident #13 had one fall since the prior assessment which resulted in an injury. The MDS coded Resident #13 used a chair alarm and bed alarm on a daily basis.The Care Plan Focus revised 7/23/25 identified Resident #13 had a risk for falls. The Care Plan directed the following Interventions:a. 6/20/22: Staff to assure fall interventions in place, clear environment, adequate lighting, and proper footwearb. 7/7/25: Staff to ensure fall mat under Resident #13 when in bed or chair, make sure the alarm worked and if not to notify the charge nursec. 7/7/25: Resident #13 to wear gripper socks when in bed. The Care Plan documented Resident #13 would remove socks when in bed - 7/7/25d. 1/6/25: Resident #13 to use a motion sensor to alert staff of movementsResident #13's Fall Risk Assessment Scored documented the following scores:a. 10/27/24 = 13b. 1/26/25 = 27c. 5/10/25 = 20d. 7/30/25 = 20The Fall Report Note dated 11/30/24 at 12:20 AM, reflected the staff found Resident #13 lying on her left side in front of the bathroom door with her walker by her side. The note documented Resident #13 did not have gripper socks on and the staff found them in her bed. Resident #13 said she was going back to bed after using the bathroom. Resident #13 complained of slight discomfort to her head without abnormalities. The note documented the new intervention as for staff to assure Resident #13 had gripper socks on throughout the night. The Fall Investigation form dated 11/30/24 documented the root cause of Resident #13's fall as she didn't have on proper footwear. The Fall Report Note dated 2/12/25 at 3:57 PM indicated when Resident #13 stood up unassisted, she fell to the floor in the dining room, and sat on her buttocks with her legs out in front. The note documented Resident #13 had a 10 centimeter (cm) by (x) 14 cm bruise that started to form. The note listed an intervention to educate staff to assure Resident #13 had the alarm under her at all times. The facility form titled 5 Why's Root Cause Analysis dated 2/12/25 identified the root cause of the fall as Resident #13 had impaired cognition, got up unassisted and didn't ask for help. In addition, it indicated Resident #13 had shoes on and had her alarm in place.The Report Note dated 3/30/25 at 5:36 AM reflected the staff found Resident #13 on the floor in her room lying on her right side near the top of her bed with both of her lower extremities extended out away from the bed. The note documented the bed alarm didn't sound and Resident #13's roommate alerted staff of her fall. The note listed the intervention as to apply gripper socks at bed time and for staff to check bed alarm placement when in bed.The facility form titled 5 Why's Root Cause Analysis dated 3/30/25 documented the root cause of the fall as Resident #13 being cognitively impaired and got up unassisted. In addition, the root cause documented Resident #13 had her gripper socks on with gripper strips on the floor in front of her bed.The Progress Note dated 7/6/25 at 12:09 AM identified the staff found Resident #13 lying on the floor on her right side in her room. She had a bed alarm in place but, it didn't work. The note documented Resident #13 had bare feet, because she removed her gripper socks in bed because her feet got too hot. The note documented Resident #13 sustained the following injuries from the fall:-right side of the head: 3 cm x (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.1 cm red raised area -right upper arm: 4 cm x 2.5 cm reddened area with 4 bruises in the proximal area of bruise. -top of the right foot: 4.4 cm x 4.1 cm bruise -left shin: 7.8 cm x 3.2 cm reddened bruise -distal area of the right elbow: 1.8 cm x 2.8 cm abrasion The note documented the intervention as staff to ensure that the bed alarm worked. If the alarm didn't work they needed to arrange for her to have a different resting place for close supervision. The facility form titled 5 Why's Root Cause Analysis dated 7/6/25 listed the root cause of the fall as Resident #13 had impaired cognition, she required assistance with mobility, and she got up unassisted without using her call light. The Fall Report Note dated 7/20/25 at 9:00 AM reflected the found Resident #13 sitting on her bottom with her legs extended and arms resting at her side in the common area in front of the TV console. The note documented Resident #13 had a skin tear to her right wrist that measured 3 cm x 2 cm. The nurse applied steri-strips. The note listed the fall intervention as to put the alarm under Resident #13 at all times and not just at bedtime. The facility form titled 5 Why's Root Cause Analysis dated 7/20/25 documented the root cause analysis of the fall as Resident #13 had impaired cognition and tried to transfer herself unassisted. The note indicated the staff didn't know why she tried to get up.On 8/20/25 at 12:10 PM, Staff H, Certified Nursing Assistant (CNA), reported Resident #13's alarm went into use at all times about a month or so ago because she continued to try and get up by herself. Staff H reported the staff transfer the alarm pad from her chair to her bed or to the couch. She said when the light started flashing on the alarm pad the battery needed to be changed. Staff H stated the facility had older alarms that didn't work, but they recently got new ones and she thought Resident #13 had one of the new alarms. During the interview with Staff H, the alarm monitor sounded at the nurses' desk. The alarm volume sounded very low, Staff H increased the volume on the alarm monitor.On 8/20/25 at 12:15 PM, the Director of Nursing (DON) acknowledged she completed the fall documentation for Resident #13 on 2/12/25 and verified she didn't have the alarm in place at the time of the fall. The DON reported they discussed resident falls and root cause analysis at a weekly meeting. When asked how they monitored Resident #13's alarm, the DON replied she thought they had the alarm on the Treatment Administration Record (TAR). She reviewed Resident #13's TAR and acknowledged it didn't contain Resident #13's bed alarm to be signed off by the nursing staff. She said that was her fault, and she would take one for the team. The DON described Resident #13 as difficult due to her cognitive impairments and that's why she had the alarm to prevent falls. She said the facility only had so much they could do. The DON acknowledged they attempted other fall interventions besides the bed alarm. On 8/20/25 at 3:12 PM, the Administrator reported the facility didn't have an alarm policy in place. On 8/20/25 at 3:14 PM, the DON reported she reviewed Resident #13's falls. She didn't find any additional fall interventions. She acknowledged the facility didn't conducted a thorough root cause analysis and the staff could have dug deeper into the falls. She said a resident always had a reason to try to get up. The Administrator was present and said they didn't like to use alarms, and the DON described alarms as a crutch for the staff. When asked regarding the fall risk assessment score, the DON responded the higher the score, the higher the risk for falls.On 8/20/25 observed Resident #13's cordless sensor had an alarm pad life good for 45 days. The pad lacked a start date and end date filled in. The warning label on the sensor pad documented the manufacturer didn't claim the device would stop elopements and/or falls.On 8/21/25 at 9:30 AM, the Social Worker reported herself as the person responsible for programming the alarms. She reported if a pad malfunctioned, the aides brought her the pad and she would replace it. The Social Worker acknowledged the facility didn't replace the alarm pad every 45 days per the manufacturer directions. She said she just changed the pads when they stopped working. The Social Worker acknowledged the sensory alarm pad had life of 45 days. She reported the facility used some of the alarm pads for over a year without issues, and some of the pads malfunctioned after 1 week of usage. She stated she educated the nursing staff that the alarms are not a fall intervention and wouldn't prevent a fall. The Social Worker said she expected the nurses to have additional fall interventions in place. She acknowledged the staff shouldn't use the alarms as interventions, and should try to figure out why the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident attempted to get up. She reported she had these types of conversations with the nursing staff, but didn't know for sure what the staff documented. The Fall Risk Assessment Policy revised December 2007 directed the staff to identify environmental factors that may contribute to falling. The staff and attending physician would collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable.The Falls - Clinical Protocol policy revised September 2012 directed the staff to attempt to define the possible causes of a resident's fall within 24-hours of the fall. The policy further directed if they had an unclear cause of a fall, if the fall may have a significant medical cause, or if the resident continued to fall despite attempted interventions, a physician would review the situation, and help identify contributing causes. The policy instructed if the facility couldn't identify or correct underlying causes, the staff would try various relevant interventions, based on an assessment of the nature or category of the fall, until their falls reduces, stops, or until the facility identified a reason the falls continued.

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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 observations, facility record review, staff interviews, and the facility policy, the facility failed to provide adequate care for a urinary catheter for 1 of 1 resident reviewed (Resident #32). The facility reported a census of 37 residents.Findings include: Resident #32's MDS assessment dated [DATE] identified a BIMS score of 2, indicating severe cognitive impairment. The MDS included diagnoses of benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland that commonly occurs in older men), Alzheimer's disease, and Parkinson's disease.The Nurse Progress Note dated 8/1/25 at 5:14 AM identified Resident #32 had a urinary catheter.The Clinical Physician Orders reviewed 8/20/25 listed an order dated 8/4/25 to change Resident #32's urinary catheter every month and as needed (PRN).On 8/18/25 at 10:22 AM, observed Resident #32's urinary catheter bag lying on the floor underneath his bed. On 8/19/25 at 1:45 PM witnessed Resident #32's urinary catheter bag hanging on the bed, lying on the floor without a dignity bag. The Catheter Care policy revised September 2014 defined the purpose of the procedure as to prevent catheter-associated urinary tract infections. The policy directed to make sure to keep the catheter tubing and drainage bag off the floor.On 8/19/25 at 2:35 PM the Director of Nursing (DON) reported they expected the catheter bag to be in a dignity bag and not touching the floor.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, policy review, and staff interviews, the facility failed to keep the medication cart locked or under direct observation of authorized staff for a minimum of 7 minutes in an area where residents could access it. The facility reported a census of 37 residents. Findings include:Findings include: On 8/18/25 at 12:26 PM, observed the south side medication cart in the hallway near the nurse's station unlocked and unsupervised. During that time, witnessed the following:a.12:26 PM - 1 housekeeper walked past the unlocked medication cart. b.12:27 PM - 1 housekeeper walked past the unlocked medication cart. c.12:30 PM - 2 housekeepers walked past the unlocked medication cart. d.12:33 PM - Staff B, Licensed Practical Nurse (LPN), approached the medication cart. Staff B verified the medication cart was unlocked. Review of the undated facility policy titled, Storage of Medications, directed compartments containing medication are locked when not in use. Trays or carts used to transport such items are not to be left unattended. Compartments include, but are not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes. During an interview 8/21/25 at 8:27 AM, the Director of Nursing confirmed they expected medications to be locked when unsupervised.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165384	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheffield Care Center	100 Bennett Drive Sheffield, IA 50475

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 observations, interviews and policy review, the facility failed to ensure infection control practices were followed during 3 resident observations (Resident #1 and Resident #32). Staff A, Registered Nurse (RN) failed to disinfect her hands between changing gloves while completing Resident #1's wound treatments. Staff F, Certified Nurse Aide (CNA), failed to complete hand hygiene between changing gloves during Resident #32's catheter and perineal (peri). In addition, the facility staff reused the same 2 personal protective gowns when caring for Resident #32 on enhanced barrier precautions (EBP) for one week before washing. The facility reported a census of 37 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score as 15, indicating intact cognition. The MDS included diagnoses of diabetes mellitus, cellulitis of left toe and non-pressure ulcer to left lower leg. The MDS reflected Resident #1 had applications of ointments/medications other than to his feet and applications of nonsurgical dressings to his feet in the lookback period. Resident #1's Clinical Physician Orders included the following: a. 8/19/25: Iodosorb and gauze to the left second toe only, soak wound for 10 minutes with Vashe or saline soaked gauze. Change 3 times per week. Clean right first toe with Vashe or saline with dressing only (no longer doing Iodosorb to R first toe) one time a day every Tuesday, Wednesday, Friday, Sunday for wound healing and every 24 hours as needed for wound healing. b. 7/22/25: Cleanse and apply a Mepilex to the left leg wound on bath days and as needed one time a day every Tuesday, Friday and Sunday for wound 3 times per week. On 8/19/25 at 11:21 AM observed Staff A, Registered Nurse (RN), complete wound treatment to Resident #1's right first toe and left leg. Staff A changed their gloves after removing the dirty dressing from Resident #1's left second toe. Staff A failed to completed hand hygiene before she applied new gloves. After completing the wound treatment to the first toe, Staff A changed gloves but failed to complete hand hygiene before applying the new gloves. The facility policy revised August 2015 and titled, Handwashing/Hand Hygiene, documented the following: a. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water after removing gloves. b. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. c. Perform hand hygiene before applying non-sterile gloves. During an interview on 8/19/25 at 11:30 AM, the Director of Nursing (DON) reported they expected staff to complete hand hygiene when changing gloves. 2. Resident #32's MDS assessment dated [DATE] identified a BIMS score of 2, indicating severe cognitive impairment. The MDS included diagnoses of benign prostatic hyperplasia (a non-cancerous (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165384	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheffield Care Center	100 Bennett Drive Sheffield, IA 50475

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	enlargement of the prostate gland that commonly occurs in older men), Alzheimer's disease, and Parkinson's disease. On 8/19/25 at 10:30 AM, observed Staff E, CNA, and Staff F, CNA, provide Resident #32 peri care and catheter care. Both CNA's performed hand hygiene and applied gloves to their hands. Staff E removed the front of the brief and performed Resident #32's front peri care and catheter care. Staff E removed their gloves and applied a new pair, without completing hand hygiene, before pulling up the front of Resident #32's brief. On 8/19/25 at 10:30 AM watched Staff E and Staff F apply a black gown that hanged on the back of Resident #32's door. Staff F stated they used the gowns for the EBPs for Resident #32. Staff F stated when they finished, they hang the gown back on the door, as they reused the gowns. Staff F stated they did that for all the residents who needed EBPs. On 8/19/25 at 1:30 PM witnessed Staff B, Licensed Practical Nurse (LPN), remove a black gown from the back of Resident #32's door and put it on to provide g-tube (a type of feeding tube) care. When Staff B completed the care, she placed the black gown on the back of the door. Interview on 8/19/25 at 11:50 AM the Director of Nursing (DON) stated the staff did reuse the gowns. The DON stated the staff reuse the gowns for the same resident, not for other residents. The DON stated she needed to contact housekeeping to see how they are cleaned. Interview on 8/19/25 at 12:10 PM the DON stated housekeeping changed the gowns on Monday mornings. Interview on 8/19/25 at 2:00 PM Staff I, Housekeeper, stated she took them to laundry and washed them separately on Monday morning and replaced them in the room. Interview on 8/19/25 at 2:15 PM Staff J, Environmental Services, described the black gowns as disposable. Staff J stated housekeeping collected them on Monday mornings and threw them away, then replaced them with new gowns. Staff J stated they had the gowns in the laundry room so if the staff needed a new one, they went to the laundry room to get a new one. Staff J stated she didn't know why they did it that way, that is just what they told her to do. Interview on 8/19/25 at 2:35 PM the DON shrugged her shoulders and stated she didn't know, they just did it that way. She stated her and the Administrator discussed it and thought it would be okay, but she was open for ideas. The undated website Iowa Health and Human Services described the one and done as the best practice for limiting the spread of hospital acquired infections. With routine use, one person used personal protective equipment (PPE), one time for one patient encounter, discard or fully cleans the equipment, as directed.