STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165386	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Manor of Elma	407 9th Street Elma, IA 50628

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review the facility failed to protect 1 of 2 resident's rights to be free from misappropriation of their opioid pain medication patches (fentanyl) (an extremely potent, synthetic (lab-made) opioid used for pain) (Resident #42). The facility reported a census of 36 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #42 documented a Brief Interview for Mental Status (BIMS) of 9, indicating moderate cognitive impairment. The MDS included diagnoses of low back pain, age related osteoporosis, and limitation of activities due to disability. The MDS reflected she took an opioid medication during the lookback period.Resident #42's Order Summary Report signed by her doctor on 10/24/25 included an order for a fentanyl patch 25 milligrams (mg) with a start date of 10/1/25. Resident #42's Orders in her Electronic Health Record (EHR) included an order for a fentanyl patch 25 mg with a start date of 10/1/25 and an end date of 12/2/25. Review of the facility's undated Investigation: Criminal Act - Medication Diversion, Final Report revealed a concern was identified for Resident #42's fentanyl pain medication. Staff N, Registered Nurse (RN), identified on 11/9/25 she found two (2) fentanyl patch packages empty. The packages looked like they were cut, the patch removed, and placed back into the box with tape on them. The facility started an investigation into the misappropriation of Resident #42 missing fentanyl pain medication. The facility notified local law enforcement on 11/9/25 and started an investigation. The facility implemented the following action plan:a. Thorough narcotic medication and record audit completed.b. Nursing staff re-education completed. Education included updated narcotic count process to ensure patch pouches are intact, patch placement location documented in the medication record, and narcotic policy review.c. Resident #42 pain assessment conductedd. A six-week narcotic count audit will be conducted bi-weeklyOn 2/19/26 at 9:52 AM the Director of Nursing (DON) reported the facility identified Resident #42 had 2 missing fentanyl patches back in November 2025. She added the facility never had anything like that happen. She explained since then, they changed how they count the fentanyl patches. Instead of just looking at the patches, they pull them out and actually look at them to see if someone tampered with them.In an interview on 2/19/26 at 1:52 AM the Administrator reported their system worked, they always counted the fentanyl patches; however, they identified Resident #42 had 2 fentanyl patches missing from their packaging and taped shut. They now verify they are sealed, not cut open and taped shut. The facility's Patient Protection Guidelines Abuse Prevention, Reporting, and Investigation policy reviewed September 2025 defined misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a patient's belongings or money without the patient's consent. The facility will upon receiving a report of an allegation of resident abuse, neglect, exploitation, injuries of unknown origin or misappropriation, immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process.

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review and staff interview, the facility failed to document non-pharmacological interventions prior to administering anti-anxiety medication for anxiety and/or restlessness for 1 of 1 resident sampled (Resident #35). The facility identified a census of 36.Findings include:Resident #35's Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 00, indicating a severe cognitive loss. The MDS listed diagnoses of non-Alzheimer's dementia and anxiety. The MDS reflected Resident #35 used an anti-anxiety medication during the lookback period. An Order Summary Report signed by the Provider on 12/11/25 documented an order dated 11/7/25 for lorazepam (anti-anxiety, psychotropic medication) oral tablet 0.5 milligrams (MG), give 0.5 tablet by mouth every 2 hours as needed (PRN) for anxiety/restlessness.The Care Plan Focus dated 2/11/25 indicated Resident #35 utilized psychotropic medication in the category of anti-anxiety medication related to agitation and anxiety. The Targeted Goal of 4/15/26 aimed for Resident #45 to remain free of complications related to the use of psychotropic medication. The Care Plan Intervention revised 10/13/25 directed the nursing and certified nursing assistant (CNA) staff to attempt to provide the following non-pharmacological interventions prior to the use of psychotropic medications: one to one, hydration, snacks, television, music, toileting, going outside, hand massage, gentle touch/hug holding hands, shoulder rub, deep breathing exercises, family visits, and phone calls.The Psychotropic Medication Monthly Review dated 1/29/26 completed by the Director Of Nursing (DON) documented Resident #35 didn't exhibit any behaviors. The As Needed Psychotropic Medication included an order for lorazepam oral tablet 0.5 MG for anxiety and restlessness. The Review lacked documentation of the non-pharmacological interventions provided. The review of the Progress Notes identified the following PRN administrations of lorazepam given without documentation of non-pharmacological interventions prior to the administration:a. 1/9/26 at 8:48 PM administered by Staff H, Registered Nurse (RN).b. 1/10/26 at 8:30 AM administered by Staff I, Certified Medication Aide (CMA)c. 1/10/26 at 8:44 PM by Staff J, Licensed Practical Nurse (LPN)d. 1/11/26 at 11:40 PM administered by Staff Je. 1/13/26 at 2:15 AM administered by Staff K, LPNf. 1/27/26 at 11:29 PM administered by Staff L, RNg. 1/29/26 at 5:13 AM administered by Staff M, LPNh. 2/5/26 at 12:48 AM administered by Staff JInterview on 2/18/26 at 3:35 PM Staff A, RN, reported they are required to do non-pharmacological interventions prior to giving an as needed medication and document the interventions in the progress notes. She reviewed several of Resident #35's January 2026 lorazepam documented administrations in the Progress Notes and confirmed the progress notes didn't have interventions documented. During an interview on 2/18/26 at 3:40 PM the DON explained she completed a monthly psychotropic medication review and looked at non-pharmacological interventions as part of that review. The nurses are to do non-pharmacological interventions prior to administering Resident #35's as needed lorazepam and document the interventions in the progress notes. She reviewed the January 2026 Progress Notes and confirmed most of the entries didn't have non-pharmacological interventions documented prior to administration.A follow-up interview completed on 2/19/26 at 9:43 AM the DON reported they added a new field on 2/18/26 into the as needed documentation field that require the nursing staff to document non-pharmacological interventions and the behaviors for which they gave the medication. The Usage of Psychotropic Medication Guidance, revised March 2025, provided by the facility, documented each resident's drug regime will be free from unnecessary psychotropic drugs. The Guidance defined Psychotropic Drug/Medication as any drug that affected the brain activities associated with mental processes and behavior. Psychotropic drugs included anti-anxiety medications. The Guidance under PRN use failed to address/direct nursing staff on the implementation and documentation of non-pharmacological interventions prior to the administration of as needed anti-anxiety medications.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to accurately code 2 of 2 Minimum Data Set (MDS) assessments for residents with a Pre-admission Screening and Resident Review (PASRR) Level II outcome (a formal determination that confirms if an individual with suspected serious mental illness or intellectual disability requires Medicaid-certified nursing facility care and defines their need for specialized services) (Resident #4 and #32). The facility reported a census of 36 residents. Findings include:1. Resident #4's MDS assessment dated [DATE] identified she didn't have a state level II PASRR serious mental illness and/or intellectual disability or related condition. The MDS documented a Brief Interview for Mental Status (BIMS) of 15, indicating no cognitive impairment. The MDS included diagnoses of anxiety, depression, bipolar, and schizophrenia. Resident #4's PASRR notice of nursing facility approval dated 12/2/15 reflected she met the criteria for mental illness as defined by PASRR. In an interview on 2/19/26 at 1:52 PM the Administrator revealed when they completed the MDS back in March 2025 they had concerns with the MDS' accuracy by the MDS Coordinator at the time. The Administrator added she no longer worked at the facility, and they haven't had problems since. In an e-mail correspondence with the Administrator on 2/19/26 at 1:32 PM she explained the facility followed the Resident Assessment Instrument (RAI) MDS guidelines (Federal requirements governing the standardized assessment of nursing home residents). 2. Resident #32's MDS assessment dated [DATE] identified he didn't have a state level II PASRR serious mental illness and/or intellectual disability or related condition. The MDS documented a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Resident #32's PASRR dated 8/10/17 reflected he met the criteria for mental illness as defined by PASRR. Resident #32's Addendum to PASRR Summary of Findings dated 12/20/17 documented a Level II approved with specialized services. On 2/19/26 at 11:02 AM Staff G, MDS Coordinator, confirmed the facility coded the Annual MDS wrong as Resident #32 is a level II PASRR.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review the facility failed to provided 1 of 2 residents with specialized services as the resident's Pre-admission Screening and Resident Review (PASRR) directs (Resident #4). The facility reported a census of 36 residents. Findings include: Resident #4's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) of 15, indicating no cognitive impairment. The MDS included diagnoses of anxiety, depression, bipolar, and schizophrenia. Resident #4's PASRR dated 12/2/15 directed she required specialized services of a behavior management plan for addressing behaviors of anxiety/worry, verbal aggression, abrasiveness/irritable behaviors and inappropriate communication of anger. Review of Resident #4 Care Plan on 2/17/16 lacked a behavior management plan. In an interview on 2/19/26 at 2:06 PM the Director of Nursing (DON) reported she didn't have a behavior management plan for Resident #4.In an e-mail correspondence with the Administrator on 2/19/26 at 1:32 PM she explained the facility followed the PASRR provider's guidelines (a two-level, federally mandated screening process for all nursing home residents to identify serious mental Illness, intellectual disability, or related conditions) for completing PASRR's.

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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, policy review, resident, and staff interview, the facility failed to ensure appropriate infection control prevention and practices to prevent cross contamination when providing incontinent cares. The observation revealed the staff failed to remove soiled gloves, perform hand hygiene, and not touch a clean brief with soiled gloves for 1 of 2 residents observed (Resident #7). The facility identified a census of 36 residents.Findings include:Resident #7's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) of 13, indicating intact cognition. Resident #7 required partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.) with lower body dressing and toileting hygiene. The MDS documented she is not on a toileting program and is frequently incontinent for bowel and bladder. The MDS included diagnoses of renal (kidney) failure, diabetes mellitus, and hypertension (high blood pressure).The Care Plan Focus with a Target date of 4/15/26 identified Resident #7 had bowel and bladder incontinence related to cognitive impairment and mobility. The Interventions directed the following:a. Resident #7 wore incontinent briefs. b. Gets frequent urinary tract infections (UTI), ensure peri cares are focused on twice per day. The Care Plan Report lacked direction on use of enhanced barrier precautions (EBP infection control measures in nursing homes and skilled nursing facilities that require staff to wear gowns and gloves during high-contact resident care to reduce the spread of multidrug-resistant organisms) when providing care. A Communication with Physician note on 2/10/26 at 1:13 PM documented a new lab draw order for a complete blood count (CBC measures the cells circulating in the blood), a comprehensive metabolic panel (CMP used to evaluate, diagnose, and monitor health conditions by measuring chemical balance, metabolism, liver/kidney function and electrolytes) and urinalysis (UA examines a urine sample's physical, chemical and microscopic properties to check for urinary tract infections UTI). with micro/culture related to right side flank pain. A Progress Note dated 2/11/26 at 10:34 AM documented Resident #7 complained of lower quadrant pain, elevated blood pressure, and requested to transfer to the emergency room. A Communication with Physician note dated 2/11/26 at 11:12 AM documented Resident #7 transferred to the emergency room prior to facility completing the labs and UA. A New Order Note on 2/12/26 at 00:52 AM documented Resident #7 returned to the facility with orders for ondansetron 4 milligrams (mg) disintegrating tablet (Zofran ODT) and cefdinir 300 mg capsule (Omnicef) for a UTI. The final Urine Culture and Sensitivity verified 2/13/26 showed >100,000 CFU/ml (colony forming units per milliliter) Escherichia coli (E-Coli) mixed growth. On 2/17/26 at 1:11 PM, Resident #7 laid on her left side on top of the bed covers. Staff E, Certified Nursing Assistant (CNA), and Staff F, CNA, applied (donned) EBP. Staff F explained incontinent cares would be provided. The unfastened brief revealed Resident #7 incontinent of urine and bowel. After Staff F completed Resident #7's incontinence care, they used the dirty gloves to open a clean brief and place it under Resident #7. Without completing hand hygiene, Staff F removed her dirty gloves and fastened the brief. On 2/17/26 at 1:14 PM Staff F verbalized she should have removed her gloves and performed handy hygiene prior to placing the clean brief on Resident #7. On 2/17/25 at 1:19 PM, the Director of Nursing (DON) acknowledged she observed Staff F provided improper incontinent care. The DON acknowledged Resident #7 recently received a diagnosis of a UTI. On 2/18/26 at 3:45 PM, Resident #7 reported when she went to the emergency room on 2/11/26 she had pain in her side. She verbalized her back hurt and didn't feel better. Review of the facility provided Incontinence Care policy revised August 2003 directed staff to:a. Cleanse the peri-area with a cleansing agent or disposable wipe wiping from front of perineum toward the rectum. Turn patient from side to side to cleanse affected area, as needed. Rinse with water if needed per cleansing agent manufacturer's instructions.b. If feces present, remove with toilet paper or disposable wipe by wiping from front of (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	perineum to rectum. Discard soiled materials and discard glovesc. Wash hands if visibly soiled and apply new gloves.d. Apply clean brief/incontinent pad/undergarment.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review the facility failed to obtain daily weights and notify the Doctor of a 3-pound (lb.) weight gain is identified in a day as the Doctor ordered for 1 of 1 resident reviewed for nutrition (Resident #6). The facility reported a census of 36 residents. Findings include:The Minimum Data Set (MDS) assessment dated [DATE] for Resident #6 documented a Brief Interview for Mental Status (BIMS) of 6, indicating severe cognitive impairment. The MDS documented diagnoses of aphasia (difficulty swallowing), metabolic encephalopathy (brain dysfunction caused by underlying systemic diseases, toxic exposure, or electrolyte imbalances), and acute respiratory failure. Review of Resident #6 Order Summary Report signed by his doctor on 11/25/25 documented an order to obtain daily weights and notify the doctor of weight greater than 3 lb. in a day and 5 lb. in a week starting 9/12/25Review of Resident #6 Weights in his Electronic Health Record (EHR) from 11/20/25 to 2/18/25 (past 90 days) identified he had a 3 lb. weight gain from the day before on: 11/24/25, 12/11/25, and 12/25/25. The Weights section lacked a daily weight on: 11/21/25, 11/29/25, 11/26/25, 1/3/26, 1/8/26, 1/12/26, 1/19/26, 1/27/26, 1/29/26, 2/4/26, 2/7/26, and 2/14/26. Review of Resident #6 Progress Notes from 11/24/25 to 12/30/25 lacked notification to his doctor regarding the 3 lb. weight gains on 11/24/25, 12/11/25, and 12/25/25Resident #6's Care Plan on 2/17/26 instructed to monitor weights and notify his doctor of significant weight changes.In an interview on 2/19/26 at 9:52 AM with the Director of Nursing (DON) revealed Resident #6 had a lot of issues with edema without a cause a few months ago and the reason they started the daily weights. She added she couldn't find a notification to the doctor for the weight gains on 11/24/25, 12/11/25, and 12/25/25, or the missing weights on 11/21/25, 11/29/25, 11/26/25, 1/3/26, 1/8/26, 1/12/26, 1/19/26,1/27/26, 1/29/26, 2/4/26, 2/7/26, and 2/14/26. She explained they should follow his daily weight order. In an interview on 2/19/26 at 1:52 PM the Administrator reported they expected the staff to obtain the weight daily and put them into the system so they can be reviewed.The facility's Weight Management Guidelines policy revised June 2023 instructed the medical practitioner may order daily weights based upon a resident's nutrition or fluid status; daily weight changes are usually related to fluid status rather than nutrition status.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, policy review and staff interview, the facility failed to ensure infection control prevention and practices to prevent touching of medication with bare hands or dirty gloves during medication administration for 3 of 5 residents observed (Residents #27, #1, and #11). The facility identified a census of 36 residents.Findings include:Observation completed during the Medication Administration Task revealed the following:A. On 2/19/26 at 7:07 AM Staff B, Certified Medication Aide (CMA), voiced she planned to give Resident #27 his medications. Staff B without performing hand hygiene applied gloves, obtained her keys, opened the double lock narcotic drawer, touched the computer mouse with her right gloved hand to check the physician order. Staff B touched multiple resident medication cards in the narcotic drawer, retrieved Resident #27's Methadone (narcotic medication) card, punched the pill into her right gloved hand, and placed it into the medication cup. Staff B administered the medication to Resident #27.B. On 2/19/26 at 7:14 AM Staff B, opened the drawers on the medication cart, she flipped through the medication cards, and touched the computer mouse with her right hand, Staff B individually popped Resident #1's Eliquis (blood thinner), metoprolol (blood pressure medicine), omeprazole (stomach acid reducing medicine), spironolactone (pill used to lower the excess fluid from the body while keeping electrolytes in the blood) from the medication card directly into her right hand and placed each pill into a medication cup. Staff B removed the stock acetaminophen (Tylenol) bottle from the medication cart, removed the lid, shook one pill into the palm of her left hand, and placed the pill into the cup with her left hand. Staff B administered the medications to Resident #1 after she got into her wheelchair. C. On 2/19/26 at 7:26 AM Staff B failed to perform hand hygiene, then placed her fingers of her right hand inside a plastic cup and placed the cup on top of the medication cart. She voiced she would get Resident #11's medication ready. Staff B opened the bottom drawer of the medication cart multiple times and pulled up several bottles of Miralax (powder put into liquids daily to help with bowel movements) looking for Resident #11's medication. Staff B opened the second drawer of the medication cart, removed a stock bottle of 81 Milligram (MG) aspirin, opened the lid, shook one aspirin from the bottle directly into her left hand, and placed the pill in a medication cup. Staff B obtained a stock bottle of multivitamins from the medication cart, removed the lid, shook one tablet from the bottle into her left hand and placed it in the medication cart. Staff B removed a generic bottle of Senokot S (medicine to help with bowel movements) from the medication cart, shook two tabs from the open bottle into her left hand and placed it in the medication cup. Staff B placed 17 grams of Miralax into the plastic cup on top of the cart, filled it with water and stirred. Staff B administered the medications to Resident #11. A review of Resident #27, #11 and #1's February 2026 Electronic Medication Administration Records on 2/19/26 revealed Staff B signed the medications listed above as administered. On 2/19/26 at 7:56 AM Staff C, CMA, reported they are to perform hand hygiene between each medication pass and pills should only be touched with a clean glove if a medication needed touched. Pills shouldn't be touched with bare hands that have touched other items or surfaces. On 2/19/26 at 9:39 AM Staff D, Licensed Practical Nurse (LPN), explained hand hygiene should be completed between each resident's medication pass. Hands should be sanitized or use gloves to handle any oral medications. If gloves are used, the gloves cannot touch anything else other than the pill. On 2/19/26 at 9:59 AM the Director of Nursing (DON) reported she expected the nursing staff to wash their hands prior to the medication pass and between each resident's medication pass. Staff should pop the medication from the medication card directly into the medication cup. If the nursing staff wear gloves, they should only touch the medication and nothing anything else. The staff really shouldn't wear gloves when they prepare the medication. The Medication Administration-Medication Pass Policy, revised May 2023, provided by the facility, documented a Purpose to safely and accurately prepare and administer medication according to the physician orders and patient needs. The Policy, under General Instructions directed not to touch medication or inside of the medication cup. Tablets and capsules if (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	obtained from a bottle, transfer to the bottle cap, then into the medication cup. If the medication/pill is obtained from a medication card, transfer it directly into the medication cup. The Policy directed to perform hand hygiene before and after each resident's medication pass. The policy lacked direction on the use of gloves in handling medication/pills.