STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165390	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
State Center Specialty Care	702 Third Street NW State Center, IA 50247

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, staff interview, menus and policy review, the facility failed to follow the menu approved by the facility Dietician for the pureed meal. The staff failed to provide bread as listed on the menu. In addition, the staff didn't post the menu correctly after substitution changes. The facility reported a census of 36 residents. Findings include: A facility document titled, Diet Type Report, dated 1/20/26 revealed 3 residents required pureed diets. A facility document titled, Diet Spreadsheet, signed by the Dietitian on 10/13/25 outlined the cycling pureed menu for the lunch meal included, an eight-ounce servicing of king ranch chicken, a half cup serving of pinto beans, a half cup serving of corn, and a wheat roll. Those on regular diet included an ice cream sundae. A document titled, Fall/Winter 2025/26 dated 10/15/25 documented the lunch menu for regular/no added salt (NAS) posted in the main dining room for the residents to view, listed the noon meal as king ranch chicken, pinto beans, buttered corn, wheat roll, and an ice cream sundae. A document hung in the kitchen titled Puree Process, undated directed steps for puree meal preparation included step 4 to measure the total volume of food after it is pureed and step five directed to divide the total volume of the pureed food by the original number of portions on pureed diets also documented to reference the pureed scoop chart. During a continuous observation on 1/21/26 of the lunch meal service beginning at 11:38 AM to 12:35 PM began with the pureed meal process for 3 residents on a therapeutic pureed diets. Staff B, Dietary, added four, eight-ounce servings of ranch chicken to the Robot-coupe (brand name mixer to puree food). Staff B reported the serving size is an 8-ounce serving. Staff B measured 4 cups of the pureed chicken and added the mixture to the aluminum container in the steam table. During continuous observation beginning at 11:38 AM Staff C, Dietary, added 4 half cup servings of green beans to the Robot-coupe pureed. The measured 1-1/2 cup of green bean puree mix was placed in the aluminum pan in the steam table. During continuous observation on 1/21/26 beginning at 11:38 AM observed Staff C added the 4 half cup servings of pinto beans to the Robot-coupe pureed the mixture and measured 2 cups. Staff C placed the pinto beans in the aluminum pan and into the steam table . Observation of Meals served to residents began at 12:01 PM included Staff C, prepared 3 plates of pureed foods. Each plate included 8 ounce serving of the chicken mixture, a quarter cup of green bean pureed mixture and a quarter cup of pinto bean mixture. On 12/21/26 at 12:35 PM, Staff C and Staff E, Certified Dietary Manager (CDM), acknowledged they didn't add bread to the pureed diets and they should have. Staff C reported they substituted green beans instead of corn. Staff C acknowledged they used the same measurements directed by the menu that did not reflect the change of the food consistency to puree. Staff C acknowledged they had a pureed graph posted to use if needed, but no observation of them using the graph. Staff C reported they didn't have ice cream for the ice cream sundaes. They felt because the staff often served the residents ice cream for a snack, it caused them to run out. Staff C acknowledged the menu in the dining room informed the staff they had ice cream sundaes for dessert and they should have updated the menu with the substitutions. On 12/21/26 at 1:30 PM, Staff E reviewed the posted meal board in the dining room. They acknowledged they didn't have an accurate menu board and agreed some residents would have looked forward to the posted, but not offered, ice cream sundae. Staff E added they should post the diet changes. On (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/22/26 2:10 PM, the Administrator acknowledged the facility didn't post the food substitutions. They explained they needed improvements in the kitchen, would initiate a performance improvement plan to address food and processes in the kitchen. The undated policy provided by the facility, titled, Pureed Food Preparation Policy and Procedure instructed a resident on a pureed diet would receive the same items as the regular diet. All residents on a pureed diet shall receive the correct portions of pureed, meat, fruit, starch, fat, vegetables and dessert. The policy directed to review the menu for food items that need pureed. Bread and butter as planned on the menu may be added to the mixture, half of the bread and butter in the meat and half in the vegetable is suggested if the bread is not pureed separately.

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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 observation, record review, staff interview, and policy review the facility failed to revise a resident's Care Plan to indicate current transfer status for 1 of 12 residents reviewed (Resident #11). The facility reported a census of 36 residents. Findings include: On 1/20/25 at 10:57 AM, observed Resident #11 get transferred to restroom with the use of a standing mechanical lift and 2 staff. On 1/20/25 at 11:07 AM, watched a staff member transfer Resident #11 with a standing mechanical lift from the toilet to the wheelchair. Resident #11's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #11 required substantial/maximal assistance with ambulating and transfers. The used a walker or wheelchair for mobility. The MDS included diagnoses of kidney failure, history of femur fracture, schizophrenia, muscle weakness, unsteadiness on feet, and lymphedema (a build-up of fluid in the tissue of the body usually in the arms and legs). Resident #11's Care Plan Conference Progress notes dated 2/26/25, 5/20/25, 8/20/25, and 12/3/25, indicated they used a standing mechanical lift for transfers with activities of daily living (ADLs). Resident #11's Care Plan Focus related to ADLS included an Intervention that directed to transfer with an assist of one with a front wheeled walker. On 1/21/26 at 2:14 PM, the Director of Nursing (DON) reported Resident #11 used the standing mechanical lift for security due to increased anxiety and fear with transfers. The DON acknowledged Resident #11's Care Plan should include the use of the standing mechanical lift. Review of facility provided Care Plans, Comprehensive Person-Centered Policy, revised December 2016, directed assessments of residents are ongoing and Care Plans are revised as information about the residents and the residents' conditions change.

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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, policy review, resident, and staff interviews, the facility failed to assess and follow-up on a rash for 1 of 1 resident reviewed for skin concerns (Resident #16). The facility reported a census of 36 residents.Findings:Resident #16's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #16 required substantial to maximal assistance with toileting hygiene. The MDS included diagnoses of Parkinson's disease(a disorder which affected movement and caused tremors and stiffness), seizure disorder, and anxiety disorder.The facility policy Skin Tears-Abrasions and Minor Breaks, Care of, revised 2013, directed staff to assess the wound and surrounding skin for swelling, redness, drainage, and tissue healing progress. The SPN-Admit-Re-Admit note dated 1/5/26 at 3:33 PM indicated Resident #16 had a rash to the groin. The note lacked additional information related to the rash including the size, color, or any signs and symptoms of pain, itching, discomfort, or infection. Resident #16's January 2026 Medication Administration Record (MAR) listed an order dated 1/5/26 for nystatin (an antifungal medication) powder to the groin three times daily for candidal intertrigo (an inflammatory skin infection caused by candida yeast). Resident #16's Care Plan lacked information related to their groin rash. On 1/20/26 at 10:01 AM, Resident #16 explained he had an itchy groin since before admission to the facility. He added the itching hasn't got better. On 1/21/26 at 9:56 AM, Resident #16 stated his groin still burned. The facility lacked additional assessments of the area from 1/5/26 until 1/21/26, after the State Agency inquired about the rash.On 1/21/26 at 10:46 AM, Staff A, Registered Nurse (RN), reported she assessed the Resident #16's sacrum the day before but didn't observe his groin. She explained Resident #16 came in with a pretty bad excoriation in his groin and they put powder on him. She said they didn't take pictures of the area but they should have.On 1/21/26 at 1:39 PM, the Director of Nursing (DON) stated upon admission, the staff carried out a skin assessment and initiated a treatment. She said the staff monitored the skin concerns weekly. She added that is how they tracked the wound.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff interview and policy review the facility failed to maintain head of bed elevated to avoid complications during tube feeding for 1 of 1 resident reviewed with a gastrostomy tube (G-tube), Resident #40. The facility reported a census of 36 residents. Findings include: Resident #40's Minimum Data Set (MDS) assessment dated [DATE] listed an entry date of 1/15/26. The Physician Order dated 1/16/26 directed to elevate the head of bed 30 degrees during feedings every shift.Resident #40's January 2026 Medication Administration Record (MAR) included an order with a start date 1/15/26 of give enteral feed with a formula flow rate at 65 milliliters per hour.The Care Plan Focus initiated 1/16/26 indicated Resident #40 had a tube feeding. The Goal documented she would remain free of side effects or complications related to the tube feeding. The Interventions directed to have the head of bed elevated thirty degrees during and thirty minutes after a tube feeding. On 1/21/26 at 9:12 AM observed Resident #40 in bed, with her head of bed slightly elevated. Resident #40 laid flat on her backside, under the slightly elevated part of the bed. At the time, she had her feeding tube running at 65 milliliters per hour. On 1/21/26 at 9:18 AM Staff C, Certified Nursing Assistant (C.N.A.), summoned to the room. When queried about Resident #40 positioning, Staff C responded they reposition her at least every two 2 hours and sometimes they would reposition her more frequently. Staff C exited the room, didn't address the head of bed elevation being lower than 30 degrees, and/or she laid with the feeding tube running at 65 milliliters per hour. On 1/21/26 at 9:20 AM Staff D, CNA, entered Resident #40's room. Staff D reported Resident #40 should sit up with her head of the bed elevated. Staff D explained Resident #40 should be up higher and would need help to get her higher in bed. Staff D reported they didn't know how to determine if they had the head of the bed at thirty degrees. On 1/21/26 at 9:24 AM Staff A, Registered Nurse (RN), came to Resident #40's room and said they would need to pause the feed while they reposition Resident #40 to have her head elevated. Staff A confirmed Resident #40's head of the bed should be at 30 degrees, but didn't know how to measure that degree. Staff A would check to see if the bed gave indication of degrees of elevation and ensure to notify the CNA staff.On 1/22/26 at 10:30 AM the Director of Nurses (DON) explained they added tape to the wall so that staff knew where to adjust her head of the bed elvation for the tube feeding. Facility policy titled Enteral Nutrition, revised November 2018 directed the provider would consider the need for supplemental orders included, head of bed elevation.