STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165399	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care Center	815 High Road Norwalk, IA 50211

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to accurately complete a Minimum Data Set (MDS) Assessment for 4 of 8 residents reviewed (Resident #6, #7, #9 and #12). The facility reported a census of 68 residents. Findings include: 1. The quarterly MDS assessment dated [DATE] documented Resident #6 had a Brief Interview for Mental Status (BIMS) Score of 4, indicating severe cognitive impairment. The MDS included diagnoses of medically complex conditions, non-Alzheimer's dementia, seizure disorder, anxiety disorder and depression. The MDS documented a wander/elopement alarm was not used. The Care Plan for Resident #6, with an initiation date of 6/5/23, included a focus area: the resident is having adjustment issues to admission. An intervention for this focus area included Wander guard in place to the left lower leg. Functioning will be checked QS (twice daily). This was initiated on 8/13/24. Review of the Electronic Health Record (EHR) Elopement Risk Evaluation for Resident #6 completed on 8/7/24 revealed the resident at risk for elopement. Review of the EHR order summary for Resident #6 showed an order to check placement and function of wanderguard each shift, left ankle every day and night shift for wandering, with a start date of 10/25/2024, and a discontinue date of 8/04/2025. The annual MDS assessment dated [DATE] for Resident #6 documented a wander/elopement alarm was not used. The quarterly MDS assessment dated [DATE] for Resident #6 documented a wander/elopement alarm was not used. 2. The annual MDS assessment dated [DATE] documented Resident #7 had a BIMS score of 3, indicating severe cognitive impairment. The resident had diagnoses to include medically complex conditions, hyperlipidemia, thyroid disorder, non-Alzherimer's dementia, anxiety disorder, depression and psychotic disorder. The MDS documented the resident had not exhibited wandering behavior and documented the resident did not use a wander/elopement alarm. The MDS documented the resident did not have indicators of hallucinations or delusions. The Care Plan for Resident #7, with an initiation date of 3/21/25, included a focus area: potential for elopement risk/wanderer risk. Interventions included: assess for elopement/wander risk and wander alert, left ankle device. The Care Plan further included the focus areas: the resident uses antidepressant medication related to depression, the resident has level 1 PASRR with mental health diagnoses of major depressive disorder, adjustment disorder with mixed anxiety and depressed mood, and psychotic disorder with delusions, the resident uses antipsychotic medications related to disease process of dementia and the resident had a mood problem related to dementia. Review of the EHR Elopement Risk Evaluation for Resident #7 completed on 3/20/25 revealed the resident at risk for elopement. Review of the EHR order summary for Resident #7 showed an order to check wander guard functioning Q shift, two times a day for wander guard, with a start date of 3/20/25. Review of the EHR for Resident #7 revealed Progress Notes which documented wandering and other behaviors:Progress note dated 3/20/25, nurses note, documented Resident was packing her room stating she needed to go home her friend was waiting for her. Resident redirected several times. Progress note dated 3/21/25, nurses note, documented resident has had no attempts to leave facility, just wandering in hallways non intrusive. Progress note dated 3/24/25, nurses note, documented resident came out to the nursing station numerous times between 2030 and 2200. Progress note dated 3/27/25, nurses note, documented late entry for 3-26-25 resident went from room to dining room in excess of 10 times within a 30 minute time frame. Progress note dated 4/6/25, nurses note, documented resident refused upper meal, after meal resident was noted to be wandering down other hallway. Progress note dated 5/15/25, SBAR summary for providers, change in condition reported were behavioral symptoms, agitation and psychosis, resident is having auditory and visual hallucinations/delusions, is wandering facility. Progress note dated 5/16/25, nurses note, Resident has been up last 2 hours wheeling up and down hallways talking to an invisible being, Demanding Show yourself loudly as well as There you are manically going the other directions. Resident is not redirectable. When you ask her questions she states mind your own business I am dealing with them.Progress note dated 5/21/25, nurses note, resident has been up and propelling self up and down hallways was noted to be standing up at water fountain near nurses station, the wandering of the building has been an ongoing habitual behavior, resident also continues with visual and auditory hallucinations and well as wandering behaviors. 3. The discharge MDS assessment dated [DATE] documented Resident #9 was rarely/never understood and a BIMS score was not conducted. The resident had diagnoses to include medically complex conditions, Alzheimer's disease and anxiety disorder. The MDS documented the resident did not exhibit wandering

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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. (continued on next page)

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and policy review, the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 12 residents reviewed (Resident #12). The facility reported a census of 68 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] documented Resident #12 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS revealed the resident was on high risk drug classes to include insulin and had received insulin injections 5 days of the 7 day look back period. Review of the Electronic Health Record (EHR) admission papers for Resident #12 revealed the resident admitted to the facility on [DATE] with a diagnosis of Diabetes Mellitus. The admission medication list for the resident included the medications Empagliflozin (used to manage type 2 diabetes) 10 mg tablet one time each day and Metformin (used to treat type 2 diabetes) 500 mg tablet two tablets two times a day with meals. Review of the hospital record dated 7/25/25 revealed Resident #12 was seen in the emergency department for a fall. Lab work was performed and the resident was found to have Hyperglycemia (high blood sugar). Review of the hospital record dated 7/29/25 revealed Resident #12 was seen in the emergency department for dizziness. Lab work was performed and the resident was found to have Hyperglycemia (high blood sugar). Diagnoses related to the emergency department visit included Hyperglycemia, history of Diabetes Mellitus and lightheadedness. Review of the Medication Administration Record (MAR) for July of 2025 revealed Resident #12 was given the following medications and had the following orders:1. Empagliflozin Oral Tablet 10 MG (Empagliflozin) Give 1 tablet by mouth in the morning for DM2 (Diabetes Mellitus type 2) -Start Date 07/10/2025.2. Check Blood Glucose BID two times a day for Blood Glucose -Start Date 07/29/2025 -D/C Date 08/06/2025.3. HumaLOG KwikPen Subcutaneous Solution Peninjector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 141 - 180 = 2 units; 181 - 220 = 4 units; 221 - 260 = 6 units; 261 - 300 = 8 units; 301 - 350 = 10 units; 351 - 400 = 12 units >400 14 units and call provider, subcutaneously before meals and at bedtime for diabetes -Start Date 07/30/2025. Review of the MAR for August of 2025 revealed Resident #12 was given the following medications and had the following orders:1.Empagliflozin Oral Tablet 10 MG (Empagliflozin) Give 1 tablet by mouth in the morning for DM2 -Start Date 07/10/2025.2. Check Blood Glucose BID two times a day for Blood Glucose -Start Date 07/29/2025 -D/C Date 08/06/2025.3. HumaLOG KwikPen Subcutaneous Solution Peninjector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 141 - 180 = 2 units; 181 - 220 = 4 units; 221 - 260 = 6 units; 261 - 300 = 8 units; 301 - 350 = 10 units; 351 - 400 = 12 units >400 14 units and call provider, subcutaneously before meals and at bedtime for diabetes -Start Date 07/30/2025.4. 472=16 units as one time order. one time only for high blood sugar until 08/06/2025 23:59 -Start Date08/06/2025 1245 Review of the EHR, MAR and Treatment Administration Record (TAR) for July and August of 2025 for Resident #12 revealed a lack of monitoring and documentation for signs and symptoms of hyperglycemia and hypoglycemia. The Care Plan for Resident #12, with an initiation date of 7/11/25, lacked a focus area, goals and interventions for Diabetes Mellitus. During an interview 8/19/25 at 1:30 PM, the Director of Nursing (DON) stated when a resident has a diagnosis of Diabetes Mellitus, she would expect this to be in the care plan with a focus, goal and interventions. The DON stated the diagnosis of Type 2 Diabetes Mellitus did not get put in the EHR under the diagnosis section until 8/12/25, however it should have been in there from the time of the resident's admission. The DON stated there should have been an entry in the MAR to monitor and document any signs and symptoms of hyperglycemia and hypoglycemia, and acknowledged this was not in the MAR or the EHR. Review of the facility policy Comprehensive Person-Centered Care Plan, with a review date of 10/23/19, documented each resident will have a person centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care. Contains services provided, preference, ability, and goals for admission, desired outcomes, and care level guidelines.

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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 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. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to ensure staff completed an accurate and timely resident assessment as necessary for 1 of 3 residents reviewed for elopement (Resident #7). The facility reported a census of 68 residents. Findings include: The annual Minimum Data Set (MDS) assessment dated [DATE] documented Resident #7 had a BIMS score of 3, indicating severe cognitive impairment. The resident had diagnoses to include medically complex conditions, hyperlipidemia, thyroid disorder, non-Alzherimer's dementia, anxiety disorder, depression and psychotic disorder. The Care Plan for Resident #7, with an initiation date of 3/21/25, included a focus area: potential for elopement risk/wanderer risk. Interventions included: assess for elopement/wander risk and wander alert, left ankle device. Review of the Electronic Health Record (EHR) Elopement Risk Evaluation for Resident #7 completed on 3/20/25 revealed the resident at risk for elopement. Review of the EHR for Resident #7 revealed Progress Notes which documented wandering behavior: Progress note dated 3/20/25, nurses note, documented Resident was packing her room stating she needed to go home her friend was waiting for her. Resident redirected several times. Progress note dated 3/21/25, nurses note, documented resident has had no attempts to leave facility, just wandering in hallways non intrusive. Progress note dated 3/24/25, nurses note, documented resident came out to the nursing station numerous times between 2030 and 2200. Progress note dated 3/27/25, nurses note, documented late entry for 3-26-25 resident went from room to dining room in excess of 10 times within a 30 minute time frame.Progress note dated 4/6/25, nurses note, documented resident refused upper meal, after meal resident was noted to be wandering down other hallway. Progress note dated 5/15/25, SBAR summary for providers, change in condition reported were behavioral symptoms, agitation and psychosis, resident is having auditory and visual hallucinations/delusions, is wandering facility. Progress note dated 5/21/25, nurses note, resident has been up and propelling self up and down hallways was noted to be standing up at water fountain near nurses station, the wandering of the building has been an ongoing habitual behavior, resident also continues with visual and auditory hallucinations and well as wandering behaviors. Progress note 6/11/25, nurses note, resident has been up this evening. Manic state. [NAME] self up and down hallways looking for invisible people. Talking to voices in the walls and vents. Redirection attempted numerous times. Unsuccessful. Review of the EHR revealed an Elopement Risk Evaluation for Resident #7 was not completed after 3/20/25 until 8/18/25, however this was not placed in the EHR until 8/20/25. The Elopement Risk Evaluation on 8/18/25 showed the resident at risk for elopement. During an interview 8/20/25 at 11:30 AM, the MDS coordinator stated she is the one to complete some of the elopement evaluations, however it can also be the Director of Nursing (DON) or the floor nurse. The MDS coordinator acknowledged the last Elopement Risk Evaluation for Resident #7 was in March of 2025. The MDS coordinator stated the resident should have had another Elopement Risk Evaluation completed in May of 2025, with her annual review. The MDS coordinator stated she would have expected another one for the resident in May. The Elopement Risk Evaluations are completed upon admission, quarterly and as needed. During an interview 8/20/25 at 12:35 PM, the DON pointed out where in the EHR the Elopement Risk Evaluations are stored, and pointed this out specifically for Resident #7. The DON acknowledged there was not another Elopement Risk Evaluation for Resident #7 after the one completed in March of 2025. The DON stated she completed an audit of the Elopement Risk Evaluations on the 5th of June, including an audit for Resident #7. During this audit, she thought the last evaluation was in May, she read the date incorrectly she believed. The DON stated Elopement Risk Evaluations are completed upon admission, quarterly and as needed. The DON acknowledged the Elopement Risk Evaluation for this resident should have been completed by or around the 20th of June 2025, and acknowledged this was not completed at that time. The DON stated they follow the Resident Assessment Instrument (RAI) Manual for completing the MDS and follow standards of practice for the Elopement Risk Evaluations. The DON stated she started another elopement risk evaluation for Resident #7 on 8/18/25 and will submit this today, 8/20/25.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interview and policy review, the facility failed to supervise residents at risk for elopement for 1 of 3 residents reviewed (Resident #9). This failure resulted in the resident eloping from the facility, his whereabouts unknown for approximately an hour and 30 minutes and sustaining fractures of five ribs, therefore causing an Immediate Jeopardy to the health, safety, and security of the resident. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as ofMay 8, 2025, on August 18, 2025 at 1:15 PM. The Facility Staff removed theImmediate Jeopardy on August 20, 2025 through the following actions: Resident assessed and sent to the hospital 100% Headcount of all Residents on 6/4/2025 100% Elopement Risk assessment review completed by DON for accuracy and current on 6/5/2025. The three residents verified at risk for elopement, and wearing wanderguard devices, had all care plan interventions reviewed and confirmed in place for supervision on 6/5/2025. 100% Care plan, TAR, placement of device, elopement binder, and device functioning audit for all residents determined to be at risk for elopement completed by MDS on 6/5/2025 Facility conducted 100% audit of all external doors to ensure they are in proper working order and checked all windows for security on 6/4/2025 Facility conducted elopement drills x 3 shifts 6/5/2025-6/7/2025 Facility conducted Ad Hoc QAPI to address this alleged deficient practice on 6/5/2025 Elopement binder reviewed and noted as up-to-date on 6/5/2025 with reviews daily and weekly as part of our quality assurance program, 8/18/2025, and ongoing Staff in-service on Elopement Policy began 6/4/2025, to include, promptly answering sounding door alarms, not resetting alarm until the source of the alarm is discovered and/or 100% resident presence is verified Resident placed on 15-minute checks upon return from hospital and continued until discharged Current resident at risk for elopement, noted effective 3/21/2025, has a wanderguard in place on her ankle with every shift checks for placement and functioning, distract from wandering by offering pleasant diversions, structured activities, food, conversation, tv or book. Care plan revised and updated 5/29/2025, 8/18/2025 as part of our ongoing compliance. As of 6/5/25, and ongoing as part of our quality assurance, all current and new admissions to the facility have had and will continue to have an elopement risk assessment done on admission, quarterly and as needed. If determined to be at risk for elopement, the new resident's individualized care plan will be developed for safety based upon their preferences and routines related to ensuring adequate supervision for safety. New hire staff receive education upon hire related to elopement, and all direct care staff have access to the resident's Kardex/care plan and are expected to be familiar with individualized needs for supervision. The scope lowered from a J to D at the time of the survey after ensuring the facilityimplemented education and their policy and procedures. In addition, the facility failed to provide for safe transfer for Resident #10 by not using adequate staff during the transfer for 1 of 3 residents reviewed for transfer. The facility reported a census of 68 residents. Findings include: 1.The admission Minimum Data Set (MDS) assessment dated [DATE] documented Resident #9 had a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. The resident had diagnoses to include medically complex conditions, hyperlipidemia, Alzheimer's disease and anxiety disorder. The resident had wandering behavior that occurred 4 to 6 days, but less than daily, which significantly intruded on the privacy or activities of others. The Care Plan for Resident #9, with an initiation date of 4/24/25, included a focus area: potential for elopement risk/wanderer risk. The resident wanders aimlessly, WanderGuard bracelet (a wearable security device, worn by residents at risk of wandering that alerts staff when the resident approaches a monitored exit or enters an unauthorized area) in use for safety. The goal included: safety will be maintained through the review date and interventions included:Assess for elopement/wander risk (created 4/24/25)Observe location frequently. Document wandering behavior and attempted diversional interventions in behavior log (created 4/24/25) On 5/31/25 resident took his wander guard off his lower extremity in his room. WanderGuard (WG) replaced on right wrist hoping that resident might not be able to take it off with his left hand (created on 6/5/25) Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes (created 4/24/25)Every 15 minute safety/location checks upon readmission from hospital (created 6/13/25)Resident noted to remove wander guard bracelet-reapplied by staff (created 5/1/25)Room change upon readmission to new private room on different unit to decrease environmental stimuli (created 6/13/25)WG alert, replaced bracelet right wrist, expires 1/12/28 (created 4/24/25) Review of the Electronic Health Record (EHR) revealed Resident #9 scored at risk for elopement on Elopement Risk Evaluations

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, resident interviews, staff interviews, and facility document review, the facility failed to ensure adequate staffing levels to meet the residents' needs safely and timely. The facility reported a census of 68. Findings include: During an observation 8/5/25 at 9:00 AM in the back hallways (Ambassador halls), observed one Certified Nursing Assistant (CNA) in the 5 hallway, one CNA in the 6 hallway and one CNA giving residents showers in the 5 and 6 hallway. A CNA was not observed in the 4 hallway. During an interview 8/5/25 at 9:50 AM, Staff F, CNA, stated to be fully staffed in Ambassador halls (halls 4, 5 and 6) they should have 2 CNA's on hall 5, two CNA's on hall 6 and then they split hall 4 with a floater CNA, they need 5 to 6 CNA's to be fully staffed on Ambassador halls. Staff F stated the back hallways are not normally staffed fully as they get more call ins back there, it is a more stressful area to work as residents have more care needs and there are more residents back there. Administration will try to find staff to replace the staff who call in, but sometimes they cannot. In the front halls (halls 1,2 and 3), Staff F stated they are able to answer call lights within 3-5 minutes and residents do not wait longer than 15 minutes for a call light response as the facility is staffed fully in the front halls more routinely. In the back halls, when Staff F has worked back there, residents have waited longer than 15 minutes for a call light response. Staff F stated there have been several times when the back (Ambassador) does not have enough CNA's. During an interview 8/5/25 at 10:45 AM, Staff I, CNA, stated to be fully staffed in the back hallways (Ambassador), they should have two CNA's for hall 5, two CNA's for hall 6, and then share hall 4, with an additional floater CNA. Today, there is just one CNA for the entire hall 6, which has 24 residents and one CNA for the entire hall 5, which has 19 residents, and these two CNA's are sharing hall 4, which has 4 residents. Staff I started a shift today at 6 AM, and the back halls have been staffed with just 2 CNA's and a floater to assist with showers all morning. Staff I stated this is the 3rd time in 3 weeks that there has been only one CNA for hall 6 and one CNA for hall 5, sharing hall 4 as well. There are 6 residents on hall 6 that are a two person lift as well as residents on hall 5 that are a two person lift. Staff I stated earlier this morning, two residents had to wait 45 minutes for a call light response, Residents #11 and #12. Resident #12 had to wait 45 minutes to use the bathroom and Resident #11 had to wait 45 minutes to be cleaned in the bathroom after having a bowel movement, this was upsetting to the resident and the resident was embarrassed and upset. Staff I stated oral care for residents have not been done this morning as there has not been time to complete this task with lack of sufficient staff. During an observation 8/5/25 at 11:00 AM, in the back hallways, (Ambassador halls), observed one CNA in the 5 hallway, one CNA in the 6 hallway and one CNA giving residents showers in the 5 and 6 hallway. A CNA was not observed in the 4 hallway. The quarterly Minimum Data Set (MDS) dated [DATE] documented Resident #11 had a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The resident required substantial/maximal assistance for toileting hygiene and partial/moderate assistance for toilet transfer and shower/bathe. The resident required setup or clean-up assistance for oral and personal hygiene. The resident used a manual wheelchair. During an interview 8/5/25 at 12:35 PM, Resident #11 stated he has had to wait longer for call lights sometimes, usually waiting longer on the weekends and at night. Resident #11 stated he has waited a half hour at times. Resident #11 stated he waited longer this morning for a call light response. The resident stated he can transfer independently onto the toilet, however needs staff assistance for toileting hygiene. Resident #11 stated he had a bowel movement this morning and did have to pull the call light to get cleaned up. The resident stated it did seem like a long time this morning before someone came to answer the call light to clean him up after his bowel movement on the toilet. Inquired as to how long, the resident stated he did not have a watch, but felt he waited a long time, over 15 minutes. Resident #11's roommate yelled out it was an hour Resident #11 waited this morning after pulling the call light. During the interview, observed Resident #11's fingernails to be very long and dirty. Resident #11 stated he cannot say when the last time it was that he had his nails trimmed, staff trim them for him after showers. While asking Resident #11 about his fingernails, he tried to hide them from view. Resident #11 stated it had been a while since staff trimmed his fingernails. The MDS dated [DATE] documented Resident #12 had a BIMS score of 15, indicating intact cognition. The resident required partial/moderate assistance for toileting hygiene, sit to lying, chair/bed to chair transfer and toilet transfer. The resident required substantial/maximal assistance for sit to stand. The resident used a manual wheelchair and a walker. During an interview 8/5/25 at 12:55 PM, Resident #12 stated she had a fall recently, she fell on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165399	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care Center	815 High Road Norwalk, IA 50211

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, staff interviews and policy review, the facility failed to provide a sanitary environment to help prevent the development and transmission of communicable diseases and infections. The facility reported a census of 68 residents. Findings include: During an observation on 8/5/25 at 9:40 AM, Staff F, Certified Nursing Assistant (CNA), and Staff G, CNA, performed a mechanical lift transfer for Resident #4. After the transfer was completed, Staff F moved the mechanical lift equipment into the hallway without cleaning or sanitizing the equipment and placed it in the hallway. The mechanical lift did not have a sanitizing agent in the basket attached to the lift. During an interview 8/5/25 at 9:50 AM, Staff F, CNA, stated during training, no one trained her on cleaning the equipment after each transfer. Staff F stated there are no cleaning/sanitizing wipes on the mechanical lift in this hallway. Staff F stated even if a resident is on Enhanced Barrier Precautions (EBP) or Transmission Based Precautions (TBP), she had not wiped down the shared mechanical lift equipment after using it, and had used the mechanical lift equipment from resident to resident without sanitizing it. During an observation 8/5/25 at 10:30 AM, Staff H, CNA, and Staff I, CNA, performed a mechanical lift transfer for Resident #2, a resident on EBP. Observed the EBP signage by the door to the resident's room. Observed fluids on the floor, dripping from the resident while he was being transferred to the bed, fluids came from his seated area which appeared to be urine. The lift wheels went through the fluid. After the transfer was completed, Staff I moved the mechanical lift equipment into the hallway without cleaning or sanitizing the equipment and placed it in the hallway. The mechanical lift did not have a sanitizing agent in the basket attached to the lift. Observed the mechanical lift in the hallway until 11:15 AM, when staff I then moved it into room [ROOM NUMBER] without sanitizing or cleaning the equipment. During an interview 8/5/25 at 10:45 AM, Staff I, CNA, stated the shared mechanical lift equipment is not sanitized or cleaned in between resident use every time. Staff I stated there used to be sanitizing wipes in a basket on the mechanical lifts, however now none of the lifts have sanitizer wipes. Staff I stated she has not observed staff cleaning the shared mechanical lifts and she has not cleaned them, even if it has been used for a resident on EBP. During an interview 8/6/25 at 8:00 AM, the Director of Nursing (DON) stated an expectation the mechanical lifts be cleaned and sanitized after each use and prior to being used for another resident. Review of the facility policy Total Lift Transfer, with a review date of 11/28/22, and the facility Hospital Clean policy, undated, documented to disinfect lift surfaces and allow them to dry and non-critical medical equipment is cleaned and disinfected between residents.