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	12/30/2025

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 - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff interviews and facility policy review the facility failed to complete an accurate Minimum Data Set (MDS) for 1 of 4 residents (Resident #2) reviewed. The facility reported a census of 68 residents. Findings include:According to the Discharge-Return Not Anticipated MDS assessment tool with reference date of 11/24/2025 documented Resident #2 was admitted to the facility on [DATE] and discharged home/community on 11/24/2025.The Care Plan Focus Area with a revision date of 11/24/2025 documented Resident #2 and responsible party choose long-term placement. Review of Resident #2's progress notes from 11/12/2025-12/1/2025 revealed no documentation of her being discharged from the facility. On 12/30/2025 at 11:45 AM Resident #2 was observed to be sitting in the dining room with her peers. On 12/30/2025 at 11:57 AM the Director of Nursing (DON) verified Resident #2 was in the building and not discharged . While reviewing the MDS that was completed on 11/24/2025 she acknowledged it documented Resident #2 was discharged but that was not accurate. At 1:30 PM she stated the corporate staff was fixing the MDS. During the exit meeting at 2:03 PM she indicated the MDS fixed the issue. The Assistant Director of Nursing (ADON) stated around that time there was talk of Resident #2 discharging home but the family realized that was not going to be an option.The facility provided a document titled Conducting an Accurate Resident Assessment. The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas. Accuracy of assessment means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument (RAI) (i.e. comprehensive, quarterly, significant change in status).Policy Explanation and Compliance Guidelines:2. Qualified staff who are knowledgeable about the resident will conduct an accurate assessmentaddressing each resident's status, needs, strengths, and areas of decline. The assessment will bedocumented in the medical record. 7. A registered nurse will sign and certify that the assessment/correction request is completed. Each individual who completes a portion of the assessment will sign and certify the accuracy of that portion of the assessment. Whether the MDS assessments are manually completed, or computer-generated following data entry, each individual assessor is responsible for certifying the accuracy of responses relative to the resident's condition and discharge or entry status.

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

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	12/30/2025

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

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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 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. (continued on next page)

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	12/30/2025

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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 0657 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 interviews, and facility policy review the facility failed to ensure 1 of 4 residents' (Resident #1) care plan was updated to include interventions to offload her heals while in bed. The facility reported a census of 68 residents. Findings include:According to the Quarterly Minimum Data Set (MDS) assessment tool with a reference date of 11/29/2025 Resident #1 had a Brief Interview of Mental Status (BIMS) score of 3. A BIMS score of 3 suggested severe cognitive impairment. Resident #1 had one pressure ulcer present upon admission/entry. She had a pressure reducing device for her bed and chair, utilized nutrition or hydration interventions to manage skin problems and received pressure ulcer care. Record review revealed wound care orders from a local hospital dated 11/21/2025. One order included to float Resident #1's heels with heel protectors at all times. The Care Plan Focus area with a revision date of 12/11/2025 documented she has the potential for impaired skin integrity and is at risk for pressure ulcers related to her diagnoses of incontinence, debility, and Alzheimer's disease. Resident #1 had an area to her sacrum and deep tissue area injury to her right heel. The care plan lacked interventions to prevent the worsening of the deep tissue injury area to her right heel.On 12/26/2025 at 12:38 AM Staff A Registered Nurse (RN) stated Resident #1 did have boots on her feet but would not always keep them on. On 12/26/2025 at 1:38 PM Staff B Licensed Practical Nurse (LPN) verified Resident wore booties on her foot and had treatments to her bilateral heels. On 12/30/2025 at 11:00 AM Staff C Certified Nursing Assistant (CNA) acknowledged Resident #1 wore booties on her feet to help with offloading her heels.On 12/30/2025 at 11:57 AM the Director of Nursing (DON) stated when Resident #1 returned to the facility from the hospital in November she had pressure injury to her heel. Initially they tried heel protectors that cupped her heels and had a single strap across the front her foot. The resident was able to easily remove them so they got pressure reducing boots. They are soft [NAME] boots with Velcro to help secure them and they were able to stay on better for her. When asked if this intervention should be included on Resident #1's care plan she indicated she would have to look at the care plan. She added she would think it should be, so yes. She indicated they have had some staffing change over with over looks the care plans being completed. The facility provided a document titled Comprehensive Care Plans. It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.3. The comprehensive care plan will describe, at a minimum, the following:a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The facility provided a document titled Pressure Injury Prevention and Management. This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. 4. Interventions for Prevention and to Promote Healinga. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. b. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). c. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: i. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.); f. Interventions will be documented in the care plan and communicated to all relevant staff. g. Compliance with interventions will be documented in the weekly summary charting. 6. Modifications of Interventions b. Interventions on a resident's plan of care will be modified as needed. Considerations for needed modifications include: i. Changes in resident's degree of risk for developing a pressure injury. ii. New onset or recurrent pressure injury development. iii. Lack of progression towards healing. iv. Resident non-compliance. v. Changes in the resident's goals and preferences, such as at end-of-life or in accordance with his/her rights.