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	05/12/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interviews, the facility failed to do the assessment for an initial Brief Interview of Mental Status (MDS), for Resident #34. The facility reported a census of 58 residents. Findings include:A Brief Interview of Mental Status (BIMS) dated 3/17/26 at 11:39 a.m., documented that Resident #34 was not assessed. On 5/7/26 at 12:41 p.m., the Administrator stated that the BIMS was not done with Resident #34's initial MDS. They had a PRN (as needed) traveling MDS person who worked on the MDS remotely. There was a miscommunication and it did not get conveyed to social services or anyone on the team in the facility that an MDS assessment needed to be done. A PRN BIMS was done today. A BIMS (PRN) dated 5/7/26 at 11:30 p.m., documented a score of 8 out of 15, which indicated moderately impaired cognition for Resident #34. A MDS 3.0 Completion policy dated 2025, directed the following:Policy:Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. Definitions: OBRA Assessment refers to an assessment mandated by the Omnibus Budget Reconciliation Act of 1987, which specifies a Minimum Data Set (MDS) of core elements for use in assessing nursing home residents. PPS Assessment refers to an assessment used in the skilled nursing facility prospective payment system to classify residents into categories for payment purposes. ARD, or Assessment Reference Date, refers to the specific endpoint in the MDS assessment process (last day of MDS observation period). Comprehensive Assessment refers to the completion of the MDS, Care Area Assessment (CAA) process, and development and/or review of the comprehensive care plan.Policy Explanation and Compliance Guidelines:According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State.Types of OBRA Assessments:Entry TrackingComplete and submit with every entry into the facility no later than entry date + 7 calendar days.The staff member who is completing the entry tracking enters his/her signature, title, and date completed.The Entry Tracking does not require an R.N. Coordinator's signature and may be completed and signed by any member of the interdisciplinary team.admission Assessment - completed within 14 days of admission counting the day of admission as day #1 when:The resident has no prior admission, orPrior admission was less than 14 days and no admission assessment was completed during the prior admission, orPrior admission ended with a Discharge Return not Anticipated; orPrior admission ended with a Discharge Return Anticipated and re-entry occurred >30 days after the discharge date .Annual Assessment - a comprehensive assessment completed using an ARD no >366 days from the most recent prior comprehensive assessment and no >92 days from the most recent quarterly assessment (counting ARD to ARD).Significant Change in Status Assessment (SCSA) - a comprehensive assessment completed within 14 days of the identification of a status change that meets the requirements outlined in Chapter 2 of the Version 3.0 RAI Manual.A significant change is a major decline or improvement in a resident's status that: (1) will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting, if a decline); (2) impacts more than one area of the resident's health status, and (3) requires interdisciplinary review and/or revision of the care plan.A SCSA is required when a resident enrolls in a hospice program or changes hospice providers and remains in the facility, or a resident in (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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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility receiving hospice services discontinues those services (known as revocation of hospice care) and remains in the facility.A SCSA cannot be completed prior to the completion of an OBRA admission assessment.Quarterly Assessment - completed using an ARD no >92 days from the most recent prior quarterly or comprehensive assessment (counting ARD to ARD).Discharge Assessment - completed using the discharge date as the ARD. Must be completed within 14 days of the discharge date /ARD.Significant Correction of a Prior Comprehensive Assessment - a comprehensive assessment completed when the resident's overall clinical status was not accurately represented (i.e., miscoded) on the erroneous comprehensive assessment and the error has not been corrected via submission of a more recent assessment. Not to be confused with a Significant Change in Status Assessment. It must be completed no later than 14 days after the ARD and not later than 14 days after the determination was made that a significant error occurred.Significant Correction of a Prior Quarterly Assessment - completed when the resident's overall clinical status was not accurately represented (i.e., miscoded) on the erroneous quarterly assessment and the error has not been corrected via submission of a more recent assessment. Not to be confused with a Significant Change in Status Assessment. It must be completed no later than 14 days after the ARD and no later than 14 days after determining that the significant error occurred.Death Tracking Complete when a resident expires in the facility or when on LOA no later than discharge (death) date + 7 calendar days.The staff member completing the death tracking enters his/her signature, title, and date completed.The Death Tracking does not require an R.N. Coordinator's signature and may be completed and signed by any member of the interdisciplinary team.Types of PPS Assessments:5 Day/Initial Assessment The ARD must be set for days 1 through 8 of each Part A SNF covered stay.Must be completed within 14 days after the ARD (ARD + 14 days). If combined with the OBRA assessment, it must be completed by the end of day 14 of admission (admission date + 13 days). This assessment authorizes payment for the entire PPS stay (except in cases when an IPA is completed).Part A PPS Discharge Assessment - required under the Skilled Nursing Facility Quality Reporting Program.This assessment is completed on planned discharges when a resident's Medicare Part A stay ends, but the resident remains in the facility (unless it is an instance of an interrupted stay).If the End Date of the Most Recent Medicare Stay occurs on the day of or one day before the discharge date of a planned discharge, the OBRA Discharge Assessment and the Part A Discharge Assessment are both required and must be combined. When the OBRA and Part A PPS Discharge assessments are combined, the ARD must be equal to the discharge date .Must be completed within 14 days of after the End Date of Most Recent Medicare Stay.Interim Payment AssessmentThis is an optional assessment that authorizes payment for remainder of the PPS stay, beginning with the ARD.The assessment is completed as the SNF determines is necessary to account for changes in patient care needs. See Interim Payment Assessment (IPA) Policy.If performed, it must be completed within 14 days after the ARD (ARD + 14 days).Optional State Assessment - this is a standalone assessment required at the discretion of the state agency for payment purposes.Care Plan Team Responsibility for Assessment Completion:Interdisciplinary Responsibility for Completion of MDS Sections:The responsibility of all sections of the MDS will be clearly assigned. See MDS 3.0 Responsibility by Discipline supplemental document.Persons completing part of the assessment must attest to the accuracy of the section they completed by signature and indication of the relevant sections.The R.N. Coordinator signs, dates, and attests (in section Z0500A) to timely completion of the RAI, once all other disciplines have completed their sections.Coding of Assessment:All disciplines shall follow the guidelines in Chapter 3 of the current RAI Manual for coding each assessment.Within 7 days after completing a resident's MDS assessment or tracking record, the facility must encode the MDS data (i.e., enter the information into the facility MDS software).Assessment Reference Date:The assessment reference date is established as reference point for all staff participating in the assessment process. Although staff members may work on completing a resident's MDS on different days, establishment of the assessment reference date ensures the commonality of the assessment period.Observation should (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assessment Move Facility Request is required. The facility will complete the form and submit to the State Agency. (See the current RAL Manual 3.0 Chapter 5, 5.7 for details.)Reproduction of Data in the Resident's Record:The facility maintains 15 months of assessment data in the resident's active clinical record. The 15-month period is defined as 15 months following the completion date for all assessments and correction requests.Assessment data may be maintained electronically.If data is maintained electronically, and electronic signatures are not used, the facility must ensure hard copies of the MDS assessment signature pages are maintained for every MDS conducted in the resident's active clinical record for 15 months.Transmission Requirements:All assessments shall be transmitted to the designated CMS system (iQIES) within 14 days of completion.Each assessment must be accepted into the system, as verified by validation reports.Validation Edits:For each file submitted, the submitter will receive confirmation that the file was received for processing and editing by iQIES (initial submission feedback).Fatal File Errors - file structure is unacceptable (e.g., not in a ZIP file), the file will be rejected. These errors must be corrected and resubmitted.Fatal Record Errors - file structure was validated; however, errors exist such as out of range response or inconsistent relationships between items. These records are rejected and must be corrected and resubmitted.Non-Fatal Errors (Warnings) - file structure was validated and accepted but with errors. Non-fatal errors should be evaluated to identify necessary corrective action.References:Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (2025 Revision) F636-F638 and F640.Centers for Medicare & Medicaid Services. Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1. (October 2025) Chapters 2 & 5.

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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 record review, interview, and facility policy review, the facility failed to revise one of one resident's care plan (Resident #68) following a significant change in the resident's pain status, placing the resident at risk for uncontrolled pain and a diminished quality of life. The facility reported a census of 58 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #68 documented a [DATE] admission date to the facility from an acute hospital stay. Her diagnoses included dementia, difficulty in walking, unsteadiness on feet, repeated falls, and need for assistance with personal care. The MDS showed the Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident was cognitively severely impaired. The MDS documented the resident's health conditions included pain management with scheduled pain medications and that the resident had not received PRN (as needed) pain medications or non-medication interventions for pain. Resident #3's Pain Assessment Interview revealed she had not experienced pain in the last 5 days. The MDS further documented the resident had shortness of breath when lying flat and with exertion. The MDS documented the resident had 2 or more falls in the past 3 months. The MDS documented the resident's medications did not include any high-risk drugs. The Care Plan for Resident #68 dated [DATE] identified the resident was at risk for falls, had pain or the potential for pain related to a history of pain to her right shoulder and arm. The interventions for Resident #68's pain directed the staff to:a. Anticipate the resident's need for pain relief and respond as soon as possible to any complaint of pain. b. Monitor and record the resident's pain severity on the 1 to 10 scale (a standard 0-10 tool where 0 is no pain and 10 is the worst imaginable pain) every shift and as needed.c. Report to Nurse any s/sx [signs or symptoms] of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing).The care plan had not been updated to include the resident's right leg pain noted on [DATE] for which she was hospitalized from [DATE] to [DATE]. In an interview on [DATE] at 2:17 p.m. with Staff L, CNA stated she had worked at the facility for 10 months and usually worked the evening shift from 2 p.m. to 10 p.m. Staff L, CNA recalled caring for Resident #68 and stated the resident was in a lot of pain in late October to [DATE], but could not recall any specific event that had caused the pain. She stated that Resident #68 had pain every day in her right knee and that every time she was moved, she would vocalize her pain. She agreed that the staff would allow Resident #68 to remain in bed as transferring the resident had caused her pain. She stated that when she rolled the resident, the resident would hold on to the side rail while she changed the resident's incontinent pad and that rolling Resident #68 had caused her to experience pain. In an interview on [DATE] at 1:30 p.m. with the Director of Nursing (DON) she revealed she had worked at the facility for the past 4 years as their DON. She recalled Resident #68 had been hospitalized from [DATE] to [DATE] for her right lower extremity pain. The DON stated that after the resident's return from the hospital on [DATE] the resident experienced pain with movement. The DON agreed that Resident #68's care plan regarding her pain had not been updated after her return from the hospital on [DATE]. The DON stated that a significant change in status MDS assessment had been scheduled, and that the resident's care plan would have been updated with that assessment, but that assessment had been cancelled when she died on [DATE]. Review of the facility's policy Care Plan Revisions Upon Status Change, dated 2025 revealed the purpose of that policy was to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. The policy directed staff to review and revise the care plan when a resident had experienced a change in status by having the MDS Coordinator and the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interdisciplinary Team discuss the resident's condition and collaborate on intervention options and update the resident's care plan with the new or modified interventions.The policy directed the Unit Manager or other designated staff member to communicate those new or modified care plan interventions to all staff involved in the resident's care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide grooming for 1 resident reviewed (Resident #34). The facility failed to trim resident's toenails which had grown long and were snagging on his socks. The facility reported a census of 58. Findings include:The 5-Day Minimum Data Set (MDS) Resident assessment dated [DATE] documented that Resident #34 (R34) required assistance from staff for the following; toileting hygiene, lower body dressing, shower/bathing, and putting on/taking off footwear. The MDS documented the R34's admission date as March 9, 2026. A care plan revised on 3/13/26, directed nursing staff that Resident #34 had a self-care deficit focus area evidenced by requiring assistance with ADLs (Activities of Daily Living).This resident was a 1 person assist. Staff were to encourage bathing 2x weekly, inspect skin during showers and alert charge nurse to any skin issues. Nursing staff were to check nail length and trim/clean on bath days and as necessary. On 5/5/26 at 9:56 AM, Resident #34 stated he would like his toenails clipped. He said that no one ever wants to trim them. Resident #34 stated his wife had her toenails trimmed recently. This resident said that when he asked why his toenails weren't trimmed, they told him he was not on the list. This resident said he didn't know how to get on the list. He repeated he just wants his toenails trimmed. On 5/6/26 at 11:15 AM, Staff K, Licensed Practical Nurse (LPN), when asked about whether or not Resident #34's toenails had been trimmed, Staff K stated that Resident #34 had not been at the facility very long. Staff K stated he initially admitted to the facility for skilled care with plans to return home. It was decided he was unable to go home. She stated this wasn't that long ago. She stated that his wife had her toenails trimmed by the podiatrist last week as she was on the list to be seen by the podiatrist. She didn't know if anyone had talked with him about being on the list. This LPN agreed to go look at his nails. She removed his socks and shoes. His large toes had approximately 1/4 inch growth from the tip of his toes. Resident #34 stated it had been difficult to put on his socks and shoes as they keep snagging on his toenails. He asked are you going to trim them. This staff person stated she would after breakfast. On 5/7/26 at 8:10 AM, Staff K stated that she did cut his toenails yesterday. She said she was able to trim all of them down. Staff K stated that Resident #24's son normally comes to pick up his laundry. She will talk with his son the next time he comes in and ask him if he wants to get on the podiatry list. She says she thinks (getting on the podiatry list) has something to do with what insurance a resident is on. Normally the Social Service Designee asks if this is a service the residents would like during the admission process. She stated that she believes it costs a little more for them to add this service on. This LPN stated the resident was happy to have his nails trimmed yesterday. On 5/7/26 at 8:44 AM, the Administrator stated that residents can get on the podiatrist list. The podiatrist comes to the facility at least every 3 months and sometimes more often. She stated that only clinical staff are able to trim nails and nurses are definitely able to trim them. They can ask if the resident would like to see the podiatrist and check if the podiatrist will be in the facility in the following week or so. If it would be awhile before the podiatrist would be in the facility, the nurses should go ahead and trim a residents nails. This administrator stated the facility is to trim residents nails no matter if they are skilled care or not. A Nail Care Policy dated 2025, directed staff:Policy:The purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health. Policy Explanation and Compliance Guidelines:Assessments of resident nails will be conducted on admission and readmission to determine the resident's nail condition, needs, and preferences for nail care, if possible.Report unusual or abnormal conditions of the nails to the physician and the responsible party (e.g., curling, color changes, separation from the nailbed, redness, bleeding, pain, odor, infection, etc.).Determine preferences regarding nail polish.Obtain history and preferences regarding podiatrist.Identify conditions that increase risk for foot or nail problems, such as diabetes, peripheral vascular disease, heart failure, renal disease, or stroke.Routine cleaning and inspection of nails will (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be provided during ADL care on an ongoing basis.Routine nail care, to include trimming and filing, will be provided on a regular schedule (such as weekly on Wednesday 3-11 shift). Nail care will be provided between scheduled occasions as the need arises.The resident's plan of care will identify:The frequency of nail care to be provided.The type of nail care to be provided.The person(s) responsible for providing nail care (e.g., licensed nurse, nurse aide, podiatrist, activity professional).Principles of nail care:Nails should be kept smooth to avoid skin injury.Only licensed nurses shall trim or file fingernails of residents with diabetes. Toenails of residents with diabetes or circulation problems shall be filed only.If a resident has a toe infection, diabetes mellitus, neurologic disorders, renal failure, or PVD, toenail trimming should be performed by a physician or practitioner.Resident without complicating disease processes, may have their toenails clipped by staff who have received education and training to provide this service within professional standards of practice and as per facility policy.Each resident will have his/her own nail care equipment (e.g., clippers, emery boards, files, etc.). Equipment will not be shared between residents. Clean equipment after each use and before storing.Procedure:Perform hand hygiene and don gloves.Fill wash basin(s) with warm water. Soak hands/feet in wash basin for 10-20 minutes, unless resident has diabetes or circulation problems.Gently clean underneath nails with orange stick.If trimming is allowed, clip nails using nail clippers straight across and even with tops of the fingers/toes.Shape nails straight across using nail file, emery board, or the like.Dry hands/feet well with towel.Apply lotion to hands/feet. Remove gloves and perform hand hygiene.Document completion of task, any complications, or if resident refuses.

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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 observation, clinical record review, resident and staff interviews, the facility failed to provide an assessment and timely intervention for the necessary care and services for 2 of 3 residents reviewed (Resident #11 and Resident #45). Resident #11 reported having chest pain over night that lasted 15 minutes. The licensed nursing staff failed to provide an assessment after receiving the information. Resident #45 had a wound requiring a wound vac (medical device that uses negative pressure to promote healing in wounds). The licensed staff failed to maintain and provide interventions to ensure proper functioning of the wound vac. The wound vac was missing several changes and was not properly secured and functioning during wound clinic visits. The facility reported a census of 58 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #11 revealed the diagnoses of Parkinson's and was independent for activities of daily living. Resident #11 denied pain during the assessment. The Brief Interview for Mental Status (BIMS) score was 15 suggested an intact cognition. The Care Plan directed staff to monitor and document pain for probable cause of each pain episode and notify the physician if pain was a significant change from past experiences. During an interview on [DATE] at 1:26 pm, Resident #11 stated she had experienced chest pain during the night on [DATE], notified Staff G, Certified Nursing Assistant (CNA) and requested to see Staff H, Licensed Practical Nurse (LPN). Resident #11 stated the pain was a crushing pain that lasted about 15 minutes and she felt scared. Resident #11 stated the nurse did not respond, the pain subsided and she did not tell the nurse the next day. Resident #11 did inform staff in the Resident Council meeting on [DATE]. During an interview on [DATE] at 1:39 pm, Staff R, CNA stated Resident #11 was clear in thought and was believable. A review of the Progress Notes for April/[DATE] revealed no documentation of Resident #11 had chest pain. During an interview on [DATE] at 2:42 pm, Staff E, LPN stated she would believe Resident #11 if she would tell her anything, she was very believable. Staff E stated Resident #11 had not reported having chest pain. Staff E stated she would assess Resident #11 and give a report to the nurse practitioner tomorrow. Progress Notes review through [DATE] failed to document an assessment for Resident #11 or notification to the provider and family. Resident council meeting minutes on [DATE] revealed the following;Nursing: Resident #11 stated she was having pains in her chest last night, she reported this to Staff G, Certified Nursing Assistant (CNA) and the nurse failed to come to her room to assess her pain. During an interview on [DATE] at 8:38 am, Staff J, Activity Director stated on [DATE] was the first resident council she conducted. Staff J stated during the Resident Council meeting, Resident #11 stated she had chest pain overnight on [DATE] and the nurse did not come see her. Staff J stated she asked the Administrator what I do with the notes of concerns and was given grievance forms to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fill out. Staff J stated she filled out a grievance form and gave it to the Director of Nursing (DON) the next morning on [DATE]. During an interview on [DATE] at 1:59 pm, Staff I, CNA stated Resident #11 did not report that she had chest pain and had a complete mind. Staff I stated the facility was short staffed and staff were not patient and ignored Resident #11. During an interview on [DATE] at 3:29 pm, The DON stated she was aware that Resident #11 complained of chest pain during a night shift and she told the CNA, who did tell the nurse but when they went back in to assess her she was asleep. The DON stated she was aware that Resident #11 filed a grievance that she complained of chest pain and the nurse did not come in to assess her. When inquired where it was documented that Resident #11 had chest pain, and the assessment and inquired if the provider was notified, the DON said no. The surveyor informed the DON that Resident #11 had the chest pain and informed Staff E, LPN on [DATE] who stated she would conduct an assessment and will notify the provider but there was no documentation of that assessment nor provider notification. The DON stated she would check on that but failed to provide a response to the survey team. During an interview on [DATE] at 8:26 am, Staff H, Licensed Practical Nurse (LPN) stated that he was the charge nurse on the over-night shift on [DATE]. Staff H denied being informed of Resident #11 having chest pain. Staff H stated if he was informed of that, he would have provided an assessment, notified the provider and provided pain management. Staff H verified he had worked on Resident #11's hall with Staff G, CNA and denied the CNA had mentioned the chest pain episode. During an interview on [DATE] at 8:55 am, The Administrator stated when Staff J, Activity Director inquired what to do with the resident council concerns, she was given grievance forms to fill out and directed to give them to the responsible manager. The Administrator stated Staff J mentioned another resident's concern but couldn't remember if she was informed that Resident #11 having chest pain. The Administrator stated chest pain was a concern that would require immediate nurse assessment. A document titled Grievance Form dated [DATE] revealed a summary of Resident #11's grievance. a. During the night on [DATE] Resident #11 experienced chest pain, reported the pain to the CNA and the nurse did not come to check on her. b. Investigation/Outcome revealed that education was provided to staff member related to communication with the nurse for complaints of pain. c. Signed by the DON, Grievance Officer and the Administrator. A document dated [DATE] a note to Staff F, LPN that revealed a directive from the DON to have a discussion with Staff G, CNA related to care expectations and reporting concerns. The document listed the complaint from Resident #11 regarding the chest pain episode that was not verified with Staff H, LPN as of yet. The document stated the report of concerns, especially chest pain, needed to be reported to the nurse immediately. The directive included to monitor Staff G for the next 3 shifts and notify the DON in writing if there were further concerns. During an interview on [DATE] at 3:29 pm, The DON stated she was aware that Resident #11 complained of chest pain during a night shift and she told the CNA, who did tell the nurse but when (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they went back in to assess Resident #11, she was asleep. The DON stated she was aware that Resident #11 filed a grievance that she complained of chest pain and the nurse on duty did not complete an assessment. When inquired where it was documented that Resident #11 had chest pain, and the assessment and inquired if the provider was notified, the DON said no. During an interview on [DATE] at 8:26 am, Staff H, Licensed Practical Nurse (LPN) stated that he was the charge nurse on the over-night shift on [DATE]. Staff H denied being informed of Resident #11 having chest pain. Staff H stated if he was informed of that, he would have provided an assessment, notified the provider and provided pain management. Staff H verified he had worked on Resident #11's hall with Staff G, CNA and denied the CNA had mentioned the chest pain episode. 2. A Minimum Data Set (MDS) dated [DATE], documented diagnoses for Resident #45 included diabetes, infection of the foot, and open lesions. A BIMS revealed a score of 15 out of 15, which indicated intact cognition. This resident required applications of dressings to feet. A Census page documented that Resident #45 was admitted to the facility on 3//26/26. A Podiatry Clinic note dated [DATE], documentation included the following: Resident #45 is approximately 3.5 weeks post-op (post surgery). He has been placed at the facility for skilled care. Resident #45 reports that the dressing wasn't changed for the first 5 days he was there. Now changes are being performed every other day. The wound VAC was not applied correctly and the whole dressing was wet. The Assessment documented that this resident had a skin ulcer of left ankle with necrosis (death of cells) of bone. This was a postoperative examination at 3.5 weeks status post left ankle I&D (incision and drainage), hardware removal (removal of orthopedic (related to bone) implants that were initially placed to stabilize fractures, correct deformities, or support healing bones), external fixator (metal frame applied outside the body to stabilize broken bones in the ankle and lower leg) and wound VAC placement. Upon presentation the dressing was noted to be saturated and the wound VAC was not adhered to the wound and completely lifted and malfunctioning. No signs of pin sit infection. Antibiotics per infectious disease. This provider called the facility and discussed that Resident #45 was an hour late to his appointment, the wound VAC was not functioning, the dressing that was applied was completely saturated and there was no compression. A Podiatry Clinic note dated [DATE], documentation included the following: Resident #45 presented with a wound VAC battery dead and cannot reapply. Continue dressing changes Monday, Wednesday and Friday. Wound VAC to the medial wound (wound closer to the midline of the body) 125mmHg (unit of pressure) continuous, change canister once weekly. A Podiatry Clinic note dated [DATE], documentation included the following: Follow-up left lower extremity. Presents today for wound evaluation. Today is Wednesday, he reports the last VAC (wound vac) and dressing change was performed on Friday which goes against the podiatry clinic's provider's recommendations. Resident #45 stated the facility was now providing routine dressing changes. The provider did inspect his VAC prior to removing the dressing and it was set at 125 mmHg continuous, however the actual was 0 mmHg continuous. The provider did remove the dressing which was noted to be completely saturated in blood, the wound VAC was not adhered to the skin and not functioning. The surrounding tissue was macerated. Given the inability for the facility to maintain a VAC, the provider will stop VAC dressings at this time. Apply Betadine medially and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	laterally into the superficial heel wound. Cover with gauze, gauze roll and Ace bandage. Strict non-weightbearing to the left lower extremity. Antibiotics per infectious disease. On [DATE] at 2:07 PM, a podiatry clinic nurse stated that multiple times they had talked with the facility related to the wound vac not functioning or not applied properly. They ended up having to discontinue it. She stated that on [DATE] the battery was dead on the wound vac. On [DATE] it was presented that the facility was not doing routine vac changes. The wound vac was set at 0 instead of 125 like it should have been set. The wound vac was not functioning. The primary concern was that we want the staff to be educated and to be able to properly use wound vacs. A Treatment Administration Record (TAR) for the month of April, had the following order: The Left Lower Extremity (LLE) was to be kept clean and dry and intact. Wound VAC was to be connected and running at 125mmHg every day and night shift. The start date was [DATE]. The discontinued date was [DATE]. The TAR was missing several entries of the wound vac changes. The [DATE] Treatment Administration Record directed the following: Wound vac to left medial ankle 125mmHg continuous. Change 3 times a week. every day shift every Monday, Wednesday and Friday. The start date for this order was [DATE]. The order was discontinued on [DATE]. The TAR was signed by a nurse on the following days [DATE], [DATE], [DATE], [DATE], and [DATE]. On [DATE] this was signed as refused and on [DATE] it was signed as held. The TAR was not signed for the wound vac changes on [DATE], [DATE] and [DATE]. The wound vac was discontinued on [DATE]. The [DATE] TAR directed the following: Left foot: Apply adaptic (non adherent dressing) followed by betadine soaked gauze to lateral incision, Xeroform (non-adherent wound dressing) around pin sites and wrap with soft roll and ace. every day shift. The start date was [DATE]. The treatment was discontinued on [DATE]. The TAR was not signed for this treatment getting done on [DATE] and on [DATE]. On [DATE] at 2:00 p.m., an observation of wound care for both right and left lower legs was done by Staff S, Registered Nurse (RN). during wound care Resident #45 stated that this nurse always did his wound care the right way but not all the nurses did. During the wound treatment observation this resident stated that the wound vac really helped a lot and his wounds have improved greatly. On [DATE] at 2:50 PM, Staff S, Registered Nurse stated that she did not know of a time that the wound vac wasn't changed or that the settings were off. She stated the wound vac settings were preset. She stated the only thing she remembers is that they had sent this resident to the podiatry clinic and his wound vac was working when this resident left the facility. However, the battery had died by the time he was at his appointment and the podiatrist was not happy about it. She stated if there were missing entries on changing the wound vac, it was probably because they had to change it in between times and that would have started the 3 day change cycle over. She said she hated to see the wound vac go as it was so helpful. She stated they had a pretty good system down and it was working well. She stated the reason they were given for the discontinuation of the wound VAC was that Resident #45 was ready for a different treatment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:05 PM, Staff T, Assistant Director of Nursing (ADON), RN, stated that she did work dayshift on [DATE], [DATE], and [DATE]. She stated that on a Friday she was busy and couldn't get to the wound VAC to change it, so she changed the wound vac on Saturday. She stated she obtained an order but forgot to put it into the electronic health record and she forgot to sign that she had changed the wound vac the next day. She stated another time the night nurse did the wound vac change. She wasn't sure what happened the 3rd time. On [DATE] at 8:39 AM, the Administrator stated she understood the concern with the management/documentation of the wound vac. A Negative Pressure Wound Therapy policy dated 2025, directed the following: Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. This policy addresses the use of negative pressure wound therapy (NPWT) for the treatment and management of wounds. Definitions: Negative pressure wound therapy is an active wound care treatment that uses controlled sub-atmospheric (negative) pressure to assist and accelerate wound healing. The therapy may be gauze based, foam based, or peel and stick, and includes an evacuation tube and a computerized pump that applies the negative pressure. Policy Explanation and Compliance Guidelines: Negative pressure wound therapy will be provided in accordance with physician orders, including the desired pressure setting, continuous or intermittent therapy, and frequency of dressing change. Clean technique shall be utilized unless otherwise specified by the physician. Negative pressure wound therapy is considered an advanced wound therapy and is usually initiated when other modalities have proven unsuccessful or to prevent complications in high risk situations. Negative pressure wound therapy shall be used only when the goal is wound healing, the wound bed has minimal necrotic tissue, and treatment is underway for any wound infection. Indications for NPWT include: Acute and chronic open wounds with depth. Partial and full thickness wounds. Partial thickness burns. Surgical incisions. Enteric fistulas. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Using the attached tubing adhesive drape, or additional dressing drape, seal the tubing assembly on top of the dressing and ensure that it will not lie on bony prominences. Connect tubing assembly to the canister tubing. Make sure canister is fully engaged into the pump. Initiate NPWT at the prescribed settings in accordance with pump/product specifications. Monitoring throughout the use of NPWT shall include, but is not limited to, the following: Pain associated with the therapy. Device is functioning. Settings as prescribed. Troubleshooting of any alarms, in accordance with pump/product specifications. Response of the therapy, including wound characteristics and progress towards healing. Whenever therapy cannot be resumed within two hours, remove the dressing and apply a moist wound dressing. Notify physician for specific orders. Therapeutic response of the therapy shall be documented in accordance with procedures for wound documentation. The physician shall be notified of any complications associated with the use of NPWT.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to assess and provide pain management to adequately control residents pain for 1 of 3 residents (Resident 68) reviewed for pain management. This failure put the resident at risk of uncontrolled pain and a diminished quality of life. The facility reported a census of 58 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #68 documented a [DATE] admission date to the facility from an acute hospital stay. Her diagnoses included dementia, difficulty in walking, unsteadiness on feet, repeated falls, and need for assistance with personal care. The MDS showed the Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident was cognitively severely impaired. The MDS documented the resident's health conditions included pain management with scheduled pain medications and that the resident had not received PRN (as needed) pain medications or non-medication interventions for pain. Resident #3's Pain Assessment Interview revealed she had not experienced pain in the last 5 days. The MDS further documented the resident had shortness of breath when lying flat and with exertion. The MDS documented the resident had 2 or more falls in the past 3 months. The MDS documented the resident's medications did not include any high-risk drugs. The Care Plan for Resident #68 dated [DATE] identified the resident was at risk for falls, had pain or the potential for pain related to a history of pain to her right shoulder and arm. The interventions for Resident #68's pain directed the staff to: a. Anticipate the resident's need for pain relief and respond as soon as possible to any complaint of pain. b. Monitor and record the resident's pain severity on the 1 to 10 scale (a standard 0-10 tool where 0 is no pain and 10 is the worst imaginable pain) every shift and as needed. c. Report to Nurse any s/sx [signs or symptoms] of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing). The care plan had not been updated to include the resident's right leg pain noted on [DATE] for which she was hospitalized from [DATE] to [DATE]. Resident #68's care plan also included her need for assistance with personal care which informed staff of her non-weight bearing to her right lower extremity and the need for a knee immobilizer brace to her right leg with skin checks two times daily. The care plan also directed staff check and change her incontinent brief as needed. Her care plan had been updated on [DATE] to include her need for hospice care related to her terminal prognosis with the goal to maintain the resident's comfort and directed staff to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met and to provide maximum comfort for the resident. Resident #68's electronic medical record (EMR) review revealed the pain medication Acetaminophen Tablet Give 650 mg (milligrams) by mouth every 6 hours as needed for Pain. not to exceed 3000 gm (grams) a day was prescribed upon her [DATE] re-admission to the facility from the hospital. Review of Resident 68's Medication Administration Record (MAR) for [DATE] showed Resident 68 was administered the pain medication on the following dates and times, and for the following documented pain levels:On [DATE] at 6:36 p.m., for a pain level of 5 which indicated moderate pain (pain level of 4 to 6, on the pain scale of 0 to 10 with 0 = no pain and 10 = worst)On [DATE] at 8:01 a.m., for a pain level of 5.On [DATE] at 8:18 a.m., for a pain level of 6.On [DATE] at 8:09 p.m., for a pain level of 4. On [DATE] at 7:36 p.m., for a pain level of 5. Review of Resident 68's EMR progress notes dated [DATE] revealed:A social service note at 8:53 a.m. indicating a referral had been made to a hospice agency as requested by Resident 68's daughter. A nurses note at 10:54 a.m. documented new physician orders had been received to discontinue Resident #68's oral medications and start the hospice comfort medications. The last progress note on [DATE] was at 1:39 p.m. which was a social service note. Review of Resident 68's Hospice (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	paperwork revealed her Medication Orders SNF (Skilled Nursing Facility) form for PRN (as needed) Medications Orders dated [DATE] that included: Acetaminophen 650mg suppository - quantity 6 Insert 1 suppository rectally every 6 hours as needed for mild pain or fever. Morphine sulfate 20 mg/ml oral concentrate - quantity 30ml Take 0.25 ml (5mg) by mouth or under tongue every 2 hours as needed for moderate to severe pain or shortness of breath. Lorazepam mg/ml 0.25 ml Take 0.25 ml by mouth every 2 hours as needed for terminal restlessness/anxiety. Review of Resident 68's paper medical record revealed the record of the resident's pain severity indicated the resident had experienced moderate pain daily since her return from the hospital on [DATE] to [DATE]. When Resident #68 was admitted to hospice care on [DATE] the facility failed to monitor and record the resident's pain severity on [DATE] and [DATE] and no pain medications had been administered those two days. On [DATE] Resident #68's granddaughter visited the facility and sat at the resident's bedside from approximately 3:30 p.m. to 9:30 p.m. during this time period facility staff came into the room twice to check the resident's incontinent pad. During the first instance Resident #68 cried out as she was checked, the unidentified Certified Nursing Assistant (CNA) stated Resident #68's incontinent pad was dry and did not need to be changed. The resident's granddaughter asked the CNA if there was pain medication the resident could be given since Resident #68 had been restless, whimpering, and crying in pain during her visit. No staff returned to the room with any pain medication. During the second instance a different unidentified staff person checked her incontinent pad and needed to change the pad as it was soiled. The staff person rolled Resident #68 on her left side and the resident's granddaughter helped hold her on her left side and comforted her as she cried out while the staff person changed her into a clean incontinent pad. Resident #68's granddaughter asked this staff person for some pain medication to be given since Resident #68 had been whimpering and crying for hours. The staff person stated she would let the nurse know of the resident's need for pain medication. When Resident #68's granddaughter left the facility around 9:30 p.m. no nurse or staff person had returned to the resident's room with pain medication. A review of Resident #68's paper medical record and EMR revealed the there was no documentation regarding the resident receiving any pain medications on [DATE]. Review of Resident 68's EMR progress notes revealed no progress notes had been documented following the [DATE] social service progress note at 1:39 p.m. until [DATE] at 7:30 a.m. when a physician progress note had been documented that indicated Resident #68 had been admitted to hospice care on [DATE]. The [DATE] physician progress note indicated the resident was Still with uncontrolled pain to her right knee [due to] a periprosthetic fracture [a fracture around a joint replacement implant] around [her] internal prosthetic right knee joint [an artificial implant used to replace damaged bone and cartilage in the right knee]. Seeing her today she is still in significant pain and appears very uncomfortable. Hospice was contacted regarding medications/pain management. Review of Resident 68's Hospice paperwork revealed the Hospice Registered Nurse (RN) had visited the resident at the facility on [DATE] from 8:47 a.m. to 9:59 a.m. and noted . upon entry pt [patient] is in her bed, occasional moans and facila [facial] grimacing noted. Facility struggled to get Morphine and Ativan delivered. Call placed to ARNP [Advanced Registered Nurse Practitioner] and collaborated with facility LPN [Licensed Practical Nurse] and morphine was taken from facility E [Emergency] kit and dose administered. The Hospice RN documented Resident #68's pain was at a level 4 (moderate pain). This was the first documented administration of the Morphine sulphate 20mg/ml oral concentrate . Take 0.25 ml (5mg) by mouth or under tongue every 2 hours as needed for moderate to severe pain or shortness of breath that was listed on the Hospice's Medication Orders dated [DATE]. Review of Resident #68's paper Individual Patient's Narcotic Record revealed Staff K, LPN, documented 0.25 mL (milliliter) of morphine was administered at 9:30 a.m., The Narcotic Record revealed the resident's morphine pain medication was further administered on [DATE] at 11:30 a.m. and 1:30 p.m. by Staff K, LPN.; at 6:30 p.m. by another LPN; and at 8:30 p.m. by Staff E, LPN. Review of Resident #68's paper [DATE] MAR revealed the resident's Lorazepam 0.25 ml medication to be taken by mouth every 2 hours as needed for terminal (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	restlessness/anxiety had been given on [DATE] at 6:30 p.m. by a staff LPN and at 8:30 p.m. by Staff E, LPN. Review of Resident #68's Narcotic Record revealed on [DATE] at 8:30 a.m. Staff K, LPN, administered Resident 68's final dose of morphine pain medication and review of the resident's [DATE] MAR revealed Staff K, LPN had administered the final dose of the resident's Lorazepam medication at the same time 8:30 a.m. On [DATE] Staff K, LPN was called to Resident #68's room at 9:20 a.m. when the resident had passed away. In an interview on [DATE] at 1:50 p.m. the Administrator and the [NAME] President (VP) of Clinical Operations revealed Resident #68 had been a long-term resident who had admitted in 2020 and died in the facility on [DATE]. They stated that [DATE] the facility had changed from the previous ownership group to the current ownership group who currently managed the facility. They revealed that the facility's EMR's database had changed on [DATE] and the facility had completed documentation on paper in some areas and they would access Resident #68's paper medical chart to provide what was needed. The Administrator and VP of Clinical Operations revealed that Resident #68's daughter had been given a list of hospice agencies on [DATE] and on [DATE] a referral was made to the hospice agency the resident's daughter had chosen and Resident #68 had been admitted to hospice care on [DATE]. The VP of Clinical Operations verified that the pain medications ordered by hospice were available in the facility's e-kit which was kept in the nurses' medication room. On [DATE] at 3:22 p.m. the VP of Clinical Operations provided Resident #68's paper medical record for the pain medications administered [DATE]. In an interview on [DATE] at 12:15 p.m. with the Administrator Resident #68's pain records were discussed which revealed no monitoring of the resident's pain level had been documented and no pain medications had been provided to the resident on [DATE] and [DATE]. The Administrator agreed and further agreed that the hospice medication orders had been made on [DATE]. Discussion continued regarding Resident 68's November MAR that had a starting date of [DATE] at 10:30 a.m. for the pain medications to which she agreed and stated the Director of Nursing (DON) was working at the facility during that time period and could provide further information. Discussion then focused the Resident 68's family being in facility on [DATE] from 3:30 - 9:30 p.m. while the resident experienced pain and the family had requested her pain medications with no pain medications having been given and no documentation of pain medications administered on [DATE]. The Administrator stated her expectation was for the nursing staff to address a resident's pain and administer the resident's pain medications appropriately to alleviate a resident's pain. In an interview on [DATE] at 2:17 p.m. with Staff L, CNA stated she had worked at the facility for 10 months and usually worked the evening shift from 2 p.m. to 10 p.m. Staff L, CNA recalled caring for Resident #68 and stated the resident was in a lot of pain in late October to [DATE], but could not recall any specific event that had caused the pain. She stated that Resident #68 had pain every day in her right knee and that every time she was moved, she would vocalize her pain. She stated she had no knowledge about the resident's pain medications as she was not responsible for giving those pain medications. Further discussion on the day of [DATE] and review of the nursing schedule for that day had Staff L, CNA assigned to Resident #68's hall for the 2:00 p.m. to 10:00 p.m. shift. She stated that she could not recall if she had told the nurse about Resident #68's pain that day as it was six months ago. She further stated that Resident #68 was always in pain, so she thought the nurse would have known about her pain. She agreed that the staff would allow Resident #68 to remain in bed as transferring the resident had caused her pain. She stated that when she rolled the resident, the resident would hold on to the side rail while she changed the resident's incontinent pad and that rolling Resident #68 had caused her to experience pain. In an interview on [DATE] at 3:05 p.m. with Staff E, LPN regarding Resident #68 she stated she could recall the resident, but could not recall specifically what had happened or when the resident was uncomfortable or in pain. In an interview on [DATE] at 10:55 a.m. with the hospice agency's RN Regional Director of Clinic Operations she revealed Resident #68 had been admitted to hospice the afternoon of [DATE] by one their agency's Hospice RNs that currently no longer worked for their agency. She stated that another Hospice RN had visited Resident #68 at the facility on [DATE] from (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	1:55 p.m. to 2:45 p.m. and at that time she had noted the patient appeared comfortable. She stated that Hospice RN also noted that the facility was changing from pharmacy provider to another pharmacy and that a conversations with the facility's DON revealed the DON stated they would pull medications from the facility's e-kit if needed. The hospice agency's RN Regional Director of Clinic Operations further revealed that the Hospice RN that had admitted the resident to hospice care visited the resident at the facility on [DATE] at 8:47 a.m. and noted that upon entry occasional moans and facial grimacing noted and that the Hospice RN worked with facility staff that day to have Morphine taken from the facility's e-kit and administered. In an interview on [DATE] at 12:17 p.m. with Staff K, LPN revealed she had worked at the facility for two and a half years and recalled caring for Resident #68. She stated Resident #68 was not a resident that complained a lot, but liked things to be done in a certain way and was a tough lady. She could not recall specific events as those events had occurred six months ago. She did recall that Resident #68 upon her return from the hospital in late [DATE] refused to get out of bed, would not feed herself, but would eat some of each meal when staff assisted her. She stated that when Resident #68 was moved, she would grimace and be in pain. Staff K, LPN recalled Resident #68's daughter had visited often and the resident's granddaughter had also visited her. She stated Resident #68's daughter had not wanted the resident to be in pain. She recalled that it was the resident's right lower leg that caused her pain and that when the staff turned her by rolling her to her left side, they would talk to her, and let the resident hold on to the staff as that appeared to comfort the resident. She stated that in early [DATE] the facility was changing their pharmacy provider and she could not recall which pharmacy had been used for Resident #68's medications. She stated the facility was having some problems with both pharmacy providers, but was not aware of any specific problems. She agreed that the facility's e-kit had pain medications available. Further discussion focused on [DATE] when Staff K, LPN had worked from 6:00 a.m. to 6:00 p.m. and the afternoon and evening that day when Resident #68 was experiencing pain. Staff K, LPN stated she could not recall that specific day, but stated the staff were aware of Resident #68's pain as she would literally just lay in her bed with her immobilizer on her right leg. She stated she could not recall any pain medications that had been requested by the granddaughter. She stated she recalled the resident's daughter asking her about the resident's pain medications and she recalled that on [DATE] she had administered her pain medications multiple times that day. In an interview on [DATE] at 1:30 p.m. with the DON she revealed she had worked at the facility for the past 4 years as their DON. She recalled Resident #68 had been hospitalized from [DATE] to [DATE] for her right lower extremity pain. She reviewed the resident's EMR and hospital reports and stated the reports indicated no acute fracture with swelling around the prosthetic joint in her right knee. The DON agreed that on [DATE] at 1:09 p.m. she had entered a progress note in Resident #68's EMR regarding the resident's current non-weight bearing status and that her assistance with personal cares had increased. She had noted the family's decision to pursue hospice services for Resident #68. The resident's pain was discussed and the monitoring and documentation of her pain level after returning from the hospital on [DATE] until [DATE], with no documentation of monitoring the resident's pain level on [DATE] until the resident's death on [DATE]. The DON stated that when hospice care began on [DATE], the facility had discontinued the oral medications when they had received the medication orders from the hospice agency. She stated that when the facility's pain medications were discontinued, the facility had also inadvertently discontinued the monitoring and documentation of the resident's pain level on the pain scale. The DON stated that Resident #68 was very stoic and did not like taking medications. She would clamp her mouth shut at times and refuse her medications. The DON agreed that after her return from the hospital on [DATE] the resident experienced pain with movement. After reviewing that upon her hospital return, the resident was getting pain medication daily from [DATE] to [DATE] and when asked regarding no pain medication administration was documented on [DATE] or [DATE], she replied that if pain medication was not documented then it had not been given. The DON stated that during that time period when the resident was admitted to (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	hospice care on [DATE], the facility's management changed from the previous management company to the current management company and stated there was a lot of chaos and electronic down time during that transition. She also stated that during that time the facility was also changing its pharmacy provider. After reviewing Resident #68's EMR documentation, she stated the documentation had not reflected the resident's pain status. The DON stated the reason for no documentation in Resident #68's EMR after the [DATE] 1:39 p.m. progress note until the [DATE] 7:30 a.m. progress note, [42 hours of no documentation] could have been related to the chaos and electronic down time with the change in the nursing facility's management company. She stated she would check Resident #68's paper medical record to see if there were any handwritten progress notes. On [DATE] at 2:04 p.m. the DON stated she had not found any hard copy progress notes for Resident #68. Review of the facility's Pain Management policy dated 2025 revealed The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. The policy revealed that the facility used a systematic approach for recognition, assessment, treatment, and monitoring of pain. The facility would evaluate the resident for pain when a significant change in condition or status occurred (e.g. with new pain or an exacerbation of pain) and staff would observe for nonverbal indicators which may indicate the presence of pain which included increased or recurring restlessness, facial expressions (e.g. grimacing), and negative vocalizations (e.g. groaning, crying, whimpering, or screaming). The policy stated the facility would use a pain assessment tool, which was appropriate for the resident's cognitive status, to assist staff in consistent assessment of a resident's pain. The policy further indicated that the facility in collaboration with the attending physician/prescriber, other health care professionals and the resident and/or the resident's representative would develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain. The policy indicated the interdisciplinary team was responsible for developing a pain management regimen that was specific to each resident who has pain or who has the potential for pain. Review of the CMS [DATE] Psychosocial Outcome Severity Guide revealed that examples of negative psychosocial outcomes as a result of the facility's noncompliance that resulted in actual harm included verbal and/or non-verbal expressions of pain (moaning, whimpering, and crying) and distress (restlessness).

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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. Based on the Centers for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Reports, staff interviews, facility assessment review, and facility record review, the facility failed to provide sufficient staff to meet resident needs for 12 of 26 weekend days during the months of October, November, and December 2025. The facility reported a census of 58 residents. Findings include: The Centers for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report for the facility for October 1 through December 31, 2025 revealed the facility had triggered the metric for Excessively Low Weekend Staffing which required follow-up during the survey process. The PBJ Nurse Staffing and Non-Nurse Staffing datasets provided information submitted by the facility on a quarterly basis. CMS had long identified staffing as one of the vital components of a nursing home's ability to provide quality care. In an interview on 5/5/26 at 1:59 p.m. Staff I, Certified Nursing Assistant (CNA) stated she had worked at the facility since July 2024. She stated the facility was really short staffed and as a result the residents showers had not been completed as assigned. In an interview on 5/6/26 at 8:26 a.m. with Staff M, CNA stated We used to have 4 CNA's but currently we have 3 [CNAs] and have been running around like chickens with our heads cut off. I don't even have time to chart as she had wiped sweat off her forehead and then she helped to pass breakfast trays to the residents. In an interview on 5/6/26 at 2:00 pm. Staff N, CNA stated she had worked at the facility for one year. She stated that down the hall that she had been assigned, she was by herself that day with six residents that required a Hoyer lift to transfer and at least eight residents that required two staff members to care for them. She stated I don't like the staffing and that the facility managers needed to look at how much care the residents needed. She stated that most of the staff try to get the residents showered as assigned, but the agreed that resident showers had not always been completed. She stated she felt that all the tasks assigned was not getting done, and stated at times the staff cannot get residents' incontinent pads checked and changed every two hours according to the residents' care plans. She stated I just feel we just don't have enough time [or staff] to give adequate care. In an interview on 5/6/26 at 2:54 p.m. with Staff O, CNA stated she had been a CNA for 20 years. She stated that staffing gets stressful at times and that at times she would stay to work the next shift because another CNA staff person had called in. She stated she was stressed as for the upcoming weekend the nursing schedule was short staffed. In an interview on 5/7/26 at 12:50 p.m. with the Administrator the PBJ Staffing Data Report for October 1 through December 31, 2025 was discussed which revealed the facility had triggered the metric for Excessively Low Weekend Staffing and the weekend Daily Staffing sheets were requested for those months. Review of the facility's 2026 Facility Assessment, revised November 2025 revealed it had been reviewed on April 2026 by the Administrator. The stated purpose of the Facility Assessment was a complete review of internal human and physical resources required by the facility to care for residents competently during day to day (including nights and weekends). operations. The assessment identified two distinct nursing units and that the CNAs were scheduled for three different eight-hour shifts: Day, Evening, and Night. On the Day Shift there were seven to eight CNAs needed, three on the smaller nursing unit and four to five on the larger nursing unit. On the Evening Shift, there were six to eight CNAs needed, two to three on the smaller unit and four to five on the larger nursing unit. On the night shift three to four CNAs were needed, the assessment did not differentiate the nursing units for the night shift. The assessment identified the licensed nurses were scheduled for two different 12-hours shifts: Day and Night. Each shift had two to four nurses working or a combination of nurses and Certified Medications Assistants (CMAs). The assessment did not differentiate the number of nurses/CMAs for each nursing unit. A review on the requested weekend Daily Staffing sheets for October 1 through December 31, 2025 revealed: a. On Sunday, 10/5/25: The Day Shift on the larger nursing unit was staffed with three CNAs. The Facility Assessment (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented four to five CNAs were needed. The Evening Shift on the larger nursing unit was staffed with four CNAs, but two of the CNA staff were crossed out with CI (Called In) noted by their names, which left two CNAs. The Facility Assessment documented four to five CNAs were needed. The Night Shift for the facility was staffed with one CNA on the smaller nursing unit and two CNAs on the larger nursing unit, but one of the CNA staff was circled with CI noted by her name, which left two CNAs for the night shift for the facility. The Facility Assessment documented three to four CNAs were needed. b. On Saturday, 10/11/25; Sunday, 10/26/25; the Evening Shift on the larger nursing unit was staffed with three CNAs. The Facility Assessment documented four to five CNAs were needed. c. On Sunday, 11/9/25 the Day Shift on the larger nursing unit was staffed with three CNAs. The Facility Assessment documented four to five CNAs were needed. c. On Sunday, 11/16/25:The Day Shift on the larger nursing unit was staffed with four CNAs, but one CNA was circled with NCNS (No Call No Show) noted by her name and another CNA was circled with CI noted by her name, which left two CNAs. The Facility Assessment documented four to five CNAs were needed. The Evening Shift on the larger nursing unit was staffed with four CNAs, but one CNA was circled with CI @ 2pm (Called In at 2:00 p.m.) noted by her name, which left three CNAs. The Facility Assessment documented four to five CNAs were needed. d. On Saturday, 11/22/25 the Day Shift on the larger nursing unit was staffed with five CNAs, but three CNAs were circled with CI noted by each of their names, which left two CNAs. The Facility Assessment documented four to five CNAs were needed. e. On Sunday, 11/23/25 the Day Shift on the larger nursing unit was staffed with four CNAs, but one CNA had been moved to the smaller nursing unit for a CNA that had CI noted by their name, which left three CNAs, The Facility Assessment documented four to five CNAs were needed. f. On Sunday, 11/30/25 the Day Shift on the smaller nursing unit was staffed with three CNAs, but on CNA had been crossed out with CI noted by their name, which left only two CNAs. The Facility Assessment documented three CNAs were needed. g. On Saturday, 12/6/5 for the Evening Shift:The smaller nursing unit was staffed with one CNA. The Facility Assessment documented two to three CNAs were needed. The larger nursing unit was staffed with three CNAs. The Facility Assessment documented four to five CNAs were needed. h. On Sunday, 12/14/25, the larger nursing unit had three CNAs scheduled. The Facility Assessment documented four to five CNAs were needed. i. On Saturday, 12/20/25 the smaller nursing unit had three CNAs scheduled with two CNAs crossed out with CI noted by their names, which left one CNA and an RN/CNA or two CNAs. The Facility Assessment documented three CNAs were needed. j. On Sunday, 12/21/25 the Day Shift on the smaller nursing unit was staffed with two CNAs. The Facility Assessment documented three CNAs were needed. In an interview on 5/11/26 at 12:06 p.m. with the Administrator the days noted above with excessively low staffing were reviewed. The Administrator revealed that the CI noted on the Daily Staffing sheets indicated that the CNA staff member had Called In for the shift that day and had not reported for work. She also revealed that the NCNS noted on the Daily Staffing sheets indicated that the staff person had been a No Call No Show for the shift that day, meaning that staff person had not called in and had not reported for work that day. The Administrator agreed with findings for the days and shifts noted above with excessively low weekend staffing.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, resident representative interviews, and policy review the facility failed to provide medically-related Social Services in assisting and obtaining Medicaid applications and Power of Attorney documents for 1 of 1 Residents (Resident #57) reviewed. The facility reported a census of 58 residents. Findings include:Review of Minimum Data Set (MDS) dated [DATE] revealed Resident #57's admission to the facility on 2/6/26 and a Brief Interview for Mental Status (BIMS) assessment completed on 2/23/26 resulting in a score of 6 indicating severe cognitive impairment. Resident #57's diagnoses included urinary tract infection, diabetes, COPD, respiratory failure, anxiety, depression, and requiring substantial/maximal assistance with the use of a wheelchair. Review of Resident #57's Care Plan initiated 2/13/26 documented impaired cognitive function and thought processes. The Care Plan documented that the resident used a walker in the bedroom with assist of one staff member, and used a wheelchair for distance mobility with assist of one staff member.Review of Resident #57's admission Record- Facesheet revealed private pay as primary payer. Review of Resident #57's Electronic Health Records (EHR) revealed admission Agreement and documentations signed by Resident #57 on 2/4/26 and signed witness Staff D, Social Services/Admissions. admission Agreement documents indicated Resident #57's expected primary payor source Medicare/Medicaid. Further documentation titled Advance Directives Policy and Record failed to indicate Resident #57 having a Power of Attorney. Review of a Progress Note- Resident Care Conference dated 4/15/26 at 10:24 AM noted Resident #57's Family Representative attended the care conference and the facility Business Office Manager to call on 4/17/26 to check Medicaid status. In an interview on 5/5/26 at 2:38 PM, Resident #57's Contracted Representative stated contracted hire started in the fall of 2025 to assist Resident #57 with Medicaid applications. This application had been completed December 2025, pending further bank statement documentation to finalized approved coverage. During this time Resident #57 was hospitalized with a UTI and the pending bank statements had not been submitted as a result voiding any Medicaid coverage. Contracted Representative explained after Resident #57's admission to the facility communication attempts had been made to the facility to discuss the Medicaid applications with no response. Resident #57 communicated with the Contracted Representative that facility staff had been asking her for the needed documents to complete this application and requested the Contracted Representative assist the facility. The Contracted Representative again tried to communicate with the facility to provide and discuss needed documents to complete the Medicaid application, with refusal from the facility to communicate with her. The Contracted Representative further explained, per the facility, due to Resident #57's cognitive status, Resident #57 was not able to make these decisions for herself so the facility had contacted a lawyer to implement an emergency conservator to control Resident #57's financials. At this time the Contracted Representative informed the facility Resident #57 does have a Medical Power of Attorney and this person should be contacted to be appointed Resident #57's financial representative. Review of provided Email communication between Resident #57's Contracted Representative and Facility's Business Office staff revealed the following communications:a. 4/16/26 at 12:19 PM Contracted Representative notified Staff A, Corporate Director of Business Office Services, providing consent and documents for Resident #57 and notifying Contracted Representatives will be at the facility later this day to assist with the Medicaid Application. b. 4/17/26 at 9:02 AM Contracted Representative provided bank statements for Resident #57 for December 2025 to March 2026 and noted charges on Resident #57's bank statements that would need clarification and follow-up to meet requirements of the Medicaid process. c. 4/21/26 at 12:48 PM, Resident #57's POA communicating to the facility his communication with the Contracted Representative and his request for the Contracted Representatives assistance with Resident #57's care. d. 4/30/26 at 7:00 PM Resident #57's POA (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communicated in the email thread, regarding recent actions taken concerning Resident #57. As POA, he was not notified the facility was pursuing an Emergency Conservatorship or bringing in legal counsel. POA stated, this is extremely concerning , he should have been contacted immediately regarding any decisions of this nature and expects to be included in all discussions going forward and requested contact information for the Emergency Conservator and/or legal representative. e. 5/1/26 at 4:39 PM, Resident #57's POA responded to the email thread to follow up on the request sent on 4/30/26. POA formally requested immediate release of all records related to Resident #57's care, evaluations, and any actions taken by the facility to include any conservatorship efforts. Lack of response was not acceptable, continued request for contact information of any attorney or legal representative as well as written clarification of any steps that had been taken for the conservatorship without his knowledge. f. 5/4/26 at 10:22 AM Staff B, Corporate VP of Revenue Cycle Management, responded to the email introducing herself and her position with the Corporation. Staff B indicated the facility did not have a copy of the POA paperwork and requested these be provided. g. 5/4/26 at 11:18 AM, Contracted Representative responded to Staff B's email stating she would be at the facility to assist Resident #57 with bank account matters so a Medicaid application could be submitted with hopes for approved coverage starting June 1, 2026. The Contracted Representative also requested cognitive testing be done for Resident #57 as her interactions with Resident #57 did not indicate the severe cognitive impairment status as previously scored on admission. h. 5/4/26 at 2:20 PM, Staff B's email response included an overview of phone conversation with the Contract Representative documenting, the facility will redo the BIMS assessment to determine Resident #57's cognitive status, Contract Representatives have agreed to restart the Medicaid application process and noting the facility does not have Resident #57's POA paperwork on file. i. 5/4/26 at 2:47 PM, Contracted Representative replied, a BIMS assessment was completed with Resident #57 scoring 15/15 (indicating cognitively intact), this is an issue as Staff A was planning on forcing Resident #57 into a designated conservatorship without discussing with Resident #57 or family. Contracted Representative had been in the facility a couple week prior and provided Staff A, a black binder containing all of Resident #57's paperwork. Today when requesting the return of this binder, Contracted Representative was told we don't have it. Contracted Representative informed yes, you do. I handed it to you when we were standing in your office. Following, Staff C, Business Office Manager, Staff C walked into her office to the filling cabinet, pulling out the binder and provided to Contracted Representative. j. 5/4/26 at 2:54 PM, Staff B replied stating the facility's need for a copy of Resident #57's POA paperwork. k. 5/5/26 at 8:42 AM Staff B responded receiving Resident #57's POA paperwork. l. 5/5/26 at 9:57 PM, Resident #57's POA replied to email thread requesting clarification regarding the facility not having a copy of the POA paperwork prior to receiving yesterday. Over the past several months, POA had received multiple calls and communication from facility staff providing updates, discussing Resident #57's care and documentation and information requests directly from POA. It appeared the POA role had been recognized and was relied on, but POA is unable to understand how these communications were taking place if the facility did not have the POA documents on file. m. 5/5/26 at 10:57 AM, Staff B responded, thanks for the email, the facility has been provided the documents by the Contracted Representative. Thank you for the follow up. In a provided phone conversation on 4/30/26, Staff A, informed Contracted Representative, she had found an attorney to do a temporary conservatorship for Resident #57 to get the Medicaid application done. During a phone conversation on 5/4/26, Staff B informed Contract Representative at that time the facility does not have Resident #57's POA documentation. The Contract Representative reiterated to Staff B, Resident #57's documents had previously been provided to Staff A and the Medicaid application could have been started. Staff B responded, this was missed steps on our part.During an interview on 5/7/26 at 12:30 PM Staff D, Social Services/Admissions, stated she had never completed an admission on a confused resident and has never had to request POA paperwork on an admission and confirmed the facility was seeking (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conservatorship for Resident #57 due to low BIMS score and poor cognition. In an interview on 5/7/26 at 2:46 PM, Facility Administrator and VP of Clinical Operations acknowledged the miscommunications between facility staff, Contracted Representatives, POA and Resident #57 and agreed the Medicaid Application process should have been initiated on Resident #57's admission as well as obtaining POA documentation for Resident #57's records on admission to the facility. Facility Administrator informed the Medicaid application for Resident #57 had been completed and submitted in the past couple of days and was pending. Review of Facility provided Resident Rights policy, revealed the following:1. The resident has the right to exercise his or her rights as a resident of the provider and as a citizen of the United States. 2. In the case of a resident adjudged incompetent the rights of the resident devolve to and are exercised by the resident representative appointed under state law to act on the resident's behalf. 3. In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative. 4. The resident or resident representative has the right to access personal and medical records pertaining to him or herself and shall have access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual. 5. Residents have the right to manage their own money and financial affairs or to choose someone to manage their money and financial affairs for them, including prior notice of any charges the Provider may impose against a resident's personal funds.6. The Provider will provide the Resident with needed social services including counseling, help solving problems with other residents, help in contacting legal and financial professionals and discharge planning.

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	05/12/2026

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

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and policy review, the facility staff failed to ensure Enhanced Barrier Precautions (EBP) were in place for residents with multidrug-resistant organisms (MDROs) (Resident #24), failure of staff to wear appropriate personal protective equipment (PPE) when providing care to residents on EBP (Resident #8), and failure to follow proper infection control practices to prevent the transmission of infection with blood sugar monitoring. The facility reported a census of 58 residents.Findings include:1. Review of MDS dated [DATE] revealed Resident #24 BIMS of 11 indicating moderate cognitive impairment with diagnoses of Multidrug-Resistant Organism ((MDRO) bacteria that have become resistant to three or more classes of antibiotics) and Urinary Tract Infection, and incontinent of bowel and bladder with need for substantial/maximal assistance with ambulation and use of walker or wheelchair. Review of Resident #24's Care Plan initiated 1/23/26 documented incontinent of bladder and risk for UTIs with interventions to provide peri-care with each incontinence episode, monitor/document for signs and symptoms of UTI, and obtain labs as ordered and notify physicians of results. Observation of resident #24's room on 5/4/26 at 12:28 PM failed to indicate EBP. Review of Resident #24's lab results revealed the following: a. 1/10/26 Urine Culture: >100,000 Proteus mirabilis/penneri. Multi-Drug Resistant Gram-Negative Rod. (Indicating growth of MDRO bacteria in urine) (Isolation required)b. 1/16/26 Urine Culture: 50,000-100,000 Proteus mirabilis-ISOLATION IS REQUIRED. (Indicating growth of MDRO bacteria in urine) (Isolation required)c. 4/9/26 Urine Culture: >100,000 Klebsiella pneumoniae, 10,000-49,000 Proteus mirabilis. (Indicating growth of MDRO bacteria in urine) (Isolation required) During an interview on 5/7/26 at 2:46 PM, VP of Clinical Operations, reviewed Resident #24's urine cultures and acknowledged due to MDRO results resident #24 should have been and should be under EBP with incontinent cares. Review of facility provided Enhanced Barrier Precautions dated 3/25/24 revealed the following: 1. Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents.2. EBPs are indicated (when contact precautions do not otherwise apply) for residents infected or colonized with CDC-targeted MDROs. 2. The Minimum Data Set (MDS) dated [DATE] for Resident #8 revealed the diagnoses of cerebral palsy, benign prostatic hyperplasia (BPH is an enlargement of the prostate gland that squeezes the urethra effecting the urinary system) and required maximal assistance from staff for personal hygiene and was dependent for toilet. The MDS identified indwelling catheter. The Care Plan for Res #8 directed staff to utilize Enhanced Barrier Precautions (EBP) related to the presence of a catheter. During an observation on 5/6/26 at 11:35 am, Staff P, Certified Nursing Assistant (CNA) provided catheter care for Resident #8. Resident #8 had a urinary leg bag attached to his left leg. Staff P placed a barrier on the floor with a container to contain the drained the urine (a graduate). Staff P put gloves on but failed to practice the EBP by putting the gown on as directed on the EBP sign on Resident #8's door. The PPE storage outside the door contained gowns, gloves and masks if needed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for splatter. Staff P paced the graduate onto her knee to stabilize it instead of releasing the straps from around Resident #8's leg and bring the bag to the graduate when she emptied it. Infection Control Policy revealed: Standard Precautions:a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services.b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures.c. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE.d. Licensed staff shall adhere to safe injection and medication administration practices, as described in relevant facility policies.e. Environmental cleaning and disinfection shall be performed according to facility policy. All staff have responsibilities related to the cleanliness of the facility and are to report problems outside of their scope to the appropriate department. Isolation Protocol (Transmission-Based Precautions):A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC guidelines.Residents will be placed on the least restrictive transmission-based precaution for the shortest duration possible under the circumstances. 3. On 5/6/26 at 11:13 AM, Staff U, Certified Medication Aide (CMA), stated she was going to check a resident's blood sugar. She went into Resident #41's room and obtained a blood sample. After obtaining the blood sample, Staff U picked up the supplies and walked out of the room. When asked if she should have done anything differently, Staff U replied that she should have removed her gloves after obtaining the blood sample and sanitized her hands (prior to touching other objects). On 5/6/26 at 12:15 PM, the [NAME] President of Clinical Operations stated that Staff U had let her know what happened. This [NAME] President of Clinical Operations stated that she had no questions and understood the infection control concerns. Policy: The purpose of this procedure is to provide guidelines for the disinfection of capillary-blood glucose sampling devices to prevent transmission of blood borne diseases to residents and employees. Definitions: Cleaning is the removal of visible soil from objects and surfaces normally accomplished manually or mechanically using water with detergents or enzymatic products. Disinfection is a process that eliminates many or all pathogenic microorganisms, except bacterial spores, on inanimate objects. Policy Explanation and Compliance Guidelines The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use. If the manufacturers are unable to provide information specifying how the glucometer should be cleaned and disinfected, then the meter will not be used for multiple residents. The glucometers will be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against HIV, Hepatitis C and Hepatitis B virus. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions regardless of whether they are intended for single resident or multiple resident use. Procedure: Obtain needed equipment and supplies: Gloves, glucometer, alcohol pads, gauze pads, single-use lancet, blood glucose testing strips, disinfecting wipes. Wash hands. Explain the procedure to the resident. Provide privacy. Put on gloves. Obtain capillary blood glucose sampling according to facility policy. Remove and discard gloves, perform hand hygiene prior to exiting room. Reapply gloves if there is visible contamination of the device or if the resident is HIV or Hepatitis B or C positive. Retrieve (2) disinfectant wipes from container. Using first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer. After cleaning, use second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following the manufacturer's instructions. Allow the glucometer to air dry. Discard disinfectant wipes in waste receptacle. Perform hand hygiene.