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	04/16/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 50500 Based on electronic health record review, staff interview, and policy review, the facility failed to update and revise resident Care Plans for 2 of 17 residents reviewed for personalized Care Plans (Residents #2 and #25). The facility reported a census of 76. Findings include: 1. The Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 with a Brief Interview for Mental Status (BIMS) Score of 12, which indicated a moderate cognitive impairment. Diagnoses on the MDS include benign prostatic hyperplasia, diabetes, neurogenic bladder, non-Alzheimer's dementia, schizophrenia, seizure disorder/epilepsy, and stroke. Resident #2 had an indwelling urinary catheter. The MDS further documented Resident #2 was independent with transfers and required staff supervision/touching assistance for ambulation (without assistive devices). The Care Plan, with a targeted completion date of [DATE], noted Resident #2 with a suprapubic urinary catheter and use of a leg urinary drainage bag. Interventions on the Care Plan documented Resident #2 preferred the leg bag, wore clothing that did not cover the leg bag, wore the leg bag at night, and used the leg bag when not in bed. The following observations on Resident #2 revealed the following: a. On [DATE] at 8:45 AM, the resident was carrying by hand the urinary drainage bag inside a privacy bag b. On [DATE] at 11:00 AM, Resident #2 acknowledged they carry around a urinary drainage bag and do not wear a leg bag. The drainage bag observed on the bed as the the resident was laying down c. On [DATE] at 8:20 AM, the resident came out of their room carrying the urinary drainage bag During an interview on ,d+[DATE] 25 at 9:50 AM, Staff B, Assistant Director of Nursing, stated a leg urinary drainage bag was once used with Resident #2 but not currently. Staff B explained the leg bag would leak and the resident would end up changing his clothes frequently during the day. Thus the change in the type of drainage bag. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:45 AM, Staff C, Certified Medication Aide (CMA), reported Resident #2 did not use a leg urinary drainage bag. During an interview on [DATE] at 2:30 PM, Staff D, Registered Nurse, explained Resident #2 had not used a leg urinary drainage bag in approximately six months. 2. The MDS assessment dated [DATE] revealed Resident #25 with a BIMS score of 13, which indicated intact cognition. The Care Plan, with a targeted completion date of [DATE], documented Resident #25's code status as Cardiopulmonary Resuscitation (CPR). Interventions, which were initiated on [DATE], include call for an ambulance, use of CPR measures, and transfer to hospital or emergency room of choice. The Physician Order Summary page, obtained on [DATE] at 3:15 PM for Resident #25, listed a Do Not Resuscitate (DNR) order with a start date of [DATE]. The Iowa Physician Order for Scope of Treatment (IPOST), dated [DATE] and signed by Resident #25, lists their code status as DNR. This current IPOST was located in a notebook at the nurses station for staff to refer to in case of emergencies. A previous IPOST, with a date of [DATE], noted a CPR code status and was located in the scanned section of the electronic medical health record. During an interview on [DATE] at 2:30 PM, Staff F, Social Services, explained they assist residents with any updates to code status. Monthly audits are completed to ensure Physician Orders match a resident's IPOST selection (either DNR or CPR). Staff F verified Resident #25's current code status order in the medical record as a DNR as well as the DNR directive on IPOST located at the nurses station. Staff F acknowledged Resident 25's current Care Plan listed a CPR intervention and noted this was not updated when the code status changed. During an interview on [DATE] at 1:25 PM, Staff E, MDS Coordinator, explained Care Plans are updated quarterly and as needed. In addition to the medical record, information for Care Plans obtained during morning and afternoon management meetings, Risk Management meetings, and from the therapy department. Staff E relies on nursing staff to provide them with specific resident care information for Care Plans, such as Resident #2's use of a leg urinary drainage bag. The policy Comprehensive Person-Centered Care Plan, with a review date of [DATE], states each resident will have a person-center plan of care that will identify how the interdisciplinary team will provide cares. The Comprehensive Person-Centered Care Plan can be reviewed and/or revised at quarterly intervals, significant changes, and annual assessments.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on observations, electronic heath record review, and staff interview, the facility failed to provide oxygen therapy as prescribed by the physician for 1 of 2 residents reviewed for respiratory care (Resident #43). The facility reported a census of 76. Findings include: The Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #43 with a Brief Interview for Mental Status score of 7, which indicated severe cognitive impairment. Diagnoses on the MDS include diabetes, heart failure, and respiratory failure. The MDS further indicated Resident #43 receiving continuous oxygen therapy and experiences shortness of breath with exertion and when laying flat. The following observations on Resident #43 revealed the following: a. On 4/15/25 at 7:45 AM, while sitting in the dining room, the oxygen setting was at 2 liters (L) b. On 4/15/25 at 9:05 AM, while laying in bed, the oxygen setting was at 2 L c. On 4/15/25 at 3:45 PM, while sitting up in a wheelchair after staff assisted with personal cares, the oxygen setting was at 2 L d. On 4/16/25 at 8:00 AM, while sitting in the dining room, the oxygen setting was at 2 L A summary of Clinical Physician Orders, obtained on 4/15/25, listed the current oxygen order at 4 L continuous. The order was initiated on 1/22/25. Review of the Oxygen Saturation Summary report from the facility's electronic health record identified the following: a. During the month of January 2025, the oxygen setting was documented at 2 L on 1/25 and at 3 L on 1/26 and 1/28 b. During the month February 2025, the oxygen setting was documented at 2 L on 2/8 and at 3 L on 2/6 and 2/10 c. During the month of March 2025, the oxygen setting was documented at 2 L on 3/15, 3/16, 3/20, 3/25, and 3/27 and at 3 L on 3/14 Review of the Medication Administration Review (MAR) sheets revealed the following: a. January 2025's MAR showed staff initials indicating oxygen setting was at 4 L between 6 AM-6 PM and between 6 PM-6 AM on 1/25, 1/26, and 1/28. No further adjustment or updates to the MAR was identified indicating the oxygen setting was decreased to 2 or 3 L on these dates. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. February 2025's MAR showed staff initials indicating oxygen setting was at 4 L between 6 AM-6 PM and between 6 PM-6 AM shift on 2/6, 2/8, and 2/10. No further adjustment or updates to the MAR was identified indicating the oxygen setting was decreased to 2 or 3 L on these dates. c. March 2025's MAR showed staff initials indicating oxygen setting was at 4 L between 6 AM-6 PM and also between 6 PM-6 AM on 3/14, 3/15, 3/16, 3/20, 3/25, and 3/27. No further adjustment or updates to the MAR was identified indicating the oxygen setting was decreased to 2 or 3 L on these dates. Review of the electronic medical record lacked documentation to support the change in the oxygen setting from 4 L to 2-3 L as identified from January 2025 to April 2025. During an interview on 4/15/25 at 3:45 PM, Staff G, Certified Medication Aide, explained Resident #43's oxygen is ordered at 2 L. When asked how they know this, Staff G voiced they have always known the oxygen at 2 L and have not been told anything different. During an interview 4/16/25 at 8:00 AM, Staff I, Registered Nurse, verbalized Resident #43's oxygen setting ordered at 4 L. When notified the oxygen was at 2 L, Staff I voiced they were not aware and immediately assessed the resident. During an interview on 4/16/25 at 1:35 PM, Staff B, Assistant Director of Nursing, acknowledged the current oxygen setting for Resident #43 is 4 L. Staff B suspected staff just missed the oxygen order and did not set it correctly earlier in the morning. Staff B, explained current oxygen orders can be found on the resident's Kardex, which staff can print and review as needed from their iPads. Per an email dated 4/16/25, the Director of Nursing confirmed the facility does not have policy related to oxygen therapy as they follow Physician Orders and Standards of Practice.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 46873 Based on observation, staff interview, clinical record review, and policy review, the facility failed to assure a medication error rate of less than 5%. Medication errors were observed for Resident #15 & Resident #61. A total of 28 ordered medications were reviewed with two errors, an error rate of 7%. The facility reported a census of 76 residents. Findings include: 1. On 4/14/25 at 8:54 am, the observation of medication pass began. Staff A, Licensed Practical Nurse (LPN) prepared a total of 17 medications for Resident #15. Among the medications observed, Staff B prepared one tablet of Folic Acid, 400 micrograms (mcg). Staff A administered the medications to the resident at 9:05 am. 2. Staff A next prepared medications for Resident #61. He was witnessed preparing and administering nine medications for Resident #61. Staff A administered the medications to the resident at 9:21 am. When reconciling the observed medication pass against the orders for Resident #15, it was noted the Resident's order for Folic Acid was for 1 milligram (mg) rather than the 400 mcg the resident received. It was also noted for Resident #61 that she was to have received Atorvastatin, 20 mg (a cholesterol medication) which was not witnessed as having been administered during the medication pass. Several of Resident #61's medications were also noted to be ordered for 8:00 am and were not administered until 9:21 am. On 4/14/25 at 11:10 am, the Director of Nursing (DON) stated she spoke to Staff A and she instructed him to call the provider regarding the Folic Acid error for Resident #15. She stated the facility follows a liberalized medication pass and morning medications are administered between 6:00 am and 10:00 am but the computer system does not always allow the orders to be entered that way. She stated medications ordered for 8:00 am are not considered late if given before 10:00 am. The facility policy Medication Administration-Preparation and General Guidelines, revised August 2024, documented the following: Point 4: FIVE RIGHTS - Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away. a. Check #1: Select the Medication - label, container and contents are checked for integrity, and compared against the medication administration record (MAR) by reviewing the 5 Rights. b. Check #2: Prepare the dose - the dose is removed from the container and verified against (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the label and the MAR by reviewing the 5 Rights. c. Check #3: Complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 Rights. Point 5: The medication administration record (MAR) is always employed during medication administration. Prior to administration of any medication, the medication and dosage schedule on the resident's medication administration record (MAR) are compared with the medication label. If the label and MAR are different and the container has not already been flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. When a medication order is changed and the current supply can continue to be used, the container should be flagged right away and the order change communicated to the provider pharmacy so that the next supply of the medication is labeled with the current directions.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50500 Based on observations, staff interview, and policy review, the facility failed to ensure proper food equipment handling practices during meal service one of one meal service observed. The facility reported a census of 76. Finding include: During a lunch service observation on 4/13/24 at 11:45 AM,Staff H, Dietary, was seen transferring resident glasses to and from their table to the drink cart with fingers inside the glasses (empty glasses) or by the rim (full glasses) for a total of six occurrences. Staff H also observed carrying drinks back to resident tables with glasses held up against their apron for a total of 3 occurrences. During an interview on 4/16/25 at 9:50 AM, the Certified Dietary Manager (CDM) voiced dietary staff should be carrying drinks to and from resident tables one at a time. The CDM also states staff should be carrying cups/glasses by the bottom and not by the rim. The policy Handling Dinnerware, Utensils, Tableware, and Smallware, with a revised date of 3/20/24, states glassware and cups should be held by their handles, and glassware should be held by the middle, bottom, or stem. Fingers should not be inside of glass or touching the rim.