STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165401	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sibley Specialty Care	700 Ninth Avenue North Sibley, IA 51249

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on clinical record review, facility record review, staff interviews and facility policy review the facility failed to report an allegation of abuse to the Iowa Department of Inspections & Appeals and Licensing (DIAL) within 2 hours of an allegation of abuse for 1 of 3 residents reviewed for abuse. The facility reported a census of 35 residents. The facility provided education to all staff on the types of abuse and process and protocol of reporting suspected abuse on 5/27/26 prior to DIAL entering the building on 6/3/26 so the deficiency is past non-compliance and no plan of correction is required.Findings include:Interview on 6/3/26 at 11:32 a.m., with Staff A, Certified Nursing Assistant (CNA) revealed on 5/23/26, she was working with Staff B, CNA getting residents up for the day. Staff B was assisting Resident #1 out of bed and Resident #1 was yelling at Staff B. Staff A tried to get Staff B to switch caring for the residents but she would not. Staff B got Resident #1 up quickly by putting her hand on the back of her neck and under her legs and swung her up quickly into a sitting position as Resident #1 was yelling at her. Staff A revealed later during the day Staff B was assisting Resident #4 to her room and stated she didn't want to go to the bathroom. Staff A stated she was outside the room doing some charting and she could see into Resident #4's room. Staff B took Resident #4 to the bathroom and slammed the door as she went out of the bathroom as the resident was saying no. Staff B went and assisted Resident #4 out of the bathroom and told her she needed to lay in her bed and Resident #4 told her she wanted to sit in her recliner and Staff B told her no. Staff B told Resident #4 to keep going and Resident #4 is very hard of hearing and she replied with, what? Staff B stated in a normal voice I don't know why I even bother talking to you anyway you can't hear anything. Staff A told Staff B that she cannot be doing that and Staff B replied I don't care, she can't fucking hear me anyway. Staff A revealed she did not report her concerns to the charge nurse but talked to Staff C about her concerns about Staff B. Staff A revealed she should have reported it to the charge nurse right away as they have 2 hours to report allegations of abuse. Staff A revealed she had received education on reporting any allegation of abuse right away to a supervising staff. Review of written statement by Staff A dated 5/27/26 revealed the following information:What do you mean by forced when you say Staff B forced Resident #2 to go to bed. She doesn't like to lay down in bed, so she told her she was going to lay down, and then just transferred her to her bed when she didn't want to. Forced was just the word I could use. It was more like firm vocally. What do you mean by rough when working with Resident #1.I was helping the roommate and Staff B, like, basically just responded negatively when trying to get her sat up in bed, had her hand on the back of her neck and kinda quickly sat her up when she was crying out and stuff. Review of written statement by Staff C, CNA dated 5/28/26 revealed what happened this weekend? Staff C revealed it was Sunday 5/24/25 at approx 1:45p.m., maybe, something like that, I was in the soiled utility room cleaning up, and Staff A came in and said I need to tell you something, I don't know what to do, Staff B was being snarky with residents. Staff C said what the heck is wrong. We discussed what was going on with Staff B and she told me that Staff B had moved the lift kind of hard working with residents. Staff C told Staff A to talk to Staff B and if you don't feel comfortable you need to report it. Apparently she did report it, but I should have done it first. It was an overwhelming weekend. Review of facility reported incident (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed submission date of 5/26/26 at 5:38 p.m Review of the facility provided document titled 5.26.26 Self Report, 5 day summary revealed the description of report : On the morning of 5/23/26, Staff B was reported by Staff A to be frustrated, using loud and at times inappropriate language with 3 residents. She was in a hurry and rough while transferring Resident #1 from supine to sitting bedside. Staff B was argumentative with Resident #2 while going to the bathroom. Staff B told Resident #4 to shut up and quit talking as she is very hard of hearing and speaks loudly during conversation. On 5/24/26 Staff B was witnessed being untruthful to a 4th Resident #3 as she tried to coerce him into participating with cares. Review of facility provided policy titled Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigating with a revision date of April 2021 revealed if resident abuse is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Immediately is defined as within 2 hours of an allegation involving abuse. Interview on 6/3/26 at 3:57 p.m., with the Assistant Director of Nursing (ADON) revealed the facility staff should have reported the incident right away. Allegations of abuse need to be reported to DIAL within 2 hours.