STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165412	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Exira Care Center	411 South Carthage Exira, IA 50076

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interview, and policy review, the facility failed to maintain dignity for 2 of 3 residents (#6, #7) by leaving a resident's blood-stained sheets on his bed for 4 1/2 hours (#6) and by reaching across the front of a resident's face to pick up a clothing protector off the table (#7). The facility reported a census of 35 residents. Findings include: 1. Resident #6's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 00 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia and arthritis. It revealed he required supervision with eating, moderate assistance with oral and personal hygiene, maximal assistance with upper body dressing, and was dependent with all other ADLs and mobility.An undated Care Plan indicated the resident had an ADL self-care deficit related to dementia and was at risk for infection related to a suprapubic catheter (urinary catheter surgically placed directly into the bladder).On 5/03/26 at 10:20 AM, Resident #6's bed had dried, red stains on the bottom half of his sheets. Resident #6 was observed sitting in his room in his wheelchair.On 5/03/26 at 12:31 PM, the red-stained sheets were still on Resident #6's bed.On 5/03/26 at 3:00 PM, staff were heard in his room with the door shut.On 5/03/26 at 3:10 PM, the bed sheets did not have a dried, red stain.2. Resident #7's MDS assessment dated [DATE] identified a BIMS score could not be obtained due to the resident being rarely or never understood. It included diagnoses of a stroke without residual deficits, one-sided severe weakness, and bilateral hearing loss. It revealed she was dependent with all ADLs and mobility.An undated Care Plan directed staff to work with nursing staff to provide maximum comfort for the resident.During a dining observation on 5/03/26 at 11:28 AM, Staff F, Certified Nurse Aide (CNA) reached directly in front of Resident #7's face, from the left side to the right side of the table, grabbed a clothing protector, placed it on the resident, then walked around the resident and sat down to the right of the resident and assisted her with eating.On 5/04/26 at 4:31 PM, Staff G, CNA stated reaching across someone's face to access a [NAME] when it was accessible from the other side would be offensive, embarrassing, and a dignity concern.On 5/04/26 at 4:35 PM, Staff E, CNA stated reaching across someone's face to access an item would be offensive, embarrassing, and not respectful. She confirmed disrespect is a dignity concern.A policy titled Promoting/Maintaining Resident Dignity During Mealtimes indicated all staff members involved in providing feeding assistance to residents promote and maintain resident dignity during mealtimes.On 5/07/26 at 10:33 AM, the Director of Nursing (DON) stated the residents' dignity should always be maintained.

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 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 clinical record review, staff interviews, and facility policy review, the facility failed to provide baths for 2 of 3 residents (#1, #3) who required bathing assistance. The facility reported a census of 35 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 02 out of 15 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia, anxiety, and hospice. It indicated she required supervision with eating and bed repositioning, required moderate assistance with oral hygiene, lying-to-sitting, and sitting-to-lying, required maximal assistance with all other Activities of Daily Living (ADLs) and forms of mobility.An undated Care Plan indicated the resident had an ADL self-care performance deficit related to dementia and directed staff to provide sponge bath when a full bath or shower cannot be tolerated.A hospice document titled Aide Visit Note dated 3/01/26 - 4/29/26 revealed the resident received a bath on 3/01/26, 3/19/26, 3/21/26, 4/10/26, 4/22/26, and 4/24.An untitled document dated March 2026 used for resident bath documentation revealed the resident received a bath on 3/03/26, 3/06/26, 3/10/26, 3/20/26, 3/24/26, and 3/31/26. Collectively, the documents indicated the resident missed a scheduled bath on 3/13/26 and 3/27/26. It also indicated she received one (1) bath in a 13-day period from 3/06/26 through 3/19/26. The facility did not provide this resident's bath log for April 2026.2. Resident #3's MDS assessment dated [DATE] identified a BIMS score of 00 out of 15 which indicated severely impaired cognition. It included diagnoses of Alzheimer's disease and non-Alzheimer's dementia. It revealed she required moderate assistance with eating and was dependent with all other Activities of Daily Living (ADLs) and all forms of mobility.An undated Care Plan indicated the resident had a self-care deficit related to Alzheimer's disease and directed staff to attempt to participate and provide assistance with bathing.An untitled document dated March 2026 used for resident bath documentation revealed the resident received a bath on 3/02/26, 3/10/26, 3/16/26, 3/23/26, 3/26/26, and 3/30/26. It indicated the resident missed a second, weekly bath during the 1st, 2nd, 3rd, and 5th weeks in March 2026. The facility did not provide this resident's bath log for April 2026.On 5/03/26 at 1:40 PM, Staff C, Certified Nurse Aide (CNA) stated the resident-assigned CNA or the bath aide was responsible for bathing the resident. She added that sometimes baths are missed due to staffing shortages.On 5/03/26 at 1:42 PM, Staff D, CNA stated the resident-assigned CNA or bath aide was responsible for bathing the resident.On 5/03/26 at 1:44 PM, Staff E, CNA stated CNAs take turns assigned as bath aides.A policy titled Activities of Daily Living (ADLs) revised 2025 indicated a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.On 5/07/26 at 10:33 AM, the Director of Nursing (DON) stated staff should complete the task and document it appropriately.

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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 clinical record review, staff interviews, and facility policy review, the facility failed to appropriately complete assessments for 3 of 3 residents (#1, #6, #7) who fell at the facility. The facility reported a census of 35 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 01 out of 15 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia, anxiety, and hospice. It indicated she was independent with eating, required setup assistance with oral hygiene, supervision with bed repositioning and personal hygiene, was dependent with lower body dressing and footwear, and required moderate assistance with all other Activities of Daily Living (ADLs) and forms of mobility.An undated Care Plan indicated the resident had impaired cognitive function/dementia or impaired thought processes related to dementia and directed staff to monitor/document/report PRN any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. The care plan also documented a risk for falls related to assistive devices for ambulation and a history of falls. An Incident Note Progress Note dated 8/02/25 at 9:50 PM revealed the resident was found sitting on the floor beside her bed with one leg in the bed and one out of bed. It indicated the fall was unwitnessed.A document titled Neurological Assessment Flow Sheet dated 8/02/25 beginning at 9:50 PM revealed the resident moved all extremities between 10:15 PM until midnight but lacked a pupil response, hand grasp strength, or pain assessment during the time the resident was documented as sleeping.An Incident Note Progress Note dated 9/22/25 at 6:45 PM revealed the resident was found on the floor next to her bed after trying to self-transfer to her bed. It indicated neurological checks were initiated per facility protocol.A document titled Neurological Assessment Flow Sheet dated 9/22/25 beginning at 6:45 PM lacked the signature of the staff who performed the assessments.An Incident Note Progress Note dated 10/20/25 at 11:30 PM revealed the resident was found sitting upright on her bathroom floor. It indicated the resident admitted to sliding off the edge of the toilet seat and was documented as a non-unwitnessed fall.A document titled Neurological Assessment Flow Sheet dated 10/20/25 beginning at 10:30 PM lacked completed level of consciousness, pupil response, hand grasp strength, extremity movement, pain, or vital signs assessments.2. Resident #6's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 00 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia and arthritis. It revealed he required supervision with eating, moderate assistance with oral and personal hygiene, maximal assistance with upper body dressing, and was dependent with all other ADLs and mobility.An undated Care Plan indicated the resident was at risk of acute on chronic pain secondary to risk of diabetes mellitus and immobility. It directed staff to monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician. The care plan also documented a risk for falls related to altered mobility secondary to chronic confusion, history of falls, poor safety awareness, relocation stress and weakness. A Health Status Progress Note dated 12/06/25 at 9:58 PM revealed the resident was found on the floor sitting next to his bed. It indicated neurological checks were initiated due to fall being unwitnessed.A document titled Neurological Assessment Flow Sheet dated 12/06/25 included neurological assessments from 9:30 PM through 11:15 PM. No further neurological assessments were documented from 11:45 PM through 12:45 PM the next day.3. Resident #7's MDS assessment dated [DATE] identified a BIMS score could not be obtained due to the resident being rarely or never understood. It included diagnoses of a stroke without residual deficits, one-sided severe weakness, and bilateral hearing loss. It revealed she was dependent with all ADLs and mobility.An undated Care Plan indicated the resident had impaired visual function and directed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff to monitor/document/report PRN (as needed) any signs or symptoms of acute eye problems: Change in ability to perform ADLs, decline in mobility, Sudden visual loss, Pupils dilated, gray or milky, complaints of halos around lights, double vision, tunnel vision, blurred or hazy vision. The care plan also documented a risk for falls related to a history of falls, poor safety awareness and weakness. An Incident Note Progress Note dated 8/04/25 at 3:00 AM revealed the resident was found on the floor beside her bed. It did not indicate neurological checks were initiated.A document titled Neurological Assessment Flow Sheet dated 8/06/25 included 30-minute vital signs from 3:30 AM through 5:30 AM but did not include pupil response, motor function, or pain assessments during those times.On 5/04/26 at 10:43 AM, Staff H, Licensed Practical Nurse (LPN) was unable to verbalize the neurological assessment frequency guidelines. She also stated all columns on the form must be completed; otherwise, it is considered incomplete assessments.On 5/04/26 at 10:58 AM, the Assistance Director of Nursing (ADON) stated if an unwitnessed fall was reported to her, she'd perform an initial assessment with vital signs and then complete the neurological assessment form every 15 minutes (min) x 4; then every 30 min x 2; then every hour x 4, then every shift x 72 hours. She stated all columns must be completed and if any information was missing, it would be considered an incomplete assessment.An undated document titled Falls directed the nurse to complete a thorough head to toe assessment for injury. If any head involvement, complete neuro checks as per policy. If an unwitnessed fall and resident has cognitive problems complete neuro checks as per policy. No other fall assessment documentation was provided.On 5/07/26 at 10:33 AM, the Director of Nursing (DON) stated staff should follow the policy.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interviews, and policy review, the facility failed to use a gait belt while transferring a resident who required assistance with mobility for 2 of 3 residents (#3, #4) and failed to lock a wheelchair while transferring a resident without a gait belt for 1 of 3 residents (#4). The facility reported a census of 35 residents.Findings include:1. Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 00 out of 15 which indicated severely impaired cognition. It included diagnoses of Alzheimer's disease and non-Alzheimer's dementia. It revealed she required moderate assistance with eating and was dependent with all other Activities of Daily Living (ADLs) and all forms of mobility.The Care Plan dated 10/15/25 indicated the resident was a fall risk related to chronic confusion and directed staff to use 2-person assistance or a mechanical standing lift for transfers as needed to promote safety.2. Resident #4's MDS assessment dated [DATE] identified a BIMS score of 01 out of 15 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia, fibromyalgia (chronic disorder with musculoskeletal pain, fatigue, and cognitive difficulties), and macular degeneration (blurry or lost central vision). It revealed she was independent with bed repositioning, sit-to-lying, and lying-to-sitting, required setup assistance with eating, moderate assistance with lower body dressing and bathing, and supervision with all other ADLs and mobility. It also indicated she used a wheelchair for mobility in the 7-day look-back period.An undated Care Plan revealed the resident was a risk for falls related to assistive devices for ambulation, chronic confusion, and poor safety awareness and directed staff to use 1-person assistance with transfers.On 5/03/26 at 11:53 AM, Staff A, Training Nurse Aide (TNA - uncertified nurse aide) wheeled Resident #3 to her room by herself in her wheelchair.At 12:07 PM, Staff A wheeled Resident #4 to her room by herself in her wheelchair. While transferring the resident from the wheelchair to her bed, Staff A grabbed the back of the resident's pants with her left hand and under the resident's right armpit with her right hand and assisted the resident out of the wheelchair to a sitting position on her bed.At 12:07 PM, Staff A stated she used the same process to transfer Resident #3 from her wheelchair to her bed except she stated she had to use more muscle to get Resident #3 up and positioned to sit on her bed. She also stated she was off training but wasn't certified yet. She added her trainer told her to put her foot and leg between Resident #3s feet and legs, grab her pants from the back and under an armpit to stand-pivot transfer her.At 12:22 PM, Staff K, Certified Nurse Aide (CNA) stated gait belts are required with every weight bearing, 1-assist transfer resident. At 3:20 PM, Staff F, CNA stated 1-assist residents always require a gait belt because staff need to hang onto the resident.At 3:21 PM, Staff G, CNA stated all 1-assist residents require a gait belt for transfers. She said it was never ok to not use a gait belt for 1-assist resident transfers.At 5:50 PM, Staff N, CNA wheeled Resident #4 to her room in her wheelchair. Once beside the bed, the resident put her hands on the armrests and stood up while Staff G stood beside the wheelchair. The wheelchair was unlocked while the resident stool up without staff assistance or a gait belt.An undated policy titled Safe Resident Handling/Transfers indicated mechanical lifting equipment or other approved transferring aids will be used based on the resident's needs to prevent manual lifting except in medical emergencies. It also indicated handling aids may include gait belts, transfer boards, and other devices and staff members are expected to maintain compliance with safe handling/transfer practices.On 5/07/26 at 10:33 AM, the Director of Nursing (DON) stated staff should perform duties within their scopes of practice and ensure they are supervised.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interviews, family interviews, staff interviews, and policy review, the facility failed to respond to resident call lights within 15 minutes for 4 of 4 residents (#1, #2, #5, #6). The facility also assigned an uncertified nursing aide to direct resident care alone, used agency staff to orientate a newly hired Certified Nurse Aide, and failed to respond timely to a request for assistance in a locked memory-care unit. The facility reported a census of 35 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 01 out of 15 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia, anxiety, and hospice. It indicated she was independent with eating, required setup assistance with oral hygiene, supervision with bed repositioning and personal hygiene, was dependent with lower body dressing and footwear, and required moderate assistance with all other Activities of Daily Living (ADLs) and forms of mobility.An undated Care Plan indicated the resident had impaired cognitive function/dementia or impaired thought processes related to dementia and directed staff to monitor/document/report PRN any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. The care plan also documented a risk for falls and an ADL self-care performance deficit related to dementia. A document titled Location Event Report dated 4/05/26 - 5/05/26 revealed 34 of Resident #1's call light requests were answered more than 15 minutes after initiated. Eleven (11) of the response times were greater than 20 minutes with six (6) of those exceeding 30 minutes.On 5/03/26 at 1:15 PM, the resident's relative stated the resident's call light has been on for 23-24 minutes before staff have responded.2. Resident #2's MDS dated [DATE] identified a BIMS score of 14 out of 15 which indicated completely intact cognition. It included diagnoses of cancer, heart failure, and a left leg fracture. It indicated she was independent with eating and oral hygiene, required setup assistance with upper body dressing and personal hygiene, required maximal assistance with all other ADLs and was dependent with all forms of mobility.An undated Care Plan indicated the resident had an ADL self-care performance deficit related to fractures and required one staff assistance with toileting.A document titled Location Event Report dated 4/05/26 - 5/05/26 revealed 23 of Resident #2's call light requests were answered more than 15 minutes after initiated. Twelve (12) of the response times were greater than 20 minutes with three (3) of those exceeding 30 minutes.On 5/03/26 at 2:35 PM, the resident's relative stated staff frequently come turn the call lights off, leave, and not return.3. Resident #5's MDS assessment dated [DATE] identified a BIMS score of 14 out of 15 which indicated completely intact cognition. It included diagnoses of high blood pressure, diabetes mellitus, seizure disorder, and asthma. It revealed he required moderate assistance with bathing and was independent in all other ADLs and repositioning and transfer mobility. It further revealed he used a walker or wheelchair as a mobility device.An undated Care Plan indicated the resident has an ADL self-care performance deficit related to activity intolerance, fatigue, musculoskeletal impairment and directed staff to encourage the resident to use bell to call for assistance.A document titled Location Event Report dated 4/05/26 - 5/05/26 revealed seven (7) of Resident #5's call light requests were answered more than 15 minutes after initiated. Three (3) of the response times were greater than 20 minutes with one (1) of those at 30 minutes.On 5/03/26, Resident #5 stated staff don't always come when he pulls the call light.4. Resident #6's MDS assessment dated [DATE] identified a BIMS score of 00 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia and arthritis. It revealed he required supervision with eating, moderate assistance with oral and personal hygiene, maximal assistance with upper body dressing, and was dependent with all other ADLs and mobility.An undated Care Plan indicated the resident was at risk of acute on chronic pain (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	secondary to risk of diabetes mellitus and immobility. It directed staff to monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician.A document titled Location Event Report dated 4/05/26 - 5/05/26 revealed four (4) of Resident #2's call light requests were answered more than 15 minutes after initiated. Four (4) of the response times were greater than 20 minutes with two (2) of those exceeding 30 minutes.A document titled Staffing Sheet dated 5/03/26 Sunday revealed Staff A, Training Nursing Aide (TNA - uncertified nurse aide) was assigned for direct resident care along on a resident hall. Another Staffing Sheet dated 4/26/26 revealed Staff A, TNA, Staff K, Certified Nurse Aide (CNA), and an agency CNA were scheduled for resident care. Staff A, TNA was assigned a resident hall alone, the agency CNA was assigned to one of the other resident halls, and Staff K, CNA was assigned to work in the separated Memory Care Unit (MCU). There was no documented assigned staff for the 3rd resident hall. On 5/03/26 at 11:00 AM, Staff I, Licensed Practical Nurse (LPN) confirmed the current shift assignment and stated the Director of Nursing (DON) was coming to work at 2:00 PM due to a staffing shortage. She confirmed residents have complained to her about delayed call light response times.A document titled Nurse Schedule May 2026 revealed the DON was scheduled to work at 2:00 PM on 5/03/26.At 11:10 AM, Staff J, LPN stated residents have complained to her about delayed call light response times.On 5/03/26 at 3:38 PM, the Social Services Coordinator/ (CNA) stated she helps feed breakfast five (5) times per week to the residents who require eating assistance and stated she believes other CNAs are giving baths and/or getting other residents up during that time. She also stated she helps residents go to the restroom with assistance and helps with CNA duties when CNAs aren't available. She further stated she checks Resident #2's leg immobilizer 1-2 times per day and readjusts it if needed.During a continuous observation on 5/04/26 that began at 12:12 PM, Staff K, CNA used a walkie-talkie to request a nurse right away to the MCU three (3) times. When she did not receive a response, she used the telephone in the MCU nurses' station to call the Long-Term Care (LTC) nurses' station telephone. When no one answered the telephone, she attempted to call the CNAs documentation room twice; the first attempt did not connect. On the second attempt, Staff M, CNA answered the telephone at 12:18 PM.On 5/04/26 at 12:18 PM, the DON stated she entered the MCU right after the surveyor left at 12:18 PM.On 5/04/26 at 3:40 PM, the DON stated the TNA should not have been assigned to a resident hall by herself on 5/03/26.On 5/04/26 at 5:32 PM, Staff L, CNA stated she has worked in the Memory Care Unit (locked unit) since [DATE] and requested staff assistance for a resident fall. She stated it took staff approximately 5 minutes to respond to the MCU.On 5/05/26 at 1:53 PM, Staff I, LPN stated she assigned Staff A to a resident hall by herself on 5/03/26 because the shift had a staffing shortage.A document titled Nurse Schedule April 2026 indicated Staff D, CNA was scheduled in orientation on 4/26/26.A document titled Facility Assessment dated 5/01/26 revealed the facility staffing was based on census and acuity of the resident population. It indicated the facility would staff 3-5 CNAs per day shift; 3-5 per afternoon shift; 2-3 per night shift during the week and weekends.On 5/05/26 at 3:25 PM, the Assistant Director of Nursing (ADON) confirmed Staff D worked on 4/26/26 based on her timecard entries and stated Staff D was in orientation with the agency CNA. She further stated she understood the staffing concern with the assignment because of the CNA orientation with an agency CNA and a TNA assigned to a hall alone.On 5/05/26 at 3:35 PM, the DON stated she felt the facility didn't have sufficient staffing based on the limitations of TNAs.A policy titled CCDI Unit Policies and Procedures dated 11/01/24 indicated there shall be at least one member of the nursing staff on the unit at all times. Other staffing will be provided according to the needs of the residents on the unit at a given time.An undated policy titled Call Lights: Accessibility and Timely Response indicated all staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified.On 5/07/26 at 10:33 PM, the DON stated staff should respond to call lights within 15 minutes. She also stated TNAs should be (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assigned to certified staff members. She further stated staff should respond to MCU staff assistance requests immediately.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinic record review, resident and staff interviews, and policy review, the facility failed to maintain competent staff by allowing a Training Nurse Aide (TNA - uncertified nurse aide) to incorrectly transfer two (2) residents (#3, #4), incorrectly apply a leg immobilizer on a resident with a broken leg (#2), and assign a Certified Nurse Aide (CNA) without evidence of dementia training to provide care for dementia residents. The facility reported a census of 35 residents. Findings include: 1. Resident #2's MDS dated [DATE] identified a BIMS score of 14 out of 15 which indicated completely intact cognition. It included diagnoses of cancer, heart failure, and a left leg fracture. It indicated she was independent with eating and oral hygiene, required setup assistance with upper body dressing and personal hygiene, required maximal assistance with all other ADLs and was dependent with all forms of mobility.An undated Care Plan indicated the resident had an ADL self-care performance deficit related to fractures and was non-weight bearing.2. Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 00 out of 15 which indicated severely impaired cognition. It included diagnoses of Alzheimer's disease and non-Alzheimer's dementia. It revealed she required moderate assistance with eating and was dependent with all other Activities of Daily Living (ADLs) and all forms of mobility.The Care Plan dated 10/15/25 indicated the resident was a fall risk related to chronic confusion and directed staff to use 2-person assistance or a mechanical standing lift for transfers as needed to promote safety.3. Resident #4's MDS assessment dated [DATE] identified a BIMS score of 01 out of 15 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia, fibromyalgia (chronic disorder with musculoskeletal pain, fatigue, and cognitive difficulties), and macular degeneration (blurry or lost central vision). It revealed she was independent with bed repositioning, sit-to-lying, and lying-to-sitting, required setup assistance with eating, moderate assistance with lower body dressing and bathing, and supervision with all other ADLs and mobility. It also indicated she used a wheelchair for mobility in the 7-day look-back period.An undated Care Plan revealed the resident was a risk for falls related to assistive devices for ambulation, chronic confusion, and poor safety awareness and directed staff to use 1-person assistance with transfers.On 5/03/26 at 11:53 AM, Staff A, Training Nurse Aide (TNA - uncertified nurse aide) wheeled Resident #3 to her room by herself in her wheelchair.At 12:07 PM, Staff A wheeled Resident #4 to her room by herself in her wheelchair. While transferring the resident from the wheelchair to her bed, Staff A grabbed the back of the resident's pants with her left hand and under the resident's right armpit with her right hand and assisted the resident out of the wheelchair to a sitting position on her bed.At 12:07 PM, Staff A stated she used the same process to transfer Resident #3 from her wheelchair to her bed except she stated she had to use more muscle to get Resident #3 up and positioned to sit on her bed. She also stated she was off training but wasn't certified yet. She added her trainer told her to put her foot and leg between Resident #3s feet and legs, grab her pants from the back and under an armpit to stand-pivot transfer her.At 12:22 PM, Staff K, Certified Nurse Aide (CNA) stated gait belts are required with every weight bearing, 1-assist transfer resident.At 2:35 PM, Resident #2 stated Staff A, TNA applied her leg immobilizer by herself that morning.At 3:20 PM, Staff F, CNA stated 1-assist residents always require a gait belt because staff need to hang onto the resident.At 3:21 PM, Staff G, CNA stated all 1-assist residents require a gait belt for transfers. She said it was never ok to not use a gait belt for 1-assist resident transfers.At 3:32 PM, the Social Services Coordinator (SSC) adjusted Resident #2's leg immobilizer and confirmed it was on incorrectly.On 5/04/26 at 3:33 PM, the Director of Nursing (DON) stated TNAs should not be applying or removing leg immobilizers.A document titled Staffing Sheets dated from 4/01/26 - 5/03/26 revealed Staff K, CNA was assigned to work in the Memory Care Unit (MCU) on 4/02/26, 4/07/26, 4/11/26, 4/12/26, 4/16/26, 4/23/26, 4/25/26, 4/26/26, and 5/03/26.A (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165412	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Exira Care Center	411 South Carthage Exira, IA 50076

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document titled Long Term Care Competencies dated 5/05/26 revealed Staff A's competencies did not include resident transfers nor applying leg immobilizers. No other competencies were available for Staff A.An undated document titled Employee Orientation Checklist revealed Staff A had not been oriented to resident transfers nor applying leg immobilizers.An untitled education document revealed Staff K, CNA did not have documentation of the following, state-required specialized training:(1) Explanation of the disease or disorder(2) Symptoms and behaviors of memory-impaired people(3) Progression of the disease(4) Communication with CCDI residents(5) Adjustment to care facility residency by the CCDI unit or facility residents and their families(6) Inappropriate and problem behavior of CCDI unit or facility residents and how to deal with it(7) Activities of daily living for CCDI residents(8) Handling combative behavior(9) Stress reduction for staff and residentsOn 5/07/26 at 10:33 AM, the DON stated staff should know and maintain their scopes of practice and complete their educations timely.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165412	A. Building B. Wing	05/06/2026

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and policy review, the facility failed to perform hand hygiene while assisting with meals for 2 of 3 residents (#3, #6) who were dependent with eating. The facility reported a census of 35 residents.Findings include:1. Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 00 out of 15 which indicated severely impaired cognition. It included diagnoses of Alzheimer's disease and non-Alzheimer's dementia. It revealed she required moderate assistance with eating and was dependent with all other Activities of Daily Living (ADLs) and all forms of mobility.An undated Care Plan indicated the resident had a self-care deficit related to Alzheimer's disease and directed staff to attempt to participate and provide assistance with eating.2. Resident #6's MDS assessment dated [DATE] identified a BIMS score of 00 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia and arthritis. It revealed he required supervision with eating, moderate assistance with oral and personal hygiene, maximal assistance with upper body dressing, and was dependent with all other ADLs and mobility.An undated Care Plan indicated the resident had an ADL self-care deficit related to dementia and indicated the resident was able to feed himself. It directed staff to encourage the resident to participate to the fullest extent possible with each interaction.During a continuous dining observation on 5/03/26 at 11:25 AM, Staff A, Training Nursing Aide (TNA - uncertified nurse aide) assisted Resident #6 with eating. After she spooned some of his food into his mouth, she wheeled her stool over to Resident #3, spooned food into Resident #3's mouth, then wheeled back over to Resident #6, and spooned food into his mouth. She did not sanitize her hands between touching each residents' utensils.At 11:38 AM, Staff B, Certified Nurse Aide (CNA) got up from the dining table, walked to the sink and washed her hands, then walked back over to Resident #3 who was holding the spoon Staff A used after touching Resident #6's utensils to feed him.A policy titled Hand Hygiene accessed May 2025 indicated all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. It directed staff to perform hand hygiene between resident contacts.On 5/07/26 at 10:33 AM, the Director of Nursing (DON) stated staff should've performed hand sanitization between residents and should followed the hand hygiene policy.