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	08/07/2025

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

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 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, staff interviews and clinical record review the facility failed to adequately supervise residents in the locked Chronic Confusion or Dementing Illness (CCDI) unit for 1 of 6 residents. The facility reported a census of 44 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #30 was severely cognitively impaired and had delusions. She used a walker and required supervision for transfers and toileting. Her diagnoses included: cerebrovascular accident (CVA), dementia and asthma. The Care Plan for Resident #30, updated on 6/18/25, showed that she had self-care deficits, secondary to chronic confusion and dementia. The resident was an elopement risk, disoriented to place and wandered aimlessly. Staff were to distract the resident from wandering and offer diversions. Resident #30 had communication problems, was rarely understood, and was at risk for falls related to altered mobility and unsteady gait. She had poor safety awareness. Staff were directed to anticipate and meet her needs. The following documentation was found in the Nursing Progress Notes: On 6/24/25 at 2:31 PM, the resident was hitting staff with a hanger, her dementia with behaviors was getting more frequent and severe. On 6/16/25 at 7:30 AM, Resident #30 was found sitting on her bottom in her room. She said she was trying to get dressed for the day. On 7/28/25 at 6:30 AM, the resident was found sitting on the floor in her room. On 7/22/25 at 9:28 PM, the resident was combative towards staff and other residents. On 8/04/2025 at 1:13 PM, observed a Certified Nurse Aide (CNA) assist Resident #30 to walk around the CCDI unit. The resident was agitated and insisted on the full attention of the staff member. On 8/05/2025 at 6:26 AM, upon entry into the CCDI unit, 2 residents were sitting in chairs by the television. The door to the nurse's station was open, there was a purse, some papers and sanitizer on the counter. There were no staff members in the area. One resident in a recliner had her eyes closed as she fidgeted with her blanket. One resident was sitting in a high-back chair with her legs resting on the seat of a walker. Resident #30 then walked out of her room with her walker. She was wearing pajamas and had shoes on her feet. She said: I don't know where my family is then asked: do you remember where I sit? She then walked closer to another resident and said: I was thinking of my mother, she's coming? Resident #30 said that her back hurt and she wanted to sit down. At 6:36 AM, the Director of Nursing (DON) came in the door with the treatment cart. The DON said that Staff H was the CNA for the morning and that she was probably in a room giving a resident a shower. At 6:43 AM Staff H came out of the resident's room to the common's area. On 8/05/2025 at 9:53 AM, Staff H said that she usually tried to get the showers done before the other residents got out of bed. She said that one of them had been in the chair by the TV before she started showering another resident. She agreed that Resident #30 tended to get easily agitated and she needed close supervision. On 8/06/2025 at 11:59 AM, the DON agreed that it was a problem to leave residents unattended in the CCDI Unit. She said that going forward, they have arranged for a bath aide to come over to the unit to do the baths and showers to ensure that proper supervision. The DON agreed that Resident #30 was unpredictable and needed supervision. A facility policy dated 11/1/24, showed that there would be at least one member of the nursing staff on the unit at all times. Other staffing would be provided according to the needs of the (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

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	08/07/2025

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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents on the unit at a given time. One CNA with appropriate CCDI training would be on the unit at all times.

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	08/07/2025

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

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and clinical record review the facility failed to provide adequate urinary catheter care for 2 of 2 residents reviewed. Resident #1 had chronic urinary tract infections and staff failed to monitor his output as ordered. Resident #28 had an order to not insert more than 10 milliliters (ml) of fluid in the catheter balloon. Staff failed to transcribe the specific order and administered fluid according to the catheter package. The facility reported a census of 44 residents.Findings include: 1. According to the Minimum Data Set (MDS) dated [DATE], Resident #28 had a Brief Interview for Mental Status (BIMS) score of 8 (moderate cognitive deficit). He required partial assistance with toileting, transfers, and dressing. The resident had an indwelling catheter and diagnoses that included: coronary artery disease, dementia, type 2 diabetes mellitus, Benign Prostatic Hyperplasia (BPH), retention of urine and edema. The Care Plan, updated on 6/5/25, showed that Resident #28 had self-care performance deficit related to dementia. He was at risk for infection related to a suprapubic urinary catheter. Staff were to monitor and document output each shift, and to observe for signs and symptoms of urinary tract infections such as pain, burning, blood tinged urine, cloudiness, no output, and deepening of urine color. According to the orders tab, Resident #28 had a Physician's Order, dated 2/27/24 at 2:00 PM, to document urinary output every shift. A Transfer Report from the primary physician dated 6/5/25, showed that on that date, the doctor place a new 24 French catheter and directed staff to not put more than 10ml in the balloon. The doctor had removed 22ml in the balloon at the appointment, and indicated that if the catheter continued to leak, he will need bladder Botox injections. The catheter order entered in the electronic record on 6/5/25 at 12:36 PM lacked direction on the amount of fluid to insert into the balloon. On 8/05/25 at 7:06 AM, Staff D, Certified Nurse Aide (CNA) said that they documented all output for urinary catheters and reported to the nurses at the end of each shift. On 8/05/25 at 8:06 AM, Resident #28 was in the recliner and said they preferred to sleep in the chair because the bed was not very comfortable. Staff D and Staff C, CNA prepared to get him cleaned up and dressed for the day. The resident was wearing a brief that was heavily soiled and he said that he did have some leaking from his catheter. Further inspection of the catheter site revealed that there was blood at and around the catheter site. Staff C said that they would notify the nurse. On 8/05/25 at 9:57 AM, Staff B, Registered Nurse (RN) said that if there wasn't an order for how much fluid to put in the catheter balloon, she would call the doctor for clarification or she would go by the amount on the catheter bag. She pulled a 24 French catheter from the shelve and demonstrated that it said to use 30 ml.A review of the nursing notes on 8/06/25 at 9:54 AM, showed that the most recent progress note was dated 7/21/25 at 3:31 PM. The chart lacked documentation that the nurse had assessed the issue or that it had been addressed. On 8/6/25 at 9:55 AM Staff A, Licensed Practical Nurse (LPN) said that she was not aware that the catheter site was sore and it was not passed on in report. On 8/6/25 at 9:32 AM, Staff A, LPN She said that the CNA's would come and tell the nurses per shift of the catheter output. She acknowledged that it didn't always get done, or the CNA's would forget to let the nurse know. On 8/06/25 at 10:24 AM, Staff E, LPN said if there was nothing specified on the order for amount to put in the catheter bulb, she would go with whatever was on the package. She said that the CNA's have been getting better about telling them the output but they need a better process that was consistent so they had accurate information. According to the Medication Administration/Treatment Administration (MAR/TAR) for Resident #28, in the month of May, there was no output documented on 7 days. The June MAR/TAR showed no output on 2 days, and the July MAR/TAR showed no output documented on 4 days. 2. The MDS dated [DATE], showed that Resident #1 had a BIMS score of 14 (intact cognitive ability). The resident was totally dependent on staff for toileting hygiene, dressing and transfers. He had an indwelling catheter, and his diagnoses included: atrial fibrillation, coronary artery disease, heart failure, Benign Prostatic (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	08/07/2025

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

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hyperplasia (BPH) and septicemia, The Care Plan for Resident #1, reviewed on 7/7/25, showed that the resident used antidepressant medication and was on diuretic therapy, staff were to administer medications as ordered. The resident had a cerebral vascular accident (CVA), chronic pain, and was at risk for complications related to diabetes mellitus. Staff were to observe and monitor for side effects. Resident #1 had an indwelling catheter related to urinary retention, staff were to monitor and document intake and output as pre facility policy. On 8/04/25 at 1:16 PM, Resident #1 was in his bed. There was a catheter tube draped down the side of the bed and the bag rested in a tub on the floor. The resident said that earlier in the summer, he had been very sick with a urinary tract infection and sepsis. A review of the record revealed an order dated 5/12/25 at 11:14 AM, to record output every shift. The MAR/TAR for July for Resident #1 showed that on 5 days there was no urine output. On 8/06/25 at 12:13 PM, the Director of Nursing (DON) said that she was aware that output for catheters had not been getting monitored as it should. She was not aware that Resident #28 had a specific order for no more than 10ml in the bulb of catheter, and said this should have been entered along with the order. The DON said that the nurses would enter notes when there were any new issues. She acknowledged that the blood around the catheter site for Resident #28, on 8/6/25 should have been noted and addressed. The DON said that given the history of urinary tract infections and sepsis for Resident #1, it was important for staff to be aware of his daily output. An undated facility policy titled: Urinary Drainage Bag-Closed, showed that staff were to record the output in the medical record and to report if there was any change in odor, color, consistency, blood, mucous or leaking bag.

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	08/07/2025

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

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, document review, resident interview, and staff interviews the facility failed to consistently monitor meal intakes for residents for sufficient nutrition to maintain proper weight for 1 of 2 residents reviewed (Resident #6). The facility reported a census of 44 residents. Findings include:Review of Resident #6's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating intact cognition. The MDS further revealed diagnoses of stroke, hyponatremia (low sodium levels in the blood), non-Alzheimer's dementia, and hemiplegia (paralysis or severe weakness on one side of the body).Interview 8/04/25 at 11:23 AM with Resident #6 revealed that she has lost some weight, and that she is on a mechanical soft diet. Resident #6 further revealed that she is on a supplement as well. Review of the Electronic Health Record (EHR) for Resident #6 revealed on 1/12/25 Resident #6 weighed 147 pounds. On 7/27/25 Resident #6 weighed 133 pounds which is a -9.52% Loss.Further review of the EHR page titled, Clinical Physician's Orders revealed an order for a regular diet with mechanical soft texture. Further review revealed an order dated 6/17/25 for house nourishment with protein powder TID (three times a day) with meals and ice cream related to weight loss. Follow up interview 8/05/25 at 11:47 AM with Resident #6 revealed that she did not want to eat breakfast this morning. Resident #6 then revealed that she just isn't that hungry anymore, and does not require that much food. Resident #6 revealed that she does eat her ice cream, and she isn't starving. Interview 8/05/25 at 11:45 AM Interview with Staff G Certified Nurses Aide (CNA) revealed that staff are to document the intakes of residents on a paper in the staff charting room. Staff G then provided the documentation book for the meal intakes. Review of a facility provided document with a date of July 2025 revealed documentation for the intakes of meals and supplements for Resident #6. Review of this document noted intakes for meals and supplements on 9 of the 31 days, with nothing charted on the supper meals or supplements except for one day during the month of July. Review of another facility provided document with a date of August 2025 revealed documentation for the intakes of meals and supplement for Resident #6. Review of this document revealed no documentation on the 1st of August for meal intakes of supplement intake. The document further revealed no documentation for the 2nd, 3rd, and 4th supper entries. Review of the EHR page titled, Progress Notes revealed an entry dated 6/17/25 entered by the contract dietician that Resident #6 had a weight warning. The entry revealed a weight of 136 pounds on 6/13/25. The entry indicates weight loss is 8.7% in the last 90 days, and that Resident #6 remains on a mechanical soft diet plus house nourishment with extra protein powder three times a day at meals. The entry further revealed that the writer would alert the primary care provider to the weight loss, and would add ice cream to the house nourishment. Further review of the progress notes revealed an entry from the contract dietician on 6/26/25 that Resident #6 had a weight of 130 pounds on 6/23/25 with a weight loss of 6 pounds in the past 10 days with an overall loss of 7.8% in the last 30 days. Another entry dated 7/10/25 revealed a current weight of 133 pounds and Resident #6 was up 3 pounds since the provider notification of loss. The note further indicated that meal intake is around 50% with frequent refusal of meals and supplements. Interview 8/05/25 at 1:18 PM with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) revealed that meal intakes should be documented to monitor. The ADON revealed that documenting is a requirement. Interview 08/06/25 at 9:40 AM with the Administrator revealed the facility doesn't have a policy related to monitoring meal intakes. Interview 8/06/25 10:00 AM with the dietician revealed that she would expect meal intakes to be monitored, and charted so as to be able to effectively communicate with the physician for residents with weight loss.

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	08/07/2025

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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff interviews, the facility failed to accurately document resident medication administration for 2 of 13 residents (Resident #1 and #2). The paper Medication Administration Record (MAR) for Residents #1 and #2 showed many days blanks, indicating that the medications had not been given. The facility reported a census of 44 residents. Findings include: 1) The Minimum Data Set (MDS) dated [DATE], showed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14 (intact cognitive ability). The resident was totally dependent on staff for toileting hygiene, dressing and transfers. He had an indwelling catheter, diagnoses included: atrial fibrillation, coronary artery disease, heart failure, Benign Prostatic Hyperplasia (BPH) septicemia.The Care Plan, last reviewed on 7/7/25, showed that Resident #1 used antidepressant medication and was on diuretic therapy. Staff were to administer medication as ordered by the physician. The resident was at risk for complications related to diabetes mellitus and congestive heart failure. A review of the April 2025 MAR for Resident #1 revealed that on April 18th and 19th the chart lacked documentation of administration of 16 different morning medications. 2) According to the MDS dated [DATE], Resident #2 had a BIMS score of 3 (severe cognitive deficits). He required substantial assistance for dressing, and was totally dependent for transfers. Resident #2 was frequently incontinent of bowel and bladder and his diagnoses included: cancer, anemia, hypertrophy of kidney, macular degeneration and arthritis. The Care Plan updated on 6/26/25, showed that Resident #2 was on antidepressant and antianxiety medication, staff were to observe for and report indications of adverse effects. The resident was on hospice services related to end stage disease. Review of the MAR/TAR for Resident #2 for the month of May 2025, showed that on the 19th, 20th, and 21st, 10 different morning medications had not been given. The chart lacked explanation of the missing documentation. On 8/6/25 at 9:32 AM, Staff A, Licensed Practical Nurse (LPN) acknowledged that the medication documentation was not always accurate. She said she could not be sure, but she thought it was a documentation problem and the medications were given. Staff A said that the cassettes with the pills have a day of the week on them so if a day was missed, they would know because the pills would still be in the cassette. On 8/06/25 at 12:08 PM, the Director of Nursing (DON) said that they became aware that some of the documentation was not being completed so they did an audit in June. They were in communication with the pharmacy to ensure that the medications were actually being given and it was a documentation issue, she said that the cassettes went back to the pharmacy weekly and the pharmacy reported that they didn't have unexplained left-over pills. They have addressed the issue with the nurses that they identified that have missed documentation. According to the facility staff education for Medication Administration Monitoring Tool, the expectation was that medication would be charted immediately after administration.