STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165438	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stacyville Community Nursing Home	413 South Broad Street Stacyville, IA 50476

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on electronic health record (EHR)review, policy review, resident, and staff interviews the facility failed to report an allegation of abuse within the required time frame to the Iowa Department of Inspection, Appeals, and Licensing (DIAL) for 1 of 1 resident reviewed (Resident #9). The facility reported a census of 22 residents. Findings Include: Resident #9's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of renal (kidney) insufficiency (poor functioning), stroke and end stage renal disease (ESRD). The MDS documented Resident #9 received dialysis services outside of the facility. During an interview on 6/2/25 at 12:10 PM, Resident #9 reported he had money missing and someone took his money. Resident #9 reported approximately $250 missing from his room over a month ago and another $57 within the past week. Resident #9 stated he reported the missing funds to the staff on each occasion. A review of the EHR Profile tab listed Resident #9 as his own responsible party. The Care Plan Focus initiated 12/9/24 listed the facility provided Resident #9 a lock box. Resident #9 had an undetermined amount of money that he refused to let the staff count. The Intervention directed the following: a. Resident #9 would keep the lock box in his room and safeguard it. He refuses to allow staff to safely lock up the money in a secure location. b. Resident #9 refused to allow staff to count the money in his possession. The review of the facility reported incidents to DIAL lacked reports of Resident #9's missing money for 2/11/25 and 5/27/25, after he reported the incident to the staff. During an interview on 6/4/25 Staff B, Certified Nursing Assistant (CNA), revealed she knew Resident #9 reported his money missing. Staff B explained she reported it to the nurse that Resident #9 reported missing money. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/25 at 10:00 AM Staff C, Social Services, verified Resident #9 reported to him on 5/27/25 that he had $57 missing. He had the money sitting out in the open in a bank envelope in his room. Staff C reported the missing money to the Administrator the next morning. Staff C confirmed Resident #9 reported a previous incident of missing money. Staff C provided a summary/investigation of report Resident #9's missing money after he reported to him on 2/11/25. The investigation documented Resident #9 reported someone stole $400 from his room. During an interview on 6/4/25 at 10:57 AM the Administrator and Staff C reported they started an ongoing investigation on 5/27/25 for Resident #9's reported missing money. The Administrator stated she talked with Resident #9 about keeping his money locked up in his facility provided lockbox. The Administrator acknowledged she didn't report Resident #9's previous or current incidents of missing money to DIAL. A review of the undated facility Abuse Policy defined: Misappropriation of Resident property as the deliberate (on purpose) misplacement, and exploitation (wrongful temporary or permanent use of a Resident's belongings or money without the resident's consent). The policy directed staff to report all allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin, and misappropriation immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative. All allegations of resident abuse shall be reported to the Department of Health and Human Services (DHHS) no later than 2 hours after the allegation is made, if the allegation resulted in serious bodily injury, or no later than 24 hours if the allegation involved neglect, exploitation, mistreatment, injuries of unknown origin, and misappropriation, but do not result in serious bodily injury. If there is a reasonable suspicion that the allegation of abuse also constitutes a crime committed against the resident by any person, whether or not facility employed the alleged perpetrator, the Elder Justice Act required the facility report the situation to law enforcement. While the federal regulations required all abuse allegations reported to DIAL within 2 hours, the Elder Justice Act has a different reporting timeframe to the police/sheriff. If the allegation of abuse (that resulted from a crime) resulted in serious bodily injury to a resident, a report must be made to law enforcement no later than 2 hours after the allegation is made. If the allegation of abuse does not result in serious bodily injury, the facility must report to law enforcement no later than 24-hours. The policy defined serious bodily injury as an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, mental faculty, or required surgery, hospitalization, or physical rehabilitation. If the person in charge is the alleged abuser, the staff member shall directly report the abuse to the DHHS immediately, pursuant to the deadlines established above. If the allegations of dependent adult abuse involve a caretaker not employed by the facility (e.g., family member, visitor), a report must also be made immediately to DHHS.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on electronic health record (EHR) review, clinical record review, the Centers for Medicare and Medicaid Services (CMS) Long term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview the facility failed to complete a Significant Change Status Assessment (SCSA) Minimum Data Set (MDS) assessment after a resident elected to start hospice for 1 of 1 residents (Resident #17) reviewed on hospice services. The facility reported a census of 22 residents. Findings include: Resident #17's Clinical Census reviewed 6/3/25 documented hospice as their primary payer effective 4/30/25. The Health Status Note dated 4/30/25 at 12:27 PM reflected Resident #17 admitted to hospice care services. The MDS 3.0 Summary page in Resident #17 EHR revealed the facility failed to complete the SCSA MDS when hospice services had been elected. The Hospice Election Statement signed by Resident #17's Representative on 4/30/25 listed they elected hospice to start that day. During an interview on 6/4/25 at 11:08 AM Staff A, MDS Coordinator, reported she started working at the facility on 5/5/25. She acknowledged Resident #17 elected hospice prior to her starting at the facility. Staff A explained they followed the RAI manual when they completed the required assessments. Staff A reported the facility had 14 days after election of hospice to complete the SCSA assessment. Staff A acknowledged the facility didn't complete Resident #17's SCSA assessment. During an interview on 6/4/25 at 11:15 AM, the Administrator acknowledged the facility followed the RAI manual timelines when they completed the MDS assessments. The Administrator confirmed the facility didn't complete Resident #17's SCSA assessment. The LTC RAI 3.0 User's manual Version 1.19.1 October 2024 identified the manual required the facility complete a SCSA when a terminally ill resident enrolled in a hospice program or changed hospice providers and remained a resident at the nursing home. The RAI Manual specified the SCSA MDS completion date as 14 days from the determination that a significant change in resident status occurred (determination date plus 14 calendar days).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews the facility failed to accurately document and submit an accurate Minimum Data Set (MDS) Assessment for 1 of 6 residents reviewed (Resident #6). The facility reported a census of 22 residents. Findings include: Resident #6's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview of Mental Status (BIMS) score of 13, indicating intact cognition. The MDS included diagnoses of hypertension (high blood pressure), diabetes, and obesity. Resident #6 received injections of insulin 7 out of 7 days during the lookback period. Resident #6's clinical record lacked documentation of insulin or even an injection given during the lookback period. During an interview on 6/4/25 at 1:43 PM the MDS coordinator reported the previous MDS coordinator coded the medication wrong. During an interview on 6/5/25 the MDS coordinator reported the facility didn't have a policy for MDS accuracy and completion. She reported the facility followed the RAI Manual.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to follow physician's orders for 2 of 6 residents reviewed (Resident #6 and #11). The facility reported a census of 22 residents. Findings include: 1. Resident #6's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview of Mental Status (BIMS) score of 13, indicating intact cognition. The MDS included diagnoses of hypertension (high blood pressure), diabetes, and obesity. Review of Resident #6's Treatment Administration Record lacked documentation of Ozempic given on 4/4/25. Review of Resident #6's Progress Note on 4/4/25 at 3:27 PM documented the Ozempic (GLP1 medication used to treat diabetes and obesity) medication will be coming from the pharmacy that evening. Further review of the Progress Notes lacked documentation that the medication came from the pharmacy and was given. During an interview on 6/4/25 at 3:50 PM the MDS coordinator reported the medication was missed on 4/4/25. It should have been given and was missed. It didn't come in from the pharmacy. During an interview on 6/5/25 8:55 AM, the Administrator reported the facility didn't have a facility policy related to following physician orders. 2. Resident #11's MDS assessment dated [DATE] identified a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of hypertension (high blood pressure), depression and dementia. During an interview on 6/2/25 at 12:53 PM, Resident #6 reported she told the Administrator she wanted to ride the bike in therapy again. The Health Status Note dated 4/2/25 at 2:35 PM documented the doctor ordered Physician Therapy (PT) to evaluate and treat because Resident #11 wanted to use the bike in the therapy room. Resident #6's clinical record lacked PT seeing them on or after 4/2/25. During an interview on 6/3/25 at 1:14 PM the Director of Nursing reported the nursing staff who received the physician orders for therapy are supposed to notify the facility's contracted therapy group. The staff missed Resident #6's order on 4/2/25 and didn't call it in.