

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2026
NAME OF PROVIDER OR SUPPLIER Stacyville Community Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure 1 of 3 sampled residents on antipsychotic medications had diagnoses to support the justification and use of the medication and the negative side effects it can cause in the elderly (Resident #19). The facility reported a census of 24 residents. Findings include: Resident #19's Minimum Data Set (MDS) assessment dated [DATE] documented an admission date of 8/20/25. Resident #19's MDS documented a Brief Interview for Mental Status (BIMS) score of 3, indicating severely cognitively impaired. Resident #19's MDS documented disorganized thinking (rambling conversation or unclear flow of ideas), fluctuating behavior (changing in severity), and delusions (firmly held false beliefs). Resident #19's MDS documented 1 to 3 days of verbal behavioral symptoms directed toward others (threatening, screaming, or cursing) and other behavioral symptoms not directed toward others (hitting or scratching self, pacing, rummaging) during the look-back period. Resident #19's MDS documented no physical behavioral symptoms directed toward others. Resident #19's MDS documented Resident #19 uses a walker, eats, puts on and takes off shoes, performs oral and toileting hygiene, moves in bed, and walks independently. Resident #19's MDS documented Resident #19 requires partial or moderate assistance (helper providing less than half effort) with showering, bathing, and dressing. Resident #19's MDS documented Resident #19 maintains bowel and bladder continence. Resident #19's MDS documented active diagnoses including non-Alzheimer's dementia (memory loss disorder), unspecified atrial fibrillation (irregular, rapidly beating heart rhythm), and chronic obstructive pulmonary disease (COPD) (progressive lung disease causing airflow blockage). Resident #19's MDS didn't list psychiatric or mood disorder diagnoses. A review of Resident #19's Physician's Orders dated 8/21/25 documented orders for Seroquel (antipsychotic medication) 25 milligrams (mg) at 3:00 PM and Seroquel 100 mg at supper. The orders didn't list a diagnosis for usage. A review of Resident #19's Psychotropic Medication Therapy Informed Consent Form for Seroquel dated 8/20/25 documented the reason for usage as dementia with psychotic behavior and irritability. The form documented expected benefits including improved functional ability, mood, social activities, sleep, and weight. The form documented potential side effects including blurred vision, confusion, constipation, drooling, dry mouth, involuntary movements, muscle rigidity, restlessness, sedation, sleep disturbances, and neck stiffness. The form included an Antipsychotic Black Box Warning stating administration in elderly patients with dementia-related psychosis treated with an antipsychotic drug increases risk of death. A review of a Health Status Note dated 1/19/26 at 1:58 PM documented Resident #19 reporting a night fall to morning staff. Resident #19 denied hitting Resident #19's head. Staff initiated neurological assessments per facility protocol. Vital signs remained stable, and Resident #19 denied pain. Staff implemented an intervention to keep Resident #19's bathroom light on during the night (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
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because Resident #19 doesn't call or wait for staff assistance. A review of Resident #19's Note to Attending Physician Prescriber dated 6/1/26 documented a second pharmacy request for a gradual dose reduction for Seroquel. Resident #19's physician declined the request, documenting Resident #19 continues displaying increased agitation. A review of Resident #19's Order Note dated 6/18/26 at 7:28 AM documented Resident #19 experiencing increased afternoon and evening behaviors. The note documented Resident #19 taking Seroquel 25 mg at 3:00 PM, requesting a dose increase and a potential additional morning dose. Resident #19's physician responded with an order for Seroquel 12.5 mg in the morning and 25 mg at noon to evaluate Resident #19's response. The order didn't include a diagnosis for the medication increase. Staff noted the order on 6/19/26. A review of a Health Status Note dated 7/1/26 at 7:19 AM documented Resident #19 experiencing an unwitnessed morning fall. A nursing assistant reported the fall at 7:00 AM. Resident #19 stated hitting Resident #19's head and sustaining an open area on the knee. Staff noted no head bruising or lacerations (cuts) and observed a penny-sized scrape on Resident #19's knee without bleeding. Staff initiated neurological assessments. Resident #19 reported slight neck pain while remaining in good spirits. A review of Resident #19's Order Note dated 7/19/26 at 9:49 PM documented Resident #19 becoming anxious and irritable after supper, requesting an increase in afternoon Seroquel. Resident #19's physician ordered a dose increase to 50 mg without documenting a diagnosis for use. Staff noted the order on 7/21/26. A review of Resident #19's Transfer/Discharge Report dated 7/21/26 at 7:41 PM documented Resident #19 experiencing a fall with possible left hip external rotation and increased pain. Resident #19 remained alert and oriented to self, prompting staff to transfer Resident #19 to the local emergency room. The report documented active orders for Seroquel 12.5 mg in the morning for monitoring (last administered at 7:12 AM), 50 mg in the afternoon for agitation and anxiety (last administered at 2:12 PM), and Seroquel 100 mg daily (last administered at 5:46 PM). A review of Resident #19's current medical diagnoses in the Electronic Health Record (EHR) on 8/5/26 didn't show documentation of psychiatric or mood disorders. The EHR documented a diagnosis of severe dementia with agitation upon admission on [DATE]. A review of Resident #19's Final Report written by Resident #19's physician dated 8/5/26 documented a diagnosis of psychosis (loss of contact with reality). The report documented Resident #19 doesn't experience hallucinations currently due to medication control. The report documented the medication provides benefit without evidence of excessive sedation or falls. The physician documented plans to continue monitoring and consider downward titration (gradual dose reduction). The report directed staff to continue monitoring for adverse effects, seek future opportunities for gradual dose reductions, and maintain non-pharmacological interventions. A review of Resident #19's diagnoses in the EHR on 8/6/26 documented an added diagnosis on 8/4/26 of unspecified psychosis not due to a substance or known physiological condition. On 8/6/26 at 10:43 AM Staff A, Activity Coordinator (AC), stated Resident #19 attends many activities. Staff A reported Resident #19 sometimes becomes upset, starts yelling, and occasionally struggles to understand prizes. Staff A stated Resident #19 experiences ornery days, prompting Staff A to reapproach and try again when an initial approach fails. Staff A reported Resident #19 claims residency in Florida and sometimes self-corrects. Staff A stated staff must remain in Resident #19's current reality. Staff A stated instructing Resident #19 to wait for assistance when wanting to leave causes anger, as does attempting gait belt placement for walking assistance. Staff A stated staff must predict when Resident #19 desires to leave and ensure staff assist Resident #19 first. Staff A reported Resident #19 adapted to staff and the facility, showing improvement since admission. On 8/6/26 at 10:49 AM Staff B, Certified Nursing Assistant/Certified Medication Aide (CNA/CMA), stated Resident #19 experiences confusion but functions fairly well. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff B reported never observing Resident #19 displaying anger or yelling. On 8/6/26 at 10:50 AM Staff C, Licensed Practical Nurse (LPN), and Staff D, Certified Nursing Assistant (CNA), stated Resident #19 remains directable and pleasant. Staff C and Staff D reported Resident #19 displays increased behavioral symptoms during evening shifts while acting pleasant and sweet during morning shifts. Staff C and Staff D stated loud noises agitate Resident #19. The Medication - Drug Regimen Review (DRR) policy dated 2022 instructed a licensed pharmacist to review each resident's drug regimen at least monthly. The policy directed the Medication Regimen Review (MRR) to include evaluating resident responses to medication therapy to determine maintenance of the highest practicable level of functioning while preventing or minimizing adverse consequences. The policy directed reporting findings and recommendations to the Director of Nursing (DON), attending physician, and Medical Director. The policy defined an irregularity as any event inconsistent with usual, proper, accepted, or right approaches to providing pharmaceutical services, or impeding or interfering with achieving intended outcomes. The policy defined psychotropic drugs as any drug affecting brain activities associated with mental processes and behavior, including antipsychotic, antidepressant, anti-anxiety, and hypnotic categories. The policy defined unnecessary drugs as any drugs used in excessive dose, for excessive duration, without adequate monitoring, without adequate indications for use, or in the presence of adverse consequences indicating required dose reduction or discontinuation.		

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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 record review, staff interviews, and policy review, the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 3 residents reviewed for catheters (Resident #6). The facility reported a census of 24 residents. Findings include: Resident #6's Minimum Data Set (MDS) assessment dated [DATE] documented an admission date of 5/2/24. The MDS revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented Resident #6 used a catheter (flexible tube used to drain urine from the bladder), maintained independence with toileting hygiene and toileting transfers, and frequently experienced involuntary leakage of urine. The MDS documented no active medical conditions related to the urinary system. A review of Resident #6's Treatment Administration Record (TAR) dated June and July 2026 showed a lack of documentation or physician orders related to catheter use. On 8/3/26 at 12:09 PM Resident #6 stated not having used a catheter since residing at the facility. On 8/4/26 at 11:28 AM Staff A, Minimum Data Set (MDS) Coordinator, stated Resident #6 doesn't currently maintain and hasn't maintained a catheter. Staff A stated incorrectly coding the July MDS assessment and plans to modify the assessment today to accurately reflect Resident #6's status. The Comprehensive Assessments policy dated 2022 directed staff to complete comprehensive assessments in line with criteria and timeframes in the Resident Assessment Instrument (RAI) User Manual. The policy instructed staff to complete an admission assessment for a new or returning resident by day 14. The policy instructed staff to complete an annual assessment every 366 days unless staff completed a Significant Change in Status Assessment (SCSA) or a Significant Correction to Prior Comprehensive Assessment (SCPA). The policy directed an SCSA occurs when the care team determines a resident experienced a major decline or improvement won't resolve independently, impacts multiple health areas, and requires care plan revision. The policy directed an SCPA occurs when the care team determines a prior assessment contains a significant error, meaning a resident's overall status is miscoded or results in an inappropriate care plan.		