STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165447	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlands Living Center L L C	2452 North Broadway Council Bluffs, IA 51503

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, family interview and staff interview, and policy review the facility failed to maintain medical records on each resident in accordance with accepted professional standards and practices that are complete and accurately documented for 6 of 19 residents (Residents #11, #1, #13, #5, #67 and #71) reviewed. The facility failed to completely fill out the Medication Administration Record (MAR) - Treatment Administration Record (TAR) - Medication Monitoring (Med Mon) for the residents. The facility failed to accurately reflect the timeframe of assessments by late documentation entry. The facility had a census of 66.Findings include:1. The Minimum Data Set (MDS) dated [DATE], showed that Resident #11 had a Brief Interview for Mental Status (BIMS) score of 7 (moderate cognitive deficit.) His diagnoses included coronary artery disease, renal insufficiency, urinary tract infection, diabetes mellitus and anxiety disorder. The Care Plan updated on 11/21/25, showed that Resident #11 had self-care performance deficit related to weakness. He required substantial assist for toileting, transfers and hygiene. A nursing note dated 9/16/25 at 4:34 PM, indicated that Resident #11 had low blood sugar readings and was sent to the Emergency Department (ED) for evaluation. The ED note dated 9/16/25 at 6:55 PM, indicated that the resident was stabilized and sent back to the nursing home. A nursing note dated 9/17/25 at 5:22 AM, showed that Resident #11 was found unresponsive at that time, and was sent back to the hospital. The Hospital Discharge Document, clinical summary dated 9/19/25 at 12:08PM, showed that Resident #11 presented to the ED on 9/17/25 at 5:43 AM. A nursing home Social Services note created on 9/19/25 at 2:58 PM, and back dated to 9/17/25 at 9:57 am, showed that the Patient Heath Qestionaire-9 (PHQ 9, screening used to measure severity of depression) was completed in the timeframe that the resident was at the hospital. A nursing home Social Determinants of Health Assessment was back-dated 9/17/25 at 9:59 AM, but created on 9/19/25 at 3:00 PM. On 1/8/25 at 6:50 AM, the Administrator said that these entries were created by the previous social services worker. 2. The Significant Change MDS for Resident #1, dated 05/23/2025, revealed a BIMS of 13, indicating (continued on next page)

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	intact cognition. The document provided the resident diagnoses of heart failure, hypertension, non-Alzheimer's dementia, and depression. It documented she took antianxiety medication, antidepressant medication, diuretic medication, Opioid pain medication, and antiplatelet medications. The resident's care plan, dated 11/25/2025, contained a focus area relating to duloxetine for a diagnosis of major depressive disorder and generalized anxiety disorder initiated on 06/14/2019 and revised on 09/30/2025. It included interventions for administering medication as ordered by the physician, monitor for potential side effects, monitor for sadness and other symptoms of depression, and document and report to physician/family as indicated. The Electronic Health Record (EHR) Clinical Physician Orders noted the following orders:Alprazolam .25mg 1 tablet by mouth daily for anxiety disorder initiated on 09/18/2025. Duloxetine 50mg 1 capsule by mouth every morning for major depressive disorder initiated on 07/13/2024. Antidepressant medication - observe for drowsiness, dizziness, nausea, dry mouth, headaches, blurred vision, confusion. Document: 'Y' if side effects are present and add a progress note to specify side effects observed. Document N if side effects are absent. Monitor for Anxiety, Nervousness, restlessness, picking, record the number of times the resident exhibited this behavior this shift, then record the corresponding non-pharm interventions every shift. Monitor for sadness, crying, self-isolation. Record the number of times the resident exhibited this behavior this shift, then, record the corresponding non-pharmalogical intervention(s): 1. Give fluids. 2. Offer food. 3. Redirect. 4. Offer activity. 5. Music. 6. Watch TV. 7. Return to room. 8. Toilet. 9. Specify E if intervention is effective. Document N if document if intervention is not effective. Every shift for routine monitoring. Review of the MAR-TAR-Med Mon for November 2025 documented the following deficits in the Medication Monitoring section:No Overnight documentation on 11/04/2025No documentation on any shift for 11/05/2025No Overnight documentation on 11/07/2025No Overnight documentation on 11/14/2025No Overnight documentation on 11/22/2025Review of the MAR-TAR-Med Mon for December 2025 documented the following deficits in the Medication Monitoring section:No Overnight documentation on 12/03/2025No Overnight documentation on 12/12/2025No Overnight documentation on 12/17/2025No Overnight documentation on 12/19/2025No Evening documentation on 12/20/2025No Evening documentation on 12/21/2025No Overnight documentation on 12/23/2025No Overnight documentation on 12/26/2025No Overnight documentation on 12/31/2025Review of the MAR-TAR-Med Mon for January 2026 documented the following deficits in the Medication Monitoring section:No Overnight documentation for 01/02/2026No Overnight documentation for 01/06/2026 3. The Annual MDS for Resident #13, dated 07/03/2025, revealed a BIMS of 15, indicating intact cognition. The document provided the resident diagnoses of coronary artery disease, hypertension, diabetes mellitus, hyperlipidemia, Non-Alzheimer's Dementia, and Depression. It documented he took antipsychotic medication, antidepressant medication, and antiplatelet medications. The resident's care plan, dated 01/05/2026, contained a focus area relating to venlafaxine for a diagnosis of major depressive disorder initiated on 08/01/2023 and revised on 09/30/2025. It included interventions for administering medication as ordered by the physician, monitor for potential side effects, monitor for sadness and other symptoms of depression, and document and report to physician/family as indicated. The Electronic Health Record (EHR) Clinical Physician Orders noted the following orders: Alprazolam .25mg 1 tablet by mouth daily for anxiety disorder initiated on 09/18/2025. Duloxetine 50mg 1 capsule by mouth every morning for major depressive disorder initiated on 07/13/2024. Antidepressant medication - observe for drowsiness, dizziness, nausea, dry mouth, headaches, blurred vision, confusion. Document: 'Y' if side effects are present and add a (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	progress note to specify side effects observed. Document N if side effects are absent. Monitor for Anxiety, Nervousness, restlessness, picking, record the number of times the resident exhibited this behavior this shift, then record the corresponding non-pharm interventions every shift. Monitor for sadness, crying, self-isolation. Record the number of times the resident exhibited this behavior this shift, then, record the corresponding non-pharmalogical intervention(s): 1. Give fluids. 2. Offer food. 3. Redirect. 4. Offer activity. 5. Music. 6. Watch TV. 7. Return to room. 8. Toilet. 9. Specify E if intervention is effective. Document N if document if intervention is not effective. Every shift for routine monitoring. Monitor for physical behaviors (kicking, hitting, biting, etc.), verbal behaviors, hallucinations (visual/auditory), delusions. Record the number of times the resident exhibited this behavior every shift. Record the corresponding non-pharmalogical interventions: 1. Give fluids. 2. Offer food. 3. Redirect. 4. Offer activity. 5. Music. 6. Watch TV. 7. Return to room. 8. Toilet. 9. Specify E if intervention is effective. Document N if document if intervention is not effective. Every shift for routine monitoring. Review of the MAR-TAR-Med Mon for November 2025 documented the following deficits in the Medication Monitoring section:No Overnight documentation on 11/04/2025No documentation on any shift for 11/05/2025No Overnight documentation on 11/07/2025No Overnight documentation on 11/14/2025No Overnight documentation on 11/22/2025 Review of the MAR-TAR-Med Mon for December 2025 documented the following deficits in the Medication Monitoring section:No Overnight documentation on 12/03/2025No Overnight documentation on 12/12/2025No Overnight documentation on 12/17/2025No Overnight documentation on 12/19/2025No Evening documentation on 12/20/2025No Evening documentation on 12/21/2025No Overnight documentation on 12/23/2025No Overnight documentation on 12/26/2025No Overnight documentation on 12/31/2025 Review of the MAR-TAR-Med Mon for January 2026 documented the following deficits in the Medication Monitoring section:No Overnight documentation for 01/02/2026No Overnight documentation for 01/06/2026 In an interview on 01/08/2026 at 09:41 AM with Staff B, RN, she confirmed nurses and those passing medication are responsible for documenting in the MAR-TAR-MedMon, and agreed that if it wasn't documented it wasn't done. She stated she is expected to finish her documentation before leaving her shift and believes the facility allows for late documentation up to 24hrs after their shift.In an interview on 01/08/2026 at 09:11 AM with Staff E, RN, she stated nurses are required to document medication monitoring in the MAR-TAR-MedMon. She stated every shift nurses or those passing medications are required to sign off on these sections and that the documentation is required as soon as possible, before you leave your shift. In an interview on 01/08/2026 at 08:56 AM with Staff J, LPN, he stated nurses are required to document in the MAR-TAR-MedMon, and the documentation is expected within 24hrs of their shift. He clarified it should be done before you leave your shift. 4. Resident #5's MDS dated [DATE] revealed a BIMS of 13/15 indicating normal cognition. The document provided the resident diagnoses of renal insufficiency, Parkinson's Disease, depression, adjustment disorder, unspecified and took medications that included antidepressants and anticoagulants. The resident's Care Plan dated 11/24/25 contained a focus area for Escitalopram related to (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	adjustment disorder initiated and revised on 2/4/25. Interventions for staff included administer mediation as ordered by physician, monitor and document side effects and effectiveness and an intervention identifying the adverse reactions of antidepressant therapy initiated and revised on 2/4/25. A focus area identified the resident took anticoagulant (blood thinner) medication related to atrial fibrillation initiated and revised 2/4/25. The interventions for the focus area include administration of medications as ordered and to monitor/document/report adverse reactions to anticoagulants. The Electronic Health Record (EHR) Clinical Physician Orders noted the following orders: Donepezil 5 mg 1 tab at bedtime for cognitive communication deficit with start stated 5/15/25. Escitalopram 10 mg for depression daily with a start date of 2/4/25. Eliquis 2.5 mg 1 tablet twice daily (BID) with a start date of 2/3/25. Escitalopram 10 mg 1 tablet daily for depression with a start date of 2/4/25. Omeprazole 40 mg, 1 capsule daily for gastro-esophageal reflux disease (GERD) with start date of 2/4/25. Antidepressant medication - observe for drowsiness, dizziness, nausea, dry mouth, headaches, blurred vision, confusion. Document: 'Y' if side effects are present and add a progress note to specify side effects observed. Document N if side effects are absent. Monitor for physical behaviors (kicking, hitting, biting, etc.), verbal behaviors, hallucinations (visual/auditory), delusions. Record the number of times the resident exhibited this behavior every shift. Record the corresponding non-pharmalogical interventions: 1. Give fluids. 2. Offer food. 3. Redirect. 4. Offer activity. 5. Music. 6. Watch TV. 7. Return to room. 8. Toilet. 9. Specify E if intervention is effective. Document N if document if intervention is not effective. Every shift for routine monitoring. Monitor for sadness, crying, self-isolation. Record the number of times the resident exhibited this behavior this shift, then, record the corresponding non-pharmalogical intervention(s): 1. Give fluids. 2. Offer food. 3. Redirect. 4. Offer activity. 5. Music. 6. Watch TV. 7. Return to room. 8. Toilet. 9. Specify E if intervention is effective. Document N if document if intervention is not effective. Every shift for routine monitoring. Observe for dry mouth, constipation, blurred vision, disorienting/confusion, difficulty urinating, hypotension, dark urine, yellow skin, nausea/vomiting, lethargy, drooling, tremors, disturbed gait, increased agitation, restlessness, involuntary movement of mouth/tongue. Document: 'Y' if side effects are present and add a progress note to specify side effects observed. Document N if side effects are absent. The Clinical Physician Orders and Care Plan failed to identify resident specific behaviors related to the use of antidepressant. Review of the MAR-TAR-Med Mon for 12/25 found the following deficits: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Missing data 12/14, 12/15 Omeprazole Capsule 40 mg Missing data 12/2 night, 12/8 night, 12/9 night, 12/13 night, 12/14 night, 12/17 evening, 12/22 night, 12/23 evening and night, 12/27 night for antidepressant medication side effects. Missing data 12/2 night, 12/8 night, 12/9 night, 12/13 night, 12/14 night, 12/17 evening, 12/22 night, 12/23 evening and night, 12/27 night for monitoring of physical behaviors and non-pharmalogical interventions. Missing data 12/2 night, 12/8 night, 12/9 night, 12/13 night, 12/14 night, 12/17 evening, 12/22 night, 12/23 evening and night, 12/27 night for sadness, self isolation and crying and non-pharmalogical interventions. Missing data 12/2 night, 12/8 night, 12/9 night, 12/13 night, 12/14 night, 12/17 evening, 12/22 night, 12/23 evening and night, 12/27 night for side effects for non-identified medication. Review of the MAR-TAR-Med Mon for 1/26 found the following deficits: Missing data 1/2 Evening night 1/5 for antidepressant medication side effects. Missing data 1/2 evening, 1/5 night for monitoring of physical behaviors with non-pharmalogical interventions. Missing data 1/2 evening, 1/5 night for antidepressant behaviors with non-pharmalogical interventions. Missing data 1/2 evening and 1/5 night for side effects of non-identified medication. 5. Resident #67's Quarterly MDS dated [DATE] revealed a BIMS of 4/15 indicating severe cognitive impairment. The document provided the resident diagnoses of Non-Alzheimer's Dementia, anxiety, depression and took antipsychotics, antianxiety and antidepressant. The resident's Care Plan dated 12/14/25 contained a focus area for potential for yelling and combative behaviors related to dementia initiated and revised 11/19/25 with staff interventions of clear explanation of activities and consistency of care dated 11/19/25. The identified focus area of Risperdal and Aripiprazole related to dementia initiated and revised on 11/7/25 contained staff interventions of administration of psychotropic medications as ordered by hospice and monitor/document/report adverse reactions related to the medications dated 11/7/25. A focus area identified as needed (PRN) Lorazepam for dementia/restlessness/agitation initiated and revised 11/7/25 included interventions of administration of medication as ordered by hospice and to monitor for side effects and effectiveness every shift dated 11/7/25. A focus area for Venlafaxine related to diagnosis of depression initiated and revised on 11/7/25 included staff interventions of administration of medication as ordered with monitoring/documenting side effects and effectiveness every shift initiated 11/7/25. The EHR Clinical Physician Orders noted the following orders: Lorazepam Concentrate 2 mg/ml give .25 ml by mouth at night for anxiety/restlessness with start date 11/11/25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Aripiprazole 2 mg 1/2 tab daily for unspecified dementia with start date 11/6/25. Risperidone .25 mg 1 tab at bedtime for unspecified dementia with a start 11/7/25. Venlafaxine capsule 37.5 ER 1 capsule daily for unspecified depression with a start date 11/6/25. Antidepressant medication - observe for drowsiness, dizziness, nausea, dry mouth, headaches, blurred vision, confusion. Document: 'Y' if side effects are present and add a progress note to specify side effects observed. Document N if side effects are absent every shift with a start date of 11/6/25. Monitor for physical behaviors (kicking, hitting, biting, etc.), verbal behaviors, hallucinations (visual/auditory), delusions. Record the number of times the resident exhibited this behavior every shift. Record the corresponding non-pharmalogical interventions: 1. Give fluids. 2. Offer food. 3. Redirect. 4. Offer activity. 5. Music. 6. Watch TV. 7. Return to room. 8. Toilet. 9. Specify E if intervention is effective. Document N if document if intervention is not effective. Every shift for routine monitoring with a start date 11/6/25. Monitor for sadness, crying, self-isolation. Record the number of times the resident exhibited this behavior this shift, then, record the corresponding non-pharmalogical intervention(s): 1. Give fluids. 2. Offer food. 3. Redirect. 4. Offer activity. 5. Music. 6. Watch TV. 7. Return to room. 8. Toilet. 9. Specify E if intervention is effective. Document N if document if intervention is not effective. Every shift for routine monitoring with a start date of 11/6/25. Observe for dry mouth, constipation, blurred vision, disorienting/confusion, difficulty urinating, hypotension, dark urine, yellow skin, nausea/vomiting, lethargy, drooling, tremors, disturbed gait, increased agitation, restlessness, involuntary movement of mouth/tongue. Document: 'Y' if side effects are present and add a progress note to specify side effects observed. Document N if side effects are absent with a start date of 11/6/25. Check preventative dressing to the sacral area. If dressing is missing or soiled, change PRN. Every shift with a start date 1/5/26. Apply adhesive foam dressing to the sacral area for prevention every day shift every Tues,, Fri., Sun with start date 1/6/26. The Clinical Physician Orders and Care Plan failed to identify resident specific behaviors related to the use of antipsychotic, antidepressant and antianxiety medications. Review of the MAR-TAR-Med Mon for 12/25 found the following deficits: Missing data 12/8 night, 12/13 night, 12/14 night, 12/17 evening, 12/22 night, 12/23 evening and night, 12/27 night for anti depressant medication side effects Missing data 12/8 night, 12/13 night, 12/14 night, 12/17 evening, 12/22 night, 12/23 evening and night, 12/27 night for monitoring of physical behaviors and non-pharmalogical interventions. Missing data 12/8 night, 12/13 night, 12/14 night, 12/17 evening, 12/22 night, 12/23 evening and night, 12/27 night for sadness, crying, self isolation and non-pharmalogical interventions. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Missing data 12/8 night, 12/13 night, 12/14 night, 12/17 evening, 12/22 night, 12/23 evening and night, 12/27 night for an unidentified medication. Missing data 12/13 night, 12/14 night for bilateral buttocks: gently cleanse with soap/water. Pat dry. Apply Calmoseptine to the areas every shift until healed Start date 12/25 and d/c date 1/5/26. Review of the MAR-TAR-Med Mon for 1/26 found the following deficits: Missing documentation 1/2 evening, 1/5 night for antidepressant side effects. Missing documentation 1/2 evening, 1/5 night for physical behaviors. Missing documentation 1/2 evening, 1/5 night for depressive behaviors. Missing documentation 1/2 evening, 1/5 night for side effects of an unidentified medication. Missing documentation 1/5 night for check preventative dressing to sacral area. Missing documentation 1/6 for applying adhesive foam dressing to the sacral area. 6. Resident #71's MDS dated [DATE] revealed a BIMS of 9/15 indicating moderate cognitive deficit. The document provided the resident had diagnoses of stroke, atrial fibrillation, hypertension, renal insufficiency, Non-Alzheimer's Dementia, hemiplegia/hemiparesis, anxiety and the resident took medications including antidepressant, anticoagulant, diuretic and antiplatelet. The resident's Care Plan dated 9/15/25 contained a focus of diagnosis of vascular dementia with agitation and takes antidepressant medication initiated 1/14/25 with staff interventions of administration of medication as ordered with monitoring of changes in mood/behavior or suicidal thoughts, verbalizing depression or sadness initiated 1/14/25 and monitoring for monitor for sadness, tearfulness, withdrawl from activities, change in appetite/weight loss or gain, change in sleep patterns or verbalization's of depression. Document and report to physician/family as indicated initiated 1/14/25. The EHR Clinical Physician Orders noted the following orders: Levothyroxine tab 75 mcg 1/2 tablet before breakfast for hypothyroidism start date 12/20/24 and end date 12/22/25. Omeprazole 40 mg 1 capsule daily for GERD with a start date 12/20/24 and end date 12/22/25. Antidepressant medication - observe for drowsiness, dizziness, nausea, dry mouth, headaches, blurred vision, confusion. Document: 'Y' if side effects are present and add a progress note to specify side effects observed. Document N if side effects are absent every shift for monitoring with end date 12/22/25. Monitor for sadness, crying, self-isolation. Record the number of times the resident exhibited this behavior this shift, then, record the corresponding non-pharmalogical intervention(s): 1. Give fluids. 2. Offer food. 3. Redirect. 4. Offer activity. 5. Music. 6. Watch TV. 7. Return to room. 8. Toilet. 9. Specify E if intervention is effective. Document N if document if intervention is not effective. Every shift for (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	routine monitoring with an end date of 12/22/25. Weekly weights in the morning every Friday start date 3/21/25 and end date 12/22/25. Review of the MAR-TAR-Med Mon for 12/25 found the following deficits: Missing data 12/2 night, 12/3 day, 12/8 night, 12/13 evening and night, 12/14 evening and night, 12/15 day for antidepressant medication side effects. Missing data 12/2 night, 12/3 day, 12/8 night, 12/13 evening and night, 12/14 evening and night, 12/15 day for monitoring depressive behaviors. Missing data 12/19 for weekly weight. The facility failed to identify individualized behaviors related to depression. On 1/6/26 at 3:44 PM Staff G, Registered Nurse (RN), stated she completed documentation at the end of her shift for behaviors or side effects. The staff stated the EHR will show green when tasks/medications were completed or if incomplete at the end of shift will be a different color. The staff stated she had to go through items to ensure completion. On 1/7/26 at 9:08 AM Staff H, RN, stated the completion of the MAR-TAR-Med Mon could be completed at any time during the shift with regards to behavior and side effect documentation. Staff H stated if completed earlier in shift and then behavior occurred would do an exception and correct the documentation. The staff stated each shift was responsible for their documentation. The staff stated when documentation completed would turn green and at the end of the shift anything not green would indicate incomplete. On 1/7/26 at 9:26 AM Staff I, Licensed Practical Nurse (LPN), stated she completed side effects and behavior charting on MAR-TAR-Med Mon throughout the shift. Staff I stated if a behavior was noted, she would go back and correct documentation if necessary and would document behavior in the chart. The staff stated she did not believe she had ever forgotten to chart behaviors or side effects. Staff I stated she goes back at the end of her shift to ensure all documentation is completed by noting the color green to ensure completed. On 1/7/26 at 9:38 AM the Director of Nursing (DON) stated if documentation was not completed it would show on the dashboard for the nurses and managers. The DON expected documentation to be completed prior to the end of each staff's shift. When provided with review of the MAR-TAR-Med Mon for 12/25 for Resident's #5 and #67, the DON acknowledged the documentation was incomplete. The DON stated if a shift was split between a Certified Medication Aide (CMA) and nurse, the expectation would still be at the end of the shift (day, evening, overnight) the staff would ensure all documentation was completed prior to leaving. On 1/7/25 at 11:20 AM the Administrator stated it was his expectation that all documentation be completed in its entirety prior to the end of the shift and staff leaving. With the request of a policy related to following physician orders/documentation, the Administrator provided in written email that the facility did not have a documentation policy. The expectation was that staff were to complete charting during their assigned shift or prior to leaving for the day.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on direct observation, clinical record review, staff interview, and facility policy review, the facility failed to administer medication as prescribed and ordered by a physician when they allowed residents without an order to self-administer medication to do so (Resident #28, #34, #61). The facility reported a census of 66 residents. Findings include: 1. The quarterly Minimum Data Set (MDS) for Resident #28, dated 10/31/2025, documented the following relevant diagnoses: heart failure, hypertension (high blood pressure), renal insufficiency (kidney failure), Non-Alzheimer's Dementia, and anxiety. It documented she took antianxiety medication as well as diuretic medication (water pills). The Care Plan for Resident #28, last revised 01/06/2026, documented she had an activities of daily living self-care performance deficit due to her diagnosis of Non-Alzheimer's dementia. It required staff to administer medication as ordered. In a direct observation of the 100 dining hall on 01/05/2026 starting at 12:11 PM, Staff E, Registered Nurse, placed noon medication in front of Resident #28 and without ensuring the resident had taken the medication moved to another resident and placed medication in front of them as well, then left the dining hall to prepare more medication. The dining hall was observed until 12:25 PM at which time the resident had taken the medication on their own without staff observation or assistance. A review of Resident #28's order summary report lacked documentation the resident had an order to self administer medication. 2. The quarterly MDS for Resident #34, dated 12/04/2025, documented the following relevant diagnoses: heart failure, hypertension, diabetes mellitus, and depression. It documented the resident took anticoagulation medication, antidepressant medication, and diuretic medication. The Care Plan for Resident #34, last revised 12/29/2025, documented the resident had an activities of daily living self-care performance deficit related to impaired safety awareness. It orders staff members to administer medications as ordered by a physician. In a direct observation of the 100 dining hall on 01/05/2026 starting at 12:11 PM, Staff E, Registered Nurse, placed noon medication in front of Resident #34 and without ensuring the resident had taken the medication moved to another resident and placed medication in front of them as well, then left the dining hall to prepare more medication. The dining hall was observed until 12:25 PM at which time the resident had taken the medication on their own without staff observation or assistance. 3. The annual MDS for Resident #61, dated 10/30/2025, documented the following relevant diagnoses: atrial fibrillation or other dysrhythmias, hypertension, and mild cognitive impairment of uncertain or unknown etiology. It documented the resident took diuretic medication, opioid pain medication, and anticonvulsant medication.The Care Plan for Resident #61, last revised 11/19/2025, documented the resident had an activities of daily living self-care performance deficit related to impaired safety awareness. It orders staff members to administer medications as ordered by a physician. In a direct observation of the 100 dining hall on 01/05/2026 starting at 12:11 PM, Staff E, Registered Nurse, placed noon medication in front of Resident #34 and without ensuring the resident had taken the medication moved to another resident and placed medication in front of them as well, then left the dining hall to prepare more medication. The dining hall was observed until 12:25 PM at which time the resident had taken the medication on their own without staff observation or assistance. In an interview on 01/08/2026 at 08:56 AM with Staff J, Licensed Practical Nurse (LPN), he stated it was never acceptable for a resident to take their medication when he wasn't watching or after he had left the room, and noted it was a choking hazard for residents with cognitive impairment. He stated the proper procedure is for him to assist a resident in taking their medications and observe the resident to ensure the medication was successfully taken before leaving the resident. He stated a resident can take medication independently if they have an order to self-administer medication and noted several of his residents did have those orders, but it was rare for the facility. In an interview on 01/08/2026 at 09:11 AM with Staff E, Registered Nurse (RN), she acknowledged she left the medication next to the residents and then walked away. She stated she often places medication with the residents and then comes back at a later time to assess if the residents took their medication. (continued on next page)

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	165447	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlands Living Center L L C	2452 North Broadway Council Bluffs, IA 51503

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She admitted she has never seen orders for the self-administration of medication for the residents in question but notes the facility does use them. In an interview on 01/08/2026 at 09:41 AM with Staff B, RN, she stated she never leaves medications alone with residents unless the resident has an order to self-administer medication. She was able to name several residents with orders to self-administer medication but noted it was something rarely done in the facility. She stated it is never acceptable to give a resident their medication and walk away without an order to self-medicate. In an interview on 01/07/2026 at 09:29 AM with the Administrator, he acknowledged that facility camera footage confirmed the direct observation of the surveyor. In an interview on 01/06/2026 at 02:40 PM with the Director of Nursing (DON), she stated the residents did not have an order to self-administer their medication. She stated her expectation is without an order to self-administer medication the nurse should not place the medication near a resident, walk away, and allow them to self-administer their medication. When asked for a policy governing medication administration the facility reported they did not have a policy, but follow nursing standards. Review of nursing standards requires a formalized and documented assessment before a resident can self-administer medication.

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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, hospital record review, resident interview and staff interview, the facility failed to obtain physicians orders for specific resident care and treatments for 1 of 17 residents reviewed. Resident #69 was admitted to the facility after heart surgery and was found to have significant edema (swelling) of his ankles and feet. Without obtaining a doctor's order, staff applied edema wear, compression hose, on bilateral lower extremities. The facility reported a census of 66 residents. Findings include:The Minimum Data Set (MDS) dated [DATE] did not include a Brief Interview for Mental Status (BIMS) score. The MDS documented an admission date of 11/7/25. Assistance required supervision, touch assistance with toileting hygiene dressing, sit to stand and transfers. Active diagnoses included: peripheral vascular disease, or peripheral arterial disease, diabetes mellitus.The Care Plan initiated on 11/7/25, showed that Resident #69 had self-care performances deficits and required one person assistance with transfers. He was admitted to the nursing home for short term stay, staff were to obtain doctors orders for medication, discharge instructions, home health services and prescription as needed. He was at risk for skin breakdown related to impaired mobility and diabetes neuropathy (nerve damage).The referring hospital report dated 10/12/25, showed that Resident #69 was hospitalized with a NSTEMI (non-ST-segment elevation myocardial infarction, heart attach) He underwent surgical re-vascularization included coronary artery bypass grafting x 4.A facility skin assessment dated [DATE] showed that the resident did not have any skin issues identified on toes.The following was found in the Nursing Progress Notes:a. On 11/7/25 at 3:16 PM, Resident #69 was utilizing compression stockings/bandagesb. On 11/11/25 at 11:00 AM, the resident was wearing TED hose (Thrombo-Embolic Deterrent Hose, designed to prevent blood clots and help blood circulation.) c. On 11/11/25 at 11:06 PM the pedal pulse was weak and the resident had a pain level of 8 out of 10. d. On 11/11/25 at 8:12 PM, the toes were purple, pedal pulses weak, 3+ edema (moderate, deep pitting) discoloration on toes. The Nurse Practitioner (NP) ordered to perform every 2-hour checks overnight, elevate legs and no TED hose.e. On 11/12/25 at 2:05 AM, the resident stated his legs felt so much better since the TED hose were removed. The clinical record for Resident #69 lacked a physician's order for edema wear, TED Hose.On 1/7/25 at 8:00 AM, Resident #69 said that after his hospitalization on 11/12/25 he returned home. He said that while at the nursing home, his right leg had a blockage, because they put on compression socks on for a day. He said that in the hospital, he had a stint (small tube placed in a narrowed or blocked artery to keep it open) placed in his ankle and knee to help with blood flow. Resident #69 said that when he was the hospital before being admitted to the nursing home, they hadn't used the TED hose. On 1/7/25 at 9:39 AM the DON said that nursing must have an order before using compression hose.On 1/7/25 at 12:47 PM, Staff F, Licensed Practical Nurse (LPN) said the she had completed the paperwork and admission assessment for Resident #69. Upon admission, his toes were normal color and he had came in with some type of compression hose. Staff F said that she had not applied the hose because there wasn't an order. She said that she talked to another nurse who was going to reach out to cardiology to see if they wanted edema wear applied, but she didn't know if there was follow through. Staff F said that the night she saw that his toes were purple, he wasn't wearing the compression socks, someone had already taken them off. She said that talked to the Nurse Practitioner (NP) and was directed to not apply TED hose related to his Peripheral Artery Disease (PAD).The Point of Care History; Shower/Bath report for Resident #69 showed that he had one shower during his stay, and that was on 11/9/25 at 1:34 PM.On 1/7/26 at 2:21 PM, Staff E, Registered Nurse (RN) said she remembered Resident #69 and that he had a lot of swelling in his feet and had come in with a stretchy thing, type of stocking, that would bunch-up, down around his ankles. She that she and a CNA took the hose off on the day that he had a shower, and two of his toes were discolored on the top. She did not contact the doctor about this at the time because it was the weekend. She said that she put them back on (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after the shower.On 1/7/25 at 3:45 PM, Staff A, CNA said she remembered having given Resident #69 a shower, specifically because his feet were very swollen. Staff A said that he came in with the light weight netted hose. When shown different pictures of the types of stockings, she identified anti-embolism hose (knee high stockings used post-surgery). She said that she told the nurse, Staff E, about the swollen feet, so the nurse came in and looked at them. Staff E then went and got some TED hose and applied those. When shown a picture, staff A identified them as edema wear compression stockings.On 1/7/26 at 3:49 PM, the nurse for the cardiologist returned a call and relayed a message that he did not have a preference on whether or not this resident with PAD should have been wearing TED hose. His vascular team may have another opinion but as far as cardiac he had no concerns. On 1/8/25 at 8:33 AM, the ADON acknowledged that with a diagnosis of PAD, TED hose may be contraindicated and the nurses were expected to call and get an order before applying them.On 1/8/25 at 6:50 AM, the Administrator said they did not have a policy on caring for residents with edema, or one on obtaining physicians orders.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview, staff interview and facility assessment review, the facility failed to provide a consistent restorative program to ensure residents maintained the highest practical physical well-being for 1 of 2 residents reviewed. Resident #21 was participating in the restorative nursing program. In a six-week timeframe the resident was provided the exercises on 4 occasions with just one documented refusal. The facility reported a census of 66 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #21 had a Brief Interview for Mental Status (BIMS) score of 14 (intact cognitive ability). The resident was totally dependent on staff for toileting hygiene, chair to bed transfers. Her diagnoses included heart failure, renal insufficiency, diabetes mellitus, parkinsonism, low back pain and neuralgia.The Care Plan last updated on 8/9/25 showed that Resident #21 had a restorative nursing program to maintain strength and mobility for functional activities. The activities included 3 sets of exercises to be offered 2-5 times a week. Staff were to encourage participation in the RNA plan of care and to report multiple refusals to the nurse.A Restorative Program Note dated 12/30/25 at 1:04 PM, showed that through time period of 11/30/25 - 12/30/25, the resident's motivation and engagement in the program was fair. She needed encouragement, her level of participation was fair, and tolerance inconsistent. Recommended continued participation in the restorative program, and one of her challenges was that she was fearful of falling.On 1/6/26 at 7:27 AM, Staff C, Certified Nurse Aide (CNA) was getting Resident #21 cleaned and dressed for the day. Registered Nurse (RN) Staff B came in to assist with moving the resident in bed the resident displayed weakness. Staff B then helped transfer Resident #21 with the full body mechanical lift (Hoyer) and said that most residents could be transferred in the Hoyer, with just one staff but they used two with Resident #21 so one could pull back on the sling back as she was lowered into the chair.Restorative Progress Notes included the following information:From November 2-8; Resident #21 had one day of exercises, and 3 days documented as No Restorative (NR). [DATE]-15; No exercise days and 4 days NR. [DATE] - 22; 2 days with detailed exercises and 3 days NR. [DATE]-29; no exercise days, and 3 days marked NR.[DATE]-[DATE]; 1 day of exercise, 1 day refused and 3 days documented as NR.[DATE]-13; no exercise days, 2 days marked as NR.On 1/7/25 at 9:04 AM, Staff D, Restorative Aide, explained that when it was documented no restorative that meant that she and the other restorative aide were not on duty so that was why the resident did not get the exercises that day. Staff D said that she documented on the Restorative Progress Note, when a resident refused. 1/7 at 11:35 AM, Staff D said that it was a challenge to provide the standing exercises with Resident #21 because she required a second person to assist.On 1/7/26 at 1:41 PM, Resident #21 said that she didn't go down to the exercise room because her insurance won't pay for it and that she was not offered exercises in her room. She said she would participate if there weren't any added costs involved.On 1/7/26 at 1:52 PM, The Assistant Director of Nursing (ADON) said that there just weren't enough hours in the day or enough staff to have consistent restorative activities. She said that Resident #21 will participate in the program on and off and sometimes when staff go in to offer, the resident may be sleeping.On 1/6/25 at 6:50 AM, the Administrator said they did not have a policy on Restorative Services.The Facility Assessment, dated 3/11/25, indicated that the purpose of the assessment was to determine resources necessary to care for residents competently during daily operations and emergencies. The assessment would be used to decide about direct care staff needs and capabilities to provide services to facility residents using a competency to maintain or attain their highest practicable physical, mental and psychosocial well-being.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and policy review the facility failed to ensure residents were free of significant medication errors to 1 of 8 residents reviewed (Resident #18). The facility reported a census of 66 residents. Findings include:Resident #18's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14/15 indicating normal cognition. The document disclosed the resident's diagnoses of heart failure, spinal stenosis (lower back), and primary arthritis to the right shoulder with no oral medications identified for pain. The MDS documented the resident has occasional pain in the last 5 days. The resident's Care Plan dated 1/6/26 contained a focus area of risk for altered comfort related to spinal stenosis, arthritis and lower extremity pain initiated on 6/11/24 and revised 12/23/25 with a staff intervention to administer pain medication as ordered initiated and revised on 6/11/25.The Electronic Health Record (EHR) contained a physician's order dated 11/3/25 for Voltaren gel 1% (Diclofenac 1%), 2 grams (gm) three times daily (TID) to the right shoulder related to arthritis. The Medication Administration Record - Treatment Administration Record - Medication Monitoring (MAR-TAR-Med Mon) 1/26 contained the following orders:Clotrimazole Cream 1% topically to left foot twice daily with a start date 1/2/26.Diclofenac Gel 1% apply 2 gm topically to the right shoulder three times daily (TID) start date 11/3/25.Observed on 1/6/26 at 6:48 AM Staff E, Registered Nurse (RN), take the Voltaren 1% and Clotrimazole from the medication cart and take the medications to Resident #18's room. The staff completed hand hygiene upon entry into the room, donned gloves and administered the Clotrimazole. Following hand hygiene and application of new gloves, Staff E opened the Diclofenac 1%, squeezed an undetermined amount onto her hand and applied it to the resident's right shoulder. Staff E failed to measure 2 gm of Diclofenac 1% prior to application. On 1/6/26 at 3:44 PM Staff G, Registered Nurse (RN), stated for the provision of Diclofenac 1% gel staff utilized a measuring stick to measure out the prescribed dose, place it in a medication cup and take it to the resident for application. On 1/7/26 at 9:08 AM Staff H, RN, stated for the provision of Diclofenac 1% gel staff use a measuring applicator, measure out the prescribed dose and apply it to the resident.On 1/7/26 at 9:26 AM Staff I, Licensed Practical Nurse (LPN), stated application of Diclofenac 1% gel was completed by using the measuring stick for the medication, dispense the prescribed amount using the stick, placing it in the medication cup and applying it to the resident. On 1/7/26 at 9:30 AM the Director of Nursing, DON, stated Diclofenac 1% gel came with a measuring stick to dispense the prescribed amount. The staff stated the medication was prescribed in grams or inches. The DON stated staff should utilize the measuring stick that came with the medication for dispensing.On 1/7/26 at 11:25 AM the Administrator stated it was his expectation that medication be administered according to the physician orders. When requested for a medication administration policy, the Administrator's response via email was that the facility followed at a minimum the 7 Rights of Medication Administration - right patient, drug, dose, route, time, reason and documentation.