STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165449	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spencer Post Acute Rehabilitation Center	711 West 11th Street Spencer, IA 51301

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. Based on resident and staff interviews, and policy review, the facility failed to have ready and reasonable access to personal funds upon request for 1 of 17 residents reviewed (Resident #10). The facility reported a census of 67. Findings Include:In an interview on 8/11/2025 12:55 PM, Resident #10 reported that if she wanted personal funds during the weekend, she had to plan to get money from the office on Friday.In an interview on 8/12/2025 at 9:25 AM, Resident #10 reported she could not remember when or which staff she asked for personal funds. Resident #10 stated, when I asked they told me that I had to wait for the office manager to be here.In an interview on 8/14/2025 at 8:38 AM, Staff C, Certified Medication Assistant/Certified Nurse Assistant (CMA/CNA) reported if a resident requested personal funds she would go to the Business Officer Manager (BOM). When asked what she would do during non-business hours, Staff C stated, I would probably try to call the head of Human Resources. When asked if a locked cash box or any other way to get funds for a resident during non-business hours, Staff C stated, no. In an interview on 8/14/2025 at 8:58 AM, Staff D, Licensed Practical Nurse, (LPN) reported if a resident requested funds after hours they would have to call whoever was on call. Staff D reported having no access to available funds for residents. Staff D reported she worked at the facility for five years and never knew there to be funds readily available. In an interview on 8/14/2025 at 9:02 AM, the Business Office Manager, BOM reported she would be on call if residents needed funds. When asked if the facility provided readily available funds for residents, the BOM reported approximately a year ago the facility had a lock box but the process needed to be updated. When informed staff interviews failed to show knowledge of a lock box, the BOM replied, the process needs to be updated. In an interview on 8/14/2025 at 9:02 AM, the Director of Nursing (DON) reported no knowledge of personal funds on site for residents. When told the BOM reported having a locked box about approximately one year ago the DON replied, I'll look into it. When asked if the facility should have funds readily available for residents upon request, the DON stated, of course, for dinner with family, or whatever they want.In an interview on 8/14/2025 at 10:56 PM, the Administrator reported the facility failed to have a policy related to personal funds. In an interview on 8/14/2025 at 1:56 PM, BOM showed an envelope with cash and reported funds now available for residents. The BOM explained the facility would work on a plan for the location and staff access to funds.

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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(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 clinical record review and staff interview the facility failed to identify non-pharmacological interventions and targeted behaviors on the care plan related to high risk medications in 2 out of 5 sampled residents reviewed (Resident #4 and #21). The facility reported a census of 67 residents.Findings include: 1.The Minimum Data Set (MDS) assessment dated [DATE] for Resident #4 documented diagnoses of stroke, aphasia, and anxiety. The MDS showed the Brief Interview for Mental Status (BIMS) score of 5, which indicated severe cognitive impairment. The Clinical Physician Orders for Resident #4 showed the following orders: Seroquel Oral Tablet 25 milligram (MG) at bedtime with a start date of 4/3/25 Olanzapine Oral Tablet 10 mg daily with a start date of 7/3/25 Oxycodone Oral Tablet 5 MG every eight hours as needed for pain with a start date of 2/11/25. The Care Plan identified Resident #4: Prescribed antipsychotic medication related to anxiety and depression. The Care Plan lacked targeted behaviors to monitor. Prescribed psychotropic medication related to anxiety and depression. The Care Plan lacked targeted behaviors to monitor. Prescribed opioid for chronic pain. The Care Plan lacked non-pharmacological interventions to use prior to opioid medication usage. In an interview on 8/13/2025 at 1:52 PM, the Director of Nursing, (DON) reported the care plan should include non-pharmacological interventions to use prior to opioid medication usage and targeted behaviors to monitor for with the usage antipsychotic and psychotropic medications. The Unnecessary Drugs policy last revised 11/12/15 identified: POLICY: It is the policy of this facility that each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:In excessive dose (including duplicate therapy); orFor excessive duration; orWithout adequate monitoring; orWithout adequate indications for its use; [NAME] the presence of adverse consequences which indicate the dose should be reduces or discontinued; orAny combinations of the reasons above. PURPOSE: The purpose of this requirement is that, each resident’s entire drug/medication regimen be managed and monitored to promote or maintain the resident’s highest practicable mental, psychical, and psychosocial well-being. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PROCEDURES: Resident receives only those medications, in doses and for the duration clinically indicated to treat the resident’s assessed condition(s). Non-pharmacological interventions are considered and used when indicated, instead of, or in addition to, medicationBehavioral interventionsExercisePrevention of constipationPain managementSleep hygieneIndividualized toileting scheduleAddressing food preferences The potential contribution of the medication regimen to an unanticipated decline or newly emerging or worsening symptom is recognized and evaluated, and the regimen is modified when appropriate. Incorporate appropriate medication related goals and parameters for monitoring the resident’s condition into the comprehensive care plan. 2) According to the MDS assessment dated [DATE] Resident #21 scored 3 on the BIMS indicating severe cognitive impairment. The resident's diagnoses included senile degeneration of the brain. The MDS did not indicate the resident took antidepressant medication. The Care Plan revised 1/2/25 identified the resident on antidepressant medication use related to insomnia. The interventions included giving antidepressant medications ordered by the physician. Monitor/document side effects and effectiveness. The August 2025 Medication Administration Record (MAR) showed the resident received Trazadone 50 MG bedtime daily for Insomnia initiated 10/1/24. The clinical record lacked documentation of a Gradual Dose Reduction (GDR) of the Trazadone. On 8/13/25 at 12:05 p.m. the Pharmacy Consultant confirmed the resident should have had a GDR. She stated she sent out a letter for a GDR in May, and again in June. She said she wondered if the Dr. addressed it in a Progress Note in June. She had the Director of Nursing (DON) looking for it. On 8/13/25 at 3:38 p.m. the DON stated they had not found any completed GDR's for the resident's Trazadone. On 8/14/25 at 12:51 p.m. a sister facility's DON showed the facility policy for psychotropic meds, that did not specifically address GDR's. He said he did not find one that did.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and facility policy, the facility failed to ensure bed hold notice was signed by residents and or the resident's responsible person when residents transferred out of the facility for 4 of 4 residents reviewed (Residents #2, #4, #5 and #9). The facility reported a census of 67 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #4 documented reentry to the facility on 2/20/25 for a short term hospital stay. Review of the Clinical Census report for Resident #4 revealed the following information:a. 11/25/24- hospital leaveb. 12/3/24- activec. 2/9/25- hospital d. 2/11/25- active Review of the Progress Notes for Resident #4 revealed the following:a. 12/12/24 at 2:55 PM, Resident admitted to the hospital on [DATE] for a fracture. b. 2/9/25 at 1:30 PM, Resident admitted to the hospital for emesis and repeated hospitalizations. Review of Resident #4’s chart on 8/13/25 at 9:19 AM showed the facility lacked a bed hold form for 11/25/24 and 2/9/25. In an interview on 8/13/25 at 1:52 PM, the Director of Nursing (DON) reported she would look for bed hold forms for 11/25/24 and 2/9/25. The DON reported that she expected staff to complete bed hold forms prior to residents leaving the building. No bed hold forms submitted. 2) According to the MDS assessment dated [DATE] Resident #2 scored 3 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident's diagnoses included a stroke and aphasia (a language disorder affecting the ability to communicate). The Progress Notes dated 6/24/25 at 7:09 a.m. documented the resident had Urinary Tract Infection (UTI) symptoms. At 11:26 a.m. a phone call from the clinic reported the Urinalysis (UA) was positive for infection. The white blood count at 19.8 (elevated). Sent to the emergency room (ER) for further evaluation, with possible admission, would call back later. At 1:18 p.m. called the ER for an update on the resident. The ER nurse stated the resident would admit to the hospital for a UTI. The resident's clinical record lacked documentation the facility notified the resident/representative of the bed hold policy. On 8/13/25 at 5:20 p.m. the DON stated the bed hold would be scanned in to the Miscellaneous tab if they had one. The Miscellaneous tab revealed no file indicating a bed hold. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The MDS assessment dated [DATE] for Resident #5 documented diagnoses of hypertension, depression and acute respiratory failure with hypoxia. The MDS showed the BIMS score of 10, indicating moderate cognitive impairment. Review of Resident #5’s Census tab revealed the following information: 3/14/25- stop billing 4/3/25- active Review of Progress Notes revealed the following: On 3/14/25 at 2:50 p.m., verbal order received to send resident to the emergency room (ER) for evaluation. On 3/14/25 at 5:41 p.m., resident admitted to the local hospital. On 4/3/25 at 4:11 p.m., resident returned to facility via transport from hospital. Review of the medical chart lacked a bed hold for resident during hospitalization. Interview on 8/13/25 at 10:30 a.m., with the Assistant Director of Nursing (ADON) revealed there was no bed hold completed for Resident #5 during hospitalization on 3/14/25. 4. The MDS assessment dated [DATE] for Resident #9 documented diagnoses of anemia, cancer and malnutrition. The MDS showed the BIMS score of 15, indicating no cognitive impairment. Review of Resident #9’s Census tab revealed the following information: 8/1/25- stop billing 8/5/25- active Review of Progress Notes revealed the following: On 8/1/25 at 7:14 p.m., resident sent to local ER for evaluation. On 8/1/25 at 10:00 p.m., resident hospitalized with right hip fracture. On 8/5/25 at 12:21 p.m., resident back to facility via facility transport. Review of the medical chart lacked a bed hold for resident during hospitalization. Interview on 8/13/25 at 10:30 a.m., with the Assistant Director of Nursing (ADON) revealed there was no bed hold completed for Resident #9 during hospitalization on 8/1/25. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility provided policy titled Bed Hold with a revision date of 5/21/21 revealed it is the policy of this facility to inform the resident, or the resident’s representative, in writing, of the right to exercise the bed hold provision, upon admission and before transfer to a general acute care hospital or before the resident goes on therapeutic leave. A copy of this notification shall become a part of the resident’s health record at the time of transfer. Interview on 8/12/25 at 1:27 p.m., with Medical Records revealed when a bed hold is completed it is uploaded into the residents charts and if they are not there they were not applicable or they didn’t get them done. Interview on 8/13/25 at 10:30 a.m., with the ADON revealed the bed holds for Resident #5 and #9 were not completed and they should have been done when the resident was transferred out of the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review and staff interview the facility failed to revise and update care plans to include a new order for oxygen usage on the comprehensive care plan for 1 of 17 residents reviewed (Resident #9). The facility reported a census of 67 residents. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #9 documented diagnoses of anemia, cancer and malnutrition. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Observation on 8/11/2025 at 11:36 AM currently wearing oxygen sitting up in bed. Observation on 8/12/2025 at 12:27 PM currently sleeping in bed with oxygen concentrator on via nasal cannula and running. Review of August Medication Administration Record (MAR) lacked orders for oxygen usage. Review of current Physician Orders lacked an order for oxygen usage. Review of the Care Plan dated 8/12/25 lacked information regarding oxygen usage. Interview on 8/13/2025 at 10:30 a.m., with the Assistant Director of Nursing (ADON) revealed the resident has an oxygen order from his current hospital discharge. The ADON revealed the order should have been added to the orders when he came back from the hospital. Interview on 8/13/2025 at 1:34 p.m., with the Director of Nursing (DON) revealed the hospital discharge order had been noted and should have been put on the orders. The order should have been on the chart and it should have been added to the care plan for the staff. Review of the facility provided policy titled Care Planning with a reviewed date of 9/2020 revealed it is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The Care Plan will be revised as needed, and interventions will be implemented. The resident's comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment and updated as appropriate. The Care Plan will be revised as needed for order changes or Resident changes in condition, and interventions will be implemented as appropriate.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record review, resident and staff interviews and facility policy review the facility failed to have a physicians order to administer medications prior to administering medications to 1 of 1 residents reviewed (Resident #70). The facility reported a census of 67 residents. Findings include:Resident #70's active diagnosis list included type 2 diabetes mellitus with hyperglycemia and hypertension.The MDS had not been completed for a Brief Interview for Mental Status (BIMS). Interview on 8/11/2025 at 12:38 p.m., with Resident #70 revealed she had a concern with her medications and the facility not having them. She further explained that on 8/9/25 she had to call the local pharmacy to get her Mounjaro (tirzepatide(diabetic medication)) delivered to the facility as they did not have it. Review of hospital discharge records revealed an order for tirzepatide every 7 days with the word hold written next to it. Review of the Order Summary Report signed by the physician on 8/5/25 lacked an order for Mounjaro. Review of current orders revealed an order for Mounjaro with an order date of 8/9/25 at 7:40 p.m., entered by Staff J, Licensed Practical Nurse (LPN). Review of the current Progress Notes lacked orders for Mounjaro medication orders on 8/9/25. Review of the Order Summary Report signed by the physician on 8/11/25 revealed an order for Mounjaro with an order date and start date of 8/9/25. Interview on 8/13/25 at 10:35 a.m., with the Assistant Director of Nursing (ADON) revealed the hospital records were her orders and the facility wrote hold on the orders and faxed that to the pharmacy so they would not send it as the resident told her she would provide the medication so she would not get charged for the medication again. Interview on 8/13/25 at 10:56 a.m., with Resident #70 further revealed that when she was admitted the facility told her she needed to provide her own Mounjaro medication. She was unsure why but she said she had to call on 8/4/25 to get it filled at the local pharmacy. She stated the pharmacy had to order it and when she called them again on 8/9/25 the pharmacy delivered it to the facility. She further revealed the evening of 8/9/25 she had to ask the nurse for the medication. The nurse told her the facility didn't have the order and a little while later she came back with it. Resident #70 explained the nurse didn't know how to use the pen so the resident told her to give it to her and she would do her own injection. Resident #70 verified she gave herself the injection that evening. Interview on 8/13/2025 at 11:06 a.m., with Staff H, Pharmacist revealed the pharmacy received an order for Resident #70 for Mounjaro on 8/4/25 and the pharmacy had to order the medication. She believed the medication was there on 8/7/25. Staff H revealed Resident #70 called the pharmacy on 8/9/25 upset that her medication had not been delivered to the facility. Staff H explained the pharmacy does not usually deliver medications on the weekends but did deliver the medication to the facility on 8/9/25 due to the resident being upset and not having any medication. Interview on 8/13/2025 at 11:46 a.m., with Staff I, Pharmacist. Staff I verified they received the order but did not have anything telling them they needed to hold it. Staff I stated if a medication is over $500 than they call the facility and ask if they are to send it and they send a form for the facility to fill out and return. Staff I revealed staff at the pharmacy had called the facility and they were told absolutely do not send the medication. Staff at the pharmacy did not have the staff member from the facility that said not to send the medication. The form was faxed to the facility but was never returned. Interview on 8/13/2025 with the Director of Nursing (DON) revealed they are unsure of where the order for the medication came from and the facility was actively trying to contact the nurse that entered the order on 8/9/25. The DON verified she had wrote hold on the admission orders as she was trying to verify when the medication was last given and when the resident was to resume the medication. The DON verified the facility admission orders lacked an order for Mounjaro. The DON further revealed the facility had not received the form from the pharmacy that she was aware of and she was unaware the resident called and ordered the medication from the local pharmacy and had the medication delivered to the building. The DON verified she was unaware of the happenings on 8/9/25. Interview on 8/14/2025 at 9:15 a.m., with Staff J, LPN revealed she worked the night of 8/9/25. Staff J verified Resident #70 had a box of Monjauro at the facility and she did not know how it got to the facility but the resident had asked for her medication. Staff J revealed she could not find the order for the medication and she called the pharmacy and the pharmacy said they would fax it to the facility. Staff J verified the pharmacy did not fax the order to the facility that evening. She never saw a physical order prior to giving the medication. Staff J further revealed she wasn't quite sure how to use the medication pen and the resident administered her own medication. Staff J explained she took the information off of the box the medication came in to enter the order into the MAR. Staff J further explained the resident had a doctor appointment on Monday and she was off on Monday but knew the doctor would sign off the order then as it

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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 observation, record review, and staff interview, the facility failed to ensure residents with significant weight loss were immediately identified, and assessed for nutritional needs for 1 of 2 resident's reviewed (Resident #21). The facility reported a census of 67 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #21 scored 3 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident's diagnoses included senile degeneration of the brain, cancer, and atrial fibrillation. The resident weighed 125#, and had a weight loss of 5% in 1 month or 10% in 6 months.The Care Plan initiated 7/30/25 identified the resident would tolerate her diet as ordered. The goal with a target date of 11/4/25, read the resident would maintain weight and nutritional balance through the review date. Interventions included diet to be followed as prescribed, monitoring food and fluid intakes daily and recording, monitoring weight as directed, and supplements as ordered. The Weights and Vitals record documented on 7/4/25, the resident weighed 126.5#. On 8/5/25, the resident weighed 118#, a -6.72% Loss. On 8/13/25 at 10:03 a.m. the resident received breakfast around 9:15 a.m. Staff did set up putting jelly on toast. The resident picked up toast and started eating while chatting. Staff added brown sugar to the resident's hot cereal. The resident started eating. A cup of supplement sat nearly empty. On 8/13/25 at 3:38 p.m. the Director of Nursing (DON) thought the weight could not be right. The Nurse Consultant (NC) said a reweight should have been obtained that day or the next day, and if the weight was correct they should have assessed and intervened. On 8/14/25 at 8:56 a.m. Staff D, Licensed Practical Nurse (LPN) brought a sticky note citing the resident weighed 118# this morning. The Weights and Vitals record documented a weight of 118# on 8/14/25 at 8:46 a.m. The facility Nutrition Policy reviewed 7/2024 documented it was the policy of this facility to ensure that all residents maintained acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrated it was not possible. Any resident weight that varied from the previous reporting period by 5% in 30 days, 7.5% in 90 days and 10% in 180 days would be evaluated by the Interdisciplinary Team to determine the cause of weight loss/gain, intervention required and need for further recommendations and/or referral.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical chart review and staff interview the facility failed to implement policies and procedures regarding the technical aspect of feeding tubes by pushing enteral medication with a syringe into enteral tube for 1 of 1 residents (Resident #9). The facility reported a census of 67 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #9 documented diagnoses of anemia, cancer and malnutrition. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Observation on 8/13/2025 at 2:33 p.m., with Staff B, Registered Nurse (RN) setting up Resident #9's medications. Staff B explained resident is able to take medications by mouth but he sometimes will get gaggy and vomit at times so they do all crushable medications through this tube. At 2:46 p.m. Staff B entered residents room to administer medications. Staff B set up each medication on the bedside table in the medication cup and added water to the crushed medications. Staff B then placed another medication cup next to each one of the medications and filled it with water. Staff B revealed she uses water after each medication. Staff B applied gloves and took a screw on the syringe and placed it into the medication cup and tried to mix the medication and water in the cup and drew the mixture into the syringe. Staff then screwed the syringe onto the tube and pushed the medication through the tubing swiftly and unscrewed the syringe and drew up the water that was in the cup and screwed the syringe back onto the tube and pushed the water into the tubing. The nurse did not check for residual or placement prior to administering the medications or water. The nurse repeated this until all medications were administered. During the administration the resident coughed and an orange like substance came out of the tubing which at this time the resident clamped the tube closed. The nurse did reopen after she was unable to push water through the tubing. After the medications were administered there was white power left in one medication cup that was then placed into the trash. Staff B took the syringe to the bathroom and rinsed the syringe. Prior to rinsing the syringe there was a white substance noted to be on the outside of the syringe and after rinsing there was a white substance noted to be on the inside of the syringe as well when placed into the graduate. At 3:02 p.m., the nurse reentered the room to date the bag the liquid was in hanging on the pole. At this time Staff B stated that she would check for residual but she just gave medications so she is just going to check placement of the tube. At 3:07 p.m., Staff B exited the room to take a phone call and at 3:08 Staff B reentered the room and applied gloves and checked the residents lung sounds. Staff B then primed the tubing and opened the end of the tubing and with the syringe pushed 60 cc of water into the tube. Staff B revealed the resident gets 60 cc of water before and after his feedings. Interview on 8/13/25 at 3:32 p.m., with the Assistant Director of Nursing (ADON) revealed when medications are being placed through the feeding tubes they need to be pushed over a couple minutes as the stomach cannot handle too much at one time and then the resident will regurgitate what was put into their stomachs. The ADON revealed she would not expect the nurse to be pushing the medications quickly. Review of the facility provided policy titled Tube Feeding with a revised date of 9/2019 revealed it is the policy of this facility to assure safe practice in providing tube feedings and to check tube for correct placement every shift or every medication administration by auscultation and spiration. If not in place hold feeding and meds, and notify physician for orders. Interview on 8/13/25 at 4:02 p.m., with the Director of Nursing (DON) revealed she is not sure why Staff B gave the medications through the feeding tub as he is able to take his medications orally. The DON verified she should not have pushed the medications swiftly into the residents stomach she should not have left any medication residual in the cup or syringe after giving the medications. The DON further revealed Staff B should have checked placement of the tube prior to administering medications and not after.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure that residents who required dialysis received services, consistent with professional standards of practice by communication with the dialysis center for 1 resident on dialysis (Resident #3). The facility reported a census of 67 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #21 scored 3 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident's diagnoses included end stage renal disease, and end chronic obstructive pulmonary (lung) disease. The resident received dialysis. The Care Plan revised 6/19/25 identified the resident needed dialysis Monday/Wednesday/Friday with chair time of 8:30 a.m. A Notebook with the resident's name on it contained pre and post (dialysis) Vital Signs (VS) (taken at dialysis center), including blood pressure, temperature, pulse and weight in kilograms.The Notebook lacked VS between 5/2/25 and 5/9/25. On 5/26/25 a note documented to remind the resident of a fluid restriction of 1500 cc per day, she was gaining too much weight. The clinical record lacked documentation the resident had a fluid restriction, or any communication with the physician about a fluid restriction.The Notebook lacked documentation of pre and post VS between 5/30/25 and 6/4/25, between 6/9/25 and 6/13/25, and between 6/13/25 and 7/4/25.The June TAR initiated documentation of the resident going to dialysis starting 6/5/25 and a refusal on 6/16/25.The Notebook lacked VS between 7/14/25 and 7/18/25, between 7/18/25 and 7/25/25, and 1 undated pre and post VS between 7/25/25 and 8/4/25.The Notebook lacked pre and post VS 8/11/25.On 8/13/25 at 4:54 p.m. the Corporate Nurse stated she had looked and could not find VS for the missing dialysis days. She said normally they would send a sheet with the resident's information on it and dialysis would fill it out and return it. Those sheets would be maintained in her record. The facility Dialysis, Pre and Post Care policy reviewed 6/2022 included collecting dialysis run sheets and following up with the provider on recommendations as needed.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, Medication Administration Record - Treatment Administration Record (MAR-TAR), Electronic Health Record (EHR) review, and staff interviews the facility failed to provide 2 of 31 medications as ordered resulting in a medication error rate of 6.45. The facility reported a census of 67 residents. Findings include:1. The Minimum Data Set (MDS) dated [DATE] for Resident #4 documented a Brief Interview for Mental Status (BIMS) of 5 indicating severe cognitive impairment. The MDS documented Resident #5 had a diagnosis of type 2 diabetes mellitus without complications.Review of Resident #4's MAR-TAR documented a physician's order for insulin Lispro injection per sliding scale if blood glucose was 140-180 2 units at 7:30 AM and insulin Glargine inject 32 units subcutaneously one time a day at 7:00 AM.Review of Resident #4's EHR titled, Orders documented a physician's order for insulin Lispro injection per sliding scale if blood glucose was 140-180 2 units at 7:30 AM and insulin Glargine inject 32 units subcutaneously one time a day at 7:00 AM.A continuous observation on 8/13/25 at 7:12 AM morning blood glucose checks and insulin administration revealed Staff B, Registered Nurse (RN) removed Resident #4's insulin Lispro and insulin Glargine from medication cart, Staff B dialed 2 units on the insulin Lispro pen for sliding scale, Staff B dialed 32 units of insulin glargine, Staff B did not prime 2 units from either insulin pen, Staff B walked down the hall, knocked on Resident #4's door, explained the procedure, cleansed the area on left abdomen with an alcohol wipe, insulin Lispro administered in Resident #4's left abdomen, area on left abdomen cleansed with alcohol wipe, insulin Glargine administered in Resident #4's left abdomen, Staff B returned to the medication cart, Staff B removed gloves and placed insulin in the medication cart.On 8/13/25 at 9:10 AM Staff B, RN stated she never primed the needle tips for insulin pens. Staff B stated she had never been told to prime the needle for the insulin pen. On 8/13/25 at 11:12 AM the Director of Nursing (DON) stated the facility's expectation was 2 units would be primed after the septum of the insulin pen was cleansed with an alcohol wipe and the needle was screwed on for each of the insulin pens.

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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 observations, staff interviews, Medication Administration Records - Treatment Administration Records (MAR-TAR) and Electronic Health Records (EHR) review the facility failed to ensure the residents were free of significant medication errors to 2 of 6 residents reviewed (Resident #4 and #7). The facility reported a census of 67 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #4 documented a Brief Interview for Mental Status (BIMS) of 5 indicating severe cognitive impairment. The MDS documented Resident #5 had a diagnosis of type 2 diabetes mellitus without complications. Review of Resident #4’s MAR-TAR documented a physician’s order for insulin Lispro injection per sliding scale if blood glucose was 140-180 2 units at 7:30 AM and insulin Glargine inject 32 units subcutaneously one time a day at 7:00 AM. Review of Resident #4’s EHR titled, Orders documented a physician’s order for insulin Lispro injection per sliding scale if blood glucose was 140-180 2 units at 7:30 AM and insulin Glargine inject 32 units subcutaneously one time a day at 7:00 AM. A continuous observation on 8/13/25 at 7:12 AM morning blood glucose checks and insulin administration revealed Staff B, Registered Nurse (RN) removed Resident #4's insulin Lispro and insulin Glargine from medication cart, Staff B dialed 2 units on the insulin Lispro pen for sliding scale, Staff B dialed 32 units of insulin glargine, Staff B did not prime 2 units from either insulin pen to ensure needle tip patency, Staff B walked down the hall, knocked on Resident #4’s door, explained the procedure, cleansed the area on left abdomen with an alcohol wipe, insulin Lispro administered in Resident #4’s left abdomen, area on left abdomen cleansed with alcohol wipe, insulin Glargine administered in Resident #4’s left abdomen, Staff B returned to the medication cart, Staff B removed gloves and placed insulin in the medication cart. On 8/13/25 at 9:10 AM Staff B, RN stated she never primed the needle tips for insulin pens. Staff B stated she had never been educated to prime the needle for the insulin pen. On 8/13/25 at 11:12 AM the Director of Nursing (DON) stated the facility's expectation was 2 units would be primed after the septum of the insulin pen was cleansed with an alcohol wipe and the needle was screwed on to ensure patency. Request for policy / procedure revealed no policy provided for insulin administration with an insulin pen. 2.The Minimum Data Set (MDS) dated [DATE] for Resident #7 documented a Brief Interview for Mental Status (BIMS) of 15 which indicated no cognitive impairment. The MDS documented Resident #9 had a diagnosis of traumatic brain injury, aphasia and bipolar. The Care Plan for Resident #7 showed initiated on 11/29/24 anticonvulsant therapy Levetiracetam related to traumatic subdural hemorrhage without loss of consciousness. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note dated 6/18/2025 at 1:01 PM for Resident #7 showed Staff B, RN documented the following: Resident's night meds omitted last night 6/17/25. No side effects/adverse effects noted. The resident states she feels fine. Family and Primary Care Provider (PCP) notified. The June 2025 Medication Administration for Resident #7 showed the following bedtime medication incorrectly documented as administered on 6/17/25 by Staff G, RN:Levetiracetam 1 tablet by mouth at bedtime for seizures. In an interview on 8/13/2025 at 10:03 AM, Staff B, RN reported in the morning of 6/18/25 Staff C, Certified Medication Assistant/Certified Nurse Assistant (CMA/CNA) reported she found bedtime medications for Resident #7 still in the medication packs from the night before. Staff B reported she couldn't remember what medications were missed but that she reported it to the Director of Nursing (DON), the physician and family. Staff B recalled the night nurse to be Staff G, Licensed Practical Nurse (LPN). In an interview on 8/13/25 at 3:02 PM, Staff G, LPN reported she recalled that she failed to give bedtime medications to Resident #7 on 6/17/25. When asked if there was a reason why she failed to administer medications, Staff B stated, I just missed giving them. The Medication Administration policy last revised on October 2021 identified:Administration of Medication POLICY:It is the policy of this facility that medications shall be administered as prescribed by the attending physician.PROCEDURES:Only licensed medical and nursing personnel or other lawfully authorized staff members may prepare, administer, and record the administration of medications.Medications must be administered in accordance with the written orders of the attending physician including following parameter orders – pulse, blood pressure, blood sugar, etc. All current drugs and dosage schedules must be recorded on the resident's medication administration record (MAR).Identification of the resident must be made prior to administering medication to the resident. Medications may not be set up in advance and scheduled medications must be administered within one (1) hour before or after their prescribed time. NOTE: Before and/or after meal orders must be administered as ordered.When PRN medications are administered, the nurse must record:Justification/ reason the medication is given The date and time administered;The medication nameAny results achieved from administering the drug and the time such results were observed; andThe signature and title of the person administering the drug.If a medication is withheld, refused, or given other than at the scheduled time, the documentation will be reflected in the clinical record. The seven rights of medication administration are as follows in order to ensure safety and accuracy of administration. Right Resident – Resident is identified prior to medication administration Right Time – Medications are administered within prescribed time frames. Right Medication – Medications are checked against the order before they are given. Right Dose – Medications are administered according to the dose prescribed Right Route – Medications are administered according to the route prescribed (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Right Documentation – Document administration or refusal of the medication after the administration or attempt and note any concerns Right Diagnosis – Medications are administered according to appropriate indication/diagnosis. In an interview on 8/13/2025 at 1:52 PM, the Director of Nursing (DON), reported she expected medications to be given as ordered and that Levetiracetam should have been given to prevent seizures.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, policy, Electronic Health Record (EHR) review and staff interview the facility failed to follow the menu and prepare food to meet the residents nutritional needs for 22 of 26 residents (all residents with a regular diet) reviewed. The facility reported a census of 67 residents.Findings include:A continuous observation on 8/12/25 at 11:40 AM revealed Staff A, Certified Dietary Manager (CDM) served the lunch meal. Staff A completed hand hygiene, completed temperature checks on the food, placed serving utensils in the steam table wells with the food, and began lunch service. Through the entire lunch service a 3 oz scoop was utilized to serve all regular diet peas.On 8/12/25 at 12:30 PM Staff A acknowledged the scoop utilized to serve the regular diets the peas was a 3 oz scoop and should have been a 4 oz scoop. Review of document dated 8/14/25 titled, Diet Type Report documented 22 regular diets served in that building for the lunch meal on 8/12/25.Review of document titled, Week 4 Tuesday Diet Spreadsheets the lunch menu revealed regular diets should have 4oz serving of Peas.On 8/12/25 at 3:21 PM the Administrator stated she would expect the staff utilized the appropriate scoop according to the meal spreadsheet. Review of an undated policy titled, Quality of Care Therapeutic Diets documented Routine therapeutic menus are planned by the corporate office or dietary manager and approved by the registered dietitian; however, unusual or complex therapeutic diets are planned in writing by the registered dietitian. A tray identification system is established to ensure that each resident receives his/her diet as ordered.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 resident interview, resident family interviews, staff interview, electronic health records (EHR), document review and policy review the facility failed to maintain medical records on each resident that were complete and accurate by failing to accurately transcribe a physicians order into the EHR for 2 of 8 residents reviewed (Resident #9 and #73). The facility reported a census of 67 residents.Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #73 did not document a Brief Interview for Mental Status (BIMS) as Resident #73 was admitted on [DATE]. On 8/13/25 at 8:40 AM Staff C, Certified Medication Assistant / Certified Nurse Assistant (CMA/CNA) stated Resident #73’s MAR did not match the bubble pack for the potassium chloride ER tablet. Staff C stated MAR read potassium chloride ER give 20 mEq BID. Staff C stated Resident #73’s bubble pack for potassium chloride documented 20 mEq give 2 tablets daily. Review of Resident #73’s bubble pack for potassium chloride documented potassium chloride ER 20 mEq give 2 tablets daily. Review of Resident #73’s MAR-TAR documented an order for potassium chloride ER with the start date 8/11/25 to give 20mEq by mouth two times a day for supplement at 7:00 AM and 8:00 PM. Review of document dated 8/11/25 titled, Home Medication List for Resident #73 from the hospital documented to stop taking 40 mEq oral twice daily and start taking 40 mEq daily as a new dose. On 8/14/25 10:05 AM the DON acknowledged MAR read Potassium Chloride ER give 20 mEq BID. Review of document revised 5/19 titled, Nursing Clinical with subject Physician Orders documented Verbal orders for drugs and treatments shall be received only by licensed nurses, psychiatric technicians, pharmacists, nurse practitioners, physicians, physicians' assistants (from their supervising physician only), and certified respiratory therapists when the orders relate specifically to respiratory care. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include the date and time of the order. The charge nurse or the director of nursing services shall place the order for all prescribed medications. 2. The MDS assessment dated [DATE] for Resident #9 documented diagnoses of anemia, cancer and malnutrition. The MDS showed the BIMS score of 15, indicating no cognitive impairment. Observation on 8/11/2025 11:36 a.m., of resident wearing oxygen sitting up in bed. Observation on 8/12/2025 12:27 p.m., of resident currently sleeping in bed with oxygen concentrator on via nasal cannula and running. Review of August Medication Administration Record (MAR) and Treatment Administration Record (TAR) lacked orders for oxygen usage. Review of current Physician Orders lacked an order for oxygen usage. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan dated 8/12/25 lacked information regarding oxygen usage. The facility did not provide a policy of maintaining accurate resident records. Interview on 8/13/2025 at 10:30 a.m., the Assistant Director of Nursing (ADON) revealed the resident has an oxygen order from his current hospital discharge. The ADON revealed the order should have been added to the orders when he came back from the hospital. Interview on 8/13/2025 at 1:34 p.m., with the Director of Nursing (DON) revealed the hospital discharge order had been noted and should have been put on the orders. The order should have been on the chart.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, Medication Administration Record (MAR), policy review, and staff interview the facility failed to provide appropriate infection prevention practices when providing care to a resident with a catheter, with wound care, and a resident with an enteral tube, that was on Enhanced Barrier Precautions (EBP) for 5 of 7 reviewed (Resident #4, #7, #9, #14 and #38). The facility reported a census of 67 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #4 documented a Brief Interview for Mental Status (BIMS) of 5 indicating severe cognitive impairment. The MDS documented Resident #5 had a diagnosis of type 2 diabetes mellitus without complications. Review of Resident #4’s MAR documented a Physician’s Order for insulin Lispro injection per sliding scale if blood glucose was 140-180 2 units. 2. The MDS dated [DATE] for Resident #14 documented a BIMS of 5 indicating severe cognitive impairment. The MDS documented Resident #5 had a diagnosis of type 2 diabetes mellitus without complications. Review of Resident #14’s MAR documented a Physician’s Order for blood sugar checks one time a day at 7:00 AM. 3. The MDS dated [DATE] for Resident #38 documented a BIMS of 6 indicating severe cognitive impairment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A continuous observation on 8/13/25 at 7:12 AM morning blood glucose checks and insulin administration revealed Staff B, Registered Nurse (RN) did not complete hand hygiene, applied gloves, knocked on Resident #4’s door, entered the residents room, barrier placed on bedside table, cleansed left index finger with alcohol wipe, utilized a lancet to obtain blood sample from left index finger, blood glucose of 153 reported. Staff B exited room, removed gloves, unlocked medication cart, placed blood glucose supplies on the medication cart, returned to Resident #4’s room, covered Resident #4 with a blanket, left Resident #4’s room walked down the hall to Resident #38’s room, knocked on the door, entered Resident #38’s room. Staff B exited Resident #38’s room, returned to the medication cart, moved the medication cart down the hall to Resident #14's room. Staff B applied gloves, knocked on Resident #14’s door, placed a barrier on the Resident #14s bedside table, cleansed the right index finger with an alcohol wipe, lancet utilized to obtain blood sample, blood glucose of 171 reported. Staff B exited room, blood glucose supplies placed on medication cart, removed gloves, pushed medication cart to the nurse station, sat down at the computer, typed on the computer. Same blood glucose machine used on both residents without being cleansed. Staff B returned to medication cart, removed heavy sani-cloth removed from medication cart, utilized sani-cloth to wipe glucose monitor, glucose monitor placed on sani cloth, obtained hand sanitizer from nurse station, placed hand sanitizer on the medication cart, utilized hand sanitizer to complete hand hygiene, Staff B removed Resident #4's insulin Lispro and insulin Glargine from medication cart, Staff B dialed 2 units on the insulin Lispro pen for sliding scale, Staff B dialed 32 units of insulin glargine. Staff B did not prime 2 units from either insulin pen. Staff B walked down the hall, knocked on Resident #4’s door, explained the procedure, cleansed the area on left abdomen with an alcohol wipe, insulin Lispro administered in Resident #4’s left abdomen, area on left abdomen cleansed with alcohol wipe, insulin Glargine administered in Resident #4’s left abdomen. Staff B returned to the medication cart, Staff B removed gloves, placed insulin in the medication cart, pushed the medication cart down the hall to next residents room, Staff B knocked on the door and entered the residents room. On 8/13/25 at 9:10 AM Staff B, RN stated she never primed the needle tips for insulin pens. Staff B stated she had never been told to prime the needle for the insulin pen. Staff B acknowledged that every resident shared one glucose monitor at the facility. Staff B stated she was nervous and forgot to cleanse the monitor the first couple times. Staff B stated she utilized the sani-cloth to cleanse the glucose machine. Staff B explained she wiped it down and allowed it to dry. Staff B stated she was unaware if the machine was required to be wet for any amount of time. Staff B acknowledged the machines were not wet for 2 minutes per the instructions on the Super Sani-wipes. On 8/13/25 at 11:12 AM the Director of Nursing (DON) stated hand hygiene should have been completed prior to application of gloves and after removal of gloves. The DON stated her expectation was the blood glucose machine would be cleansed according to the manufactures requirements and between residents. The DON stated the facility’s expectation was the rubber septum of insulin pens prior to application of the needle tip. Review of document dated 4/18/25 titled, Hand Hygiene documented hand hygiene should be utilized before and after direct contact with residents, before preparing or handling medications, after contact with a resident’s intact skin, after contact with bloody or bodily fluids and after removing gloves. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165449	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spencer Post Acute Rehabilitation Center	711 West 11th Street Spencer, IA 51301

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of document reviewed 6/25 titled, Infection Control Policy / Procedure with subject Glucometer, Cleaning and Decontamination of documented the facility’s policy was to follow recommendation from the CDC or manufacturer’s guidelines. Review of Assure Platinum Blood Glucose Monitoring System User Instruction Manual documented cleaning and disinfection could be completed by using a commercially available EPA-registered disinfectant detergent or germicide wipe. To wipe, remove from the container and follow product label instructions to disinfect the meter. Review of directions for use of Super Sani-Cloth Germicidal Disposable Wipe documented to unfold wipe and thoroughly wet surface. Allow the surface to remain wet for 2 minutes. Let air dry. 4. The Clinical Physician Orders for Resident #7 showed an order on 5/15/25 to:a. Cleanse buttocks with wound cleanser and 4x4'sb. Dampen collagen with normal saline before inserting into wound c. Place a small piece of calcium alginate on topd. Cover with a 4x4 silicone bordered dressing, changing daily and PRN for dislodgment, drainage, or if it gets soiled. Observation on 8/13/2025 at 10:11 AM of Resident #7 showed Staff E and Staff F Certified Nursing Assistants, (CNA) completed peri care, catheter care then removed the pressure ulcer dressing to the coccyx area, and completed peri care. After care Staff B, Registered Nurse (RN) entered the room to complete the dressing change to the coccyx. Upon arrival to the room the nurse reported she wasn't sure if the pressure ulcer had healed. The nurse washed hands, donned gloves and cleansed the area. The nurse failed to don Personal Protective Equipment (PPE) per Enhanced Barrier Precaution (EBP) protocol. In an interview on 8/13/2025 at 1:52 PM, the Director of Nursing (DON), reported the nurse should follow EBP precautions when completing cares for a resident with a catheter or pressure ulcer. The DON reported the nurse to be knowledgeable in infection control practices. The DON stated, I don’t know why she didn’t. 5. The MDS assessment dated [DATE] for Resident #9 documented diagnoses of anemia, cancer and malnutrition. The MDS showed the BIMS score of 15, indicating no cognitive impairment. Observation on 8/11/2025 at 11:37 a.m., resident noted to be hooked up to feeding tube and sitting up in bed sleeping with an EBP sign on the door into the residents room. Observation on 8/13/2025 at 2:46 p.m., with Staff B, RN entered residents room to administer medications via feeding tube and to hook up his feeding. Staff B entered the residents room and did not apply any personal protective equipment (PPE) upon entering the residents room. Staff B administered medications into the feeding tube with no PPE. At 3:00 p.m., Staff B exited the room after removing gloves and washing her hand to return a basket to her medication cart. At 3:02 p.m., Staff B returned to the room and did not apply any PPE. Staff B checked tube placement and exited the room to take a phone call. Staff B reentered the room at 3:08 p.m., and did not apply PPE prior to listening to the residents lungs and hooking up the residents tube feeding. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 8/13/2025 at 3:34 p.m., Staff B was asked if she was aware of what EBP was? Staff B paused and stated yes she was aware of what EBP was and she should have used it in the room but she had forgotten about the feeding tube. Staff B looked in Resident #9’s room and revealed the room contained PPE for the staff to wear during cares. Review of the Centers for Disease Control website titled Frequently Asked Questions about Enhanced Barrier Precautions in Nursing Homes dated June 28, 2004 visited on 8/14/25 revealed the following information: Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). The studies that informed EBP, including defining which care activities most commonly result in transfer of MDROs to staff hands and clothing, were conducted in adult nursing home populations. Assuming Contact Precautions do not otherwise apply, Enhanced Barrier Precautions are recommended for residents with any of the following: 1) infection or colonization with a MDRO or 2) a wound or indwelling medical device, even if the resident is not known to be infected or colonized with a MDRO. Enhanced Barrier Precautions are recommended for residents with indwelling medical devices or wounds, who do not otherwise meet the criteria for Contact Precautions, even if they have no history of MDRO colonization or infection and regardless of whether others in the facility are known to have MDRO colonization. This is because devices and wounds are risk factors that place these residents at higher risk for carrying or acquiring a MDRO and many residents colonized with a MDRO are asymptomatic or not presently known to be colonized. Interview on 8/13/2025 at 3:32 p.m., with the ADON revealed she expected staff to be wearing PPE when they were coming into contact with body fluids. When asked if she would expect the staff to wear PPE during a tube feeding the ADON verified the staff should be wearing PPE when providing care to a resident with a tube feeding. Interview on 8/13/2025 at 4:02 p.m., with the DON revealed the staff and nurses should be wearing PPE when providing care to Resident #9 as he has a feeding tube. During the interview with the DON she revealed Staff B used to be the infection control nurse for the building and she knows that she should have been wearing PPE during the medication administration and working with the tube feeding. The DON verified Staff B should have been wearing PPE.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, Centers for Disease Control and Prevention (CDC) guidelines and facility policy review, the facility failed to screen for eligibility, offer, provide education and document vaccine consent or refusal for the pneumococcal immunization for 1 of 5 resident reviewed (Resident #8) for immunizations. The facility reported a census of 67 residents. Findings include: Resident #8 Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.Review of the clinical record revealed Resident #8 had received the Pneumococcal Conjugate Vaccine 13-valent (PCV13) on 05/19/20, and Pneumococcal Polysaccharide Vaccine 23-valent (PPSV23) on 10/14/98. The clinical record lacked documentation that Resident #8 was educated, offered a consent for or refusal of the Pneumococcal Conjugate Vaccine PCV20 or PVC21 vaccination. Review of the CDC recommendations dated October 2024 for adults 50 years or older who have received the PCV13 at any age and the PPSV23 less than [AGE] years of age, recommended to give one dose of PCV20 or PVC21 at least 5 years after the PCV13.On 08/14/25 at 3:00 PM, the Director of Nursing (DON) reported she expected vaccinations to be offered per resident preference and education to be given if the resident refused the vaccination. A facility policy titled Immunization, Influenza and Pneumococcal revised 7/2015 documented the facility to offer pneumococcal immunization unless the immunization was medically contraindicated or the resident has already been immunized. In addition, the policy documented before offering the pneumococcal immunization, each resident or the resident's legal representative was to receive education regarding the benefits and potential side effects of the immunization.