STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Carroll	2241 North West Street Carroll, IA 51401

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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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on the Center for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report (October1 - December 31) review, facility staffing reports review, and staff interviews, the facility failed to submit accurate staff reports for the PBJ Staffing Data Report. The facility reported a census of 48 residents.Findings include:Review of the PBJ Staffing Data Report with a run date of 3/25/26 revealed the facility triggered for excessively low weekend staffing. Further review of the document revealed that the submitted weekend staffing data was excessively low. Review of facility provided daily staffing assignment sheets for the months of October 2026 through December 2026 revealed there was sufficient staffing throughout the morning shift through the nights shift with several nurses and certified nursing assistants working these shifts.Interview on 3/31/26 at 11:58 AM with Staff B Registered Nurse (RN) revealed that the excessively low weekend staffing was due to a failed audit for the quarter 4 2025 period while we were using an outside company PBJ module. Staff B then revealed that this outside company had double-counted hours for a number of employees, resulting in over-reporting that quarter. Staff B then revealed that this was corrected now, and would expect this to be correct going forward. Interview on 3/31/26 at 12:37 PM with the Director of Nursing (DON) revealed the facility has no policy on correctly submitting the PBJ, and the facility just follows the regulations.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on document review, staff interviews, and facility policy review the facility failed to demonstrate good faith attempts to correct quality deficiencies based on issues that were identified with repeat deficiencies during the current survey process in 1 area and corrections that remained incomplete in a reasonable time frame. The facility reported a census of 48 residents.Findings include:Review of Federal Centers for Medicaid and Medicare Services (CMS) form 2567 for the survey results with correction dates of 10/16/25, and 1/31/26 indicated that the facility had received deficiency F725 related to insufficient nursing staff.Interview on 4/02/26 at 11:13 AM with the Administrator and Staff B Registered Nurse (RN) revealed the facility is currently working on call light audits. The Administrator further revealed that the facility has been providing education to staff on answering call lights in a timely manner while management is completing the call light audits. The Administrator further revealed call lights have gotten a little better, but they are still a concern. Review of a facility provided policy titled, Quality Assurance and Performance Improvement Plan (QAPI) with an updated date of 5/23/23 revealed:a. The QAPI committee analyzes the performance to identify, and follow up on areas of opportunity.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, cleaning schedule review, and staff and resident interviews, the facility failed to ensure residents had housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 4 of 4 residents reviewed (Resident #21, #11, #25 and #24). The facility reported a census of 48 residents.Findings include:The Resident Council notes dated 3/19/26 had none circled, indicating the rooms were not clean, and 1 resident citing a need to sweep under the bed.1.An Assessment Scoring report documented Resident #21 scored 14 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.On 3/30/26 at 11:11 a.m. Resident #21 stated sometimes they didn't make her bed. In subsequent interview on 3/31/26 at 2:49 p.m. Resident #21 stated the trash gets so full it won't hold anymore, and some ends up on the floor.2. An Assessment Scoring report documented Resident #11 scored 13 on the BIMS indicating no cognitive impairment.On 3/30/26 at 10:57 a.m. Resident #11 stated she is having trouble getting them to make the bed. She had to wipe things down it got so dusty. Observed dust on the window sill, and a pile of tissue under the bed on the floor. The floor under the resident's recliner black. On 3/31/26 at 2:50 p.m. continued dust on window sill and tissues on floor under the bed. On 4/2/26 at 10:43 a.m. no change with window sill or under bed. The resident's garbage can was over full and garbage on the floor around it.3. An Assessment Scoring report documented Resident #25 scored 9 on the BIMS indicating moderate cognitive impairment.On 3/30/26 at 11:15 a.m. Resident #25's headboard damaged and 1 side torn 1/2 way up from the bottom, and hanging free. The window sill in the room with a thick layer of dust. 4. An Assessment Scoring report documented Resident #24 scored 11 on the BIMS indicating moderate cognitive impairment. On 3/31/26 at 1:13 p.m. Resident #24's window sill had a thick layer of dust. Resident #24 stated he tried to keep the room clean, but he could not get to the window sill because the bed was up against it.On 4/2/26 at 8:25 a.m. Staff O Housekeeping worked in a Resident #25's room. She stated the beds were up against the wall with the window sills so they had to find a time when resident's were not in bed to do them. She acknowledged the broken headboard and unsure how long it had been that way. She didn't realize it was that bad. She said they cleaned the rooms every other day.The March Housekeeping Cleaning Schedule for 3/16/26-3/31/26 showed no checks for cleaning rooms 201 to 213. The schedule documented spot cleaning 3/20, 3/22, 3/25, 3/27, and 3/29/26. The schedule lacked documentation of deep cleaning. The schedule lacked documentation of cleaning rooms [ROOM NUMBERS] from 3/28-3/31/26. The schedule directed rooms would be deep cleaned weekly and as needed. Rooms would be spot cleaned daily.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on document review, staff interview, and policy review the facility failed to implement the abuse and neglect policy by not completing background checks prior to staff employment. The facility reported a census of 48 residents.Findings include:Review of Staff C Certified Nursing Assistant (CNA) personnel file revealed no single contact repository (SING) background check. Review of a facility provided document titled, Employee Roster with a date of 3/30/26 indicated that Staff C had a hire date of 2/3/25.Interview 3/31/26 at 12:52 PM with the Director of Nursing (DON) revealed that SING was most likely completed as a third party background check was completed prior to Staff C's hire date. The DON further revealed that the facility could not log into the SING system to obtain the background check as results could not be obtained after 30 days in the system. Follow up interview 4/1/26 at 9:13 AM with the DON confirmed that Staff C did not have a SING background check completed in her file. The DON then confirmed that another background check had been completed prior to Staff C's start date. The DON then revealed that her expectation would be for a SING background check to be completed prior to start dates of new employees. Review of a facility provided policy titled, Nursing Facility Abuse Prevention, Identification, Investigation and Reporting with an updated date of 10/19/22 indicated the facility will conduct an Iowa criminal record check and dependent adult/child abuse registry check on all prospective employees and other individuals engaged to provide services to residents, prior to hire.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and resident interview, the facility failed to administer medications in a timely manner for 11 of 20 residents reviewed (Resident # 21, #29, #27, #6, #25, #10, #2, #12, #16, #18 and #9). The facility reported a census of 48 residents.Findings include:Resident Council notes dated 3/19/26 indicated pills and treatments were not given timely.1. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #21 scored 14 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident's diagnoses included stroke, emphysema, and insomnia.On 3/30/26 at 11:09 a.m. Resident #21 stated a nurse didn't get her her meds until after 10 pm and she usually got them around 8 pm. That disrupted the schedule. She wants them earlier so she can get ready for bed. She said she was supposed to get them earlier, and this was not the 1st time this happened. A Medication Administration Audit dated 4/2/26 documented Resident #21 had the following medications scheduled at 8 p.m. on 3/27/26: Flonase Allergy Relief Nasal Suspension 50 mcg, 2 sprays both nostrils at bedtime, Magnesium Glycinate 100 mg, 4 capsules, Omeprazole delayed release 20 mg, and Melatonin 3 mg. The audit documented the medications were administered at 10:01 p.m. 2. A Medication Administration Audit dated 4/2/26 documented Resident #29 had Tylenol Extra Strength 500 mg 2 tablets scheduled on 3/27/26 at 8 p.m. and administered at 9:24 p.m.The Audit documented the resident had Ropinirole 0.5 mg scheduled for 2 p.m. The medication was administered on 3/29/26 at 5:02 p.m.3. A Medication Administration Audit dated 4/2/26 documented Resident #27 had the following medication scheduled at 8 p.m.: On 3/27/26 Lantus injection 6 units administered at 11:13 p.m. On 3/28/26 Omeprazole 20 mg and Zyprexa 2.5 mg scheduled for 5 a.m. administered at 8:17 a.m. On 3:29/26 Omeprazole 20 mg and Zyprexa scheduled at 5 a.m. administered at 8:16 a.m.4. A Medication Administration Audit dated 4/2/26 documented Resident #6 had Insulin Glargine 50 units scheduled at 8 p.m. and administered at 10:12 p.m.5. A Medication Administration Audit dated 4/2/26 documented Resident #25 had Novolog 8 units scheduled at 7 p.m. The audit showed the insulin administered at 11:13 p.m. On 3/29/26 Resident #25 had Insulin Glargine 36 units scheduled at 8 p.m. and administered at 11:13 p.m.6. A Medication Administration Audit dated 4/2/26 documented Resident #10 had Fluticasone 50 mcg 1 spray in each nostril scheduled for 5 a.m. administered at 8:30 a.m. on 3/27/26 and at 8:08 a.m. on 3/29/26.7. A Medication Administration Audit dated 4/2/26 documented Resident #2 had Pantoprazole 40 mg scheduled for 5 a.m. and administered at 9:01 a.m. on 3/27/26.8. A Medication Administration Audit dated 4/2/26 documented Resident #12 had Levothyroxine 100 mcg scheduled for 5 a.m. and administered at 9:08 a.m.9. A Medication Administration Audit dated 4/2/26 documented Resident #16 had Levothyroxine 25 mcg scheduled for 5 a.m. and administered at 8:06 a.m. on 3/27/26.10. A Medication Administration Audit dated 4/2/26 documented Resident #18 had Levothyroxine 75 mcg scheduled for 5 a.m. and administered at 8:16 a.m. on 3/27/26.11. A Medication Administration Audit dated 4/2/26 documented Resident #9 had Omeprazole 40 mg, Tylenol 650 mg, Levothyroxine 50 mcg, and topical Voltaren Gel 1% to right hip and low back, all scheduled for 5 a.m. and administered at 8:28 a.m. and 8:31 a.m. on 3/27/26.On 4/1/26 at 10:26 a.m. the Interim Director of Nursing stated medications could be given 1 hour before to 1 hour after their scheduled time. She stated she printed off the medications for this hall that were administered late. The facility Medication Administration Policy updated 12/3/25 documented medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the The policy included ensuring the six rights of medication administration were followed included the right time. Medications could be administered within 60 minutes prior to or after the scheduled time unless otherwise ordered by physician.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, document review, resident interviews, and staff interviews, the facility failed to provide nursing staff to assure residents safety by not responding to call lights in a timely manner for 4 of 6 residents reviewed (Resident #2, #45, #6, and #36). The facility reported a census of 48 residents.Findings include:1. Review of Resident #2's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognitive functioning. The MDS further indicated that Resident #2 was dependent on staff for toileting hygiene, personal hygiene, and transferring from chair/bed-to-chair transfers. Interview on 3/30/26 at 11:34 AM with Resident #2 revealed that call lights can take fifteen minutes or longer at times. Resident #2 revealed that she watches the clock, and can tell how long it takes. Review of a facility provided document titled, Location Event Report dated 3/16/26 to 3/31/26 revealed call light response times for Resident #2's room. This document reflected times of 25 minutes, 17 minutes, 26 minutes, and 18 minutes. 2. Review of Resident #45's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognitive functioning. The MDS further indicated that Resident #45 was dependent on staff for toileting hygiene, personal hygiene, and transferring from chair/bed-to-chair transfers. Interview on 3/30/26 at 10:31 AM with Resident #45 revealed that call lights can take a long time to answer at times. Resident #45 further revealed that he watches the clock on his phone. Resident #45 then revealed that he just feels as though there is not enough staff with all the demands of the residents. Review of a facility provided document titled, Location Event Report dated 3/16/26 to 3/31/26 revealed call light response times for Resident #45's room. This document reflected times of 23 minutes, 39 minutes, 18 minutes, 31 minutes, 20 minutes, 28 minutes, 26 minutes, 33 minutes, 22 minutes, 17 minutes, and 22 minutes. Review of facility provided documents titled, Resident Council with dates of 1/22/26, 2/19/26, and 3/19/26 indicated each month that residents had concerns of call lights not being answered in a timely fashion of 15 minutes or less. Interview on 3/31/26 at 10:52 AM with Staff A Certified Nursing Assistant (CNA) revealed that staffing has gotten way better, but it was never really low. Staff A then revealed that she thinks the 2-10pm staff struggle with call lights lasting longer than 15 minutes at times. Staff further revealed that she had heard some call lights taking 15 minutes or longer. Interview on 3/31/26 at 2:40 PM with the Director of Nursing (DON) revealed that she would expect call lights to be answered in 15 minutes or less. 3. The MDS for Resident #6 dated 2/10/26 assessment identified a BIMS score of 14, indicating intact cognition. The Clinical Census revealed Resident #6 resided in room [ROOM NUMBER]-A. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/30/26 at 11:08 AM, Resident #6 reported she has waited two hours for her call light to be answered. She said she turned the light on a little before 11:00 AM and the light was not answered until after 1:00 PM. She said she could not remember which day or what she wanted. She said it was over dinner time so that might explain the long call light. She said the call light response time depends on staffing and call ins. She said she watched the clock on the wall to time the call lights. A facility form titled Location Event Report for room [ROOM NUMBER]-A dated 3/16/26 to 3/31/26 revealed the following call light times: 3/16/26- 5:55 PM to 6:15 PM= 19 minutes 3/17/26-10:25 AM to 10:43 AM= 17 minutes 3/17/26- 11:54 AM to 12:13 PM= 19 minutes 3/17/26- 1:55 PM to 2:15 PM= 20 minutes 3/19/26- 3:58 PM to 4:21 PM= 23 minutes 3/20/26- 6:29 PM to 6:52 PM= 22 minutes 3/20/26- 6:53 PM to 7:13 PM=19 minutes 3/21/26- 5:39 PM to 6:02 PM= 23 minutes 3/23/26- 11:50 AM to 12:27 PM= 36 minutes 3/29/26- 7:17 AM to 7:56 AM= 39 minutes 3/31/26- 8:59 AM to 9:16 AM= 17 minutes 4. The MDS for Resident #36 dated 3/9/26 assessment identified a BIMS score of 12, indicating moderately impaired cognition. The Clinical Census revealed Resident #36 resided in room [ROOM NUMBER]-A Private. On 3/30/26 at 12:10 PM, Resident #36 reported call lights are usually 15 minutes or more. He said that he has had a call light on for over an hour. He said he times the call light with the clock on the wall. He said the long call light was in the afternoon after dinner time. He said he did not recall what he needed at the time. A facility form titled Location Event Report for room [ROOM NUMBER] A and B dated 3/16/26 to 3/31/26 revealed the following call light times: 3/18/26- 7:59 PM to 8:20 PM= 21 minutes 3/25/26- 7:45 PM to 8:13 PM= 27 minutes 3/25/26- 9:09 PM to 9:48 PM= 39 minutes (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 3/31/26 at 2:50 PM with Staff B Registered Nurse (RN) revealed that the facility does not have a policy regarding call light response times, but the facility does refer to the standards of care.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility investigative file review, observation, staff interviews, and facility policy review the facility failed to document on the Controlled Drug Use Record and the electronic Medication Administration Record (MAR) when lorazepam (Ativan) medication were administered for 3 of 3 resident reviewed for controlled substance use (Resident #22, #23 and #47). The facility also failed to consistently and accurately reconcile controlled medications and remove expired medications/treatments from the medication room. The facility reported a census of 48 residents. Findings include: The facility self reported to the State Agency on 3/3/26 at 8:54 AM they revealed a total of 33 ml (milliliters) of liquid Ativan (antianxiety medication/controlled substance) was missing between three residents (Resident #22, #23 and #47). On 2/28/26 at approximately 6:00 AM, Staff G, Registered Nurse (RN) and Staff H, Licensed Practical Nurse (LPN) noted an Ativan discrepancy with Resident #22, #23, and #47. Staff H noticed that the bottles were sticky to touch and Staff G said it looked like the bottles had been leaking. On 2/28/26 at approximately 10:19 AM, Staff I, Certified Medication Aide (CMA) notified the Assistant Director of Nursing (ADON) of the Ativan discrepancy. The Director of Nursing (DON) requested Staff I and Staff E, LPN complete a narcotic count. On 2/28/26 at approximately 1:00 PM, it was determined Resident #22 Ativan count was off by 20.75 ml, Resident #23 Ativan count was off by 8 ml and Resident #47 count was off by 5 ml. Staff I, CMA said that the boxes the Ativan bottle were stored in looked like they were wet at one point as if the bottles possibly leaked. It was determined that Resident #23's Ativan box was wet and had leaked through. On 3/2/26 Staff J, LPN had confirmed Resident #22 and Resident #47 Ativan bottles had been previously leaking. Staff J stated that he had noted on 2/23/26 that Resident #22 Ativan bottle had been leaking and Resident #47's Ativan bottle was sticky, but had failed to notify management of this. After receiving witness statements from all nurses and CMAs, all staff indicated they had not been routinely counting refrigerated narcotics. 1. The Minimum Data Set (MDS) for Resident #22 dated 02/11/26 assessment identified a Brief Interview for Mental Status (BIMS) score was a 10, indicating moderately impaired cognition. Resident #22's MDS included diagnoses of non-Alzheimer's dementia, anxiety disorder, bipolar disorder and schizophrenia. The MDS documented Resident #22 received antianxiety medication during the last 7 days. The Care Plan with a target date of 5/17/26 revealed Resident #22 used antianxiety medication related to anxiety. The care plan directed staff to give medications as ordered. The February 2026 Medication Administration Record (MAR) directed to give Lorazepam (Ativan) intensol Oral Concentrate 2mg (milligrams)/ml, 0.25 ml every two hours as needed (PRN) for anxiety, restlessness, and short of breath. The Controlled Drug Use Record January 2026 to March 2026 revealed:a. One- 30 ml bottle of Ativan was received on 12/27/25.b. Ativan was signed out on the Controlled Medication Record but not recorded on the MAR on the following dates: 1/2, 1/9, 1/16, 1/20, 1/23, 1/26, 2/3 , 2/6, 2/7, 2/10, 2/13 (13 times)c. Ativan was documented on MAR as given but not signed out on the Controlled Drug Use Record on the following dates: 1/1, 1/2, 1/9, 1/20, 1/23, 2/7, 2/10 (9 times)2. The MDS for Resident #23 dated 01/22/26 assessment identified a BIMS score was a 04, indicating severe cognitive impairment. Resident #23's MDS included chronic respiratory failure with hypoxia and shortness of breath. The MDS documented Resident #23 did not receive antianxiety medication during the last 7 days.The Care Plan with a target date of 5/12/26 revealed Resident #23 used antianxiety medication related to restlessness and comfort. The care plan directed staff to give medications as ordered. The February 2026 MAR directed to give Lorazepam (Ativan) intensol Oral Concentrate 2mg/ml, 0.25 ml every two hours PRN for restlessness and comfort. The Controlled Drug Use Record January 2026 to March 2026 revealed:a. One- 30 ml bottle of Ativan was received on 1/23/26.b. Ativan was signed out on the Controlled Medication Record but not recorded on the MAR on the following dates: 2/1, 2/12, 2/16, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/18, 2/20 (5 times)c. Ativan was documented on MAR as given but not signed out on the Controlled Drug Use Record on the following dates: 2/1, 2/3, 2/17, 2/18, 2/24 (5 times)3. The MDS for Resident #47 dated 01/14/26 assessment identified a BIMS score as 13, indicating intact cognition. Resident #47's MDS included non-Alzheimer's dementia, anxiety disorder, depression, and schizophrenia. The MDS documented Resident #47 received antianxiety medication during the last 7 days.The Care Plan with a target date of 4/19/26 revealed Resident #47 used antianxiety medication related to diagnosis of paranoid schizophrenia. The care plan directed staff to give medications as ordered. The February 2026 MAR directed to give Lorazepam (Ativan) intensol Oral Concentrate 2mg/ml, 0.25 ml every two hours PRN for increased anxiety and restlessness. The Controlled Drug Use Record December 2025 to March 2026 revealed:a. One- 30 ml bottle of Ativan was received on 12/10/25.b. Ativan was signed out on the Controlled Medication Record but not recorded on the MAR on the following dates: 12/28, 12/29, 12/31, 1/5, 1/6, 1/7, 1/9, 1/10, 1/15, 1/20, 1/26, 2/8, 2/11, 2/12, 2/16, 2/18, 2/22, 2/25 (19 times)c. Ativan was documented on MAR as given but not signed out on the Controlled Drug Use Record on the following dates: 12/11, 12/12, 12/21, 12/23, 12/31, 1/5, 2/4, 2/7, 2/18 (13 times)A facility form titled Monthly Narcotic Count Record labeled Hall 100 documented staff who signed the form, acknowledge transfer of responsibility for the narcotic count and have found that the quantity of each medication counted to be in agreement with the quantity stated on the Individual Narcotic Count Record. The record required documentation of the Nurse on signature and the Nurse off signature for each shift. Review of the count record for Hall 100 revealed the lack of staff signatures, indicating reconciliation of controlled medications for Hall 100 did not occur on the following months, dates and shifts:December 2025:12/3- 2-10 shift on and off12/5- 2-10 shift on and off12/6- 6-2 shift on and off12/7-- 6-2 shift on and off, 2/10 shift on and off12/10- 2-10 shift on and off12/12- 6-2 shift off12/13- 2-10 shift on and off12/15- 2-10 on and off12/16- 6-2 on and off, 2-10 shift on and off12/17- 2-10 shift on and off12/20- 6-2 shift off, 2-10 on and off12/21- 6-2 shift off, 2-10 shift on and off12/26- 2-10 shift on12/27- 6-2 shift off, 2-10 shift on and off12/31- 2-10 shift on and offJanuary 2026:1/15- 2-10 shift on and off1/16- 2-10 shift off1/31- 6-2 shift off, 2-10 shift onReview of the February 2026 Monthly Narcotic Count Record for 100/400 Hall revealed staff signed off each shift that the narcotic count had been completed. A facility form titled Monthly Narcotic Count Record labeled Hall 200 documented staff who signed the form, acknowledge transfer of responsibility for the narcotic count and have found that the quantity of each medication counted to be in agreement with the quantity stated on the Individual Narcotic Count Record. The record required documentation of the Nurse on signature and the Nurse off signature for each shift. Review of the count record for Hall 200 revealed the lack of staff signatures, indicating reconciliation of controlled medications for Hall 200 did not occur on the following months, dates and shifts:December 2025:12/1- 6-2 shift on and off12/8- 6-2 shift on and off12/11- 2-10 shift on and off12/13- 6-2 shift on and off12/14- 6-2 shift on and off12/15- 6-2 shift on and off12/17- 2-10 shift off12/18- 2-10 shift off12/24- 6-2 shift off and 2-10 shift on12/27- 6-2 shift on and off12/28- 6-2 shift on and off12/29- 6-2 shift on and offJanuary 2026:1/10- 6-2 shift off, 2-10 shift on and off1/11- 6-2 shift on and off, 2-10 shift on and off1/26- 6-2 shift off1/28- 2-10 shift on and offFebruary 2026:2/19- 2-10 shift on and off2/28- 2-10 shift on and off, 10-6 shift [NAME] facility form titled Monthly Narcotic Count Record labeled Hall 300 documented staff who signed the form, acknowledge transfer of responsibility for the narcotic count and have found that the quantity of each medication counted to be in agreement with the quantity stated on the Individual Narcotic Count Record. The record required documentation of the Nurse on signature and the Nurse off signature for each shift. Review of the count record for Hall 300 revealed the lack of staff signatures, indicating reconciliation of controlled medications for Hall 300 did not occur on the following months, dates and shifts:December 2025:12/19- 6-2 shift off12/30- 6-2 shift on and offJanuary 2026:1/31/26- 10-6 shift onFebruary 2026:2/9- 6-2 shift on and off2/28- 6-2 shift on and offThe Written Statement dated 3/2/26 from Staff L, LPN documented last week Resident #23's box of Ativan was wet and the bottle had less than what it should have in it. Then when taking out (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #47's Ativan the label on the bottle was sticky like the bottle had leaked. Staff L documented Staff D was present in the medication room with her. Staff L reported she got busy and forgot to say something. Staff L documented the last time she had counted the Ativan was last week. The Written Statement dated 3/2/26 from Staff M, CMA reported the last time Staff M counted the Ativan was on 2/22/26. She said the Ativan was left in the medication cart and was not in the refrigerator. She said she was unaware that the Ativan was supposed to be refrigerated. An undated Witness Statement from Staff A, CMA documented she could not remember that last she had counted the liquid narcotics. An undated Witness Statement from Staff N, CMA documented she could not remember the last time she had counted the Ativan in the refrigerator in the medication room. On 4/1/26 at 8:32 AM, the DON reported on 2/28/26 she received a call from Staff H, LPN, Staff E, LPN and Staff I, CMA reporting they had found missing liquid Ativan. The DON reported she suggested to the staff to recount all narcotics. She said the first narcotic discrepancy was noticed was on Resident #22. She said there was only 1 ml in Resident #22's Ativan bottle and the Narcotic Record showed 21 ml. She said the count was significantly off. She said the staff counted all the liquid Ativan medications and noted Resident #23's narcotic record to be off 8 ml and Resident #47's narcotic record to be off 5 ml. She said she thought the total of liquid Ativan missing was 33 ml. She said she did compare the Narcotic Administration Records to the Medication Administration records for all three residents and was not able to account for all the missing Ativan. She said she did notice that some of the nurses were giving the liquid Ativan but missing documentation either on the Narcotic Administration Record or the MAR. She said there were three different nurses that wrote in their statements about Ativan spillage. The DON reported she had provided education to the nurses and CMAs regarding narcotic count and reporting spillage to management. When asked about education for medication administration/documentation, she reported she probably should have provided education on that and she did not. The DON said she had made a mistake. She reported she was focused on the concern that multiple nurses' statements voiced they had not been counting the refrigerated narcotics but documenting on the form the narcotic count had been completed. The DON said she felt that everyone was too comfortable and did not document properly. The DON reported she expected staff to count narcotic medication each shift or when handing off the keys including the medication in the refrigerator, staff to document on the Narcotic Medication Administration Records and the MAR when controlled medications are given and staff to report any medication discrepancy or spillage to the management immediately. The DON said the liquid Ativan was kept in a lock box that looked like a brief case. She said the lock box does not stand up and the liquid Ativan lays on its side. She said the liquid Ativan comes in a dark glass bottle. She said she was not sure on the manufacturer's direction related to storage. She said she knows the liquid Ativan has to be kept in the refrigerator. She reported she had pictures of one of the Ativan bottle that showed the box had been wet. On 4/1/26 at 10:57 AM, Staff E, LPN reported the morning of 2/28/26 around 9-10 AM she was informed by Staff I, CMA that the liquid Ativan counts were off. She said she confronted Staff H, LPN who was on the 300 medication cart to see what had been done. Staff E reported she was on the 200 medication cart and did not have any residents on refrigerated controlled medications. Staff E said after lunch she talked to the DON and was instructed to count all the narcotic medications. She said Staff I and herself counted the narcotics and found the same discrepancies as that morning. She said she wrote down the resident names, discrepancies and provided the information to the DON. She said the facility was no longer doing liquid Ativan or morphine. She reported it was an expectation to complete narcotic count with the off-going nurse and sign the form. She said it was an expectation when a narcotic medication was given to document on the MAR and Narcotic Administration Record.On 4/1/26 at 11:16 AM, the ADON reported Staff I, CMA called her on 2/28/26 to report the liquid Ativan counts were off. She said Staff H, LPN had counted that morning with Staff G, RN but had not notified her the counts were off. She said she called the DON. She said the DON and the previous Administrator started an internal investigation and called the Police. She said when Staff I called her she also told (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	her to call the DON and write statements. On 4/1/26 at 1:56 PM, Staff G, RN reported on the morning of 2/28/26 she counted narcotics with Staff H, LPN and then changed her mind and said she counted narcotics with Staff I, CMA. She said they identified missing liquid Ativan during the narcotic count. She said she did not recall who the residents were or how much liquid Ativan was missing. She said Staff I said she would report the missing medications to the DON so she went home. She said there have been so many times things have been wrong. She said the narcotics in the refrigerator were not counted routinely. She said she would ask the staff about counting liquid Ativan and they would say they have not given any so they weren't going to count it. She said when she came back to work she was told the problem had been corrected by removing all the liquid Ativan and morphine. She said when Staff I and herself did the narcotic count, she said she asked Staff I to check the bottles for wetness and Staff I said they looked dry. On 4/1/26 at 2:09 PM, Staff H, LPN reported Staff G, RN/overnight nurse pointed out when counting the narcotics that the liquid Ativan was off. She said one of the bottles of Ativan looked like it had leaked in the box. She said the bottle belonged to Resident #23. She said she did not recall any other liquid damage on the other boxes. She said she could not recall who the other residents were that were short on the Ativan. She said she thought there were a couple of residents down the 100/400 hall. She said the liquid Ativan was kept in a locked box in the refrigerator and the boxes were kept on their sides. She said the Ativan shortage was reported to the DON. She said the DON had her print off the administration record and compare it to the narcotic records. She said there wasn't much difference and did not account for all the Ativan that was missing. She said liquid narcotics are either more or less. She said there was not a solid method of measuring liquid narcotics. She said when administering narcotics it was an expectation to document in the Narcotic book and on the MAR. On 4/1/26 at 2:44 PM, Staff I, CMA reported she came in at 8 AM on 2/28/26 and did a narcotic count with Staff H, LPN. She said Staff H made the comment the Ativan counts were off and did not know what to do. She said Staff E, LPN and Staff H, LPN had not notified management so she reached out to the ADON. She said she was asked by the DON to do a recount of the narcotics. She said Staff E and herself counted the narcotics with the DON on the phone. She said Resident #22, #23 and #47 Ativan counts were off. She said she did not recall the amounts that were off but Resident #22's count was off quite a bit. She said they did look at the narcotic records and it appeared the medication was being signed off but the narcotic records were not compared to the MAR at that time. She said the last time she recalled counting the narcotic including the liquids Ativan was on 2/15 and the counts were correct. She said when she counted the narcotics on 2/28, Resident #22's Ativan box did not look like it had been wet. She said Resident #23 and #47 Ativan boxes had what looked like grease stains, like something had spilled on it. She said the bottles were not sticky and there was no wetness. She said the caps were on tight and the stopper was in place with the hole for the syringe. On 4/1/16 at 3:00 PM, Staff K, RN reported nobody counted the liquid Ativan. He said the last time he counted a bottle of liquid Ativan was for a dying patient at the beginning of February.On 4/1/26 at 9:21 PM, Staff J, LPN reported the liquid Ativan was stored in the refrigerator in the medication room in a locked box. He said the Ativan could not stand upright in the lock box and laid on its side. He said if the lids did not get put back on the bottles they would leak. He said there have been times the boxes have been saturated and he would have to put on gloves and wash the bottles off. He said the facility needed to get something so the bottles/boxes could stand up properly. He said he has told the DON, new ADON and asked the dayshift nurses to pass it on. He reported there had been several Ativan boxes wet and he would not know what bottle had been leaking. He said the boxes were soaked so much the card board would change color to a dark grey. He reported one time Resident #22's bottle of Ativan had the lid off and you could actually see the liquid on the box. He reported he works 6 PM to 6 AM and when he comes in at 6 PM he completes a narcotic count depending on what hall he is assigned. He said in the morning he would count with the day shift nurses coming on. He said sometimes the day shift nurses come in late so only pills are counted on the medication carts and that is it. He reported the liquid Ativan's do not get (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	counted as much. He reported he thought the Ativan shortage was related to the spillage as the boxes have been soaked. He said it was an expectation when administering a control substance to document on the Narcotic Administration Record and on the MAR. On 4/2/26 at 8:45 AM, Staff D, LPN said she had not been counting the narcotic in the refrigerator since January. She said she did not think about the liquid medications since it was in the refrigerator. She said she could not recall which resident's box of Ativan appeared wet or who's count was off. She said she did not report that the count was off to anyone. She said Staff L, LPN was the nurse who was dealing with it. On 4/2/26 at 9:07 AM, an outside Pharmacist said having the liquid Ativan stored upright was most important. He said having the Ativan laying on its side would risk medication leaking out if the lid was not on tight. He said he recommended the Ativan to be upright in the box.On 4/1/26 at 11:45 AM, observation in the medication room revealed the following:1. 53 Tylenol Suppositories- all expired with a variety of dates with the oldest date October 2024 2. 24 boxes of Adhesive remover wipes expired on July 20253. Bottle of [NAME] Aspirin expired February 2026A facility policy titled Controlled Substance updated on 10/19/22 documented the purpose of the policy was the following:To complete a physical inventory of narcotics at each change of shift by two nurses to identify discrepancies and need for reconciliation and accountability.To assure controlled drugs are handled, stored, and disposed of properly.To assure proper record keeping for controlled drugs.The policy directed authorized staff going off duty and coming on duty must count and validate accuracy of narcotic supply for every resident at the change of shift. After the supply was counted and justified, each nurse must record the date and his/her signature verifying that the count was correct.The facility policy titled Medication Administration updated 12/3/25 directed staff to sign the MAR after medications are administered and if the medication was a controlled substance to sign the narcotic book.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview, staff interview, and facility policy review the facility failed to ensure a resident's preference for med time for 1 of 2 resident's reviewed (Resident #21). The facility reported a census of 48 residents.Findings include:According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #21 scored 14 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident's diagnoses included stroke, emphysema, and insomnia.On 3/30/26 at 11:09 a.m. Resident #21 stated a nurse didn't get her meds until after 10 pm Saturday night, and she usually gets them around 8, that disrupts the schedule. She wants them earlier so she can get ready for bed. She said she was supposed to get them earlier, and this was not the 1st time this happened.A Medication Administration Audit dated 4/2/26 documented Resident #21 had the following medications scheduled at 8 p.m.: Flonase Allergy Relief Nasal Suspension 50 mcg, 2 sprays both nostrils, Magnesium Glycinate 100 mg, 4 capsules, Omeprazole delayed release 20 mg, and Melatonin 3 mg. The medications were administered at 10:01 p.m. Resident Council notes dated 3/19/26 indicated pills and treatments were not given timely.On 4/1/26 at 10:26 a.m. the Interim Director of Nursing stated medications could be given 1 hour before to 1 hour after their scheduled time. She confirmed Resident #21's medications were not administered timely.The facility Medication Administration Policy updated 12/3/25 documented medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. The policy included ensuring the six rights of medication administration were followed including the right time. Medications could be administered within 60 minutes prior to or after the scheduled time unless otherwise ordered by physician.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on clinical record review, staff interview and guidance from the 2025 Resident Assessment Instrument (RAI) manual, the facility failed to complete and transmit a Minimum Data Set (MDS) assessment within federal guideline for 2 of 2 resident reviewed for MDS assessments (Resident #4 and #17). The facility reported a census of 48 residents. Findings include: 1. Review of the census tab in the electronic health record (EHR) revealed Resident #4 was discharged on 1/7/26. The Progress Note on 1/7/26 indicated Resident #4 had been discharged to Assisted Living. The MDS section of the EHR revealed a discharge MDS had not been set up or completed. 2. Review of the census tab in the EHR revealed Resident #17 was discharged on 2/10/26. The Progress Note on 2/10/26 indicated Resident #17 had returned home. The MDS section of the EHR revealed a discharge MDS had not been set up or completed. On 3/30/26 at 3:48 PM, the Interim Director of Nursing (DON) acknowledged Resident #4 and Resident #17 discharge MDS was not completed. She said a discharge MDS was expected to be completed when a resident discharges from the facility according to the RAI manual. On 3/30/26 at 4:20 PM, the MDS Coordinator reported she had missed completing the discharge MDS for R#4 and R#17 as she was learning new job tasks. According to the 2025 RAI, a discharge assessment must be dated for the date of the resident's discharge from the facility and must be completed no later than 14 days following the discharge date .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and pharmacist interview, the facility failed to intervene and call the pharmacy and follow up with a physician when medication was unavailable for 1 of 6 residents reviewed (Resident #51). The facility reported a census of 48 residents.Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #51 scored 10 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident's diagnoses included fractures and other multiple trauma, a seizure disorder, a mood disorder, and mild cognitive impairment. The Care Plan initiated 12/11/25 identified Resident #51 at risk for adverse effects from the routine/as needed (PRN) use of anticonvulsants. The resident had a diagnosis of epilepsy. Interventions included observing for the effectiveness of medications, reporting significant side effects to the physician, and reviewing medications as necessary. The Medication Administration Record (MAR) for December showed the Resident #51 to receive Cenobamate 100 mg daily at breakfast related to seizures. The MAR documented the resident did not receive the medication 12/10-12/14/25, or 12/16-12/24/25. The MAR documented by check the resident had received the medication on 12/15/25, however the medication was not available. The Progress Notes dated 12/10/25 at 9:43 a.m. documented Cenobamate Oral Tablet 100 mg not available, pending approval. The Progress Notes dated 12/11/25 at 7:25 a.m. documented Cenobamate not available, pending delivery. The Primary Care Provider (PCP) notified. The Progress Notes dated 12/12/25 at 7:33 a.m. documented Cenobamate not available, pending delivery. PCP notified. The Progress Notes dated 12/15/25 at 10:39 a.m. documented the Advanced Registered Nurse Practitioner (ARNP) in house reviewed admission paper work. No new orders obtained. The record lacked documentation they discussed not receiving the Cenobamate. The Progress Notes dated 12/16/25 at 7:31 a.m. documented Cenobamate not available, pending delivery. PCP notified. The Progress Notes dated 12/18/25 at 7:56 a.m. documented Cenobamate not available. The Progress Notes dated 12/19/25 at 7:57 a.m. documented Cenobamate not available. The Progress Notes dated 12/21/25 at 07:12 a.m. documented Cenobamate not available, pending delivery. PCP notified. The clinical record lacked documentation the facility called the pharmacy to find out why the medication had not arrived, identified the risks of not receiving the medication, or monitored the resident for possible negative effects of the resident not receiving the medication. A hospital Progress Note dated 12/22/25 documented the resident seen at the nursing home for an acute concern. The resident had continued pain. Staff reported she continued to have behaviors and yell out. Staff reported the resident had not received an antiseizure medication since she had been at the facility. Hospital staff called the pharmacy and they reported they did not receive a prescription from the hospital at the time of discharge. A Psych Consult report dated 12/23/25 documented it was noted from the review of Resident #51's medication, that she did not receive one of her antiseizure medications from the previous 2 weeks. The pharmacist made a note in her medical record the information around her not receiving the medication and potential withdrawal symptoms which included increased anxiety, depressed mood, insomnia, increased seizure risk, and with case reports showing panic attacks and aggressive behaviors. The resident not receiving the Cenobamate for 2 weeks may contribute to behavioral concerns as withdrawal symptoms may correlate with this or at least exacerbate symptoms. Would recommend getting back on the anticonvulsant medication that she had not recently been getting, pending the recommendations from the medical provider/neurologist that prescribed the medication. On 4/1/26 at 3:10 p.m. the Assistant Director of Nursing (ADON) looked through Resident #51's records and confirmed there was no documentation facility staff had called the pharmacy about the Cenobamate to find out why they had not received it. She confirmed the resident would have received the medication sooner if they had. On 4/2/26 at 10:22 a.m. a Pharmacist at the resident's pharmacy stated if Cenobamate was stopped abruptly, it could cause nervous system excitability, emotional instability, agitation, and an increased risk of seizures.

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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. Based on observations, clinical record review and policy review the facility failed to give medications according to manufacturer's instructions for 2 out of 5 residents observed during medication pass (Resident #24 and #14). The facility reported a census of 48 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #24 dated 2/11/26 identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS identified Resident #24 was independent with bed mobility and transfers. The MDS included diagnoses of non-alzheimer's dementia, seizure disorder and anxiety disorder. The April 2026 Medication Administration Record (MAR) directed staff to administer Fosamax (used to treat or prevent osteoporosis) 70 MG (milligrams) one tablet by mouth one time a week in the Early AM on Wednesday related to osteoporosis. The order lacked specific directions on how the medication should be administered. During observation with the morning medication pass on 4/1/26 with Resident #24 and review of April 2026 MAR revealed the following medications were given at the same time as the Fosamax:-Lisinopril 10 mg 1 tablet -Memantine Hydrochloride 5 mg 1 tablet -Multivitamin with minerals 1 tablet-Potassium Chloride ER 10 mEq 1 tablet-Thiamine 100 mg 1 tablet-Carbamazepine 200 mg 2 tablets-Clonazepam 0.5 mg 1/2 tablet-Levetriacetam 750 mg 1 tablet-Risperdone 0.25 mg 1 tablet -Buspirone HCL 10mg 1 tablet-Gabapentin 300 mg 1 capsuleOn 4/1/26 at 7:19 AM, observed Staff D, Licensed Practical Nurse (LPN) administer the Fosamax medication to Resident #24 with other medications during breakfast with a glass of apple juice. Resident #24 was sitting at the table eating breakfast. On 4/1/26 at 9:21 AM, Staff D, LPN reported Early on the MAR indicated to administer the medication prior to 7 AM. She said the night nurses do not administer any medications except for as needed (PRN) medications. She said when she worked at a previous facility and the Fosamax medications were delivered 30-60 minutes prior to breakfast with no other medications. The Fosamax medication manufacturer's instructions instructed patients to swallow the medication whole with 6 to 8 ounces plain water at least 30 minutes before the first food, drink or medication of the day and not to lie down for at least 30 minutes after taking the medication and until after food. The manufacturer's instructions documented calcium supplement, antacids, vitamins or other oral medications can interfere with the absorption of the Fosamax. 2. The MDS assessment for Resident #14 dated 3/18/26 identified a BIMS score of 06, indicating severe impaired cognition.The MDS identified Resident #14 required substantial/maximal assistance with bed mobility and sit to stand transfers. The MDS included diagnoses of hypothyroidism. The April 2026 MAR directed staff to administer Levothyroxine Sodium 125 mcg (micrograms) one tablet by mouth every Monday, Tuesday, Wednesday, Thursday, Friday and Saturday at breakfast related to hypothyroidism. The order lacked specific directions on how the medication should be administered. During observation with the morning medication pass on 4/1/26 with Resident #14 and review of April 2026 MAR revealed the following medications were given at the same time as the Levothyroxine:-Tylenol 325 mg 2 tablets-Loratadine 10 mg 1 tablet-Multivitamin with mineral 1 tablet-Osyter Calcium 500 mg 1 tablet-Cholecalciferol 125 mcg 1 tabletOn 4/1/26 at 7:25 AM, observed Staff E, LPN administered Levothyroxine medication to Resident #14 with other medications during breakfast. Resident #14 was sitting at the table eating breakfast. On 4/1/26 at 8:20 AM, Staff E acknowledged she administered the Levothyroxine with other medications and with breakfast.On 4/1/26 at 9:05 AM, the Interim Director of Nursing (DON) reported it was an expectation for nursing to administrator Fosamax and the Levothyroxine medications on an empty stomach prior to breakfast. The Levothyroxine medication manufacturer's instructions instructed patients to take the medication at the same time before breakfast on an empty stomach with water. The facility policy titled Medication Administration updated 12/3/25 instructed staff to administer medications as ordered in accordance with manufacturer specifications.

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	165455	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Carroll	2241 North West Street Carroll, IA 51401

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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 clinical record review, staff interviews, and Pharmacy interview, the facility failed to ensure residents were free of significant medication errors for 1 of 6 residents reviewed (Resident #51). The facility reported a census of 48 residents.Findings include:According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #51 scored 10 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident's diagnoses included fractures and other multiple trauma, a seizure disorder, a mood disorder, and mild cognitive impairment.The Care Plan initiated 12/11/25 identified Resident #51 at risk for adverse effects from the routine/as needed (PRN) use of anticonvulsants. The resident had a diagnosis of epilepsy. Interventions included observing for the effectiveness of medications, report significant side effects to the physician, and review medications as necessary. 1. The Medication Administration Record (MAR) for December showed the resident to receive Cenobamate 100 mg daily at breakfast related to seizures. The MAR documented the resident did not receive the medication 12/10-14/25, or 12/16-24/26. The MAR documented by check the resident had received the medication, however the medication was not available.The Progress Notes dated 12/10/25 at 9:43 a.m. documented Cenobamate Oral Tablet 100 mg not available, pending approval.The Progress Notes dated 12/11/25 at 7:25 a.m. documented Cenobamate not available, pending delivery. The Primary Care Provider (PCP) notified.The Progress Notes dated 12/12/25 at 7:33 a.m. documented Cenobamate not available, pending delivery. PCP notified.The Progress Notes dated 12/15/25 at 10:39 a.m. documented the Advanced Registered Nurse Practitioner (ARNP) in house reviewed admission paper work. No new orders obtained. The record lacked documentation they discussed not receiving the Cenobamate.The Progress Notes dated 12/16/25 at 7:31 a.m. documented Cenobamate med not available, pending delivery. PCP notified.The Progress Notes dated 12/18/25 at 7:56 a.m. documented Cenobamate not available.The Progress Notes dated 12/19/25 at 7:57 a.m. documented Cenobamate not available.The Progress Notes dated 12/21/25 at 07:12 a.m. documented Cenobamate not available, pending delivery. PCP notified.The clinical record lacked documentation the facility called the pharmacy to find out why the medication had not arrived.A hospital Progress Note dated 12/22/25 documented the resident seen at the nursing home for an acute concern. The resident had continued pain. Staff reported she continued to have behaviors and yell out. Staff reported the resident had not received an antiseizure medication since she had been at facility. Staff called pharmacy and reported they did not receive prescription from the hospital at time of discharge.A Psych Consult report dated 12/23/25 documented it was noted from the review of her medication that she did not receive one of her antiseizure medications from the previous 2 weeks. The pharmacist made a note in her medical record the information around her not receiving the medication and potential withdrawal symptoms which included increased anxiety, depressed mood, insomnia, increased seizure risk, and with case reports showing panic attacks and aggressive behaviors. The resident not receiving the cenobamate for 2 weeks may contribute to behavioral concerns as withdrawal symptoms may correlate with this or at least exacerbate symptoms. Would recommend getting back on the anticonvulsant medication that she had not recently been getting, pending the recommendations from the medical provider/neurologist that prescribed the medication.On 4/1/26 at 1:05 p.m. a representative of the Resident's pharmacy stated Xcopri (cenobamate) is a controlled drug and they have to have a script to dispense. She said they sent a script request to the hospital on [DATE]. They did not receive one. On 12/10/25 they sent a script request to the Nurse Practitioner and was returned denied. A second request sent to the Nurse Practitioner was also denied. They received information from the hospital on [DATE], and a script, so they could obtain and send the medication out.On 4/1/26 at 3:10 p.m. the Assistant Director of Nursing (ADON) looked through Resident #51's records and confirmed there was no documentation facility staff had called the pharmacy about the Cenobamate to find out why they had not received it. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She confirmed the resident would have received the medication sooner if they had.On 4/2/26 at 10:22 a.m. a Pharmacist at the resident's pharmacy stated if Cenobamate was stopped abruptly, it could cause nervous system excitability, emotional instability, agitation, and an increased risk of seizures.2. The Medication List from the hospital dated 12/9/25 included Resident #51 should start taking Clobazam (for seizures)10 mg, 1.5 mg tablets (15 mg total) in the morning.The December 2025 MAR for Resident #51 documented the medication Clobazam 10 mg daily at breakfast with a start date of 10/10/25 at 7 a.m. The MAR documented Resident #51 received Clobazam 10 mg at breakfast on 12/10/25.A Pharmacist's Report to Nursing dated 12/10/25 informed them Resident #51 admitted on Clobazam 10 mg a.m. and 20 mg p.m. Hospital records indicated the resident should be on Clobazam 15 mg a.m. and 20 mg p.m.The December 2025 MAR documented Clobazam 10 mg, give 1.5 tablet by mouth one time a day with a start date of 12/11/25 at 7 a.m. 3. The Medication List from the hospital dated 12/9/25 included Resident #51 should start taking Lacosamide (for sezures) 50 mg 5 tabs at bedtime.The December 2025 MAR documented Lacosamide 50 mg 1 tablet by mouth at bedtime with a start date of 12/09/25 at 8 p.m. A Pharmacist's Report to Nursing dated 12/10/25 documented Resident #51 had an order for Lacosamide 200 mg a.m. and 50 mg HS, but hospital records indicated the dose should be Lacosamide 200 mg a.m. and 250 mg p.m.The December 2025 MAR documented Lacosamide Oral Tablet 50 mg, give 5 tablet by mouth one time a day with a start date of 12/10/25 at 8 p.m.On 4/1/26 at 3:10 p.m. the ADON confirmed medication errors occurred due to transcription errors the day the resident admitted to the facility. The Pharmacy Consultant caught the errors on 12/10/25. Resident #51 had received the wrong dose of 2 medications.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, resident interviews, staff interview, and policy review the facility failed to provide food at an appetizing temperature to 3 of 15 residents (Residents #2, #5, and #45) reviewed. The facility reported a census of 48 residents.Findings include:1. Review of Resident #2's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognitive functioning. Interview on 3/30/26 at 11:35 AM with Resident #2 revealed the food that comes on lunch trays is often cold, and not warm when it is delivered. 2. Review of Resident #5's MDS dated [DATE] revealed a BIMS score of 13 indicating intact cognitive functioning. Interview on 3/30/26 at 11:14 AM with Resident #5 revealed the food is often cold when it is delivered on room trays when it should be hot. 3. Review of Resident #45's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognitive functioning. Interview on 3/30/26 at 10:32 AM with Resident #45 revealed the food does not taste good, and sometimes the food is not up to temperature. During continuous observation on 4/1/26 from 11:30 AM until 11:44 AM room trays observed to be delivered to the East hallway on an open air cart with plates covered with lids. At 11:33 AM room trays were delivered to the North hallway and left in the same manner as the East hallway and both were left in the hallways. At 11:35 AM the staff were then observed passing the trays in the East hallway, with trays being passed in the North hallway at 11:38 AM. On 4/1/26 at 11:44 AM a test tray obtained and temperatures were obtained revealing the mashed potatoes having a temperature of 129.7 degrees and the mixed vegetables being 121 degrees. Interview on 4/1/26 at 11:51 AM with the Certified Dietary Manager (CDM) revealed that she would like to have food served at 135 degrees or warmer. The CDM then revealed that this would be her expectation. Review of a facility provided policy titled, Food Temperatures with a date of 2021 indicated that all hot food items must be cooked to appropriate internal temperatures, held, and served at a temperature of at least 135 degrees.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, resident interview, staff interviews, and policy review the facility failed to use universal infection control measures (hand hygiene) during care of two separate wounds for 1 of 5 residents reviewed for infection control (Residents #2). The facility reported a census of 48 residents. Findings include:Review of Resident #2's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognitive functioning. Further review of the MDS revealed Resident #2 had diagnoses of hypertension (high blood pressure), diabetes mellitus, stroke, and a stage 3 (full-thickness skin loss injury) pressure ulcer to the right buttocks. Interview on 3/30/26 at 11:37 AM with Resident #2 revealed that there were open areas to her buttocks. Resident #2 further revealed the areas to her buttocks are getting dressing changes. Review of Resident #2's Electronic Healthcare Record (EHR) page titled, Clinical Physician Orders revealed an order dated 3/7/26 indicating all wounds were to be cleansed with foaming cleanser, then to cleanse wounds with wound cleanser soaked gauze and let sit for 3-5 minutes. Further review of the physician orders revealed an order dated 3/24/26 indicating to apply a wound paste daily. Another order was entered 3/27/26 for vaseline impregnated gauze to wound following application of the wound paste. Observation on 4/1/26 at 10:19 AM Staff F Licensed Practical Nurse (LPN) completed hand hygiene, and then donned gowns and gloves. Staff F was then observed removing old dressings from Resident #2's left and right buttocks while wearing the same gloves. Staff F then doffed her gloves, and completed hand hygiene. Staff F then donned new gloves and placed wound cleanser soaked gauze onto the left and right buttocks wounds while wearing the same gloves. Staff F then doffed her gloves, and completed hand hygiene. Staff F donned new gloves, and after 4 minutes removed the soaked gauze while wearing the same gloves. Staff F doffed and donned new gloves with proper hand hygiene and completed the wound paste treatment and vaseline treatment to the open areas while donning and doffing gloves between the areas at the appropriate times. Interview on 4/1/26 at 10:46 AM with Staff F LPN revealed that she should have changed gloves between the areas when taking the old dressings off, and when completing new treatments to the separate areas. Interview on 4/1/26 at 10:49 AM with the Assistant Director of Nursing/Infection Preventionist (ADON/IP) revealed that she would have expected the staff to change gloves in between wounds, and when completing care/treatments to different wounds. Interview on 4/1/26 at 10:53 AM with the Director of Nursing (DON) revealed that she would expect gloves to be changed when switching to different open areas on different parts of the body, as this would be a cross contamination concern. Review of a facility provided policy titled, Hand Hygiene with an updated date of 11/13/24 indicated staff should always complete proper hand hygiene between resident care sites.