STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. Based on resident interviews, staff interviews, facility document review and policy review the facility failed to provide ongoing education to residents and/or their representatives on Resident Rights in a format that is understandable to them. The facility had a census of 28.Findings include:On 1/27/26 at 10:25 AM during the Resident Council meeting, the residents present indicated they were unaware of having rights, knowing what the Resident Rights were or if they were posted within the facility for their knowledge.Review of Resident Council Minutes for 11/25, 12/25 and 1/26 revealed a variety of facility leadership in attendance at the meetings with no education provided to the residents on Resident Rights. During the Resident Council meeting on 1/27/26 Staff K, Life Enrichment Director, stated she normally assisted with leading the Resident Council, but if she was not available an Activity Coordinator filled her position. Staff K acknowledged the staff had not been reviewing/educating residents on Resident Rights during Resident Council meetings. The Director of Nursing, DON, during the Resident Council meeting on 1/27/26 stated the residents were provided the Resident Rights as part of their admission packets, but concurred the Resident Rights needed to be reviewed with the residents on an ongoing basis. Neither Staff K nor the DON could confirm the Resident Rights were posted and readily available for the residents. The facility's Resident Rights Policy, undated, revealed the residents had the right to be supported by the facility in exercising their rights, be informed about their rights and the resident rights were to be posted throughout the facility.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, resident interviews, family interviews, and staff interviews the facility failed to provide an opportunity for a comprehensive care plan to be reviewed and revised by an interdisciplinary team composed of each resident and resident representative to allow developing the care plan and making decisions about his or her care. The facility also failed to complete revisions to care plans when there was a change in the residents care to 10 of 20 residents reviewed (Resident #23, #11, #7, #8, #21 #2, #3, #9, #29, and #30). The facility reported a census of 28 residents.Findings include:1.According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 10/24/2025, Resident #23 had a Brief Interview of Mental Status (BIMS) score of 3. A BIMS score of 3 suggested severe cognitive impairment. The MDS documented the following diagnoses for Resident #23: Alzheimer's disease, hip fracture, anxiety, depression, muscle weakness and diabetes mellitus. The MDS documented an admission date of 2/7/2025. Record review revealed a document titled Baseline Care Plan Summary with an effective date of 12/17/2024. The resident's Power of Attorney (POA) signed and dated on 1/9/2025. Record review revealed no care conference attendance sheets or documents. On 1/20/2026 at 11:28 AM Resident #23's emergency contact #1 stated since the new company has taken over, the family has not been a part of her care plan meetings. The previous owners were holding meetings quarterly with family present but that has not happened since January 2025. On 1/23/2025 at 10:39 AM via email communication the Administrator acknowledged facility was unable to locate Resident #23's care plan attendance sheets. 2. Review of Resident #11's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognitive functioning. The MDS further revealed that Resident #11 was dependent on staff for chair/bed to chair transfers, transferring to the toilet, and tub/shower transfer. The MDS then revealed a diagnosis of unspecified fracture of the lower end of the right femur, muscle weakness, and difficulty in walking. Interview 1/20/26 at 10:43 AM with Resident #11 revealed that the staff utilize a whole body mechanical lift when transferring him with a sling. Resident #11 then revealed that sometimes there will only be one staff when transferring him with the lift, and sometimes there will be two staff. Review of Resident #11's Care Plan with a created date of 12/9/25 revealed Resident #11 requires staff assistance of one staff member for toilet transfer, and toileting with a gait belt. The Care Plan further revealed that Resident #11 was a stand pivot assist with one staff member and a gait belt. Interview 1/21/26 at 12:20 PM with Staff G Occupational Therapist Assistant revealed Resident #11 was a whole body mechanical lift transfer. Staff G then revealed on 12/17/25 she documented Resident #11 was a whole body mechanical transfer. Staff G further revealed when the physical therapy does the evaluation physical therapy will inform the nursing staff of how the resident transfers. Staff G then revealed Resident #11 was non-weight bearing on the right leg because of a right hip fracture that was on 12/3/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview 1/21/26 at 2:10 PM with the DON revealed that care plans should be updated accordingly. Interview 1/21/26 at 2:14 PM with Staff H LPN revealed that she did not get the update on the whole body mechanical lift from OT/PT and would expect them to update the care plan accordingly. 3. Resident #7's MDS dated [DATE] revealed a BIMS score of 11/15 indicating moderate cognitive deficit. The resident utilized a wheelchair (w/c) with partial/moderate assistance. The document disclosed diagnoses including chronic kidney disease, nonrheumatic aortic valve stenosis, unspecified osteoarthritis. The resident's Care Plan dated 1/7/25 contained 19 focus areas with goals/target dates and interventions. All 19 focus areas reflected goals that were revised on 1/7/25 with a target date of 4/8/25. 18/19 focus areas contained interventions for staff to follow that had not been changed since 4/23/24. The facility failed to revise Resident #7's Care Plan to reflect current needs, goals and target dates. The facility failed to reflect discontinuation of restorative nursing services as the facility does not offer this. Review of the Electronic Medical Record (EMR) on 1/21/26 identified no documentation in the Progress Notes or scanned documents indicating Care Conferences were held or updates were made to the Care Plan. On 1/22/26 at 1:40 PM Staff H, Licensed Practical Nurse (LPN)/MDS Coordinator/Infection Preventionist, stated the resident's Care Plan should have been revised when reviewed with the Director of Nursing (DON) and should be dated to reflect the updates. Staff H stated she did not schedule Care Plan Conferences. On 1/22/26 at 1:49 PM Staff N, Interim Director of Social Services, stated she had been in the position since 5/25. The staff stated Care Plans were reviewed quarterly. When asked about Care Conferences the staff stated she would have to locate the documents indicating the conferences were held with the resident representative. On 1/26/26 at 8:44 AM Staff N provided documents from Social Services indicating Care Plans were reviewed with the resident's representative on 6/16/25, 9/5/25 and 11/26/25. On 1/26/26 at 8:58 AM Staff N stated invitations for Care Conferences would go out to the resident/resident representative and interdisciplinary team (IDT) and a note should be placed in the Progress Notes. The staff acknowledged there were no entries in the Progress Notes for Care Conference invitations. The staff stated notices for conferences should go out 2-3 weeks in advance. At this time the Progress Notes revealed late entries dated 6/13/25 (time stamp 1/22/26 3:18 PM), 9/5/25 (time stamp 1/22/26 3:20 PM) and 11/26 (time stamp 1/22/26 3:21 PM) phone meetings were held for Care Plans. Staff N acknowledged she entered the Progress Notes following the interview on 1/22/26 at 1:49 PM. The staff stated the documents provided were completed by herself, but she could involve other IDT members. Staff N acknowledged Care Conference Notes should be in the Progress Notes and documentation should be put in the EMR at the time of the occurrence. The staff stated she had not been uploading documents into the EMR as part of the assessment/meeting process. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/26/26 at 11:51 AM resident representative stated she had not been invited to or taken part in a Care Plan Conference since the facility transition to new ownership the previous year. 4. Resident #8's MDS dated [DATE] revealed a BIMS score of 8/15 indicating moderate cognitive impairment. The document provided that the resident required partial/moderate assistance for upper and lower body dressing and required supervision/touching assistance for transfers and ambulation up to 50'. The document disclosed resident diagnoses of diabetes mellitus, cognitive communication deficit and obstructive sleep apnea. The resident's Care Plan reviewed on 1/20/26 at 3:50 PM revealed a focus of assistance with ADLs revised 4/8/24 with staff interventions of stand pivot transfer with assistance of 1 using a wheeled walker and ambulation with wheeled walker and assistance of 1 revised 4/8/24; walking with a device revised 9/23/25 and walking with assistance of 1 with a gait belt initiated 9/23/25. At the time of the review the facility failed to update the Care Plan to reflect a change in transfer status to the need for a dependent full body mechanical lift and the resident's diagnosis of Influenza A requiring personal protective equipment (PPE). The resident's Care Plan showed an intervention entered on 1/21/26 for the use of a Hoyer lift (dependent full body mechanical lift) with assistance of 2. The After Visit Summary dated 1/17/26 revealed the resident was transferred to the hospital following a fall and was discharged back to the facility with a diagnosis of the flu on the same date. On 1/20/26 at 11:35 AM observed signs posted outside of Resident #8's room for Enhanced Barrier Precautions (EBP) and Droplet Precautions. On 1/20/26 at 1:54 PM Resident #8 stated he had fallen recently, went to the hospital and got the flu. The resident stated he hasn't been able to stand up and transfer since getting sick. Observed a Hoyer lift in the resident's room during the interview. On 1/21/26 at 8:20 AM Staff C, CNA, stated when she worked on 1/16/26 the resident required standby assistance of 1 with a walker and was completing tasks for himself. The staff stated since getting Influenza A the resident had required significantly more assistance with care and transfers. On 1/22/26 at 12:27 PM Staff D, Certified Medication Aide (CMA), stated staff would look at the Electronic Medical Record/the Kardex for information on the resident's needs. On 1/22/26 at 1:40 PM Staff H, stated if she was aware of changes in a resident status she would put it on the Care Plan. The staff stated she was she was unaware of Resident #8 had a change in transfer ability. The staff stated any nurse could revise the Care Plan to change a resident's status. The staff acknowledged the resident did have a change in respiratory status with the diagnosis of Influenza A and the need for precautions. 5. Resident #21's MDS dated [DATE] Significant Change export ready revealed a BIMS score of 8/15 indicating moderate cognitive impairment. The document disclosed the resident did not have a catheter, was incontinent of bowel and bladder, and dependent for bed mobility and transfers. The document indicated the resident's diagnoses included heart failure, atrial fibrillation (A-fib) and impaired brain function. The MDS revealed the resident had (1) Stage 2 pressure ulcer, partial thickness loss of skin presenting as a shallow open ulcer with a red or pink wound bed, at the time of admission. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The EMR Clinical Physician Orders revealed the following orders: Urinary catheter: output every shift; start date 12/23/25 and discontinued 12/24/25. Urinary catheter: output every shift; start date 12/23/25 and discontinued 12/24/25. Urinary catheter: change urinary catheter 16f 10cc bulb; start date 12/23/25 and discontinued 12/24/25. Urinary catheter: catheter diagnosis: urinary retention; revision date 12/24/25 and discontinued 12/24/25. Urinary catheter: provide urinary catheter care every shift; start date 12/23/25 and discontinued 12/24/25. The EMR Progress Note entry on 12/24/25 disclosed staff observed the resident had removed her catheter with the balloon still inflated. The nurse obtained a physician order to discontinue the catheter use due to placing the resident at risk; the resident's daughter was present at the time and updated. The resident's Care Plan dated 12/30/25 revealed a focus area for indwelling catheter initiated on 12/23/25 and revised on 12/30/25. The interventions for staff included Enhanced Barrier Precautions (EBP) (initiated 12/24/25), monitor/record report signs/symptoms of urinary tract infection (UTI) (initiated 12/23/25), keep per area clean, position catheter bag and tubing below the level of the bladder, provide catheter care daily and as needed, record output every shift all dated 12/30/25. A focus area related to a pressure injury revised 12/30/25 included an intervention for use of EBP related to the wound and catheter. The facility failed to revise the Care Plan to reflect the discontinuation of the indwelling catheter per physician order on 12/24/25 and revise an intervention related to EBP needs on a pressure injury focus area. On 1/22/26 at 1:40 PM when asked about Resident #21's catheter, Staff H stated the resident did have a catheter. When asked about the Significant Change MDS dated [DATE] revealing the resident did not have a catheter and was incontinent of bowel and bladder, the staff responded the resident had a significant change related to hospice services being initiated. When provided with knowledge the catheter was discontinued on 12/24/25, Staff H acknowledged the Care Plan should have been updated to reflect that change in status. The staff stated any nurse could revise the Care Plan to reflect a change in a resident's status. On 1/26/26 at 8:58 AM Staff N stated Care Conferences were held quarterly and IDT members have their own components to complete. The staff stated the MDS Coordinator updates the Care Plan; however there may be sections in the Care Plan that were updated by whoever was assigned and the MDS Coordinator oversees the Care Plan to ensure all sections were completed. On 1/26/26 at 2:39 PM Staff J, Registered Nurse (RN), stated he did not update Care Plans. The staff stated when the residents were admitted as part of the admission process an initial Care Plan was started. The staff stated the MDS Coordinator and Social Services complete the Care Plans. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/26/26 at 10:12 AM the DON and the Administrator discussed Care Plans and Care Plan Conferences. The Administrator stated that in normal circumstances he would expect the IDT to be in attendance at the Care Plan Conferences. Neither the Administrator nor the DON could answer to the frequency of Care Plan Conferences. The Administrator stated he was not aware the Care Plan Conferences were not being held with IDT members present. The Administrator acknowledged there was not a corporate liaison for the facility regarding skilled care social services. The DON stated she started to notice the previous week there might be a problem as she thought a Care Plan Conference should be held regarding a resident's change in needs. The DON expected Care Plans to be revised as needed, including the goals and target dates. The DON and Administrator concurred that the Care Plans and Kardex needed to be current regarding the resident's needs to allow for pulled staff and/or contract staff to meet the needs of the residents. 6. The Minimum Data Set (MDS) dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. MDS documented Resident #2 was at risk for developing pressure ulcers/injuries and Moisture Associated Skin Damage (MASD) present. Review of Resident #2's MAR-TAR documented a physician's order with a start date of 1/11/26 and discontinued 1/12/26 to paint right heel deep tissue injury (DTI) daily with betadine and cover with dry dressing. A physician's order with a start date of 1/12/26 and discontinued 1/14/26 for the right heel to be cleansed, dry, painted with betadine and covered with mepilex foam once a day related to DTI. A physician's order with start date of 1/14/26 for wound on the right heel to be cleansed with wound cleanser, pat dry, apply Triple Antibiotic Ointment (TAO) and cover with foam dressing one time a day. A physician's order with a start date of 1/11/26 to evaluate right heel wound / peri-wound for complications including symptoms of infection. A physician's order with a start date of 11/28/25 to cleanse buttocks with soap and water, pat dry, apply Z guard every shift until healed. A physician's order with a start date of 11/28/25 to evaluate buttocks wound / peri wound for complications including symptoms of infection. A physician's order with a start date of 1/15/26 to cleanse sacral stage 2 pressure ulcer with wound cleanser, pat dry, apply a foam dressing and change every 3 days and as needed (PRN). A physician's order with a start date of 1/15/26 to evaluate stage 2 pressure wound/peri-wound for complications including symptoms of infection. Resident #2's MDS dated [DATE] documented treatments for skin injury included pressure reducing device for chair, pressure reducing device for bed, nutrition hydration intervention to manage skin problems. Resident #2's EHR titled, Care Plan documented a focus initiated on 11/28/25 that Resident #2 had potential for pressure injury development. Resident #2's care plan did not have MASD documented or intervention in place. Resident #2's care plan did not have treatments for skin injury including pressure reducing device for chair or bed, nutrition hydration interventions to manage skin problems documented. Resident #2's care plan identified Resident #2 required the assistance of 1 staff for bed mobility and required the assistance of 1 staff for personal hygiene. On 1/12/26 at 11:20 am an observation of Resident #2 lying on a scoop mattress. Review of Resident #2's EHR dated 1/11/26 at 7:53 AM entered by Staff P, RN, ADON, Assistant Director of Health and Wellness, and Wound Nurse titled, Wound Evaluation documented a DTI to the right heel minutes old that was in-house acquired that had an area of 1.25 cm2, length of 2.42 cm, and width of 1.1 cm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #2's EHR dated 1/6/26 at 7:41 PM titled, Skin Check documented no injury to right or left heel. Review of Resident #2's EHR dated 1/11/26 at 9:54 PM titled, Progress Notes documented reported on the am shift Resident #2 had an open area to the right heel. The exam showed suspected DTI. The area was cleansed, painted with betadine and protective dressing applied. Review of Resident #2's EHR dated 11/28/25 at 2:50 PM entered by Staff P titled, Wound Evaluation documented incontinence associated dermatitis that was present on admission on the buttocks that had an area of 1.42 cm2, length of 3.42 cm, and width of 0.61 cm. Review of Resident #2's EHR titled, Care Plan documented a focus initiated on 11/28/25 that Resident #2 had potential for pressure injury development. Resident #2's care plan did not have MASD or DTI on the right heel documented or intervention in place. Resident #2's care plan did not have treatments for skin injury including pressure reducing device for chair or bed, nutrition hydration interventions to manage skin problems documented. Resident #2's care plan identified Resident #2 required the assistance of 1 staff for bed mobility and required the assistance of 1 staff for personal hygiene. On 1/13/26 at 1:59 PM Resident #2, stated with Staff A present in the room, that her left foot heel protecting boot was applied 1/12/26. Resident #2 stated she had not been assisted with repositioning the whole day. Resident #2 stated it was hard for her to turn to the right because she had a left sided stroke. Resident #2 stated the triangle wedges helped her to stay on her side when staff use them. Resident #2 stated it feels good because then she is off her back. On 1/13/26 at 1:59 PM an observation revealed no triangle wedges present in Resident #2's room. On 1/13/26 at 2:00 PM Staff R, CNA stated the facility was supposed to get Resident #2 an air mattress. On 1/21/26 at 1:51 PM Staff J, RN explained frequently on the long term side of the facility the positioning wedges were not utilized appropriately. Staff J acknowledged Resident #2 had a scoop mattress in her bed and that was not appropriate for pressure relief. Staff J stated the scoop mattress prevented Resident #2 from turning in bed. Staff J stated Resident #2 did not have any interventions in place that were being utilized when the MASD was present on her buttocks. Staff J stated the wedges in Resident #2's room were not being utilized. Staff J explained he assessed Resident #2's MASD the area had turned into a stage 2. Staff J stated that was when the pressure relief wedge was being utilized. On 1/26/26 at 11:35 AM Staff H, Licensed Practical Nurse / MDS Coordinator / Infection Preventionist stated she was familiar with Resident #2. Staff H stated she was not aware of any MASD on Resident #2's buttocks. Staff H stated the MASD should have been addressed on the care plan but everybody should be updating the care plan. Staff H stated she would not expect any other interventions in place besides creams for MASD on Resident #2 for pressure ulcer prevention. On 1/26/26 at 3:13 PM the DON explained the scoop mattress that Resident #2 had in her room was not appropriate for pressure relief. 7. The Minimum Data Set (MDS) dated [DATE] documented Resident #3 had a Brief Interview for Mental (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Status (BIMS) of 11 indicating moderate cognitive impairment. On 1/12/26 at 10:49 am Resident #3 stated she had not been invited to any care conferences. On 1/13/26 at 4:11 PM Resident #3's son stated he had not been contacted every 3 months to discuss his mothers care at the facility. Resident #3's son stated he had not been invited to a care conference for his mother since she had been at the facility. Review of Resident #3's EHR titled, Progress Notes documented no family invitation or Care Conference meetings held with resident or family. Review of Resident #3's EHR documented admission to the facility on 4/9/25. On 1/26/26 at 9:00 AM Staff N, Interim Social Services Director stated she would enter resident and resident family invites to care conferences in resident's EHR titled, Progress Notes. Staff N stated she could complete the Social Services Comprehensive Quarterly assessment by herself without any IDT but she invites the IDT. Staff N stated there was a base care plan meeting, then one at 30 days and then there was a care conference completed quarterly (every 3 months). Staff N explained things were dropped a little on her part. Staff N acknowledged a lot of the care conferences were not completed. Staff N stated she could not find any care conference meetings for Resident #3. Staff N stated the assessment should include who was present for the meeting. Staff N acknowledged the family and residents had not been a part of the quarterly assessments or the Social Services Comprehensive Quarterly assessment. Staff N stated the family, resident and team members should be identified in the comments sentence. Staff N stated she had discussed concerns with care conferences not being completed appropriately with the previous Administrator and then brought it to the current Administrator. Staff N stated she spoke to the Administrator about the concern when he started. Staff N stated the Administrator would work on getting more resources to help her get caught up to help things move smoothly and would reach out to corporate to ask if there was someone she could talk to about things she was unsure of. Staff N explained the corporation did not have anybody to help but to reach out to somebody that might have that knowledge because they do not have any other skilled facilities. Staff N stated she had reached out to a previous Social Services Director at the facility. Staff N explained during the care conference meeting the IDT should be invited and a part of development. Staff N stated the family and resident should be a part if they can. Staff N explained family and residents should be invited and the care conference meeting should be completed quarterly. On 1/26/26 at 10:08 AM the DON stated she expected nursing to be part of a care conference meeting. The DON explained the MDS Coordinator was a nurse and would represent both the nurse department and MDS. The DON stated care conferences should be completed when there was a significant change or if the resident had reached a plateau. The DON stated social services set the care conferences up. The DON stated residents and or family should be invited to the care conferences. 8. The Minimum Data Set (MDS) dated [DATE] documented Resident #9 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. The MDS documented Resident #9 was at risk for developing pressure ulcers/injuries and one or more unhealed pressure injuries. On 1/20/26 at 11:31 AM Resident #9 stated the area on her buttocks started as a bed sore. Resident #9 explained the area got better then got worse. Resident #9 stated she did not remember if she was wearing heel protectors or not when she was in bed before she had the area on her right heel. Resident #9 stated she did not have the area on her right heel when she entered the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #9's MAR-TAR documented a physician's order with a start date of 12/9/25 and discontinued date of 12/30/25 to cleanse right heel DTI with soap and water, pat dry, and apply skin prep twice a day. A physician's order with a start date of 12/30/25 and a discontinued date of 1/16/26 to cleanse right heel DTI with soap and water, pat dry, apply betadine, an ABD dressing and secure with roll gauze every 3 days until healed. A physician's order with a start date of 12/9/25 and discontinued date of 1/7/26 to cleanse left inferior buttocks stage 2 pressure ulcer with wound cleanser, pat dry, apply Z guard every shift until healed. A physician's order with a start date of 12/9/25 and a discontinued date of 12/23/25 to cleanse left superior buttocks stage 2 pressure ulcer with wound cleanser, pat dry, apply Z guard every shift until healed. Review of Resident #9's EHR documented Resident #9 entered the facility on 12/4/25 with no documentation of pressure injury or DTI. Review of Resident #9's EHR dated 12/4/25 at 3:03 PM titled, admission / readmission Screener documented no injury to buttocks, right or left heel. Review of Resident #9's EHR dated 12/4/25 at 3:37 PM titled, Braden Scale for Predicting Pressure Sore Risk documented Resident #9 had a Braden score of 18 that indicated Resident #9 was at risk for development of a pressure sore. Review of Resident #9's EHR dated 12/8/25 at 2:37 PM entered by Staff P titled, Wound Evaluation documented an in-house acquired stage 2 pressure ulcer that was minutes old on the left superior gluteus that had an area of 6.35 cm2, length of 8.73 cm, and width of 1.98 cm. Review of Resident #9's EHR dated 12/9/25 at 10:01 AM entered by Staff P titled, Wound Evaluation documented an in-house acquired stage 2 pressure ulcer that was minutes old on the left inferior gluteus that had an area of 3.65 cm2, length of 2.54 cm, and width of 1.98 cm. Review of Resident #9's EHR dated 12/9/25 at 10:04 AM entered by Staff MM, Licensed Practical Nurse (LPN) titled, Wound Evaluation documented a minutes old in-house acquired DTI on the right heel that had no measurements but was present in the photo of the area. Review of Resident #9 EHR titled, Care Plan documented no focus, goals or interventions on prevention of a pressure sore. Pressure injury stage 2 left buttocks and DTI to right heel documented as initiated on 12/15/25 after pressure injuries had occurred. Review of Resident #9 EHR titled, Care Plan documented no focus, goals or interventions on prevention of a pressure sore. Pressure injury stage 2 left buttocks and DTI to right heel documented as initiated on 12/15/25 after pressure injuries had occurred. 9. The Minimum Data Set (MDS) dated [DATE] documented Resident #29 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. The MDS documented Resident #29 had one or more unhealed pressure ulcers. The MDS documented a Stage 2 pressure ulcer present. The MDS documented Resident #29 had an admission date of 11/11/25. Review of Resident #29 MAR-TAR documented a physician's order with a start date of 11/28/25 and end date of 12/16/25 to cleanse the sacral wound with wound cleanser, pat dry and apply Plurogel and foam patch daily until healed. A physician's order with a start date of 12/29/25 for Cephalexin 500mg, give one tablet by mouth every 12 hours for buttocks ulcer infection for 5 days. A physician's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	order with a start date of 12/16/25 and discontinued date of 1/2/26 to cleanse the sacral wound with wound cleanser, pat dry and apply Santyl and foam patch every other day. Review of Resident #29's document dated 1/12/26 titled, Hospital Progress Notes documented Resident #29 was concerned about returning to the facility because she did not get repositioned. Document explained Resident #29 acknowledged she had never had an ulcer ever before entering the facility in November. Discharge plan for return to facility repositioning every 2 hours and placement of wound vacuum. Review of Resident #29's document dated 1/6/26 at 5:06 PM titled, Operative Report documented Resident #29 had a known sacral decubitus pressure ulcer for the last 2 months, who presented to the hospital with fevers and concern for sepsis from her sacral decubitus wound. She has undergone some minimal debridement of this in the wound care clinic already. Her wound had a foul smell and significant necrotic tissue, warranting urgent debridement in the operating room. Debridement of all of the nonviable completely necrotic tissue which had a foul odor. The base of the wound was down onto the ligamentous structures running along the posterior sacrum and there was exposed bone. A bone biopsy which was sent separately. Area was debrided, removal of the necrotic soft tissue down to the bone centrally, and then to the bilateral gluteal muscles. The total debrided area was 6 cm x 5.5 cm. Review of Resident #29's EHR titled, Care Plan documented a focus for potential for pressure injury development related to assist needed initiated on 11/11/25 with a in house stage 2 pressure ulcer on sacrum initiated 11/28/25. No new interventions in place for in-house acquired a stage 2 pressure ulcer that was found from 11/28/25. The care plan does not reflect any new interventions since returning from the hospital with a surgically debrided stage 4 pressure ulcer that requires a wound vacuum. 10. The MDS dated [DATE] documented Resident #30 had a BIMS of 13 indicating no cognitive impairment. The MDS documented Resident #30 was at risk for development of pressure ulcers. The MDS documented no pressure ulcers. The MDS documented Resident #30 had an admission date of 12/2/25. Review of Resident #30 EHR titled, Care Plan documented no care plan update or intervention with unstageable skin found 12/23/25. On 1/26/26 at 11:35 AM Staff H, MDS Coordinator stated she was familiar with Resident #30. Staff H acknowledged there was no care plan update with unstageable skin found 12/23/25 and would have updated interventions as well. On 1/26/26 2:43 PM Staff J, RN stated he does not update care plans. Staff J stated Staff H, updated care plans. Staff J stated he does not think floor nurses updated the care plans or develop the interventions on the care plans. On 1/27/26 at 11:03 AM the DON stated there should be non-pharmaceutical interventions in place right away with any pressure ulcers like off loading and those interventions should be on the residents care plan. The DON explained Staff H builds the baseline care plan. The DON stated Staff H completed all the care plan updates. The DON stated a charge nurse sh

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff and family interviews, and facility policy review. The facility failed to provide oral cares for 5 of 5 residents (Resident #22, #2, #3, #29, and #30) reviewed and also failed to provide toileting and repositioning for Resident #29. The facility reported a census of 28 residents. Findings include:1.According to the Quarterly Minimum Data Set (MDS) assessment tool with a reference date of 10/31/2025 documented Resident #22 had a Brief Mental Status (BIMS) score of 4. A BIMS score of 4 suggested severe cognitive impairment. The MDS documented the resident required substantial/maximal assistance with oral hygiene. Resident #22 had the following diagnoses listed: multiple sclerosis, neurogenic bladder, dementia and depression. The Care Plan Focus Area with a revision date of 11/18/2020 documented Resident #22 had activities of daily living (ADL) self-care performance deficit due to her multiple sclerosis diagnoses and required the assistance of one staff for daily grooming (personal hygiene and oral care). On 1/20/2026 at 10:30 AM observed a sign on top of her heating/cooling unit. A hand written note was present that stated please brush Resident #22's teeth every day. On 1/20/2026 at 11:15 AM Resident #22's emergency contact #1 stated sometimes her teeth are not brushed much. She has noticed this a lot when she visits. When asked if Resident #22 would refuse her teeth be brushed, she indicated the resident would allow staff to complete oral cares on her. On 1/22/2026 at 8:25 AM Resident #22 was asked if staff brushed her teeth this morning, she stated not today. On 1/27/2026 at 11:02 AM the Director of Nursing (DON) was informed of the sign in Resident #22's room informing staff to brush her teeth every day. She stated that has not been brought to her attention and she has not been in her room. She indicated oral cares should be completed at least twice a day. When asked who is to complete this task, she indicated ideally the Certified Nurses Assistants (CNA) but nurses or anyone on the clinical team could complete oral cares. She added if the resident is receiving occupational therapy (OT) oral care can be completed with them as well. 2. The Minimum Data Set (MDS) dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. The MDS indicated Resident #2 required supervision or touching assistance from staff for oral hygiene. Review of Resident #2's EHR documented no documentation of oral care provided. On 1/12/26 at 11:21 AM Resident #2 stated she does have a toothbrush in her bathroom. Resident #2 stated it does depend on the staff if oral care was provided. Resident #2 stated her husband came to the facility in the evenings and would help her with brushing her teeth. Resident #2 stated in the morning if she was going to therapy she would be in the wheelchair and would go to the bathroom. Resident #2 stated Occupational Therapy used to help her but she no longer saw OT. Resident #2 stated occasionally a Certified Nurse Assistant (CNA) would assist her with oral care. Review of Resident #2's Electronic Health Record (EHR) titled, Care Plan with initiation date of 12/5/25 documented Resident #2 required an assist of 1 staff for oral care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The Minimum Data Set (MDS) dated [DATE] documented Resident #3 had a Brief Interview for Mental Status (BIMS) of 11 indicating moderate cognitive impairment. The MDS indicated Resident #3 required partial / moderate assistance with oral hygiene. On 1/13/26 at 4:11 PM Resident #3's son stated his mother would require staff to complete oral care for her because she can not get out of bed by herself. Review of Resident #3's EHR titled, Care Plan with initiation date of 4/12/25 documented Resident #3 required an assist of 1 staff for oral care. Review of Resident #3's EHR documented no documentation of oral care provided. On 1/12/26 at 10:49 AM an observation revealed no toothbrush in Resident #3's room. On 12/26/26 at 1:00 PM an observation of Staff P, Assistant Director of Health and Wellness / Assistant Director of Nursing (ADON) entered Resident #3's room, looked for a sponge dental swab or a toothbrush. On 12/26/26 at 1:05 PM Staff P acknowledged there was no equipment in Resident #3's room to provide oral care. On 1/12/26 at 12:17 PM Staff C, CNA stated the staff provide oral care to the residents. Staff C stated she completed oral care with Resident #3 that morning. Staff C stated she gets Resident #3 a new toothbrush everyday because she does not know what happened to the toothbrush the day prior. Staff C stated she offers Resident #3 a basin and toothbrush and Resident #3 did her own brushing. Staff C stated she Resident #3 only required set-up only according to the care plan. 4. The Minimum Data Set (MDS) dated [DATE] documented Resident #29 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. MDS documented Resident #29 required supervision or touching assistance for oral hygiene. Review of Resident #29's EHR titled, Care Plan documented an intervention / task for oral care dated 11/19/25 that Resident #29 required an assistance of one for oral care. Review of Resident #29's EHR documented no documentation of oral care provided. On 1/15/26 at 1:30 PM Resident #29 stated she had to set an alarm on her phone to ensure the staff come to turn her every 2 hours or the staff will not reposition her. Resident #29 stated her doctor wants her repositioned every 2 hours. Resident #29 stated prior to going to the hospital the staff were not repositioning her every 2 hours some overnight shifts the staff would only come in at 3:00 AM or 4:00 AM to reposition her in bed. Resident #29 stated she had multiple sclerosis and was not able to reposition herself in bed. Resident #29 stated she required the assistance of staff for repositioning. Resident #29 stated the staff rarely provided oral care to her. Resident #29 stated she would like oral care but felt like she should be able to do it on her own but she could not even sit up in bed on her own. Resident #29 stated she would appreciate staff assisting with oral care. On 1/22/26 at 11:29 AM Resident #29 stated she was told last night by Staff EE, Certified Nurse Assistant (CNA) refused to change her brief. Resident #29 stated she was out of briefs and Staff EE refused to change her last night. Resident #29 stated she had not had a bowel movement but was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incontinent of urine and nobody changed her at all last night. Resident #29 stated the Staff EE only repositioned her at night but never changed her. Resident #29 stated she has had problems with Staff EE from the get go. Resident #29 stated Staff EE was not supposed to be caring for her because she had voiced concerns about how she cared for her in the past. Resident #29 stated Staff EE treated her undignified. Resident #29 stated she did not feel like Staff EE had provided her with the appropriate dignity or respect when requesting to be cleaned up and change her brief. Resident #29 stated she had told Staff R, CNA the concerns she had with Staff EE. Resident #29 said she thought Staff EE told Staff P, Assistant Director of Nursing (ADON) about the concerns with Staff EE. 5. The MDS dated [DATE] documented Resident #30 had a BIMS of 13 indicating no cognitive impairment. The MDS documented Resident #30 required substantial / maximal assistance for oral hygiene. Review of Resident #30's EHR titled, Care Plan documented an intervention / task for oral care dated 12/3/25 that Resident #30 required an assistance of one for oral care. Review of Resident #30's EHR documented no documentation of oral care provided. On 1/20/26 at 1:05 PM Resident #30's daughter stated frequently she would come to the facility at random times and would have food on her mother's face and mouth. Resident #30's daughter stated it looked as though her mother's teeth had not been brushed. On 1/12/26 at 12:49 PM Staff P stated Resident #29 did not want Staff EE or RR in her room because they were talking about their own lives and another resident down the hall. Staff P stated Resident #29 thought it was disrespectful for them to talk about other residents in her room. Staff P stated it was an expectation that all residents receive oral care even if the resident does not have teeth. Staff P stated if the resident had dentures they should be cleaned or soaked overnight. On 1/12/26 on 1:09 PM the DON stated oral care should be completed or offered and documented if refused. The DON explained assistance the resident required should be on their care plan as well. On 1/21/26 at 8:11 AM Staff R, CNA stated if the resident is cognitive she would ask if the resident wanted their teeth brushed before or after the meal. Staff R stated if the resident was not cognitively aware she would complete the oral cares before breakfast. Staff R stated she frequently found residents with food on residents faces and hands not cleaned from dinner. Staff R stated she had brought it up to the management at the facility. On 1/27/26 at 11:03 AM the DON stated oral care should be completed twice a day ideally by CNA or the nurses if the CNA's are too busy. Review of undated policy titled, Oral Care documented the purposes of the procedure was to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent oral infection. Review the resident's care plan to assess any special needs of the resident. Assemble the equipment and supplies as needed. The following information should be recorded in the resident's medical record: The date and time the mouth care was provided. The name and title of the individual(s) who provided the mouth care. All assessment data obtained concerning the resident's mouth. The certified nursing assistant should report to the licensed nurse to record in the medical record. Complaints of pain or discomfort of mouth. The certified nursing assistant should report to the licensed nurse to record in the medical record. If the resident refused the treatment, the reason(s) why and the intervention taken. The signature and title of the person recording the data.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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, provider interview, resident and family interview, staff interviews, and policy review the facility failed to appropriately assess a resident with a head injury and appropriately complete assessments / provide interventions for a diabetic ulcer for 2 of 8 residents (Resident #15, and #30). The facility reported a census of 28 residents.Findings include:1.The MDS dated [DATE] documented Resident #15 had a BIMS of 15 indicating no cognitive impairment. On 1/20/26 at 11:49 AM Resident #15 stated she told Staff P RN / Assistant Director of Nursing (ADON) about the sore on her foot and she did nothing about it. Resident #15 stated Staff J, RN was the nurse that finally did something about it. Review of Resident #15's (Treatment Administration Record) TAR documented a physician's order with a start date of 1/15/26 to cleanse 2nd toe on left foot with wound cleanser, pat dry, apply Triple Antibiotic Ointment (TAO) and cover with band aid daily.Review of Resident #15's (Electronic Health Record) EHR dated 1/5/26 titled, Progress Note admission readmission Progress Note documented at 2:48 PM Resident #15 had an admission date of 1/5/26. The Progress Note documented reason for admission weakness post hospitalization for acute and chronic renal failure. The Progress Note documented no impaired skin integrity, no bruise, burn, deep tissue injury, diabetic ulcer, incontinence associated dermatitis, moisture associated skin damage, open areas, wound, rash, redness, skin tear or surgical incisions.Review of Resident #15's EHR dated 1/15/26 at 10:05 AM entered by Staff J, RN titled, Wound Evaluation documented a diabetic ulcer on left foot second digit that was present on admission that had an area of 0.33 cm2, length of 0.98 cm, and width of 0.5 cm. Wound note described area red with slough and Physician notified.Review of Resident #15's EHR dated 1/16/26 at 4:57 PM entered by Staff J, RN titled, Wound Evaluation documented a diabetic ulcer on left foot second digit that was present on admission that had an area of 0.33 cm2, length of 0.98 cm, and width of 0.5 cm. Review of Resident #15's EHR dated 1/23/26 at 5:27 PM entered by Staff J, RN titled, Wound Evaluation documented a diabetic ulcer on left foot second digit that was present on admission that had an area of 0.11 cm2, length of 0.62 cm, and width of 0.28 cm. Review of EHR documented no physician notification or treatment completed for Resident #15's wound since admission on [DATE] until 1/15/26 when Staff J RN addressed the area. On 1/26/26 at 3:26 PM the DON stated her concern was the initial admission skin assessment for Resident #15 was completed by Staff A, RN. The DON explained Staff A completed the assessment and left without documenting the assessment. The DON stated the evening nurse went in and completed the assessment again. The DON stated she did not think Staff A made an observation of her foot / toe. The DON explained Staff J documented the area as not facility acquired because Resident #15 stated she had the area before entering the facility. The DON stated Resident #15 was a good historian. The DON stated there were a lot of balls that were dropped when it comes to wound care in the facility. The DON stated the area should have been noticed on the admission skin assessment, the physician should have been notified then and a treatment started if the physician thought it warranted. The DON acknowledged Resident #15 was at the facility for a week and the wound was not assessed and not treated. The DON stated the CNA's should have noticed the wound when cleaning Resident #15's feet. 2. The MDS dated [DATE] documented Resident #30 had a BIMS of 13 indicating no cognitive impairment. Review of Resident #30's EHR dated 12/22/25 titled, Skin Check documented no skin issues.On 1/14/26 at 7:39 AM Staff M, Licensed Practical Nurse (LPN) stated she had cared for Resident #30. Staff M stated she had reported an injury of unknown origin, a bruise to the forehead. Staff M stated on 1/4/26 she went into Resident #30's room at 7:00 AM or 7:30 AM. Staff M stated Resident #30 had a scratch on the right side of her forehead. Staff M explained Resident #30 reported she had hit (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the table and also said she did not know what had happened. Staff M stated that afternoon when she was going to document the injury and Resident #30's daughter came to the nursing desk. Staff M stated the area on Resident #30 had become a hematoma. Staff M acknowledged she started neuro checks and notified the doctor at that time. Staff M stated Resident #30's daughter notified a CNA and the CNA told her that Resident #30's daughter would like to talk to her. Staff M stated she entered Resident #30's room and the area was no longer a red mark. Staff M stated the area on the right side of her forehead was swollen. Staff M stated it looked like a goose egg and had started bruising. Staff M stated she called the on call provider at that time and he asked if the neuro had been started and if there was any altered mental status. Staff M reported Resident #30 was at her baseline. Staff M stated the daughter was at the facility late morning. Staff M stated she was going to call Resident #30's daughter and the physician but had not at that time. Staff M stated Resident #30 initially reported she hit her head on the table and then said she had fallen in her bathroom and daughter assisted her in getting into bed. Staff M stated Resident #30's daughter said she did not assist Resident #30 to get up. Staff M reported it did not look like Resident #30 had hit her head there was no induration or swelling. Staff M stated Resident #30 was a poor historian. Staff M stated they did do an initial set of vitals when the red mark was found. Staff M explained she did an assessment at the same time when she was completing her daily assessment. Staff M stated the red area was documented in the daily assessment. Staff M stated she did not know if there was a procedure for injury of unknown origin. Staff M stated she was not aware of any procedure for injury of unknown origins with injury to the head or witness / unwitnessed head injury. Staff M stated Resident #30 was wearing pants and it was difficult for her to get up and would often get agitated if the staff tried to move her. Staff M stated she did not remove Resident #30's clothes. Staff M explained she pulled Resident #30's pant legs up but did not assess the hips or buttocks. Staff M stated Resident #30 was being transferred to the ER the next day and the daughter wanted her to be seen the next day based on the general decline of the resident. Staff M acknowledged she did not initiate neuro assessments when the injury was found on the head that morning. On 1/20/26 at 1:05 PM Resident #30's Daughter / Power of Attorney (POA) stated she walked into the facility around 12:30 PM or 1:00 PM on 1/4/26. Resident #30's Daughter / POA stated she found Resident #30 with a bruise on her knee and a wound on the right side of her head. Resident #30's Daughter / POA stated her mother said she fell in the bathroom that morning. Resident #30's Daughter / POA stated the staff said her mother told them she leaned forward toward the table and hit her head. Resident #30's Daughter / POA stated she was told the staff had used a full body mechanical lift on her and possibly bumped her head. Resident #30's Daughter / POA stated she was then told her mother was combative on Saturday night and might have bumped her head. Resident #30's Daughter / POA stated she asked where the knee bruise came from. Resident #30's Daughter / POA stated she came to the facility the next day and told the DON she wanted her mother sent to the hospital. Resident #30's Daughter / POA once at the hospital there was a huge bruise noticed on Resident #30 right hip and sent a picture to the DON. Resident #30's Daughter / POA was told they would have to look into the bruise. Resident #30's Daughter / POA stated Resident #30's right shoulder blade had a huge bruise on it as well when she was rolled over in the Emergency Department (ED) where both bruises were noted. Resident #30's Daughter / POA stated the goose egg was very large on the right side of Resident #30 head. Resident #30's Daughter / POA stated the bruising was not brought to her attention at all until seen in the ED. Resident #30's Daughter / POA stated the DON stated the bruising could have happened when transferred to hospital. On1/20/26 at 4:32 PM the DON stated there was an injury of unknown origins that had happened to Resident #30. The DON explained the facility (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had completed an investigation and determined the injury was no longer of unknown origins. The DON stated that Resident #30 had a red area on the right side of her forehead at approximately 7:30 AM on 1/4/26. The DON explained Staff M notified her, an assessment was completed, and the physician was notified. The DON stated she asked Staff M if Resident #30 was on a blood thinner and Staff M told her no. The DON explained she would have only started neuro assessments if the resident was on a blood thinner and had an injury to the head of unknown origins or a change in cognition. The DON explained a neuro assessment was also completed. The DON stated Resident #30's daughter was notified. The DON stated Resident #30's daughter had come to the facility later in the afternoon and asked about the area on Resident #30 forehead as it was now a raised area. The DON stated Resident #30's daughter must have forgotten about the earlier notification. The DON stated the raised area was only there for about a day and had decreased and was almost gone the next day. The DON stated there was no other injuries to Resident #30 from the incident. The DON stated she completed an investigation and interviewed the staff. The DON explained the staff had stated Resident #30 did have a shower the day prior but had not fallen. The DON stated Resident #30 was aggressive and combative the night prior. The DON explained Resident #30 had kicked an employee in the groin and hit an employee. The DON stated Resident #30 stated she had hit her head on the bedside table on the morning of 1/4/26. The DON stated Resident #30's cognition was enough that she felt that is where the injury had come from. The DON explained the injury probably occurred from the aggression and combativeness of the evening before. The DON explained the staff had not notified the physician or family appropriately and some writes came from that incident. The DON stated she would have expected the staff would have notified the DON at 7:30 AM on the day the injury was found when the injury was found and the staff did not. The DON stated she expected the nurse would have notified the physician of the area on the head at 7:30 AM when it was found as well and that was not completed. The DON stated she would have expected the family of Resident #30 would have been notified of the injury as well at 7:30 when the injury was noticed. The DON stated neuro assessments should have been initiated when the area was found on Resident #30 forehead at 7:30 AM and the neuro assessments were not imitated. Review of Resident #30's EHR dated 1/4/26 titled, Neurological Assessment Flow Sheet documented neurological assessments were not started at 6:00 PM on 1/4/26.Review of Resident #30's EHR dated 1/4/26 at 7:49 PM titled, Skilled Note entered by Staff M documented Resident #30 had a hematoma to the right side of the forehead. On call provider made aware, DON made aware, Resident #30's daughter in and aware.Review of Resident #30's document dated 1/4/26 at 7:27 PM titled Fax documented physician notification that Resident #30 had a 3 cm x 2.5 cm hematoma to the right forehead of unknown origin. On 1/4/26 evening propranolol was held due to blood pressure 102/50 and pulse of 53. Called to inform the on call provider with no return call at this time.On 1/13/25 at 11:29 AM the Nurse Practitioner stated she was notified on 1/4/26 of Resident #30's area on her forehead. The Nurse Practitioner stated the staff reported Resident #30 gave several conflicting stories. The Nurse Practitioner stated she was not made aware of Resident #30 goose egg after the contusion or bruising anywhere else. The Nurse Practitioner stated she would expect staff to call with any head injuries and start neuro assessments immediately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, provider interviews, resident interviews, staff interviews, family interviews and policy review the facility failed to ensure staff provided skin assessments, failed to notify the provider of deterioration timely and failed to implement interventions to prevent and treat the development and worsening of pressure ulcers for 7 of 8 residents reviewed (Resident #29, #2, #9, #30, #22, #23, and #21). The facility failure to assess a Stage II pressure ulcer from 12/16/25 through 1/3/26 resulted in Resident #29's wound to deteriorate to an unstageable ulcer due to necrosis (dead tissue) with infection that required debridement of the wound and then hospitalization. Significant debridement required with the wound base extending down into ligamentous structures running along the posterior sacrum and there was exposed bone. The facility reported a census of 28 residents.The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of January 2, 2026 on January 14, 2026 at 4:00 p.m. The facility staff removed the immediacy of the IJ on January 14, 2026, and decreased the scope to E through the following actions:In-service/education/training for pressure ulcer prevention and wound care - policy and practice update.a. All full time and part time clinical staff to complete the mandatory education/training before their next scheduled shift. All as needed (PRN) clinical staff to complete before their next scheduled shift.b. Audits to begin 1/15/26: completed weekly x 12 weeks.This was implemented due to an Immediate Jeopardy and focused on required practices to protect residents from avoidable skin breakdown and wound deterioration.Education Topics Covered:a. Review of updated Pressure Ulcer Prevention Policyb. Weekly wound assessment completion and weekly skin assessment completion.c. Weekly Wound Care Rounds every Friday (mandatory participation & documentation)New skin concerns evaluated by Interdisciplinary Team (IDT) for Director of Nursing (DON) / Assistant Director of Nursing (ADON) notification, pressure relief interventions, proper Medical Doctor (MD) notification and order entry.d. Mandatory notification to DON and ADON of any skin or wound changes.e. Mandatory MD notification for any wound decline, worsening, or lack of improvement.Resident repositioning at least every 2 hours to be audited by charge nurse or leadership team member each shift every 2 hours.f. Repositioning residents at least every 2 hours - importance, frequency, and documentation. Daily shower/bath completion form to be implemented beginning 1/15/26 that included a section for new skin concerns, nurse notification and DON/ADON notification. Nurse to sign stating they documented a progress note regarding the new findingsg. Nurse aides must immediately notify the nurse on duty of any skin changes noted during bathing/showering. Findings include:The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Unstageable Ulcer: inability to see the wound bed. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (unstageable, stage 3, or stage 4). Do not use DTI to describe vascular, traumatic, neuropathic, or dermatologic conditions. 1. The MDS dated [DATE] documented Resident #29 had a BIMS of 15 indicating no cognitive impairment. The MDS documented Resident #29 had one or more unhealed pressure ulcers. The MDS documented a Stage 2 pressure ulcer present. The MDS documented Resident #29 had an admission date of 11/11/25. Review of Resident #29's (Electronic Health Record) EHR dated 11/26/25 titled, Braden Scale for Predicting Pressure Sore Risk documented a Braden Score of 16 that indicated Resident #29 was at risk for development of a pressure ulcer. Review of Resident #29 TAR documented a physician's order with a start date of 11/28/25 and end date of 12/16/25 to cleanse the sacral wound with wound cleanser, pat dry and apply Plurogel and foam patch daily until healed. A physician's order with a start date of 12/16/25 and discontinued date of 1/2/26 to cleanse the sacral wound with wound cleanser, pat dry and apply Santyl and foam patch every other day. Review of Resident #29's EHR dated 11/11/25 titled, Braden Scale for Predicting Pressure Sore Risk documented a Braden Score of 20 that indicated Resident #29 was not at risk for development of a pressure ulcer. Review of Resident #29's EHR, titled Skin Check documented the following: On 11/12/25 completed by Staff M, LPN documented no concerns. On 11/29/25 open area on coccyx with no measurements or description. On 12/6/25 open area on coccyx with no measurements or description. On 12/6/25 slit above sacrum with current treatment in place with no measurements. Review of Resident #29's EHR titled, Wound Evaluation documented the following: On 11/28/25 at 7:37 AM entered by Staff MM, a minutes old in-house acquired Stage 2 pressure ulcer on the sacrum that had an area of 1.63 cm2, length of 3.24 cm, and width of 0.94 cm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 12/6/25 at 9:29 PM entered by Staff MM, an in-house acquired Stage 2 pressure ulcer on the sacrum that had an area of 2.5 cm2, length of 4.17 cm, and width of 0.98 cm. Wound Evaluation documented additional care of cushion, incontinence management, and nutrition / dietary supplementation. Notes reported area stalled treatment changed and encouraged to allow staff to reposition. On 12/16/25 at 10:43 AM entered by Staff P, an in-house acquired stage 2 pressure ulcer on the sacrum that had no measurements. Wound Evaluation documented stage 2 pressure ulcer with no evidence of infection and additional care of cushion, nutrition / dietary supplementation and turning / reposition program. Review of Resident #29's EHR dated 12/16/25 titled, Skin and Wound Evaluation documented an in-house acquired stage 2 pressure ulcer with no measurements, superficial loss of tissue and no odor. Review of Resident #29's EHR, titled Skin Check documented the following: On 12/18/25 a pressure injury on coccyx and sacrum with no measurements or description. On 12/25/25 a pressure injury on sacrum with no measurements or description. On 1/1/25 a pressure injury on sacrum with no measurements or description. Review of Resident #29's EHR dated 12/23/25 titled Progress Notes documented wound condition reported to nurse practitioner order for wound care appointment. Review of Resident #29's EHR dated 12/25/25 titled, Braden Scale for Predicting Pressure Sore Risk documented a Braden Score of 9 that indicated Resident #29 was at a very high risk for development of a pressure ulcer. Review of Resident #29 TAR documented a physician's order with a start date of 12/29/25 for Cephalexin 500mg, give one tablet by mouth every 12 hours for buttocks ulcer infection for 5 days. Review of Resident #29's EHR dated 12/31/25 titled, Progress Notes documented Nurse Practitioner in facility to review chart and see resident. New orders for air mattress to bed. Review of Resident #29's EHR documented no skin assessments completed between 12/16/25 and 1/3/26. Interventions for wound management were not changed until 1/2/26 when seen at a wound clinic. Review of Resident #29's EHR titled Infection Documentation dated 1/1/26 through 1/5/26 documented sacral ulcer infection with odor, no measurements, no description of wound and no medical doctor notification. On 1/3/26 at 9:54 AM entered by Staff J, an in-house acquired unstageable pressure ulcer on the sacrum that had an area of 14.6 cm2, length of 6.63 cm, and width of 3.72 cm. Wound Evaluation documented unstageable pressure ulcer due to slough and / or eschar with a light amount of serous drainage and a strong odor. Wound Evaluation documented additional care of air flow pad, incontinence management, positioning wedge, repositioning devices, and turning / repositioning program. On 1/5/26 at 9:43 AM entered by Staff P, an in-house acquired stage 2 pressure ulcer on the sacrum that had an area of 15.78 cm2, length of 6.57 cm, and width of 4.36 cm. Wound Evaluation documented (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	stage 2 pressure ulcer with moderate amount of serous drainage and no odor. Wound Evaluation documented additional care of cushion, incontinence management, mattress with pump, nutrition / dietary supplementation and turning / reposition program. Review of Resident #29's EHR dated 1/5/26 titled, Skin and Wound Evaluation documented an unstageable pressure ulcer with slough and/or eschar that had an area of 15.8 cm2, length of 6.6 cm, and width of 4.4 cm with no physician notification. Review of Resident #29's EHR titled, Care Plan documented a focus for potential for pressure injury development related to assist needed initiated on 11/11/25 with a in house stage 2 pressure ulcer on sacrum initiated 11/28/25. No new interventions in place for in-house acquired a stage 2 pressure ulcer that was found from 11/28/25. The care plan does not reflect any new interventions since returning from the hospital with a surgically debrided stage 4 pressure ulcer that requires a wound vacuum. Review of Resident #29's document dated 1/6/26 at 5:06 PM titled, Operative Report documented Resident #29 had a known sacral decubitus pressure ulcer for the last 2 months, who presented to the hospital with fevers and concern for sepsis from her sacral decubitus wound. She has undergone some minimal debridement of this in the wound care clinic already. Her wound had a foul smell and significant necrotic tissue, warranting urgent debridement in the operating room. Debridement of all of the nonviable completely necrotic tissue which had a foul odor. The base of the wound was down onto the ligamentous structures running along the posterior sacrum and there was exposed bone. A bone biopsy which was sent separately. Area was debrided, removal of the necrotic soft tissue down to the bone centrally, and then to the bilateral gluteal muscles. The total debrided area was 6 cm x 5.5 cm. Review of Resident #29's document dated 1/12/26 titled, Discharge Summary documented Resident #29 entered the Emergency Department (ED) at 4:40 PM with chief complaint of sacral wound ulcer. Resident #29 had a temperature of 101.3, a pulse of 116 and was found to be positive for influenza A. During review Resident #29 reported she underwent debridement though the wound care clinic on 1/2/26, at that time it was determined she may need a more aggressive surgical debridement and had been referred to the surgical clinic for debridement. Sacral dressing was removed to inspect the ulcer. Documented ulcer measured approximately 5cm x 5cm in surface area with significant soft tissue loss. There is a large necrotic area centrally, the ulcer itself was unstageable as the base was not able to be visualized. Foul smell from the wound consistent with tissue necrosis. Suspect the ulcer was down to at least muscle gluteal region, possibly down to the posterior aspect of the sacrum itself. Review of Resident #29's document dated 1/12/26 titled, Hospital Progress Notes documented Resident #29 was concerned about returning to the facility because she did not get repositioned. Document explained Resident #29 acknowledged she had never had an ulcer ever before entering the facility in November. Discharge plan for return to facility repositioning every 2 hours. On 1/12/26 at 1:09 PM the DON stated Resident #29 had an unstageable pressure ulcer on her sacrum. The DON explained Resident #29 had entered the facility on 11/11/25 and the wound must have been facility acquired. The DON acknowledged Resident #29's wound was not on the admission. The DON explained the first photograph of the wound was taken on 11/28/25. The DON stated the area on Resident #29 was on the gluteal fold or sacral area. The DON acknowledged the wound on Resident #29's sacral area had declined. The DON acknowledged the facility did not complete assessments with pictures, measurements, or description of the wound from 12/16/25 - 1/3/26. The DON acknowledged Resident #29's wound had deteriorated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/12/26 at 7:43 PM entered by Staff J, a stage 4 pressure ulcer on the sacrum that was present on admission that had an area of 22.4 cm2, length of 6.98 cm, and width of 4.6 cm. Wound Evaluation documented stage 4 pressure ulcer with light amount of serosanguineous drainage and no odor. Wound Evaluation documented additional care of incontinence management, positioning wedge, repositioning device and turning / reposition program. On 1/13/25 at 11:29 AM the Nurse Practitioner stated she was not notified that Resident #29 had returned and currently had strict orders for 2 hour repositioning. The Nurse Practitioner stated just seen Resident #29 and the CNA had told her Resident #29 was not adequately turned last night. The Nurse Practitioner stated she was shown the picture of the wound on 12/16/25. The Nurse Practitioner stated she did not hear anything again until the week of Christmas. The Nurse Practitioner stated she received a text from Staff MM reporting the wound was looking worse and requested a wound care visit. The Nurse Practitioner stated she gave an order for Resident #29 to be seen at wound care. The Nurse Practitioner explained she never received a report as to what wound care said. The Nurse Practitioner stated Resident #29 was sent to the ED on 12/5/25 with fever and concerns with vitals. The Nurse Practitioner explained she had seen an updated picture. The Nurse Practitioner stated the wound looked awful. The Nurse Practitioner stated she did not know it was unstageable or was no longer a stage 2. The Nurse Practitioner stated with the changes in the wound she would have expected to be notified. The Nurse Practitioner explained Resident #29's wound was debrided all the way to the bone. The Nurse Practitioner stated she would have expected an update if the wound had deteriorated. The Nurse Practitioner stated the wound did appear to be preventable and should have never gotten to where it was at currently. On 1/13/26 at 2:00 PM Staff R, CNA stated she talked to the nurse about Resident #29 not being repositioned or changed appropriately last night. Staff R stated she spoke to Staff A, RN about it that morning. Staff R stated Resident #29 reported she had not been repositioned or changed the way she should have been last night. Staff R explained Resident #29s' care plan specified every 2 hours. On 1/13/26 at 2:50 PM Staff A, RN acknowledged that Staff R had told her Resident #29 had reported she had not been repositioned the night prior. Staff R stated Resident #29 had been soaked through the pad, the sheet to the bed when Staff R provided care that morning. Staff A stated the overnight nurse reported off to her that he repositioned her every 2 hours. Staff A acknowledged there was a dark ring around Resident #29 on the bed pad that appeared to be indicative of not checking or changing but, did know if Resident #29 was repositioned. Staff A stated she assisted Staff R with repositioning Resident #29 that morning. On 1/14/26 at 7:39 AM Staff M, Licensed Practical Nurse (LPN) acknowledged she was the nurse that sent Resident #29 to the hospital the day she went out. Staff M stated when she came in on her shift at 2:00 PM that afternoon, Staff M explained Resident #29 had an elevated temperature and pulse. Staff M stated she was going to be seen by the surgeon on 1/5/26 or 1/6/26 and the surgeon canceled the appointment till 1/9/26. Staff M stated Resident #29 had just finished her course of antibiotic and requested to send Resident #29 to the hospital. Staff M stated Resident #29 had been seen by the wound clinic and they were going to schedule her consult for a surgical debridement of her wound. Staff M stated the wound clinic did a debridement in the office then scheduled her to see a surgeon. Staff M stated she had cared for Resident #29's wound a few days before when it was evaluated by the nurse practitioner. Staff M explained Resident #29's sacral wound had deteriorated. Staff M stated Staff MM said she did not know what had happened to the wound but it looked like it was worse overnight. Staff M explained she had been off a couple days during the holiday. Staff M stated the wound had eschar at the time and initially it was just a slit in the sacral area. Staff M stated the nurses (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	are expected to notify the physician with any changes in the wound and if the wound is not improving or deteriorating. Staff M stated if a wound became open then she felt that was a change in condition of the wound and would prompt a call to the physician. On 1/14/26 at 1:51 PM MM, RN acknowledged she cared for Resident #29. Staff MM stated she notified Staff P of the change in condition of the wound. Staff MM stated she notified the nurse practitioner of the change of condition for Resident #29's wound on her buttocks. Staff MM stated she was off for a while and 12/23/25 was her first day back. Staff MM stated the wound had gotten larger and was open. Staff MM stated this was noticed and she notified Staff P wound nurse / interim DON. Staff MM stated the wound was still a stage 2 at that time but was larger. Staff MM stated there was no eschar present at that time. Staff MM stated the wound had worsened but was not showing signs of infection. Staff MM stated the treatment did not change at that time. Staff MM stated Staff P was supposed to take the picture that day. Staff MM stated she notified the nurse practitioner as well about the change in condition. Staff MM stated Resident #30 had a deterioration in the wound. On 1/14/26 at 2:45 PM Staff P acknowledged there was no assessment for Resident #29 and unclear of what actually was notified to the physician as far as the wound description. Staff P stated she was informed about the wound from Staff MM and does not know why an assessment with measurement, description and photo was not completed. Staff P acknowledged she had worked that day and she did not look at the wound either. Staff P stated Staff MM said the wound looked worse. Staff P said it was concerning there was no assessment completed, no documentation of what exactly the physician was notified of and no photo of the area taken when the area was found on Resident #29. Staff P acknowledged there had not been any change in Resident #29's orders from 12/16/25 till seen at the wound clinic on 1/2/26. Staff P stated the physician should have been notified of Resident #29's worsening condition to the wound, assessments should have been documented to ensure appropriate treatment and physician update. On 1/14/26 at 3:00 PM the DON stated her expectation was with all wounds an assessment would be completed weekly with measurements and description of the wound. The DON stated her expectation was to notify the physician if there was any deterioration or lack of improvement to ensure the appropriate treatment was being completed. The DON stated documentation of the physician notification would be documented in the resident's electronic health records. The DON stated her expectation was that all changes in wounds worsening, lack of improvement or deterioration would also be reported to her or the ADON. The DON acknowledged Resident #29 skin assessments lacked an accurate assessment from 12/16/25 - 1/3/26 with measurements, a description of the wound or a photo. The DON acknowledged Resident #29's wound did not go from a stage 2 wound to that size of an unstageable pressure overnight and should have been documented with a physician notification before 1/3/26. On 1/15/26 at 1:30 PM Resident #29 stated she had to set an alarm on her phone to ensure the staff come to turn her every 2 hours or the staff will not reposition her. Resident #29 stated her doctor wants her repositioned every 2 hours. Resident #29 stated prior to going to the hospital the staff were not repositioning her every 2 hours and some overnight shifts the staff would only come in at 3:00 AM or 4:00 AM to reposition her in bed. Resident #29 stated she had multiple sclerosis and was not able to reposition herself in bed. Resident #29 stated she required the assistance of staff for repositioning. Resident #29 stated she had reported not being repositioned by the overnight staff several times to staff. Resident #29 stated when she entered the facility, she did not have any wounds on her bottom. On 1/21/26 at 1:51 PM Staff J, RN acknowledged he worked with Resident #29 prior to having the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	wound on her buttocks. Staff J stated he felt the deterioration of the wound on Residents #29 buttocks could have been prevented. Staff J stated Resident #29 was not being repositioned appropriately prior to the wounds appearing. Staff J stated some CNA's had reported the wound was not getting better and requested the nurse to look at it. Staff J explained the CNA was told to put some cream on it and did not assess the area. Staff J stated Resident #29 had an alarm to remind staff to reposition her since she had returned. Staff J stated he knew Resident #29 had issues brought up about overnight CNAs not being in her room. Staff J acknowledged if those aides are working, she told him she will set the alarm every 2 hours. On 1/22/26 at 11:29 AM Resident #29 stated last night Staff EE, Certified Nurse Assistant refused to change her brief and stated she was out of briefs. Resident #29 stated she had not had a BM. Resident #29 stated she was wet and nobody changed her at all last night. Resident #29 stated Staff EE only repositioned her at night but never changed her. Resident #29 stated she has had problems with Staff EE from the get go. Resident #29 stated Staff EE was not supposed to be caring for her because she had voiced concerns about how she cared for her in the past. Resident #29 stated she had told Staff R, CNA the concerns she had with Staff EE. Resident #29 said she thought Staff R told Staff P about the concerns with Staff EE. On 1/22/26 at 12:58 PM Staff EE, CNA stated she has very little interaction with Resident #29. Staff EE stated she was not supposed to have contact with Resident #29 but the facility kept putting her on that side. Staff EE stated she does work with Resident #29 and had worked with her last night. Staff EE stated she did have contact with Resident #29 last night. Staff EE acknowledged Resident #29 was on a 2 hour reposition schedule. Staff EE stated she repositioned her. Staff EE explained she did not toilet Resident #29 at night. Staff EE explained Resident #29 would turn on her call light at night asking for a brief change. Staff EE stated Resident #29 turned her call light on last night to be repositioned. Staff EE stated she took Staff Y when she was there but she left early but did not know what time. Staff EE stated she provided peri care to freshen her up down there but did not have to change her brief. Staff EE stated Resident #29 had not requested for her brief to be changed at any time overnight the night before. Staff EE stated Resident #29 had thought that she had a BM and wiped her up to show her that she had not had a BM. Staff EE stated she had Staff Y in the room with her at that time. Staff EE stated Resident #29 told her that she was a 3XL in brief size. Staff EE stated she did not change her brief because it was changed prior to her going in the room. Staff EE stated Resident #29 never asked her to change the brief. Staff EE stated if she was doing peri care and the brief is dirty, she changed the brief but she told her that she had not had a BM then she said she would just wear the same brief. On 1/22/26 at 2:06 PM Staff R stated when she came in at 6:00 AM on 1/22/26 and Resident #29 stated she had asked to be changed because she had some urine incontinence on the overnight shift. Staff R stated Resident #29 explained Staff EE said there was no brief to change her with. Staff R stated Resident #29 told her that she told Staff EE that she was a 3XL brief. Staff R reported Resident #29 said Staff EE told her that she would not get her another brief, reapplied the brief in the front, walked out of the room and did not return the rest of the night. Staff R said Resident #29 told her Staff EE refused to change her. Staff R reported Resident #29's brief was saturated when she provided care that morning. Staff R stated she reported the concern to Staff J, RN. On 1/22/26 at 2:10 PM Staff J, RN stated Staff R had informed him Resident #29 reported she had not been changed on the overnight shift. Staff J reported Staff R stated Resident #29 stated she had asked to be changed because she had incontinence. Staff J stated Resident #29 stated Staff EE said there was no brief to change her with. Staff J stated Resident #29 told Staff EE that she was a 3xl (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	brief. Staff J stated Resident #29 said Staff EE told her that she would not get her another brief, reapplied the brief in the front, walked out of the room and did not return the rest of the night. Staff J said Resident #29 told her Staff EE refused to change her brief. On 1/23/26 at 2:00 PM Staff Y, CNA stated she had assisted Staff EE with care on Resident #29. Staff Y stated she assisted Staff EE with repositioning Resident #29. Staff Y stated Resident #29 stated she had a bowel movement. Staff Y stated Staff EE checked Resident #29's brief, it was dry and there was no bowel movement. Staff Y stated Resident #29 does not always void at night. Staff Y stated Resident #29 was cognitive of when she needs to use the bathroom. Staff Y stated Resident #29 did not have incontinence. Staff Y stated she did not notify the nurse because Resident #29 had not urinated that shift. Staff Y stated Resident #29 told the staff that she did not need her briefs changed if it was not soiled. Staff Y stated she did not go back in Resident #29's room after that time. Staff Y stated typically during personal care she would change the brief but she let Resident #29 exercise her rights and her wishes. Staff Y stated Resident #29 was not soiled, the 2 of them just freshened her up. Staff Y stated Resident #29 was dishonest and a troublemaker. Staff Y stated she did not know if there were briefs because she was only the second person. Staff Y stated Resident #29 had never said anything about her brief size. Staff Y stated Staff EE did not have a conversation about not having any briefs available. Staff Y stated she minds her own business. On 1/26/26 at 2:43 PM Staff J, RN stated the CNA's have never notified him of a stage 1 or any discoloration. Staff J stated he does not know if CNA's know what pressure injuries are or when to notify the nurse. On 1/26/26 at 3:26 PM the DON stated she had heard CNA's report they had told the nurse and there was no documentation. The DON stated Resident #29 did not want Staff E in their room. The DON stated there were a lot of balls that were dropped when it comes to wound care in the facility. 2. The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. The MDS documented Resident #2 was at risk for developing pressure ulcers/injuries and Moisture Associated Skin Damage (MASD) present. The MDS documented admission date for Resident #2 of 11/28/25. It also documented treatments for skin injury included pressure reducing device for chair, pressure reducing device for bed, nutrition hydration intervention to manage skin problems. Review of Resident #2's Care Plan documented a focus initiated on 11/28/25 that Resident #2 had potential for pressure injury development. The Care Plan lacked any other skin issues and lacked the interventions identified on the MDS. It identified Resident #2 required the assistance of 1 staff for bed mobility and required the assistance of 1 staff for personal hygiene. Review of Resident #2's EHR dated 11/28/25 titled, Discharge Summary documented a Braden scale score of 17 with a reposition schedule at least every 2 hours. The Discharge Summary documented a wound undiagnosed gluteal cleft mid right. Review of Resident #2's Treatment Administration Record (TAR) documented a physician's order with a start date of 11/28/25 to cleanse buttocks with soap and water, pat dry, apply Z guard every shift until healed. A physician's order with a start date of 11/28/25 to evaluate buttocks wound / peri wound for complications including symptoms of infection. A physician's order with a start date of 1/15/26 to cleanse sacral stage 2 pressure ulcer with wound cleanser, pat dry, apply a foam dressing and change every 3 days and as needed (PRN). A physician's order with a start date of 1/15/26 to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	evaluate stage 2 pressure wound/peri-wound for complications including symptoms of infection. Review of Resident #2's EHR documented the following: On 11/28/25 at 2:50 PM entered by Staff P titled, Wound Evaluation incontinence associated dermatitis that was present on admission on the buttocks that had an area of 1.42 cm2, length of 3.42 cm, and width of 0.61 cm. On 12/5/25 at 8:03 PM entered by Staff P titled, Wound Evaluation incontinence associated dermatitis that was present on admission on the buttocks that had an area of 19.8 cm2, length of 8.86 cm, and width of 5.66 cm. On 12/12/25 at 8:29 AM entered by Staff P titled, Wound Evaluation incontinence associated dermatitis on the buttocks that was present on admission that did not have any measurements with the assessment. On 12/23/25 at 10:14 AM entered by Staff P titled, Wound Evaluation incontinence associated dermatitis on the buttocks that was present on admission that had an area of 1.4 cm2, length of 2.57 cm, and width of 1.29 cm. On 12/30/25 at 6:48 AM entered by Staff J, RN titled, Wound Evaluation incontinence associated dermatitis on the buttocks that was present on admission that had an area of <0.1 cm2, length of 0.25 cm, and width of 0.21 cm. On 1/6/26 at 7:21 PM entered by Staff P titled, Wound Evaluation incontinence associated dermatitis on the buttocks that was present on admission that had an area of 15.65 cm2, length of 7.01 cm, and width of 3.06 cm. Observation of the photo on EHR dated 1/6/26 at 7:21 PM entered by Staff P titled, Wound Evaluation revealed 2 areas of stage 2 present on sacrum / coccyx area at that time that were undocumented. Review of Resident #2's EHR dated 1/15/26 at 10:18 AM entered by Staff J titled, Wound Evaluation documented Stage 2 pressure ulcer on the sacrum that was in-house acquired that h

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, interviews and policy review the facility failed to protect residents from possible accidents and injuries for 4 of 12 residents (Residents #7, #41, #2 and #3) reviewed. The facility failed to protect residents when dependently pushed in manual wheelchairs (w/c's) without the use of footrests and using only 1 staff member with the use of dependent non-weight bearing mechanical lifts. Additionally the facility failed to protect the residents from possible scalding injuries with water temperatures above the recommended temperature range for burn prevention. The facility reported a census of 28 residents. Findings include:1. Resident #7's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11/15 indicating moderate cognitive deficit. The resident utilized a manual w/c with partial/moderate assistance. The document disclosed diagnoses including chronic kidney disease, nonrheumatic aortic valve stenosis, unspecified osteoarthritis. The resident's Care Plan dated 1/7/26 disclosed a focus area of requiring assistance with activities of daily living (ADLs) revised 4/23/24. Interventions for staff included manual w/c for mobility with assistance of 1, transfers with a sit to stand lift with staff assistance of 2 and dressing and bathing with maximal assistance of 1. On 1/21/26 at 7:10 AM observed Staff I, Certified Nursing Assistant (CNA), push Resident #7 without w/c foot pedals down 2 hallways from the resident's bedroom until stopped at Staff H's, Licensed Practical Nurse (LPN)/MDS Coordinator/Infection Preventionist office. Staff H directed Staff I that she had passed the shower room and needed to go back the other direction. Staff A, Registered Nurse (RN), was also present at Staff H's office. Staff A followed Resident #7 and Staff I down the hallways to the shower room. The total distance the resident traveled through the facility was 240' or ¾ of a football field. The facility failed to stop the transport of Resident #7 in a w/c without footrests. On 1/21/26 at 7:48 AM Staff H stated she hadn't noticed Resident #7 did not have footrests on her w/c. The staff stated residents must have footrests on the w/c prior to being pushed. 2. Resident #41's MDS dated [DATE] revealed a BIMS score of 3/15 indicating severe cognitive impairment. The document disclosed the resident was dependent on staff for the use of a manual w/c. The document provided the resident had diagnoses including acute kidney failure, high blood pressure, and diabetes mellitus. The resident's Care Plan dated 1/20/26 provided a focus area for ADL assistance revised on 1/10/26 with staff interventions for use of manual w/c with assistance of 1 and transfers with assistance of 1 using a gait belt dated 1/12/26. On 1/20/26 at 1:04 PM observed Staff E, CNA, push Resident #41 from the dining room to the living room meeting 1 unidentified staff member in the hallway. Observed the resident's feet to be dragging on the floor during the dependent mobility. The distance traveled was approximately 75'. The facility failed to ensure the resident's feet were on footrests while being transported in a w/c. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/21/26 at 2:22 PM Staff J, Registered Nurse (RN), stated a resident must have footplates prior to being pushed in a w/c. On 1/22/26 at 12:27 PM Staff D, Certified Medication Aide (CMA), stated residents' feet must be on the foot pedals prior to pushing them in their w/c's. On 1/27/26 at 9:28 AM Staff G, Certified Occupational Therapy Assistant (COTA), stated residents should have their feet on footrests prior to being pushed. On 1/27/26 at 11:01 AM the Director of Nursing (DON) stated she expected that residents have their feet on footrests, dignity bags if necessary, clean appearance, dressed and/or covered prior to being pushed in a w/c. The DON stated she would expect any staff, especially a Charge Nurse or someone on the Leadership Team, to step in to stop w/c dependent mobility if the resident's feet were not on footrests. On 1/28/26 at 11:14 AM during an interview with the Administrator and DON, the Administrator acknowledged footrests should be in place prior to pushing a resident in a w/c. The DON stated during the Nurse Meeting on the previous day she started training on a w/c policy. On 1/29/26 at 11:13 AM the Administrator provided the facility did not have a policy related to w/c safety and use. On 1/29/26 at 11:50 AM when asked for clarification about the w/c policy that was referenced by the DON that was being trained, the Administrator stated he had not reviewed that policy and wanted to read through it first. 3. The Minimum Data Set (MDS) dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. The MDS documented Resident #2 was dependent on staff for the chair to bed transfer and required the staff to do all of the effort. Resident #2 does none of the effort to complete the activity or the assistance of 2 or more staff is required for the resident to complete the activity. Review of Resident #2's EHR documented Resident #2 required a full body mechanical lift with the assistance of 2 staff. On 1/12/26 at 11:21 AM Resident #2 stated she was required to use a full body mechanical lift for transfers. Resident #2 stated it depended on the staff as to how the full body mechanical lift was utilized. Resident #2 stated some staff use 1 staff but most staff use 2 when they transfer her. Resident #2 stated she has been a nurse for 30 years and knows there should be 2 staff when a resident was transferred in a full body mechanical lift. Resident #2 stated she would tell the staff to get a second staff for the full body mechanical lift and the staff asked her if she didn't trust the staff. Resident #2 stated she told the staff it was not that she did not trust them but what if the sling breaks? Resident #2 explained she was worried she would end up on the floor. Resident #2 stated it did worry her when she was being transferred. 4. The MDS dated [DATE] documented Resident #3 had a Brief BIMS of 11 indicating moderate cognitive impairment. The MDS documented Resident #3 was dependent on staff for the chair to bed transfer and required the staff to do all of the effort. Resident #3 does none of the effort to complete the activity or the assistance of 2 or more staff is required for the resident to complete the activity. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/12/26 at 10:49 am Resident #3 stated she does not like to use the full body mechanical lift. Resident #3 stated she grabs the staff around the neck and the staff place her in the wheelchair. Resident #3 stated she did not remember when the staff last used a full body mechanical lift to transfer her. Resident #3 stated the staff will wheel the full body mechanical lift into her room but they decide not to use it. On 1/8/26 at 5:22 PM Staff BB stated when he was trained the staff told him that the lift was based on the manufacturer's recommendations and they were able to utilize the full body mechanical lift with only one person. Staff BB stated he reported the incident to Staff MM, Licensed Practical Nurse (LPN) and did not think anything became of it. On 1/12/26 at 12:37 PM Staff A, Registered Nurse (RN) stated occasionally she will be asked to help with full body mechanical lift transfers but not very often. Staff A stated she had seen staff transfer residents that required a full body mechanical lift with only one staff. Staff A stated she always reeducated the staff to request help and she would be able to help. Staff A stated all the staff do it all the time. Staff A stated she frequently saw Staff RR, Certified Nurse Assistant (CNA) and Staff JJ, CNA transfer residents that required a full body mechanical lift with only one staff. On 1/12/26 at 1:09 PM the DON stated every mechanical lift at the facility required 2 staff to utilize for resident transfers. On 1/14/26 at 1:51 PM Staff MM, RN stated there were a couple staff that she had to remind they needed 2 people to transfer residents with a full body mechanical lift. Staff MM stated there were reports from other staff that so and so was in the room transferring by themselves with a full body mechanical lift. Staff MM stated Staff BB came to her about a complaint that staff were not helping him with full body mechanical lift transfers. On 1/21/26 at 7:52 AM Staff R, CNA stated staff are not supposed to transfer residents with full body mechanical lifts alone but when a nurse will not help she has to transfer with only one staff. On 1/28/26 at 2:04 AM a review of a document titled, Water Temperature logs documented on 1/27/25 water temperature in resident room on a-hall 122, b-hall 121, rehab hall 122 and laundry 145. On 2/26/25 water temperature in resident rooms on a-hall 121, b-hall 121, rehab hall 122 and no water temperatures taken in laundry. On 3/25/26 water temperature in resident rooms on a-hall 122, b-hall 122, rehab hall 122 and no water temperatures taken in laundry. On 4/22/25 water temperature in resident rooms on a-hall 121, b-hall 122, rehab hall 122 and no water temperatures taken in laundry. On 5/20/25 water temperature in resident rooms on a-hall 122, b-hall 122, rehab hall 119 and no water temperatures taken in laundry. 6/18/25 water temperature in resident rooms on a-hall 121, b-hall 120, rehab hall 120 and no water temperatures taken in laundry. On 7/18/25 water temperature in resident rooms on a-hall 122.4, b-hall 121.9, rehab hall 122.3 and laundry 140.1. On 8/22/25 water temperature in resident rooms on a-hall 122, b-hall 121.4, rehab hall 122.3 and laundry 139.7. 9/26/25 water temperature in resident rooms on a-hall 121.9, b-hall 122.1, rehab hall 122 and laundry 143. On 10/21/25 water temperature in resident rooms on a-hall 122.3, b-hall 121.4, rehab hall 120.7 and laundry 120.2. On 11/14/25 water temperature in resident rooms on a-hall 122.4, b-hall 122.6, rehab hall 123.2 and laundry 144.5. No water temperatures obtained since 11/4/25. On 1/28/26 at 2:04 PM Staff Z, Director of Plant Operations explained it was probably his job to review the temperatures every month but he did not. Staff Z acknowledged he did not know what water temperature was too hot for resident rooms or for resident showers. Staff Z explained he was unaware (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of appropriate water temperature for the facility high or low. On 1/29/26 at 10:27 AM the DON said 124 degrees for resident room water temperatures was a little too hot. The DON explained she was not sure what the temperature should be to prevent burns or the timeframe as to when a burn would occur. On 1/28/26 at 2:56 PM the Administrator stated he was not a temperature expert and could not speak to the appropriate temperature of water for the shower or resident rooms off the top of his head. The Administrator stated it would be good if Staff Z was trained in the appropriate water temperatures for resident use but was not sure if Staff Z had ever been trained in the appropriate water temperatures for resident use. No policies presented for appropriate water temperatures for resident rooms and shower rooms, full body mechanical lift use or transportation of residents in wheelchairs.