STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165468	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastern Star Masonic Home	715 West Mamie Eisenhower Boone, IA 50036

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on facility investigation review, clinical record review, staff interviews and policy review the facility failed to report an allegation of resident to resident abuse within 2 hours to the Iowa Department of Inspections, Appeals and Licensing (DIAL) for 2 of 2 residents reviewed (Residents #74 and #80). The facility reported a census of 73 residents.Findings include:The Progress Note dated 2/18/26 documented Resident #74 came to the nurse to take her to his room. Resident's #74's roommate (Resident #80) was lying on the floor in a pool of blood above his head. Resident #74 reported he had a confrontation with Resident #80. Resident #74 was separated from Resident #80 and was brought to the west dining room. The Incident Report (IR) dated 2/18/26 at 8:10 PM documented Resident #80 was observed laying on the floor in a pool of blood. Resident #80 had a 13 centimeter laceration to the back of his head related to a fall and was sent to the emergency room. Review of the document titled Self Report revealed the facility contacted the state agency regarding the allegation of resident to resident abuse on 2/19/26 at 5:03 PM. On 5/19/26 at 2:46 PM, the Director of Compliance reported the self report was initially called in to DIAL around 9 or 10 PM and then the self report was filed online the next day after the facility was able to gather further information regarding the incident.On 5/19/26 at 3:30 PM, the Director of Compliance reported he did not have any documentation that the phone call was made to DIAL. On 5/20/26 at 1:21 PM, DIAL Intake Specialist reported there were no calls documented from the facility on the call logs around 9 or 10 PM on the evening of 2/18/26.The facility policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy updated 07/2025 documented if the incident prompting the investigation results in serious bodily injury to a resident and there was reasonable belief that it was result of a crime committed, the Elder Justice Act requires the matter to be reported to law enforcement and DIAL within two hours by all persons having knowledge of the matter.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility document review, staff interviews and policy review, the facility failed to provide care and services according to accepted standards of clinical practice by not following physician orders resulting in medication errors for 2 of 2 residents reviewed (Residents #65 and #6) for medication errors. The facility reported a census of 73 residents.Findings include: 1. The Clinical Census revealed Resident #65 was admitted on [DATE] for hospice services. Resident #65 did not have a Minimum Data Set (MDS) completed. The facility form title Medication Error dated 5/9/26 revealed Resident #65 was incorrectly administered Oxycodone (opioid narcotic) 5 milligrams (mg). The form documented Resident #65 was drowsy but alert and responsive to verbal stimuli following the medication error. The Progress Note dated 5/9/26 documented a medication error. Resident #65 was given Oxycodone 5 mg instead of the prescribed Tramadol (opioid narcotic) 50 mg. The May 2026 Medication Administration Record (MAR) for Resident #65 lacked a physician order for Oxycodone. The MAR directed to give Tramadol 50 mg two tablets every 6 hours as needed for low back pain. On 5/20/27 at 2:31 PM, Staff D, Certified Medication Aide (CMA) acknowledged the medication error with Resident #65. Staff D said she thought the medication error had to do with having two brand new residents in rooms 14E (Resident #65) and 16E (Resident #82) with their last name both starting with the letter S. She said both residents wanted pain medication at the same time. She said she saw the letter S on the medication card and grabbed the wrong one. She said when she went to do a narcotic count at 10 AM she realized there was more Oxycodone gone then there should have been. She said there were three Oxycodone tablets gone and there should only have been one tablet gone. She said she gave Resident #82 one Oxycodone tablet (5 mg) and she had given Resident #65 two Oxycodone tablets (10 mg total). She said Resident #65 had an order for Tramadol 50 mg 2 tablets. Staff D said she self identified the medication error and reported it to the nurse. She said the nurse completed the required notifications. Staff D said she received reeducation to make sure to identify the resident and to triple check the medication cards with the resident name. She said normally she would pull the medication card out of the drawer and put it on top of the cart to compare it to the MAR. She said she did not do that and had left the card in the drawer. She said she also signed off the medication before she gave the medication and she normally does not do that. She said usually she administers medication and then signs the medication out. The Controlled Medication Utilization Record for Resident #82 documented on 5/9/26 at 9:08 AM one tablet of Oxycodone 5 mg was deducted with the remaining amount of 13 tables. The document reflected the count was corrected on 5/9/26 with the amount remaining to be 11 tablets instead of 13 tablets. The Controlled Medication Utilization Record for Resident #65 documented on 5/9/26 at 8:33 AM two tablets of Tramadol were deducted with the remaining amount of 40 tablets. The entry was crossed off with a line through it and the word error was written on the side. On 5/20/26 at 4:14 PM, the Director of Compliance reported he would expect the staff to follow the 3 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	checks and 6 rights of medication administration. The Director of Compliance reported he had talked to Staff D, CMA and she had reported to him also that she gave Oxycodone 5 mg 2 tablets (10 mg total) to Resident #65 which was consistent with the documentation on the narcotic record. He acknowledged the Medication Error Report did not reflect that two tablets of Oxycodone were given. He said Resident #65's Physician would be updated with the correct information. The facility policy titled Medication Administration reviewed 07/2025 documented the facility staff member will prepare and administer the medications to the resident following the 3 Checks and 6 Rights of Medication Administration and/or current best practices for Medication Administration. The facility form titled Medication Administration Audit documented the 6 rights of Medication Administration include the following: a. Right Resident b. Right Medication c. Right Time d. Right Route e. Right Dose f. Right Documentation In addition, the 3 Check prior to pulling and administering the medication included the following: a. Before removing from drawer b. As the drug is removed from the card c. Before returning the medication card to the cart. 2. The Minimum Data Set (MDS) dated [DATE] triggered Care Areas included cognitive impairment and poor memory. The admission Record revealed Resident #6 was admitted to the facility on [DATE] with diagnoses of osteoarthritis and pain. The Clinical Physician Orders revealed tramadol (a strong prescription painkiller used to block moderate to severe pain) 50 mg 2 tablets 3 times daily was discontinued on 2/17/26. The progress note on 2/17/26 at 2:10 PM documented the signed order to discontinue tramadol and start oxycodone (a strong, semi-synthetic opioid pain medication prescribed to relieve moderate-to-severe pain) 20 mg one tablet twice daily. The February 2026 Medication Administration Record (MAR) for Resident #6 directed to give oxycodone 20 mg one tablet twice daily for osteoarthritis which was started on 2/17/26 at 7:00 PM. The MAR showed the order for tramadol 50 mg two tablets three times daily order was discontinued (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 2/17/26 at 2:07 PM. The MAR revealed the resident received the scheduled night dose of oxycodone. The Situation Background Assessment Recommendations (SBAR) dated 2/18/26 at 7:57 AM, documented tramadol 50 mg 2 tablets every 8 hours as needed was discontinued and started orders for oxycodone 20 mg twice daily on 2/17/26. The medication card was still in the medication cart after the tramadol was discontinued. Staff, H Certified Medication Aide (CMA) gave the tramadol by mistake. The facility form titled Medication Error dated 2/18/26 revealed Staff H, CMA incorrectly administered 2 tablets of tramadol (opioid narcotic) 50 milligrams (mg) on 2/18/26 at 6:30 AM. The form documented Resident #6 was alert, responsive to verbal stimuli, and vital signs were stable following the medication error. On 5/21/26 at 3:00 PM, the Director of Compliance indicated he would expect the CMA to follow the 6 rights of medication administration. Also, informed he would expect medication be pulled from the medication cart after the medication was discontinued. The resident's pocket care plan dated 5/20/26 documented protocols for opiod use and comfort risk.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 clinical record review, staff interviews, and policy review, the facility failed to provide adequate nursing supervision to prevent an elopement for 1 of 1 resident reviewed (Resident #7). The facility reported a census of 73 residents. Findings include:The Clinical Census revealed Resident #7 was admitted on [DATE]. Resident #7 did not have a Minimum Data Set (MDS) completed. The facility assessment titled Wandering Risk Assessment completed on 2/13/26 at 1:26 PM identified a score of 11 indicating Resident #7 was a high risk to wander. The Baseline Care Plan signed by Resident #7's wife and dated 2/13/26 did not address high risk for wandering. The Incident Report dated 2/13/26 at 3:45 PM documented the incident category as an elopement. The form revealed a dietary staff member let Resident #7 out of the health center (supervised area) to a non-supervised area. Resident #7 went outside and a residential care facility (RCF) certified nursing assistant (CNA) saw Resident #7 walking by the RCF building and brought Resident #7 back to the health center.The facility form titled SBAR (Physician Notification) documented on 2/13/26 a dietary staff member let Resident #7 out of the health center. Resident #7 got outside. The RCF CNA noticed Resident #7 wandering near the RCF building. The RCF CNA brought him back to the health center. Resident #7 did not fall and there were no injuries. On 5/21/26 at 11:55 AM, Staff A, Registered Nurse (RN) reported Resident #7 had moved to the health center on 2/13/26. She said the dietary aide let Resident #7 out the door in the west hallway that goes to the RCF. She said Resident #7 then went out door #15 by the dumpsters. She said Resident #7 was found outside on the sidewalk by himself. She said she did not think he was outside very long as the dietary staff member had come up to her to ask if Resident #7 had moved to the health center. She said the dietary staff member told her that she had let Resident #7 out the health center door because she thought he still lived in RCF. She said she thought Resident #7 was outside for maybe 5-10 minutes. She said she went outside to look for Resident #7. She said an RCF aide was outside in her car taking a break and had seen Resident #7 by himself on the sidewalk. She said when she got outside she met the RCF aide and Resident #7. She said they had to get a wheelchair to bring him back to the health center. She said Resident #7 was wearing pants, a short sleeve t-shirt and shoes. She said he did not have a coat or winter clothes on. She said the weather was chilly but it was not snowing or raining at the time. When asked what interventions were put into place after the incident, she said, that's a good question. She said she thought she had left that up to the Co-Don's (Director of Nursing). She said she thought the intervention was about making sure all staff know the residents in the health center and making sure staff are informed so it does not happen again. She said she provided education to the dietary aide regarding double checking with the staff before letting a resident out and verifying if they should be let out or not. On 5/21/26 at 1:00 PM, observation revealed doors at the end of the west hallway in the health center are secured and required a code to leave. When exiting the health center through the west door, there's a door on the right side labeled #15 that leads to the loading dock/sidewalk, dumpsters and a residential street. Door #15 was not secured or alarmed. There was a sign on the door #15 stating video surveillance. On 5/21/26 at 2:49 PM, Staff B, Dietary Aide reported she was pulling a cart, entered the main health center door and Resident #7 exited out of the door into RCF. She said she thought Resident #7 still lived upstairs in the RCF. She said Resident #7 let himself out the back door where the dumpsters were located. She said she ran down the hallway in the health center and found the first staff member closest to the door which was Staff A, RN. She said she told Staff A that Resident #7 had gone out the door. She said Staff A panicked a little bit and then grabbed another CNA from a resident's room to help. Staff B said she went back outside and saw Resident #7 was walking down the sidewalk towards the elementary school. She said no one was with him. She said she called his name but he kept walking and did not turn around. She said at the end of the sidewalk there was a RCF CNA (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	standing there and she grabbed Resident #7. She said Resident #7 was probably outside for a whole minute. She said everyone responded really quick. When asked if anyone in Administration had called her about the incident, she said not at that time but recently. When asked how recent, she said Staff E, Co-DON called her today (5/21/26) and she told her the same information. Staff B reported Resident #7 was outside by himself but she could not say where the RCF staff member had been the whole time. When asked if she had received any education after the incident, she said no. She said the situation was an accident. She said she was not paying attention and when she realized it was Resident #7, she went to the nurse and found out he had been moved. She said she has worked in the dietary department for 3 years, she said she knew she was not to let residents out the door. On 5/21/26 at 3:12 PM, the Co-DON's and the Director of Compliance reported the dietary aide was with Resident #7 and had eyes on him when he went outside. The Administrator reported the video surveillance was not available as the incident occurred more than 3 months ago. On 5/21/26 at 3:20 PM, Staff C, RCF CNA reported she was on break in her car and and she saw Resident #7 exit the door. She said she was parked along the road. She said when Resident #7 came out of the door, he was by himself. She said Resident #7 exit the door, he went left and started walking down the sidewalk towards the school. She said he did not have his walker with him. She said she jumped out of her car and headed to him. She said a dietary aide came outside and was walking behind him. She said she approached from the front and got to him first. She said she had him sit down on the ledge and then two other staff members came out with a wheelchair. She said the dietary staff member did not know Resident #7 had moved to the health center. She said she did talk to her the RCF Director of Nursing (DON) about what had happened and the RCF DON said the health center staff would take care of it. She said no one had reached out to her about the incident prior to today (5/21). She said the Director of Health Services reached out to her today to ask what had happened. On 5/21/26 at 4:05 PM, the Director of Compliance reported his expectation was for staff to stay with the resident if the resident exited the health center and required supervision. He said from what he knew the staff had eyes on Resident #7 the whole time. He said he did not consider the incident an elopement. He said the facility used a 5 minute form to provide education. The facility was not able to provide any documentation to show education was completed with the staff after the incident occurred. The facility policy titled Elopements and Wandering Residents reviewed 4/1/26 documented the facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The policy directed the following when monitoring or managing resident at risk for elopement or unsafe wandering:a. Residents will be assessed for risk for elopement and unsafe wandering upon admission and throughout their stay by an interdisciplinary care plan team.b. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person centered care plan.c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risk associated with hazards will be added to the resident's care plan and communicated to appropriate staff. d. Adequate supervision will be provided to help prevent accident or elopementse. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions and document accordingly.f. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on personnel file reviews, facility policy review and staff interview, the facility failed to provide dependent adult abuse (DAA) training within 6 months of hire for 1 of 5 employees reviewed. The facility identified a census of 73 residents. Findings include:The personnel file for Staff F, Registered Nurse (RN) documented a hired date of 8/5/25. Review of the Dependent Adult Abuse Mandatory Reporter Training Certificates documented Staff F completed the 2 hour dependent adult abuse training on 3/24/26.The facility policy titled Abuse Prevention, Identification, Investigation and Reporting Policy reviewed 07/2025 revealed each employee shall be required to complete 2 hours of training related to identification and reporting dependent adult abuse within six months of initial employment. On 5/20/26 at 10:00 AM, the Director of Compliance acknowledged the DAA training was completed late. He reported the facility had recently changed their process where new hires would be enrolled in the DAA class right away and not wait the 4-6 months.