STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165474	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Ambassador Sidney Inc	115 Main Street Sidney, IA 51652

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility document review, clinical record review, staff interview, and policy review the facility failed to provide residents and families with 48 hour notification of financial responsibility when Medicare Part A services were scheduled to be discontinued for 1of 3 residents reviewed (Resident #53). The facility reported a census of 43 residents.Past non-compliance achieved through the following:On 3/11/26 at 11:50 AM the Administrator stated the facility had identified a concern regarding Advanced Beneficiary Notice (ABN) in 1/26 and as part of their Quality Assurance had developed a Performance Improvement Plan (PIP). The Social Services Director stated she typically received a notice from therapy regarding planned discharge 72 hours to a week in advance. The Administrator stated the facility also has weekly Medicare Meetings and as part of the morning Stand Up meeting of the Leadership Team they go over the therapy caseload and planned/potential discharges. Findings include:According to the Minimum Data Set (MDS) dated [DATE], Resident #53 had a Brief Interview for Mental Status (BIMS) score of 8/15 indicating moderate cognitive impairment. The document revealed the resident had diagnoses of stroke, atrial fibrillation (irregular heart rhythm), and paralysis of one of his body. The clinical record census revealed Resident #53 admitted to the facility on [DATE] with Medicare A as a payor source and on 12/30/25 the resident was discharged from Medicare A services. The Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review, Form Center for Medicare Services (CMS)-20052 (2/2017), provided by the facility revealed Resident #3 did not receive the Notice of Medicare Non-Coverage (NOMNC), Form CMS 10123-NOMNC and the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) Form CMS-10055 (2024).The facility failed to provide the resident and/or family with 48 hour advance notice of discharge from Medicare A services and allow the resident and/or family time to follow the process of appeal if desired. On 3/11/26 at 11:50 AM the Administrator and Social Services Director acknowledged Resident #53 had not received the proper documents for signature prior to discharge from Skilled Medicare A services. The facility's Notice of Medicare Provider Non-Coverage and Verification of Receipt Notice Policy, updated 9/5/23, disclosed the residents would be provided with notification of the ending of Medicare services no later than 48 hours before the termination of services.

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

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on clinical record review, resident interview, staff interviews, and policy review the facility failed to develop programs maintaining residents strength, range of motion (ROM), communication needs based on the comprehensive assessment for 1 of 14 residents reviewed (Resident #3). The facility reported a census of 43. Findings include:The Minimum Data Set (MDS) for Resident #3 dated 12/16/25 provided a Brief Interview for Mental Status (BIMS) score of 14/15 indicating normal cognition. The document revealed the resident had diagnoses of quadriplegia, anxiety disorder and depression. The document included the resident had functional limitations of ROM in all extremities. The document disclosed that the resident received 1 day of passive range of motion (PROM) and 1 day of communication of at least 15 minutes in the last 7 calendar days.Resident #26's Care Plan dated 3/11/26 identified a problem area for contractures related to quadriplegia post spine injury dated 9/29/25 and reviewed/revised 12/26/25 with staff interventions of PROM exercises for hand, wrist, elbows and shoulders daily. The resident's Care Plan failed to address the resident's restorative programs for PROM to the lower extremities and communication. The clinical record contained a nursing order dated 9/26/25 for Restorative PROM - to follow the instructions on the handout in the resident's room for PROM. Perform PROM daily, go slowly and gently (never force a joint past natural ROM). Support each limb fully (especially at joints). Observe pain/intolerance, resistance, or spasm. Use clean hands and explain each movement (person may not have feeling in extremity). Frequency once a day. The clinical record contained a nursing order dated 9/26/25 for Restorative Communication - general conversation about current events, reminiscing, orientation while speaking in slow, clear, loud and concise manner. Frequency once a day. The Restorative Treatment Administration Record (TAR) Administration History for 2/9/26 - 3/11/26 provided the resident received both the communication and PROM restorative programs 8/30 days. The document contained documentation that on 3 days the staff ran out of time, 1 entry for the resident sleeping, 1 entry for the resident having visitors and 1 entry for staff not being available. The document revealed 14 days of no entries. On 3/9/26 at 4:24 PM Resident #3 stated she did receive Restorative Nursing services, but hadn't received them in the past 3 days. The resident stated she felt it was related to the facility not having enough staff.On 3/11/26 at 8:41 AM Staff A, Certified Nurse Aide (CNA)/Restorative Nursing Assistant (RNA) stated she was primarily assigned to Restorative Nursing; however if there was a staff shortage she will be pulled to the floor. The staff stated when the RNA was pulled to the floor residents may have missed programs or decreased time. Staff A stated in the past 3 months she had been pulled to the floor more frequently. The staff stated there were 2 other staff that were assigned to Restorative Nursing to complete the programs when she was off. The staff stated she was unsure if other staff completed the Restorative Nursing programs when she was pulled to the floor. On 3/11/26 at 2:56 PM the Assistant Director of Nursing (ADON)/MDS Coordinator/Restorative Nurse stated that staffing has varied and when there was a shortage of staff on the floor, the RNA will be pulled from Restorative Nursing to work the floor. The staff acknowledged there were 3 staff that had been trained to work in Restorative Nursing but no more than 1 was assigned to it at a time. The staff stated if a program was written for daily then the facility should try to meet that goal. On 3/11/26 at 3:55 PM the Administrator and Director of Nursing (DON) stated the residents had nursing orders for completion of their programs. The Administrator and DON both stated they felt Resident #3 received more than 8 days of Restorative Nursing in the past 30 days, but acknowledged that without documentation on Restorative TAR there was no evidence of completion. The facility's Restorative Nursing Services Policy, approved 1/29/24, revealed the resident's restorative goals and objectives were individualized, resident-centered and outlined in the resident's plan of care. The document included documentation of completed restorative therapy and/or refusals would be documented in the medical record.

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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 observation, clinical record review, staff interview, and policy review, the facility failed to apply foot pedals to a resident's wheelchair during transport for 1 of 3 residents (#22) reviewed. The facility reported a census of 43 residents.Findings include: Resident #22's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 07 out of 15 which indicated severely impaired cognition. It included diagnoses of diabetes mellitus, non-Alzheimer's dementia, and osteoporosis. It also revealed the resident required supervision with eating, required moderate assistance with oral and personal hygiene, upper body dressing, tub and toilet transfers, rolling left-to-right, and sitting-to-lying, and maximal assistance with all other Activities of Daily Living (ADLs) and other forms of mobility. It also indicated the resident used a wheelchair and walker in the 7-day look-back period.The Care Plan dated 8/07/23 indicated the resident was independent with locomotion in his wheelchair and staff helps him at times.On 3/10/26 at 8:06 AM, Staff A, Certified Nurse Aide (CNA) transported Resident #22 in his wheelchair from the dining room to the lobby without foot pedals.On 3/10/26 at 9:19 AM, Staff A stated she should not have pushed the resident in his wheelchair because it didn't have foot pedals attached.On 3/11/26 at 10:32 AM, Staff B, Certified Medication Aide (CMA) stated staff should make sure the foot pedals are on a resident's wheelchair before transporting them in it.A policy titled Wheelchair General Guidelines dated 10/2025 indicated the purpose of the policy was to ensure wheelchairs used by residents are safe, properly maintained, and appropriate for each resident's needs in order to promote mobility, independence, and injury prevention. It also directed staff to ensure residents' feet are positioned properly on footrests when seated.On 3/12/26 at 9:30 AM, the Director of Nursing (DON) stated if the resident asked to be pushed in the wheelchair, staff should've reminded the resident they can't be pushed without pedals. If the resident did not ask to be pushed, staff should not have pushed him.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, resident and staff interviews, and policy review, the facility failed to consistently perform required pre-hemodialysis and post-hemodialysis assessments for 1 of 1 resident (#2) reviewed. The facility reported a census of 43 residents.Findings include:Resident #2's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated completely intact cognition. It included diagnoses of atrial fibrillation (irregular heartbeat), hypertension, End-Stage Renal Disease (ESRD), and thyroid disorder. It also revealed the resident was independent with eating, required supervision with oral hygiene, moderate assistance with personal hygiene, sitting-to-lying, and lying-to-sitting, maximal assistance with bathing, upper body dressing, and bed mobility, and was dependent with all other Activities of Daily Living (ADLs) and mobility. eating and oral hygiene, and was dependent with all other Activities of Daily Living (ADLs). It indicated the resident received hemodialysis upon admission and within the previous 14 days.The Care Plan dated 2/03/26 included a dialysis focus and directed staff to coordinate dialysis schedule and transportation for the resident's time at dialysis.The Progress Notes and Vital Signs documentation revealed the resident's Monday, Wednesday, and Friday pre-dialysis and post-dialysis site assessments and vital signs were not consistently documented between 1/28/26 to 3/09/26.On 3/10/2026 at 11:10 AM, the resident stated staff doesn't always take vital signs before she goes to dialysis because she usually leaves at 5:20 AM.The Electronic Health Record (EHR) included orders dated 3/10/26 for staff to complete a pre-dialysis and post-dialysis assessment and to send the communication form to the hemodialysis facility every Monday, Wednesday, and Friday.The EHR staff Task List revealed a dialysis pre-assessment and dialysis post-assessment entry dated 3/11/26 at 5:00 AM that directed staff to ensure assessment and communication completion on the resident's dialysis days.The EHR's 14-day Administration History lacked documented pre-dialysis and post-dialysis site assessments and vital signs until 3/11/26.A policy titled Dialysis (Hemo) Patient Care dated 10/01/25 directed staff to complete appropriate dialysis forms with pertinent resident information to send with resident.On 3/12/26 at 9:30 AM, the Director of Nursing (DON) stated staff should've been ensuring the assessments were consistently completed and sent with the resident and returned.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interview, and policy review, the facility failed to implement infection control practices by lifting an indwelling catheter drainage bag above the resident's bladder during perineal care for 1 of 1 resident (#7) reviewed and by carrying Personal Protective Equipment (PPE) out of the resident's room after it was used. The facility reported a census of 43 residents.Findings include:Resident #7's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated completely intact cognition. It included diagnoses of obstructive uropathy (urine unable to drain normally), diabetes mellitus, Alzheimer's disease, and non-Alzheimer's dementia. It indicated the resident was independent with eating, required setup assistance oral hygiene, moderate assistance with upper body dressing, maximal assistance with bathing, lower body dressing, personal hygiene, and bed mobility, and was dependent with all other Activities of Daily Living (ADLs) and mobility. It also indicated the resident had an indwelling catheter (urinary catheter) in the 7-day look-back period.The Care Plan revised 4/19/24 indicated the resident had an indwelling catheter and a history of UTIs (urinary tract infections). The Care Plan directed staff to provide catheter care on rounds and as needed.During a continuous observation on 3/11/25 that began at 7:00 AM, Staff C, Certified Nurse Aide (CNA) and Staff D, CNA performed Resident #7's hygiene and urinary catheter care. Both staff performed hand hygiene and put on PPE in the resident's room. No concerns were identified during hygiene or catheter care. After hygiene care was completed, Staff B, Certified Medication Aide (CMA) entered the resident's room and Staff C removed her PPE and took it out of the resident's room without performing hand hygiene. Staff E, Registered Nurse (RN) entered Resident #7's room and performed catheter care without observed concerns. Staff E completed catheter care and left the resident's room while Staff A and Staff B proceeded to dress the resident for breakfast. While Staff A and Staff B gathered the resident's clothes, the resident's urinary catheter drainage bag was observed lying on the floor beside the resident's bed. Staff A picked up the urinary drainage bag and hung it on the bedframe. While the resident lied in bed, she lifted the urinary catheter drainage bag above the resident and threaded it through the left pantleg before putting the pants on the resident. They dressed the resident and transferred him into a wheelchair and transported him to the dining room for breakfast.On 3/11/2026 at 7:35 AM, Staff C stated she shouldn't have taken the gown out of the room. She added that staff normally discard PPE and perform hand hygiene in the resident's room prior to leaving.On 3/11/26 at 9:35 am, Staff A stated she should not have raised the resident's urine catheter bag above his body when she was putting his pants on.A policy titled Standard Precautions dated 10/25 indicated soiled gowns are removed as promptly as possible and hands washed to avoid transfer of microorganisms to other residents or environments. On 3/12/26 at 9:30 AM, the Director of Nursing (DON) stated staff should've disposed of the gown in the resident's room and performed hand hygiene immediately afterward. She also stated staff should've put the resident's leg and bag through the pantleg together at the resident's level.