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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>165478 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing  | (X3) DATE SURVEY COMPLETED<br><br>04/22/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Arbor Court  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>701 East Mapleleaf Drive<br>Mount Pleasant, IA 52641 |  |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
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| <p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, review of Long Term Care Ombudsman notifications of transfers and discharges, and staff interview, the facility failed to notify the Ombudsman of a transfer to the hospital for 2 of 3 residents sampled (Residents #58 and #7). The facility reported a census of 57 residents. Findings included: 1. Review of the Minimum Data Set (MDS) assessment for Resident #58, dated 2/27/26, revealed the resident discharged to an acute care hospital on 2/27/26 and was not expected to return to the facility. Review of Notice of Transfer Form to the Long-Term Care (LTC) Ombudsman, dated February 2026, revealed Resident #58 not listed as a hospital transfer/discharge.</p> <p>During an interview on 4/22/2026 at 8:09 AM, the Administrator reported being responsible for sending a monthly notification of resident transfers and discharges to the LTC Ombudsman. The Administrator explained that she did not send notification to the LTC Ombudsman if a resident was sent to the hospital and the resident was expected to return to the facility. For Resident #58, the Administrator reported that she had missed sending the notification to the LTC Ombudsman.</p> <p>2. Review of the MDIS assessment for Resident #7, dated 3/31/26, revealed the resident admitted to the facility on [DATE].</p> <p>Review of the electronic health record (EHR) revealed a Nurses Note dated 3/15/26 at 5:58 AM, revealed at 4:15 AM resident stated she had 10/10 pain in ruq (right upper quadrant). Denied SOB (shortness of breath), but lips looks purplish and she was pursed lip breathing. Notified DON (Director of Nursing) and provider. Order to transfer to ED (Emergency Department) for further eval (evaluation). Notified [name redacted], per resident request.</p> <p>A Nurses Note dated 3/15/26 at 6:06 AM, revealed resident left facility via ambulance at 5:05 AM. Did not take any personal belongings.</p> <p>The Nurses Note dated 3/15/26 at 10:18 AM, revealed resident returned to facility via ambulance.</p> <p>Review of the Notice of Transfer Form to Long Term Care Ombudsman dated March 2026 lacked Resident #7 name for being an emergency transfer to the hospital.</p> <p>During an interview on 4/22/26 at 11:04 AM, the Administrator stated she didn't know she needed to notify the Ombudsman for emergency transfers if the resident wasn't admitted to the hospital.</p> |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |   |  |
| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, clinical record review and staff interview, the facility failed to ensure staff administered medicated inhalers per physician order for 2 of 3 sampled residents (Residents #24 and #7). The facility reported a census of 57 residents. Findings included:</p> <p>1. Review of the Minimum Data Set (MDS) Assessment for Resident #24, dated 4/15/26, revealed a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which indicated a severe cognitive impairment, and a diagnosis of dementia.</p> <p>Review of the Physician Order List for Resident #24 revealed an order, dated 11/5/25, for Asmanex Inhaler (an inhaled corticosteroid medication) 200 micrograms (mcg) per actuation, two puffs inhaled orally two times per day for chronic obstructive pulmonary disease (COPD) with acute exacerbation. Rinse mouth with water and spit (after use).</p> <p>Review of the Medication Administration Record (MAR) for Resident #24, dated February 2026, revealed an order for Asmanex Inhaler two puffs two times per day and to rinse mouth with water and spit.</p> <p>On 4/20/2026 at 4:20 PM, Staff A, Certified Medication Aide (CMA), administered the Asmanex inhaler for a total of two puffs to Resident #24. Staff A did not have the resident rinse and spit after use of the inhaler.</p> <p>In an interview during the same observation, Staff A reported the Medication Administration Record (MAR) did not include instructions to rinse and spit after use of the inhaler, so she did not have the resident rinse and spit.</p> <p>On 4/22/2026 at 8:22 AM, during an interview, Staff B, Registered Nurse (RN) reported residents needed to rinse and spit after use of a corticosteroid inhaler. Staff B explained the directions for use of the inhaler should be included in the physician order and flow over to the MAR.</p> <p>On 4/22/2026 at 8:23 AM, during an interview, the Director of Nursing (DON), reported residents should have been instructed to rinse and spit after the use of corticosteroids, and Resident #24's MAR did include an order for the resident to rinse and spit after use.</p> <p>On 4/22/26 at 9:46 AM, during an interview, Staff A, CMA, reported residents needed to rinse and spit after the use of a corticosteroid inhaler, because if the medication sat in the resident's mouth, it could lead to thrush (a type of yeast infection). Staff A explained that she was unfamiliar with the medication, and was unaware of the need to have the resident rinse and spit after inhalation.</p> <p>Review of the undated facility policy, titled Medication Administration Procedure, revealed, in part, for staff to review the resident's Medication Administration Record (MAR) prior to administration of medications.</p> <p>2. The MDS assessment dated [DATE] revealed Resident #7 scored a 13 out of 15 on the BIMS exam, which indicated cognition intact. The MDS revealed diagnoses for pulmonary embolism, and asthma/chronic obstructive pulmonary disease/ or chronic lung disease.<br/>(continued on next page)</p> |   |  |

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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Review of Physician Orders revealed an order for Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 mcg (micrograms)/act (actuation)- 1 puff inhale orally in the morning for COPD with acute exacerbation Rinse Mouth After Use; Hold breath for 5-10 seconds after use</p> <p>During an observation on 4/21/26 at 8:19 AM, Staff C, Certified Medication Aide (CMA), administered a Trelegy inhaler to Resident #7. Resident #7 inhaled one puff and held her breath for 10 seconds and then Resident #7 took another drink of the water mixed with Miralax. Resident #7 did not swish and spit after taking a puff from the Trelegy inhaler and Staff C did not prompt Resident #7 to swish and spit.</p> <p>During an interview on 4/21/26 at 8:35 AM, Staff C, CMA queried if there were any special instructions with some inhalers and Staff C stated she administered a few residents that swished and spit after administering an inhaler. Staff C asked why a resident would need to swish and spit after inhalation of an inhaler and Staff C stated to get the extra particles out.</p> <p>During an interview on 4/21/26 at 8:57 AM, Staff C, CMA stated residents swish and spit with steroid inhalers to get out the residual particles and prevent fungal infections.</p> <p>During an interview on 4/22/26 at 8:13 AM, Staff C, CMA queried if residents needed to swish and spit after administration of the Trelegy inhaler and Staff C looked it up and stated yes, and Staff C would start doing that with all steroid inhalers.</p> |   |  |