STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165488	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twilight Acres	600 West 6th Street Wall Lake, IA 51466

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure a consistent code status between the IowaPhysician's for Scope of Treatment (IPOST), and the Electronic Health Record (EHR) for 3 of 12 resident reviewed for advanceddirectives (Resident #18, #23 and #26). The facility reported a census of 26 residents. Findings include: 1.The Care Plan initiated date of [DATE] failed to indicate Resident #23 desired to be a do not resuscitate (DNR) per his IPOST. The Clinical Physician Orders reviewed on [DATE] included an order dated [DATE] for Resident #23 to be DNR. Review of Resident #23's IPOST dated [DATE] reflected she desired a DNR status. Interview on [DATE] at 4:00 p.m. with Staff A, Licensed Practical Nurse (LPN), stated there is a list in the nurses station with the code status of the residents. Staff A stated when she looked for it she could not find it. Staff A stated the charts are color coded with dots, green dots are for DNR, red are for CPR and yellow is the limited interventions on the IPOST. Staff A looked up Resident #23's electronic health record and acknowledged that it was blank. Staff A stated it must have been missed since all the administration changes have happened. Staff A stated she is not sure who is responsible for putting the code status in the electronic health record. Staff A stated if there was an issue and she had to look for a resident's code status, she would go to look in the electronic health record. Interview on [DATE] at 4:20 p.m. with Staff B, LPN, stated if there is an incident with a resident that she needed to find the code status, Staff B stated that she would look in their electronic health record. Interview on [DATE] at 4:30 pm with Administrator and Director of Nursing (DON) stated that it is the nurse's responsibility to put the code status in the electronic health record. An undated policy named Resuscitation Procedure states the purpose is to ensure that resident wishes regarding cardiopulmonary resuscitation (CPR), life-sustaining measures, and life-prolonging interventions are honored and implemented within the capabilities of the facility. All residents will be asked about their resuscitation preferences upon admission and during quarterly care conferences. These preferences must be documented in the medical record and communicated to (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the physician. Residents have the option to sign a directive specifying which life-sustaining measures they wish to receive or decline. Staff are responsible for ensuring that these preferences are clearly visible and accessible in both the resident's chart and care plan. 2.Resident #18's IPOST dated [DATE] reflected a DNR code status. Resident #18's Clinical Physician's Orders and base information in the EHR, printed [DATE] at 9:28 a.m. lacked identification of the resident's code status. Resident #18's Care Plan printed [DATE] at 9:32 a.m. did not address the resident's code status. 3.Resident #26's IPOST dated [DATE] reflected a DNR code status. Resident #26's Clinical Care Plans page in the EHR, printed [DATE] at 9:35 a.m. lacked identification of the resident's code status. Resident #26's Clinical Physician's Orders in the EHR, printed [DATE] at 9:42 a.m. added DNR on [DATE]. Resident #26's Care Plan printed [DATE] at 9:38 a.m. did not address the resident's code status. On [DATE] at 12:40 p.m. Staff C Registered Nurse (RN) stated the list of resident's code status was printed from PCC, so the resident's code status was input into their EHR. The outgoing DON showed if you knew where to look, it could be found.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on clinical record review, staff interviews and policy review, the facility failed to offer to provide pneumococcal vaccine for 5 of 5 residents reviewed for Resident #2, #3, #10, #11, and #24. The facility reported a census of 26 residents. Findings include: 1)The Minimum Data Set (MDS) dated for 10/23/25, Resident #2 had a Brief Interview for Mental Status (BIMS) score not completed noting severe impaired cognition. Review of the immunization tab in the electronic health record revealed the last Pneumococcal Immunization was the PVC 13 on 5/16/16. 2) The Minimum Data Set (MDS) dated for 9/18/25, Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. Review of the immunization tab in the electronic health record revealed the last Pneumococcal Immunization was the PVC 13 on 7/18/16. 3) The Minimum Data Set (MDS) dated for 9/25/25, Resident #10 had a Brief Interview for Mental Status (BIMS) score of 3 indicating severe impaired cognition. Review of the immunization tab in the electronic health record revealed the last Pneumococcal Immunization was the PVC 13 on 4/23/15. 4)The Minimum Data Set (MDS) dated for 9/25/25, Resident #11 had a Brief Interview for Mental Status (BIMS) score of 3 indicating severe impaired cognition. Review of the immunization tab in the electronic health record revealed the last Pneumococcal Immunization was the PVC 13 on 3/8/18. 5)The Minimum Data Set (MDS) dated for 12/4/25, Resident #24 had a Brief Interview for Mental Status (BIMS) score of 0 indicating severe impaired cognition. Review of the immunization tab in the electronic health record revealed the last Pneumococcal Immunization was the PVC 13 on 6/3/15. A facility policy titled Infection Control and Prevention Plan dated 2025 showed that residents are encouraged to receive routine vaccinations as recommended by public health authorities, including but not limited to: Influenza annually, Pneumococcal vaccines, COVID-19 vaccines and boosters, Tetanus, Diphtheria, Pertussis, Shingles and Hepatitis B. Upon admission, the resident's vaccination history will be reviewed and documented in their medical records. Any missing or overdue vaccinations will be identified and scheduled accordingly. Residents and their families will be informed about the importance of vaccinations and the recommended schedule. Residents with medical contraindications to certain vaccines will be exempt from those vaccinations. Documentation of medical exemptions will be maintained in the resident's medical records. Interview with the Infections Preventionist (IP) on 12/17/25 at 3:45 p.m. stated that the facility did a complete audit of all the charts to see where the residents were currently at with their immunizations. The IP acknowledged they have not done a pneumococcal clinic and that the residents/resident representative have not been offered or given the updated immunizations.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure as needed (PRN) orders for psychotropic medications were limited to 14 days unless the attending physician or prescribing practitioner believed it appropriate for the PRN order to be extended beyond 14 days, and documented their rationale in the resident's medical record and indicated the duration for the PRN order, for 2 of 5 resident's reviewed (Resident #7 and #24). The facility reported a census of 26 residents.Findings include: 1) According to the MDS assessment dated [DATE] Resident #7 scored 2 on the BIMS indicating severe cognitive impairment. The resident's diagnoses included non-Alzheimer's dementia. Resident #7 did not take antianxiety medication. A facsimile (fax) dated 9/30/25 notified the physician Resident #7 had an increase in behaviors and explained some of them. The fax included current meds the resident took and asked for a PRN medication. The physician responded on 10/2/25 with an order for Lorazepam 0.5 mg every 6 hours PRN for agitation. The Medication Administration Record (MAR) for October 2025 added Lorazepam 0.5 mg every 6 hours PRN on 10/3/25, and the 1st dose given 10/3/25 (with the 17th at 14 days). The medication continued PRN through the month of October including receipt on the 25th and 27th without reconsideration by the provider. An Outpatient Psychiatric/Mental Health Progress Note dated 11/4/25 documented treatment recommendations and orders included continuing Resident #7's as needed lorazepam- renewing for 14 days (through the 18th). The provider sent a renewal for 14 days again on 11/11/25 (through 11/25/25). The MAR for November showed no documentation the resident received Lorazepam in the month. The MAR for December showed the resident received the Lorazepam on the 3rd and the 7th without an extension of the order. On 12/18/25 at 8:15 a.m. the DON confirmed they had no additional orders related to the PRN Lorazepam prior to discontinuation this month. The undated facility Policy for the Use of Psychotropics Drugs identified the purpose to ensure the safe and appropriate use of psychoactive drugs. The procedure included the facility would Facility will follow current state and federal regulations regarding psychotropic medications. The use of PRN orders for psychotropic medications were limited to 14 days. Excluding anti-psychotic drugs, if the attending physician or provider believed that was appropriate for the PRN order to be extended beyond 14 days, he or she would document their rationale in the resident's medical record and indicate the duration for the PRN order. 2) According to the MDS assessment dated [DATE] Resident #24 scored 00 on the BIMS indicating severe cognitive impairment. The resident's diagnoses included non-Alzheimer's dementia and anxiety disorder. Resident #24 did take an antianxiety medication during the last 7 days of the look back (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	period. A facsimile (fax) dated 9/19/25 notified the physician Resident #24 had an increased anxiety and exit seeking behaviors, and increased anxiety appears very problematic for resident. Family questions if something as needed would be helpful. The physician responded on 9/19/25 with an order for Alprazolam 0.25 milligrams (mg) by mouth every 8 hours as needed, may repeat dose times 1, one hour after if no improvement in symptoms. A Consultant Pharmacist Communication to Physician facsimile (fax) dated 11/25/25 notified the physician Resident #24 had an order for Alprazolam 0.25mg every 8 hours as needed which is being used for anxiety. This medication needs to be reviewed every 2 weeks for continuation. Could this be renewed at this time. The physician responded on 12/10/25 with a yes, please renew. Review of Resident #24's medical record failed to find end dates for the Alprazolam for the dates of 9/19/25 and 11/25/25.