STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165500	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rotary Senior Living	500 South Blaine Avenue Eagle Grove, IA 50533

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility investigation, staff interview and review of policy and procedures, the facility failed to ensure all alleged violations involving mistreatment, neglect, including injuries of unknown source, were reported to the Department of Inspection and Appeals and Licensing (DIAL) within 2 hours for a resident who sustained a left hand middle finger fracture (Resident #3). The facility failed to conduct a thorough investigation to determine the cause of the fracture. During the interviews, the staff reported they didn't know how his injury occurred and even added they didn't think of abuse. The facility reported a census of 29 residents.Findings include:Resident #3's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 3, indicating severe impaired cognitive decisions. Resident #3 sometimes could understand others and others understood them. They had adequate hearing, and vision with no behaviors or rejection of cares documented. Resident #3 required substantial to maximal assistance with all aspects of daily living (dressing, personal hygiene, transfers, oral hygiene and positioning). The MDS included diagnoses of Non-Alzheimer's Dementia, Polyneuropathy (widespread damage of peripheral nerves, causing numbness, tingling, burning pain, and muscle weakness, starting in the feet and hands), and macular degeneration (common eye disease that destroys sharp, central vision). The MDS lacked documentation of falls since the previous assessment.The Care Plan Focus initiated dated 2/17/23, indicated Resident #3 had self-care deficit related to activity intolerance, Alzheimer's, dementia and paranoid schizophrenia. The Interventions instructed the following:a. Resident #3 required 2 staff for transfers with the full-body mechanical lift, turning and repositioning, movement between surfaces, and a quarter inch bed rail to be used to promote independence with bed mobility. b. Protect Resident #3's arms with long sleeve shirts, place pillows on their side when in bed to protect from bumping arms and feet on the bed. Observe and report any changes to the physician as needed.The Nursing Note dated 1/27/26, labeled late entry at 6:35 AM, documented, the staff notified the nurse of Resident #3's swollen arm. The nurse observed significant non-pitting (a type of swelling where the skin does not indent after pressure is applied) edema (swelling caused by excess fluid trapped in the body tissues) to Resident #3's left-hand with no pain or discomfort when touched. The nurse removed the left arm protector due to circulatory restriction on the arm and elevated on a pillow.The Nursing Note dated 1/27/26 at 11:05 PM, indicated the nurse sent a facsimile with the following communication, noticeable significant edema to left-hand, no pain with movement, and range of motion. No edema elsewhere. Please advise. The facility received the following order from the physician, raise arm above the heart every couple of hours. With a question about the ability to get an X-Ray? Resident #3's swelling decreased per the overnight staff. The X-Ray report dated 1/28/26 at 4:18 PM, documented the impression as an acute non-displaced (a bone break where the pieces remain in their proper alignment) fracture noted through the 3rd middle phalanx (between the proximal and distal).The Nursing Note dated 1/28/26 at 5:31 PM, reflected nursing received a verbal report Resident #3 had a 3rd middle finger fracture. The physician would call the facility with orders. At 7:25 PM, the nurse and physician placed a splint on Resident #3's left-hand middle finger. Resident #3 (continued on next page)

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
	165500	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rotary Senior Living	500 South Blaine Avenue Eagle Grove, IA 50533

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	didn't cooperate during the application of the splint.On 2/26/26 at 3:40 PM, observed Resident #3 lying in bed on their right side wearing a splint on their middle finger of the left-hand. On 3/3/26 at 12:45 PM the Interim Director of Nursing (DON) brought a one-page investigation of Resident #3's fracture, adding in retrospect they could have done a better investigation and looked at all of the possibilities of the fracture of his middle finger. However, the staff said they didn't know what happened and he would get his fingers caught in his shirt. With that information, the Administrator, the Corporation, and her felt they didn't need to report it since the staff didn't know how it happened. They didn't call it in or do further investigations as they thought it was due to his geri-sleeve being too tight. They were shocked the Advanced Registered Nurse Practitioner (ARNP) ordered an x-ray and then it turned up as a fracture. The Interim DON added they should have done more of an investigation since he had a fracture, and no one knew how it happened. She added she couldn't make the decision on whether or not they would notify DIAL. The Interim DON explained she didn't think staff abuse/neglect, she said the staff wouldn't come forward and tell her the truth. Something happened to his finger; they just don't know what.The undated, untitled facility investigation pertaining to Resident #3's fractured left middle finger, documented no staff witnessed anything happen. The investigation reflected Resident #3 constantly rubbed his fingers together, and putting his hands in his shirt. The X-Ray noted degenerative changes. The facility determined the cause of the broken finger as the combination of Resident #3 rubbing his fingers together and his degenerative changes. On 3/3/26 at 1:00 PM Staff A, Certified Nurse Aide (CNA), and Staff B, CNA, reported Resident #3 grabs onto the rails to assist with rolling so they can change him. They both said he had days when he will grab his fingers and pull or twist them. They added they didn't know how his left middle finger got broke but they know he had days with him awake and other days with him sleepy. They said he could have possibly got his middle finger stuck in the top half of his side rails or maybe by twisting his fingers. They added he liked to swing out some days, while other days he remained perfectly content.On 3/3/26 at 1:35 PM the Interim DON acknowledged the facility didn't do a thorough investigation on Resident #3 and understood how thought of abuse could occur due to the fracture of a middle finger. She learned the facility needed to do a better investigation and look at everything that could have possibly happened to his finger and have a file ready. She added she learned something new every day, especially with abuse rising in the facilities it is easy to understand how and what DIAL is looking for to determine abuse didn't occur to any of the residents. On 3/3/26 at 4:45 PM, the Administrator interrupted the regulation as the fracture did not meet the criteria of reporting for injury of unknown origin and disagreed it was a reportable incident. Review of the Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated 10/19/22, all allegations of Resident injuries of unknown origin shall be reported to the Iowa Department of Inspection and Appeals, not later than 2 hours after the allegation is made. Following the investigation, the Administrator or designated agent will be responsible for forwarding the results of the investigation to the Department of Inspections and Appeals. This written report shall be forwarded to the Department within 5 days of the initial report.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165500	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rotary Senior Living	500 South Blaine Avenue Eagle Grove, IA 50533

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 observation, clinical record review, resident and staff interviews, and facility policy, the facility failed to do document weekly skin location and measurements for 1 of 3 resident reviewed with skin impairments. (Resident #4). The facility reported a census of 29 residents. Findings include:Resident #4's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating no impaired cognitive decisions. Resident #4 could understand others and others understood them. They had adequate hearing, and vision. Resident #4 required substantial to maximal staff assistance with dressing and toileting hygiene and partial to moderate assistance with repositioning and total dependence with transfers. The MDS included diagnoses of hypertension (a condition where blood consistently pushes hard against artery walls), diabetes mellitus, pneumonia and non-pressure ulcer of the skin.The Care Plan Focus initiated dated 10/15/25, indicated Resident #4 had a potential/actual impairment to skin integrity, due to an itchy rash on their skin. The Interventions instructed the following:a. Ensure Resident #4 had adequate footwear on at all times, at least non-skin socks. b. Monitor/document location, size and treatment of skin injury.c. Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surfaces.d. Weekly treatment documentation to include measurement of each area of skin break downs (width, length, depth, type of tissue and exudate) and any other notable changes or observations.The Skin Observation Tool dated 1/25/26 at 6:41 PM, documented the left and right toes had a skin tear. The documentation lacked measurements. The notes indicated the big toe on the left foot got the skin tear from footboard on the bed. The 5th digit on the right foot, indicated the skin tear resulted from the foot board on the bed. The Skin Observation Tool dated 1/28/26 at 1:44 PM, documented in the notes section, fading bruising to left forearm, Resident #4 continued to have multiple different areas of scratches and small scabs from scratching self. No documentation of location or measurements.The Skin Observation Tool dated 2/4/26 at 10:51 AM, included only the documentation in the notes section. The note indicated Resident #4 continued to have abrasion/skin tears to the bottom of his right foot. The note included Resident #4 had multiple areas of scratches from scratching himself.The Skin Observation Tool dated 2/11/26 at 7:56 AM, included only the documentation in the notes section. The note indicated Resident #4 continued to have abrasion/skin tears to the bottom of his right foot. The note included Resident #4 had multiple areas of scratches from scratching himself.The admission Assessment note dated 2/23/26 at 3:52 PM documented Resident #4 returned from the hospital. The note described his skin as warm and dry. He had normal skin turgor (the skin ability to change shape and return to normal the faster response usually shows adequate fluid intake) with no alteration in skin condition.The re-admission assessment dated [DATE] at 3:52 PM, in the skin section, documented Resident #4's skin as warm, dry, with no alteration in skin noted.The re-admission Braden Scale for Predicting Pressure Sore Risk dated 2/23/26 at 1:26 PM, identified Resident #4 as a high risk for developing pressure sores.The Skin Observation Tool dated 2/25/26 at 4:17 PM, documented Resident #4's right toe skin tear measured 0.5 centimeters (cm) in length by 0.5 cm, and continued to have scabs to the bottom and side of the 5th digit of his right foot. The Skin Issues Note dated 3/2/26 at 11:42 AM, documented the staff evaluated Resident #4's skin issue of the right lateral foot skin tear, wound acquired in-house, it is unknown how long the wound has been present. The wound measured 1.18 cm length by 0.76 cm with no depth and noted as improving.On 2/26/26 at 2:15 PM, observed Resident #4 lying on his back with the bottom of his feet resting against the foot board on his bed. On 2/26/26 at 2:15 PM, Resident #4 stated his feet rest against the foot board at the end of his bed and felt that caused the sores on the bottom of his right foot and toes.On 2/27/26 at 10:24 AM, observed Resident #4 lying in bed with the bottom of his right and left foot resting against the foot board.On 3/3/26 at 11:00 AM, the Director of Nursing acknowledged the clinical record lacked documentation of the locations and size of the areas (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165500	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rotary Senior Living	500 South Blaine Avenue Eagle Grove, IA 50533

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	on the bottom of Resident #4's right foot. The DON reported they expected the nursing staff to follow the facility policy on documenting weekly skin locations and measurements.The Weekly Skin Assessment and Documentation Process dated 1/20/23, instructed the facility wound nurse to address all skin ulcers and non-ulcers and document them weekly. The nurse who initially identified the skin issue would complete the appropriate skin assessment. They would complete a separate skin assessment for each identified skin/wound alteration. The staff would update and review the Care Plan to ensure it included the identification of the skin/wound alteration and appropriate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165500	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rotary Senior Living	500 South Blaine Avenue Eagle Grove, IA 50533

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 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on observation, interviews, and document review, the facility's administrative staff failed to ensure the nursing staff adequately monitored the INR level (international normalized ratio, a test measured how quickly blood clots) for 1 of 1 resident on warfarin (Resident #2), including after Resident #2's physician prescribed medications which could increase Resident #2's INR. Resident #2's physician started Resident #2 on an antibiotic (which can increase the INR) on 1/21/26, and added another antibiotic on 1/22/26. The nursing staff discovered a large bruise on Resident #2's mons pubis (the fatty area surrounding the penis) on 1/24/26. The nursing staff did not begin increased monitoring of Resident #2's bruising or check Resident #2's INR upon discovery of the bruise. The nursing staff reported they relied on the Pharmacist to notify them of drug interactions, such as a medication which would increase a resident's INR. Resident #2's wife checked Resident #2's INR on 1/26/26 (2 days after staff discovered the bruise), which showed Resident #2's INR as 7.3 (therapeutic range is 2.0 - 3.0). The nursing staff received orders from the clinic monitoring Resident #2's INR and adjusting the warfarin, but before the staff could implement the orders, Resident #2's condition changed and required emergent hospitalization. The hospital staff identified Resident #2's INR was greater than 13 (a critical level) and had a large internal bleed in the abdominal muscles. The hospital staff had to transfuse 2 units of blood due to Resident #2's internal bleeding. Due to the location of the bleeding, the hospital staff could not stop the bleeding, which resulted in the hospital staff placing Resident #2 on hospice. Resident #2 died at home on 1/31/26. The facility's administrative staff reported a census of 29 residents with 7 residents taking blood thinning medication.The Department of Inspections, Appeals, and Licensing notified the facility staff on 3/13/216 at 4:30 PM that the situation rose to the level of Immediate Jeopardy (a situation where the safety of residents is at risk for serious injury, serious harm, serious impairment, or death). The Immediate Jeopardy situation began on 1/24/26 when the nursing staff failed to implement increased monitoring for Resident #2's bruising while Resident #2 was on medications that increased the risk for bleeding. The facility staff removed the immediacy on 3/14/26 by taking the following actions:a. 3/14/26: The Administrator and the Director of Nursing (DON) began educating all nurses on the facility's High Risk Medications Anticoagulant policy.b. On 3/14/26: The Administrator and DON started staff education for all nurses on the facility's Risk Management process. This process included proper assessment and intervention. Staff would complete a head-to-toe assessment if a resident's condition changed, complete a risk management assessment, when necessary, notify the resident or the resident's representative and physician, and add the resident to their hot chart list for further follow-up and assessment.c. On 3/14/26: Current agency nurses received education or completed it before starting their next shift.d. All nursing staff would receive education on the two policies on 3/14/26 or before starting their next shift.e. On 3/13/26: The DON and Nurse Specialist audited all residents who received anticoagulant medications to ensure no one was experiencing adverse side effects related to the medications. The audit noted no additional concerns with the medication regimens.Findings include:Resident #2's Minimum Data Set (MDS) assessment, which the facility completed on 12/2/25, showed a Brief Interview for Mental Status (BIMS) score of 6, meaning Resident #2 had severe cognitive impairment. Resident #2 also had limited range of motion on one side of his upper and lower arms and legs. Resident #2 required substantial/maximal assistance—meaning the caregiver provided more than half the effort, lifting or holding the body or limbs—with personal care activities, including toileting hygiene, managing footwear, personal hygiene, and dressing his upper and lower body. The MDS also confirmed Resident #2 received an anticoagulant medication during the lookback period. The Care Plan Focus, which the facility revised on 6/6/25, noted Resident #2 received anticoagulant therapy (blood thinners) because he had a history of a stroke. A stroke is when blood flow to the brain (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165500	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rotary Senior Living	500 South Blaine Avenue Eagle Grove, IA 50533

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 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	is blocked or a blood vessel in the brain ruptures. The goal stated Resident #2 would be free from discomfort or bad reactions from using the blood thinner. The Interventions directed staff to do the following:a. 9/9/25: Check INR according to physician orders.b. 6/25/25: Monitor, document, and report adverse reactions to the blood thinner as needed (PRN)—meaning as the situation required. Adverse reactions included blood-tinged or red blood in the urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle/joint pain, lethargy (extreme sleepiness), bruising, blurred vision, loss of appetite, sudden changes in mental status, or sudden significant changes in vital signs. The plan also directed staff to make sure the Certified Nurse Aides (CNAs) knew Resident #2 used a blood thinner and had a risk for bruising, requiring them to protect his skin during transfers and clothing changes. The Care Plan did not include instructions on how to monitor Resident #2's INR or interactions with the use of antibiotics with the blood thinner. Resident #2's January 2026 Medication Administration Record (MAR) included these orders:a. 1/20/26: Warfarin Sodium (a blood thinner) oral tablet 3 mg. The order was to give one tablet by mouth every evening shift for blood thinning. Documentation showed Resident #2 received warfarin every evening from 1/20/26 through 1/25/26.b. 1/21/26: Rocephin (antibiotic), 1 gram (GM). The order was to inject 1 GM intramuscularly (IM)—meaning injected into the muscle—one time only for bronchitis, until 1/21/26.c. 1/22/26: Metronidazole (antibiotic also known as Flagyl) oral tablet 500 mg. The order was to give one tablet three times a day for Clostridium difficile (C. diff)—an infection in the bowels—for 10 days. Resident #2's January 2026 Treatment Administration Record (TAR) included an order dated 5/3/25 to monitor for discolored urine, black tarry stools, sudden severe headache, diarrhea, muscle/joint pain, lethargy, bruising, sudden changes in mental status, vital signs, shortness of breath, and nose bleeds. Staff documented 'N' if they monitored and observed none of these symptoms. They documented 'Y' if they monitored and observed any of these symptoms, requiring a progress note with findings twice a day. The documentation showed 'N' on 1/24/26 and 1/25/26, with a 'Y' noted on 1/26/26. The MAR and TAR did not include an order for an INR. The Nursing Note dated 1/19/26 at 11:00 AM Resident #2's wife showed the nurse Resident #2's INR of 3.9. The nurse received a call from Staff C, who was the Anticoagulant Provider. Staff C gave a new order to hold the warfarin night and begin 3 mg of warfarin once daily. The Nursing Note dated 1/21/26 at 8:00 AM The nurse informed the Medical Doctor (MD)—the primary physician—about Resident #2's changes in condition. The MD gave new orders to administer Rocephin 1 GM IM day and the following day for bronchitis. The MD directed staff to schedule Resident #2 for rounds on Friday, 1/23/26. The Nursing Note dated 1/23/26 at 6:11 PM The nurse received signed orders from the MD to give Rocephin 1 GM IM for five days total. The Nursing Note dated 1/24/26 at 6:40 AM documented the nurse found a 7 cm by 5 cm bruise on Resident #2's mons pubis/penis area. When asked if the area hurt, Resident #2 stated he felt no pain. Resident #2 reported he did not know what happened when the nurse asked. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165500	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rotary Senior Living	500 South Blaine Avenue Eagle Grove, IA 50533

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 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Nursing Note dated 1/26/26 at 8:00 AM documented staff identified Resident #2 as lethargic extremely sleepy and unable to follow commands. Resident #2's head hung low with his chin resting on his chest, he was drooling, and staff found him difficult to wake up. The Nursing Note dated 1/26/26 at 12:45 PM documented Resident #2's wife showed the nurse an INR reading of 7.3. The nurse spoke with Staff C at the anticoagulation clinic, who managed Resident #2's warfarin plan. Staff C recommended Resident #2 eat cooked spinach or take 1-2 mg of Vitamin K once, hold the warfarin for three days, and recheck the INR on Thursday (1/29/25). Staff C explained the medications Rocephin, metronidazole, and his recent upper respiratory illness would severely affect his INR levels. Staff members tried unsuccessfully to help Resident #2 eat lunch. Resident #2 appeared lethargic, unable to follow commands, had his head hanging low with his chin resting on his chest, and drooled. The nurse saw a noticeable muscle twitching in his left upper arm. When the nurse listened to his lungs, she heard abnormal sounds and observed him cough. Resident #2's condition quickly declined. After the assessment, the nurse sent Resident #2 to the hospital by ambulance. The ED Provider Notes dated 1/26/26 at 2:42 PM reflected Resident #2 arrived at the hospital from the nursing home because of an altered mental status. Resident #2's wife reported he had been sick with a cough and congestion for about one week and started on Rocephin injections a few days prior, along with prednisone. The provider also gave him Flagyl to prevent C. diff. Resident #2's wife reported his condition significantly worsened, and he would not even drink from a straw the day before. On day, he would not respond to her at all. The provider could not complete a full assessment because of Resident #2's change in mental status. Lab results showed a glucose level of 668, while the healthy range was 70 to 100 mg/deciliter (dL)—a measurement of concentration—and an INR of greater than 13.0. Because of the bruising, the Emergency Department (ED) completed an abdomen/pelvis Computed Tomography (CT) Scan—a detailed form of imaging. The CT Scan revealed an uneven, bumpy, thick mass (density) along the lower left rectus sheath, which is the tissue surrounding the abdominal muscle. This finding suggested an acute or subacute hematoma—a large collection of blood under the skin from larger blood vessels. The mass measured 12.3 cm long by 7.8 cm across by 5.3 cm from front to back (AP dimension). Adjacent to this was poorly defined, dense fluid in the left lower section of the abdomen/pelvis, which suggested hemoperitoneum/hematoma—bleeding in the lining of the abdomen, which doctors considered a medical emergency because the large volume of blood the abdomen could hold could lead to hemorrhagic shock. Because Resident #2 lost a large volume of blood, the hospital gave him 2 units of packed red blood cells (PRBC)—meaning blood—and 10 mg of Vitamin K. The provider spoke extensively with Resident #2's wife and son. They decided against pursuing surgery or an interventional radiology procedure. They felt comfortable keeping him in the hospital. Per the Cleveland Clinic article titled Hemoperitoneum updated 12/11/23, hemoperitoneum is blood in the abdominal or pelvic cavity. This condition occurs when something inside the cavity breaks or ruptures, representing an emergency. While it can result from an injury, it can also happen spontaneously, meaning without injury. The Nursing Late Entry Note dated 1/27/26 at 7:32 AM documented the facility called the hospital for an update on Resident #2. The hospital reported Resident #2 received a blood transfusion and a diagnosis of a rectus sheath hematoma an accumulation of blood in the stomach lining surrounding the muscle, usually due to a rupture of the epigastric arteries or a tear in the muscle itself likely caused by a chronic cough. On 2/27/26 at 1:30 PM, Staff E, Registered Nurse (RN), reported Resident #2 went out to breakfast (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165500	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rotary Senior Living	500 South Blaine Avenue Eagle Grove, IA 50533

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 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and managed okay. Staff members needed to feed him and ensure he swallowed his food. He needed more help eating but could still chew and swallow. Staff E heard he was well over the weekend and fairly alert. After making sure she could assist him with eating, staff helped him eat lunch. When staff members went to his room, they noticed he was not doing well while in bed. Liquids and food came out of his mouth. His wife approached Staff E and reported Resident #2 had an INR of 7. His wife stated she already contacted the anticoagulant clinic about the INR, and they would provide orders on what to do. Staff E said she knew something was wrong with Resident #2 and urged his wife to send him to the emergency room (ER). When the ambulance arrived, Resident #2 became increasingly lethargic. Staff E described him as a sick person and later learned he passed away at home. On 3/3/26 at 2:20 PM, Staff F, Certified Nurse Aide (CNA), reported staff found the bruise on Resident #2 on 1/24/26. Staff F said she helped Staff D, Licensed Practical Nurse (LPN), care for Resident #2 night. When she went in to do the final rounds, they found the area. When asked about how she provided care, including whether she picked up the penis shaft and placed her hand on the pubis area to hold up the penis while doing care, Staff F stated she did not. She picked up the penis to perform care and then placed it back down. When she and Staff D did rounds between 3:00 AM and 4:00 AM, Resident #2 did not have a bruise there. Staff F stated Resident #2 did not get out of bed night and did not complain anything bothered him or anyone hurt him. Both staff members were shocked when they saw the bruise on his pubis area. Staff F was unsure where the bruise came from and did not believe staff caused this type of bruise. On 3/3/26 at 4:00 PM, Staff D said around 6:30 AM on 1/24/26 Staff F reported Resident #2 had an unusual bruise she had not seen when she performed rounds earlier. Staff D then went in, saw the bruise, and documented it in the progress notes. She told the day shift nurse the area needed watching and monitoring. She asked Resident #2 if someone hurt him and he said no. She asked if someone abused him and he said no. She asked if he had pain and he said no. She asked if he knew what happened and he said no. Staff D faxed a note to the doctor and informed Resident #2's wife about the area. Staff D reported the Medical Examiner (ME) (a public official who investigates deaths) called her about the bruise found in the pubis area and asked what she thought happened. Staff D told the ME she did not know what happened. When Staff D returned to work, she asked about his bruise, but no one knew anything at the time and Resident #2 was already in the hospital. Staff D was not certain how the bruise got there. She recorded it in the progress notes but did not complete a skin sheet. Staff D described the bruise as quite large and deep purple. On 2/27/26 at 2:20 PM, the Advanced Registered Nurse Practitioner (ARNP) stated after she reviewed Resident #2's chart, she determined the abdominal sheath likely caused the bruising to the groin area. She explained the sheath was probably shifting and rupturing, and the blood then moved down to area, which was common. The bruising resulted from the rupture of the membranes and the bleeding followed down to the pubis area. She confirmed the bruise was dark purple. The ARNP explained there was no cure or treatment other than giving Vitamin K and observing him. No local hospital would accept him because they could not treat specific kind of bleeding and its location. Because of this, his family chose to enroll him in hospice care. He left the hospital and went home. On 3/3/26 at 3:10 PM the DON stated the progress notes for Resident #2 described a 7 cm by 5 cm bruise on his mons pubis/penis area. Staff members notified the doctor but did not include follow-up documentation in the progress notes on 1/24/26. Resident #2 went to the hospital on 1/26/26. Staff attributed the bruise to the high INR sent him to the hospital. The nurse who found the area did not take a picture or complete an investigation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165500	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rotary Senior Living	500 South Blaine Avenue Eagle Grove, IA 50533

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 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/3/26 at 4:15 PM the DON explained Staff D knew about the bruise but did not follow up with staff on an investigation. The DON stated on 1/26/26, the risk management team reviewed the situation and felt Resident #2's bruise resulted from his high INR Monday morning. When questioned about finding the bruise on 1/24/26 but not drawing an INR until 1/26/26, and how one correlated the bruise to a high INR when the INR was not drawn until Monday, the DON admitted she had not considered it that way. The risk management team believed the high INR caused the bruise. The DON acknowledged a bruise could signal abuse and staff needed to investigate any injury of unknown source to find the cause and analysis. She stated staff failed to do this with Resident #2 and would learn from it moving forward. On 3/12/26 at 1:36 PM Resident #2's wife reported she monitored his INR through the hospital. She checked his levels every Monday and they were generally fine until that week. His level increased to 8, which was very high. She immediately took the monitoring machine to the nurses because the result was high, and they called the nurse. She did his testing because the anticoagulant clinic told her they received the results right away if she performed the test. When asked about the bruise on his penis, she reported she learned about it at the hospital. Resident #2's wife stated she usually visited him twice a day but stayed home sick for a few days before he went to the hospital. When she returned, she learned he did not eat well over the weekend. She attempted to help him eat three times that day, but he refused, so they decided to send him to the hospital. Once he arrived at the hospital, they immediately gave him three small bags of blood. They told her he needed the blood due to his significant blood loss and did not expect him to survive the night. He survived from Monday until he passed away at home on Saturday. On 3/12/26 at 2:25 PM, Staff A, CNA, explained a few days before Resident #2 went to the hospital, he felt unwell and did not get out of bed. The morning he went to the hospital he got up and fed himself, had more energy, and ready to get out of bed. Staff A stated she saw his bruise, noting it was not black when she saw it. When she told the nurse, they said they had already documented it. On 3/12/26 at 2:25 PM, Staff I, Licensed Practical Nurse (LPN) reported she had not worked with Resident #2 recently because she worked on the south side. She explained the facility did not have anyone on Coumadin, except veteran patients. The facility typically changed residents from Coumadin because it was difficult to monitor and was an older drug. They did not change the veteran residents because it was their right, and the Veterans Administration (VA) would only pay for Coumadin. On 3/13/26 at 11:25 AM, Staff G, RN, explained Resident #2's wife performed his INRs using her own machine. She would show the nurse the machine, which sent the information directly to the anticoagulant clinic. Staff G assumed the facility had a standing order from the anticoagulant clinic for his INR. She recalled the reading was clearly off, approximately 7. That was the only time Resident #2's wife showed her the number; otherwise, she did not show the number. Staff G assumed the numbers were in the normal range during those other times. Resident #2's wife would tell staff they should receive orders based on his number. She only told them the 7.1 number one time. The anticoagulant clinic worked through his wife, and staff needed to get the orders from her. That day, Resident #2's wife gave Staff G her personal phone to speak with one of the nurses at the clinic, who gave verbal orders. After receiving those orders, staff contacted the local provider for orders, who then confirmed them. Staff tried to get him spinach, but the kitchen did not have any. His wife offered to get some for the kitchen to cook. At lunch, Resident #2 refused to eat because he was very lethargic. He could not follow simple commands to eat; the food stayed in his mouth, and he would not eat. After this, she contacted the DON, and they all agreed to send him to the emergency room (ER). Although they had Vitamin K in an ampule in the Emergency Kit (Ekit)—a supply of medications (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165500	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rotary Senior Living	500 South Blaine Avenue Eagle Grove, IA 50533

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 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and equipment for urgent use—they did not give it to him because of how much his condition deteriorated. At that point, they needed to send him to the hospital. Staff G stated they did not have an INR tracking sheet to her knowledge and did not know how frequently they should have monitored his INR. Staff G explained they had other residents on anticoagulant medications, like Xarelto and Eliquis. They performed weekly checks and routine lab work for those residents but had no specific requirements to check for them. They documented the assessments in the TAR. If they found anything abnormal, they documented it in the progress notes; otherwise, everything was fine. Staff G did not see Resident #2's bruise herself. She saw it after an order came back from the physician. Staff D sent a note to the physician, who acknowledged it. When Staff G reviewed the order, she learned of his bruising. By time, Resident #2 was already in the hospital. On 3/13/26 at 12:30 PM the DON explained they rarely saw people on Coumadin because most switched to Eliquis or newer blood thinners. However, the VA was holding off and did not yet cover the newer blood thinners. Resident #2 used Coumadin and had a machine to check his INR. His wife performed the finger poke and showed staff the machine. She would call the anticoagulant clinic to report the result and receive an order. Staff would then document it and get the physician to sign off on the official order. The DON reported they documented the INR in the progress notes and thought they had an INR log but said she would check the progress notes. If his wife was not at the facility to check his INR, they would choose another day to check it, as she visited daily unless she was sick. The DON reported when residents used Coumadin, staff regularly helped them avoid Vitamin K in their diet and watched them closely if they started an antibiotic. If they started antibiotics, the pharmacy typically alerted them. They needed to watch the resident if they took Coumadin because antibiotics effected the INR rate. The DON explained Resident #2 was very ill with a respiratory issue, and the physician ordered an antibiotic for him. Resident #2 had weekly INR orders. The DON did not know if they should have ordered more frequent INR checks. They should monitor for bruising or bleeding gums, which indicated an elevated INR. If staff saw bruising, they needed to report all bruising to the nurse. The nurse should then investigate the cause of the bruise. The DON explained this happened with Resident #2; he got a bruise over the weekend. Staff D was his nurse. Staff reviewed the bruise morning during risk management. Since Resident #2 had a bruise, staff figured it resulted from his high INR. She explained Resident #2 started on an antibiotic Thursday because he saw the physician Friday. The physician added Flagyl because of a history of C. diff. With an order for antibiotics and INR, the physician placed the orders and decided how often to check. The facility did not have a standard order, but they would have to call and check. The DON acknowledged in hindsight, they did not have a standing order for an INR when someone started an antibiotic or an expectation for how often to check the INR. The DON stated she did not know if she would have thought about it if the pharmacy did not flag them. During a follow-up interview on 3/13/26 at 1:25 PM, Staff A reported she did not remember who helped Resident #2 get out of bed. She explained she did not see his bruise herself but knew he had bruises on his lower body. She noted he was diabetic and thought the bruises could have resulted from insulin injections. Staff A stated if she had seen a skin problem, which she did not, she would have talked to the nurse as soon as possible (ASAP) meaning immediately. She believed she helped transfer him with Staff H, CNA. On 3/13/26 Staff H reported she possibly helped Resident #2 get out of bed because she charted on him, but she was not sure. She explained he had bruises on his stomach area and his buttocks were always purple. When asked about the abdominal bruises, she stated he normally had a small amount, but the progress notes should contain everything, as she always reported all her findings to the nurses immediately. Staff H did not remember any private bruising; his penis was eventually black. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165500	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rotary Senior Living	500 South Blaine Avenue Eagle Grove, IA 50533

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 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff H added she would have noticed that. On 3/13/26 at 3:10 PM Staff D reported she learned of his bruise sometime after 5:00 AM because that was when she checked blood sugars. He had a HI blood sugar—a high reading exceeded the meter's capacity—and she received orders for 10 units of Novolog (insulin). Staff D did not know how Resident #2 got the bruise. She told the day nurse, Staff J, to monitor him because Staff D had many things happening and was working to lower his blood sugar to a readable number. After this, Staff D did not work for several days. When she returned Tuesday night, she received a report from Staff G about Resident #2 being in the hospital. Staff G explained everything about his INR, but Staff D had no idea about his bruise. On a different night, Resident #2's son called to report he passed away. Staff D reported she asked Staff J to call Resident #2's wife about the bruise that day because his wife was home sick. During the interview Staff D questioned the cause of his high INR and wondered if Flagyl interacted with the Coumadin. She explained if she had placed the order, she would have inquired because staff fax the physician if they receive any alerts and ask questions. Staff D stated they relied on the pharmacist for education. On 3/13/26 at 2:15 PM, the Administrator and the DON reported the facility found the bruising on Resident #2's abdomen during the overnight shift from 1/23/26 to 1/24/26. He had a new bruise, and the nurse created an Incident Report. They explained approximately 36 hours passed between the time the nurse found the bruise and the time Resident #2's wife received the elevated INR result. They stated a bruise would not automatically require the nurse to notify the provider immediately. The record showed the nurse documented finding the bruise on 1/24/26 at 6:40 AM. The nurse also called the doctor for a high blood sugar level on 1/24/26 at 5:59 AM because the Accu-Chek was HI at 5:26 AM. If they had Resident #2 on increased monitoring, staff would have documented it in the progress notes. They noted approximately 36 hours passed between the time staff notified the provider about the high INR and when they found the bruise. When asked about the requirement for shift monitoring and the side effects of blood thinners, they responded staff performed monitoring in some way. The CNAs reported anything abnormal. The nurse did not perform an assessment on everyone every shift. The nurse documented assessing the resident for side effects every shift in the TAR. The documentation in the TAR did not show the nurses identified any signs or symptoms of side effects. They assumed staff would document finding a new bruise. Staff G documented 'Y' (yes to side effects) on 1/26/26. The other entries showed an 'X' on 1/23/26 did not match a code, and on 1/24/26, staff documented an 'N' (indicating no side effects) on the TAR. On the Sunday (1/25/26) shift, the TAR did not contain documentation of the bruising or any other documents. They added the identification of the bruise and the realization of a high INR occurred within a short timeframe, only 24-36 hours. They did not have any photos or documentation of the pelvic bruising in any other part of the system. The Administrator and the Director of Nursing (DON) reported that the facility discovered bruising on Resident #2's abdomen during the overnight shift spanning 1/23/26 – 1/24/26, leading a nurse to create an Incident Report. They noted that approximately 36 hours elapsed between the discovery of the bruise and the time Resident #2's wife was notified of the elevated INR result. They argued that a bruise does not automatically mandate immediate provider notification. According to the record, the nurse documented finding the bruise at 6:40 AM on 1/24/26. Earlier that morning, at 5:59 AM on 1/24/26, the nurse had already contacted the doctor regarding a high blood sugar level, as the Accu-Chek reading was HI at 5:26 AM. Facility representatives indicated that if the resident required increased monitoring, it would have been documented in the progress notes. They reiterated that about 36 hours separated the notification to the provider about the high INR and the initial bruise discovery. When questioned about the requirement for shift monitoring and the side effects of blood thinners, they stated that monitoring was performed in some manner, with CNAs reporting anything abnormal. They clarified that the nurse did not perform a full assessment on every resident every (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165500	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rotary Senior Living	500 South Blaine Avenue Eagle Grove, IA 50533

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 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	shift, but the nurse documented assessing the resident for side effects every shift in the Treatment Administration Record (TAR). The documentation in the TAR, however, did not show nurses identifying any signs or symptoms of side effects. Staff assumed that finding a new bruise would be documented. On the TAR, Staff G documented 'Y' (yes to side effects) on 1/26/26. Other entries included an 'X' on 1/23/26, which did not correspond to a code, and an 'N' (indicating no side effects) documented on 1/24/26. Crucially, the TAR for the Sunday (1/25/26) shift contained no documentation of the bruising or any other related documents. Finally, they asserted that the identification of the bruise and the realization of a high INR occurred within a short timeframe, only 24-36 hours apart, and confirmed they had no photos or documentation of the pelvic bruising in any other part of the system. On 3/13/26 at 2:50 PM, the Physician reported he could look up the information but did not recall being told about Resident #2's 5 cm by 7 cm pelvic bruise on 1/24/26. He stated he could look it up but did not remember being told. He saw Resident #2 on 1/23/26 and completed a note on him day. He had no way of knowing if staff called him on 1/24/26 and could not remember if he gave a verbal order. On 3/17/26 at 9:50 AM, Staff J explained she arrived the morning after staff found Resident #2's bruise. Staff D reported in rounds she found a bruise, so they went and looked at it together. The bruise appeared as if something, like a pad or brief, had rubbed or pinched his skin. Resident #2 used blood thinners, so they said they would watch the area. They did not notify the doctor or Resident #2's wife. Staff J explained the bruise was not large and looked like the brief sat incorrectly. When she returned to work a few days later, Resident #2 was in the hospital. Resident #2's wife performed his INRs, and Staff J was not involved in process. They recorded the information related to his INRs in the progress notes. For other residents who needed INR checks, the facility drew their blood for INR and sent it to the lab. If they received an abnormal result, they would call the physician and document it in the electronic health record within the lab information.