

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165501	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 325 Southwest Seventh Street Stuart, IA 50250	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on clinical record review, staff interviews and facility policy review, the facility failed to notify the Physician and family of an allegation of abuse for 1 of 1 resident reviewed (Resident #1). The facility reported a census of 53 residents. Findings include: The Minimum Data Set (MDS) for Resident #1 dated 12/28/25 identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Resident #1's MDS included diagnoses of Alzheimer's, Non-Alzheimer's disease, anxiety, and depression. A facility form titled Complaint Investigation dated 1/6/26 documented Staff A, Certified Nursing Assistant (CNA) and Staff B, CNA reported to the Administrator that Staff C, CNA told them she slapped Resident #1 when he had his hands down her sweater and she said she told him to keep his f***ing hands off her. Review of the Clinical Record lacked documentation the allegation of abuse was reported to Resident #1's Physician or family. On 1/27/26 at 10:58 AM, the Director of Nursing (DON) verified the family had not been called regarding the allegation of abuse on 1/6/26. On 1/28/26 at 10:55 AM, the Administrator verified Resident #1's Physician was not notified of the allegation of abuse on 1/6/26. The facility policy titled Abuse Prevention, Identification, Investigation and Reporting Policy revised 9/29/21 revealed the Administrator would complete documentation of the allegation of Resident abuse and collect any supporting documents relative to alleged incident which included providing proper notification to the primary care provider and responsible party.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165501	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 325 Southwest Seventh Street Stuart, IA 50250	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on staff interviews, facility investigation review, and facility policy review the facility failed to notify DIAL (Department of inspection, appeals and licensing) and the law enforcement of an allegation of abuse for Resident #1 that was reported on 1/6/25 at approximately 4:15 PM. The facility reported a census of 53 residents. Findings include: The facility form titled Complaint Investigation dated 1/6/26 documented Staff A, Certified Nursing Assistant (CNA) and Staff B, CNA reported to the Administrator that Staff C, CNA told them she slapped Resident #1 when he had his hands down her sweater and she said she told him to keep his fucking hands off her. Review of the document titled Self Report List from January 2025 to January 2026 revealed the facility failed to file the allegation of abuse with DIAL. On 1/26/26 at 11:45 AM, Staff A reported she was in toileting Resident #2 and Staff C came in and said Resident #1's call light was going off and that she was not comfortable answering the light on her own. Staff A said Staff C reported on Christmas she was wearing an ugly grinch sweater and Resident #1 reached down her shirt, grabbed her breast and she smacked him across the face. Staff A reported she told Staff D, Registered Nurse (RN) since she was a mandatory reporter and Staff D told her that she would have throat punched him. She said she then went to the Administrator about it and the Administrator told her that she was not believable since she was showing emotion. On 1/26/26 at 3:44 PM, Staff B reported she was taking Resident #2 to the toilet. She said Staff A came into the room with Staff C. Staff B said she asked Staff C if she took a second person in Resident #1's room and Staff C said yes, that she refused to go in the room by herself. Staff B said Staff C told her on Christmas she was wearing a lighted Christmas sweater and Resident #1 reached down her shirt, grabbed her boob and she slapped him across the face. She said Staff C used the F word and B word to describe what happened. Staff B said she did not know if Staff C said those words to Resident #1 or not. The facility policy titled Abuse Prevention, Identification, Investigation and Reporting Policy revised 9/29/21 documented all resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse was responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative. All allegations of Resident abuse shall be reported to the Iowa Department of Inspections, Appeals & Licensing Health Facilities Division not later than two hours after the allegation was made. If there is a reasonable suspicion that the allegation of abuse also constitutes a crime committed against the resident by any person, whether or not the alleged perpetrator is employed by the facility, the Elder Justice Act requires the matter must also be reported to law enforcement. While the federal regulations require all abuse allegations to be reported to DIAL within 2 hours, the Elder Justice Act has a different time frame for reporting to the police/sheriff. If an allegation of abuse that results from a crime results in serious bodily injury to a resident, a report must be made to law enforcement not later than two hours after the allegation was made. If the allegation of abuse does not result in serious bodily injury, a report to law enforcement must be made not later than twenty four hours. On 1/26/26 at 1:15 PM, the Administrator said she did not file a report to DIAL as she did not believe there was a potential for abuse. On 1/27/26 at 3:17 PM, the Administrator reported she did not notify the police of the allegation of abuse.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165501	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 325 Southwest Seventh Street Stuart, IA 50250	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on staff interviews, facility investigation review, facility payroll review and facility policy review the facility failed to separate a staff member from dependent residents accused of alleged abuse that was reported on 1/6/26 at approximately 4:15 PM for Resident #1. The facility reported a census of 53 residents. Findings include: The facility form titled Complaint Investigation dated 1/6/26 documented Staff A, Certified Nursing Assistant (CNA) and Staff B, CNA reported to the Administrator that Staff C, CNA told them she slapped Resident #1 when he had his hands down her sweater and she said she told him to keep his fucking hands off her. On 1/26/26 at 11:45 AM, Staff A reported she was in toileting Resident #2 and Staff C came in and said Resident #1's call light was going off and that she was not comfortable answering the light on her own. Staff A said Staff C reported on Christmas she was wearing an ugly grinch sweater and Resident #1 reached down her shirt, grabbed her breast and she smacked him across the face. Staff A reported she told Staff D, Registered Nurse (RN) since she was a mandatory reporter and Staff D told her that she would have throat punched him. She said she then went to the Administrator about it and the Administrator told her that she was not believable since she was showing emotion. On 1/26/26 at 3:44 PM, Staff B reported she was taking Resident #2 to the toilet. She said Staff A came into the room with Staff C. Staff B said she asked Staff C if she took a second person in Resident #1's room and Staff C said yes, that she refused to go in the room by herself. Staff B said Staff C told her on Christmas she was wearing a lighted Christmas sweater and Resident #1 reached down her shirt, grabbed her boob and she slapped him across the face. She said Staff C used the F word and B word to describe what happened. Staff B said she did not know if Staff C said those words to Resident #1 or not. Review of the Employee Time Cards Report from 1/6/26 to 1/27/26 revealed Staff C worked full shifts on the following dates: 1/6/26, 1/8/26, 1/9/26, 1/12/26, 1/13/26, 1/14/26, 1/15/26, 1/17/26, 1/18/26, 1/21/26, 1/22/26, 1/23/26, and 1/26/26. On 1/27/26 at 4:30 PM, the Administrator verified the staff member was not separated from Resident #1 and acknowledged the abuse policy was not followed. The facility policy titled Abuse Prevention, Identification, Investigation and Reporting Policy revised 9/29/21 documented upon receiving a report of an allegation of resident abuse, neglect, exploitation or mistreatment, the facility shall immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. If this involves an allegation of abuse by an employee, this will be accomplished by separating the employee accused of abuse from all residents through the following or a combination of the following, if practicable: (1) suspending the employee; (2) segregating the employee by moving the employee to an area of the facility where there will be no contact with any residents of the facility; and in rare instances (3) separating the employee accused of abuse from the resident alleged to have been abused, but allowing the employee to care for and have contact with other residents, only if there is a second employee who remains with and accompanies the employee accused of abuse at all times to supervise all contacts and interactions with the residents. The policy further documented following completion of the facility investigation, if the facility concludes that the allegations of resident abuse are unfounded, the employee may be allowed to return to job duties involving resident contact, but the employee must maintain a separation and have no contact with the resident alleged to have been abused, by reassigning the accused employee to an area of the facility where no contact will be made between the accused employee and the resident alleged to have been abused. This separation must be maintained until the Department concludes its investigation and issues the written results of its investigation.</p>		