STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165501	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview and policy review the facility failed to ensure that kitchen staff used adequate hand hygiene practices to mitigate cross contamination during the meal service. The facility reported a census 52 residents. Findings include:On 12/9/25 at 10:20 AM, Staff A, Dietary Aid, prepared one pureed and 7 ground meat servings for the lunch meal. At 10:30 AM, Staff A removed a pan of stew from the oven and stirred it with a large serving spoon. She then laid the spoon directly on the counter without a barrier. She scooped out the number of servings needed for the ground menu into the mixer, between the scooping, she laid the spoon on the counter. At 10:45 AM she pulled the meat balls out of the oven and prepared 5 mechanical soft and one pureed. Several times during the pureed and ground meat process, she laid the scoop on the counter alongside the large oven mitts that are very stained and soiled. In an observation of the lunch service at 12:20 PM, Staff A donned gloves, grabbed a bag of bread, reached in and got 2 pieces of bread, buttered them and put them on the grill for a grilled cheese sandwich. With the same gloved hands, she grabbed a meal ticket from a staff member, touched several surfaces, opened the refrigerator and got a bag of cheese slices. She then reached in the bag and got a couple of slices of cheese and put them on the bread on the grill. Staff A then took the disposable gloves off and failed to wash her hands before going back to serving up the plates of food. On 12/10/2025 at 7:11 AM, the Dietary Manager (DM) said that she did witness the hand hygiene issues during the lunch service, and she had a conversation with Staff A about placing utensils on the counter between scoops of stew, and regarding the use of gloves and cross contamination concerns. She said they have worked on education with Staff A on some of these issues and having difficulty getting her to understand. According to a facility policy titled: Hand Hygiene, last reviewed on 8/30/2021, the purpose of the hand hygiene education was to reduce the spread of potential pathogens on the hands, and to protect residents and staff. The use of gloves should be used as an adjunct, not a substitute for hand washing. Gloves should be used for hand contaminating activities, should be removed and the hands washed after such activity. Gloves may need to be changed between procedures, and disposable gloves should only be used once and should not be washed for reuse.

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observations, staff interviews, and policy review, the facility failed to properly protect resident information from unauthorized access by leaving 16 residents' information accessible when staff walked away from the Electronic Health Record (EHR) laptop. The facility reported a census of 52 residents. Findings include:On 12/08/25 at 2:59 PM, an open laptop was observed in the dining room area with 16 residents' EHR information accessible. There were three (3) residents in the dining room and no staff present.At 3:00 PM, Staff F, Registered Nurse (RN) stated she thought she locked the laptop when she walked away. She said they do not leave the resident information open when they leave the computer.At 3:02 PM, Staff G, Certified Nurse Aide (CNA) stated two (2) of the three (3) residents were ambulatory.On 12/11/25 at 8:34 AM, the Director of Nursing (DON) stated the laptop should be locked when staff aren't present.A policy titled Dignity, Privacy, and Confidentiality revised 5/29/18 indicated resident records are limited to the use of the staff and will be safeguarded at all times to ensure confidentiality.

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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 clinical record review and staff interview the facility failed to identify non-pharmacological interventions and targeted behaviors related to high risk medications in 1 out of 5 residents reviewed (Resident #3). The facility reported a census of 52 residents.Findings include: Review of Resident #3's Minimum Data Set (MDS) dated [DATE] revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. The MDS showed Resident #3 also took antipsychotropic medication during the review period. The MDS further revealed diagnoses of non-Alzheimer's dementia, depression, and hallucinations. Review of Resident #3's Electronic Healthcare Record (EHR) page titled, Physician's Orders revealed an order dated 10/29/25 for Quetiapine (antipsychotic) 50mg 1 tablet at bedtime for dementia. Further review revealed another order for Quetiapine 25mg 1 tablet in the morning for dementia with a start date of 11/24/25. Review of the Care Plan with a revised date of 12/2/25 lacked non-pharmacological interventions and targeted behaviors with antipsychotic medications. Interview 12/09/2025 at 12:05 PM with the Director of Nursing (DON) revealed that she would expect nonpharmacological interventions to be placed in the care plan for residents with psychotropic medications. The DON further acknowledged there were no nonpharmacological interventions currently on Resident #3's care plan. Review of a facility provided policy titled, Care Plan Creation with a revision date of 9/27/17 revealed: a. To provide a documented interdisciplinary plan of care that focuses on attaining or maintaining physical, social, mental health of the resident. b. To increase and make more comprehensive communication to all care givers to improve continuity of resident care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on electronic record review (EHR), staff interviews, and policy review the facility failed to develop a comprehensive care plan related to a resident with a diagnosis of dementia for 1 of 5 residents reviewed (Resident #3). The facility reported a census of 52 residents.Findings include: Review of Resident #3's Minimum Data Set (MDS) date 11/5/25 revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 7 indicating severe cognitive impairment. The MDS further revealed a diagnosis of non-Alzheimer's dementia. Review of Resident #3's Care Plan with a revision date of 12/2/25 revealed no goals, focus, or interventions related to Resident #3's diagnosis of dementia. Interview on 12/9/2025 at 12:36 PM with the Director of Nursing (DON) confirmed there was no implementation of a care plan concerning dementia with the interventions to assist resident #3. The DON further revealed she would expect more to be on the care plan concerning dementia for Resident #3. Review of a facility provided policy titled, Care Plan Creation with a revision date of 9/27/25 revealed:a. Identify needs and problems of resident based on nursing history and assessment, physician's orders, inter-facility transfer forms (when available), past history and physical examination, and any other available information.

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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 lock the wheelchair during a resident transfer for 1 of 1 residents (#17) reviewed for safe transfers. The facility reported a census of 52 residents. Findings include:The Minimum Data Set (MDS) for Resident #17 dated 11/12/25 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated completely intact cognition. It included diagnoses of thyroid disorder, Parkinson's Disease, hallucinations, and multiple right rib fractures. It indicated he required setup assistance with eating, supervision with oral and personal hygiene, moderate assistance with toileting and dressing, maximal assistance with bathing, and was dependent with footwear. It also indicated he required moderate assistance with sit-to-stand, was dependent with toilet, tub, and car transfers and used a walker or wheelchair for mobility. It further indicated other forms of bed mobility or transfers were not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.The Care Plan dated 11/23/25 indicated the resident required one-person assistance with transfers. It also directed staff to keep the wheelchair brakes locked next to the resident's bed and indicated the resident would sometimes try to self-transfer.The Progress Notes indicated the resident fell on [DATE] during a self-transfer attempt.On 12/10/25 at 10:38 AM, Staff B, Certified Nurse Aide (CNA) and a CNA nursing student transferred Resident #17 in the dining room from a recliner to a wheelchair. The wheelchair was unlocked throughout the transfer process.At 10:49 AM, Staff B, CNA and Staff C, Certified Medication Aide transferred Resident #17 from a wheelchair to a recliner. The wheelchair was unlocked until the resident stood up with staff assistance and a CNA student locked the right wheel.At 10:50 AM, Staff A stated she forgot to lock the wheelchair before transferring Resident #17.At 10:52 AM, Staff C stated she left it unlocked so she could move it out of her way when she got the resident to shuffle to the recliner. She also stated it would normally be locked, but there was a CNA student who was holding the wheelchair.At 10:59 AM, the CNA Clinical Instructor stated students can help if they were comfortable.At 12:50 PM, Staff D, Licensed Practical Nurse (LPN) stated when transferring a resident from or to a wheelchair, the wheels should be locked.At 1:56 PM, Staff E, Registered Nurse (RN) stated the wheels should be locked when transferring a resident to or from a wheelchair.On 12/11/25 at 8:34 AM, the Director of Nursing (DON) stated staff should have locked the wheelchair during the transfer.A policy titled Mobility: Assisted Transfer revised 11/18/17 directed staff to lock the wheels during transfers involving a wheelchair.