

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165523	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2026
NAME OF PROVIDER OR SUPPLIER  Estherville Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2001 First Avenue North Estherville, IA 51334	
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 0558  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident.  **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff and resident interview, along with facility policy review, the facility failed to provide a call light system within reach for which the call light was caught in the hinge of the side rail and was not able to be triggered when pulled for 1 of 3 residents (Resident #5) reviewed. The facility reported a census of 38 residents. Findings include:Resident #5's Minimum Data Set (MDS) assessment dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 14 for which indicated intact cognitive decisions, was able to be understood and understand others. The MDS addressed the resident as dependent for toileting, hygiene, showers/bathing, lower body dressing, sit to lying, sit to standing and transfers. The MDS included diagnosis of hypertension (when the pressure in your blood vessels is too high) anxiety, depression, after-care following replacement of total knee, weakness and need for assistance of personal cares. The Care Plan Focus with no date, indicated Resident #5 was at risk for falls related to recent hospitalization. Interventions include to have call light with in reach, resident room rearranged to put phone within reach of resident. Bed placed on other side of room to prevent call light/cord from being entrapped within bed, and I sleep in my chair rather than my bed.The Incident Note dated 2/15/26 at 10:23 AM, documented writer was standing at the medication cart in the dining room when a resident was heard calling out for help down east hall. Upon investigation, resident was sitting with her back against the south room door with feet out in front facing north. Resident stated she was attempting to get her cell phone to call for help. Residents call light was within reach but call light cord was caught in hinge of bed rail and was unable to be triggered when pulled. Phone was sitting on the sink counter. Bed placed on other side of room to prevent call light cord from being entrapped with in bed. Resident with no injuries at this time.The Health Status Note dated 2/16/26 at 8:15 AM, documented 24 hour follow-up from fall. No new injuries or marks noted to skin. Complains of lower back pain related to fall.The Facility Self Report dated 2/18/26 at 2:19 PM, documented that on 2/15/26 at approximately 8:15 AM, staff could hear someone calling out for help down the east hall. Resident was sitting with her back against the south room door with her feet straight out in front of her, facing north. It appeared as though residents call light was within reach of resident (while she was sitting in her recliner), however, the cord of the call light had fallen down and was caught under her bed grab bar preventing her from being able to pull it. After the resident attempted to pull her call light/cord for assistance to the bathroom, she got up out of her recliner and walked to her dresser area to get her cell phone (which was charging) to call the facility for assistance. Resident was not ambulating with the use of her walker at the time of incident. Resident had no injuries following fall. Bed was moved to the other side of room to prevent the call cord from getting caught in the bed rail anymore. Resident is also getting a longer phone cord to be able to plug her phone in near her recliner.Observation on 3/11/26 at 4:15 PM, revealed Resident #5 cell phone was across the room on a table underneath the north window, long cord attached to the cell phone, however, the cell phone was not with in reach.On 3/13/26 at 10:50 AM, Resident #5 stated that on the morning of her fall, 2/15/26, about 8:10 AM, she attempted to put her call light on, but the cord was wrapped around the top of the side rail and fell down and she was not able to reach it, and she needed to go to the bathroom. Resident #5 decided to (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
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>get out of bed and walk to the sink where the cell phone was plugged in, then the left leg buckled and down on the floor she went. Resident #5 stated that she had no injuries from that fall, and feels that the fall at the physician office on 2/17/26 was the culprit on the ruptured quad left tendon, not the fall at the facility. On 3/19/26 at 10:10 AM, the facility Director of Nursing, acknowledged that the expectation from all staff are to make sure that call lights are within reach and the call light cords are not wrapped around the bed rails. On 3/19/26 at 3:00 PM, the facility Administrator did not think they had a policy on call lights being within reach, but stated that the expectation of all staff are to be aware of the call lights being within reach and call light cords not wrapped around the bed rails. The facility policy statement with no date, documented that all resident call lights are accessible, functional, and answered promptly to maintain resident safety, dignity, and well-being. Every resident must have a working call light within reach at all times.</p>		

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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, staff and family interview along with policy/procedure review, the facility failed to ensure that discharge instructions were documented in the residents medical record with the necessary information to the resident/resident representative that is easy to understand in a written form and language for 1 of 4 residents reviewed (Resident #1). The facility identified a census of 38 residents. Findings include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognitive decisions, is able to be understood and understand and no behaviors present. The MDS addressed that the resident is independent in the facility with all activities of daily living (dressing, personal hygiene, transfers, ambulation) and a walker is used for mobility. The MDS included diagnoses of cerebrovascular accident (damage to the brain from interruption of its blood supply), hemiplegia (paralysis of one side of the body, resulting from brain damage) anxiety, depression and Schizophrenia. The MDS revealed no active discharge plan for the resident to return to the community with no referrals wanted.The Care Plan Focus with no date indicated Resident #1 wishes to return home when appropriate. Interventions include to establish a pre-discharge plan with resident/family/caregivers and evaluate progress and revise plan as needed, evaluate and discuss the prognosis for independent or assisted living, discuss limitations, risks, benefits and needs for maximum independence and the residents motivation to return to the community.Health Status Note dated 11/6/25 at 3:05 PM, documented: During activities for several days now, 3 other residents are asking Resident #1 if he's going home soon and he replied Yes I think so I'm just not sure when and talks to them about his apartment. Answer every time it is asked replies Yes. This writer heard that a conversation has been held with family and Administrator and Director of Nursing (DON) and that No he is not going home. Writer placed a call to family to hear from the decision maker is this still a possibility. Family said yes absolutely it's still a possibility. Family is still working on getting resident back home and that it's not off the table yet and feels I don't feel Resident #1 should have to live in a nursing home for the rest of his life.Care Conference Note dated 12/16/25 at 11:35 AM, documented care conference held with resident and family, discussed returning home and family would like to re-evaluate in the spring.Care Conference Note with late entry dated 1/26/26 at 11:30 AM, documented that the resident came into my office to ask if I had spoken to his brother about residents discharge home in March of 2026. Re-educated the resident that the last care conference held on 12/16/25, with the family that the goal was to return home in the spring of 2026. Discussed that the next care conference is on March 18, 2026 and would discuss discharge in that care conference. Resident stated ok and left my office.Elopement Evaluation dated 2/4/26 at 10:46 AM, documented resident verbally expressed the desire to go home.Care Conference Noted dated 2/4/26 at 11:53 AM, documented discussed returning home and family would like to re-evaluate in the spring. The resident came to my office to ask if I had spoken to the brother about the residents discharge home in March 2026. I re-educated the resident that the last care conference with the family that they had anticipated the residents return home in the spring of 2026. Communication with Provider dated 2/24/26 at 6:40 PM, documented received orders for resident to discharge to home on 2/28/26.Health Status Note dated 2/28/26 at 2:22 PM, resident discharge from the facility.On 3/11/26 at 4:30 PM, the residents family member stated that no discharge instructions or orders were reviewed or given to the family or Resident #1 when family came to the facility on 2/28/26 to take the resident home.On 3/18/26 at 1:45 PM, the facility Administrator confirmed and verified that Resident #1's brother called on 2/24/28 and informed that Resident #1 was going to be discharged home on 2/28/26. Resident #1's family stated that they have taken care of Resident #1 before and they can do it again.On 3/18/26 at 2:50 PM, the facility DON, stated that she went over the discharge instructions with (continued on next page)</p>		

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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>Resident #1 prior to being discharged on 2/28/26 and the discharge instructions were not signed by Resident #1. The DON confirmed and verified that the discharge instructions were mailed to Resident #1 on 3/3/26 to sign and return back to the facility and the facility has not received the signed discharge orders. On 3/18/26 at 3:30 PM, Staff A, Registered Nurse (RN) stated that no discharge paperwork was given to Resident #1 or family/representative when discharged on 2/28/26. Family came in the afternoon packed up all the belongings and left the facility. The facility policy statement with no date, documented, that all required information will be communicated to the receiving provider, and residents will receive proper written notice consistent with federal regulations. The Discharge planning must: Address the resident's ability to care for themselves, Assess caregiver availability, capacity, and capability, Ensure the receiving location can meet the resident's needs and preferences, and Include documentation of all planning activities.</p>		