STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165537	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hiawatha Care Center	405 North 15th Avenue Hiawatha, IA 52233

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record review, staff interview, and facility policy review, the facility failed to develop and implement a comprehensive care plan for four of five residents reviewed for unnecessary medications (Resident #6, #9, #10, #27). Findings include: 1. The Minimum Data Set (MDS) for Resident #6 dated 2/9/26 recorded the resident reported no days of little interest in doing things or of feeling down or depressed over the 14 day lookback period. The MDS documented the resident exhibited no behavioral symptoms during the seven day lookback period. The MDS documented diagnoses that included depression. The MDS documented the resident received an antidepressant during the lookback period. The Care Plan for Resident #6 revealed a Focus Area of Antidepressant Medication related to depression, dated 2/18/26. The Care Plan directed staff to monitor for adverse side effects of the medication. The Care Plan failed to reflect the targeted behaviors which indicated signs of depression personalized to Resident #6. 2. The MDS for Resident #9 dated 3/1/26 recorded the resident reported no days of little interest in doing things or of feeling down or depressed over the 14 day lookback period. The MDS documented the resident exhibited no behavioral symptoms during the seven day lookback period. The MDS documented diagnoses that included non Alzheimer's dementia, anxiety, depression and bipolar disorder. The MDS documented the resident received an antipsychotic and an antidepressant during the lookback period.The Care Plan for Resident #9 revealed a Focus Area of Antidepressant Medication related to depression, dated 3/9/26. The Care Plan directed staff to monitor for adverse side effects of the medication. The Care Plan failed to reflect the targeted behaviors which indicated signs of depression personalized to Resident #9. The Care Plan further revealed a Focus Area for Antipsychotic medication related to Bipolar disorder, dated 3/9/26. The Care Plan directed staff to monitor for adverse side effects of the medication. The Care Plan failed to reflect the target behaviors which indicated signs of psychosis personalized to the resident. 3. The MDS for Resident #10 dated 1/4/26 recorded the resident reported no days of little interest in doing things or of feeling down or depressed over the 14 day lookback period. The MDS documented the resident exhibited no behavioral symptoms during the seven day lookback period. The MDS documented diagnoses that included non Alzheimer's dementia and anxiety disorder. The MDS documented the resident received an antipsychotic and an antidepressant during the lookback period.The Care Plan for Resident #10 revealed a Focus Area of Behavior which stated may forget requires assistance with transfers, possibly be non-compliant. At risk for injury. Becomes impatient some and sometimes refuses showers, initiated on 5/28/25 and revised 10/9/25. The Care Plan further revealed a Focus Area for Antidepressant Medication related to depression, dated 5/27/25. The Care Plan directed staff to monitor for adverse side effects of the medication, and failed to reflect the targeted behaviors which indicated signs of depression personalized to Resident #10.The Care Plan for Resident #10 also revealed a Focus Area for antipsychotic medication related to dementia with mood disorder, dated 5/27/25. It directed staff to administer medications as ordered and for the pharmacist to perform Drug Regimen reviews. The Care Plan failed to reflect the targeted behaviors which indicated signs of psychosis personalized to Resident #10.4. The MDS for Resident #27 dated 3/1/26 recorded the resident reported no days of little interest in doing things or of feeling (continued on next page)

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
	165537	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hiawatha Care Center	405 North 15th Avenue Hiawatha, IA 52233

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	down or depressed over the 14 day lookback period. The MDS documented the resident exhibited no behavioral symptoms during the seven day lookback period. The MDS documented diagnoses that included Alzheimer's Disease. The MDS documented the resident received antipsychotic, antianxiety, and antidepressant medications during the lookback period.The Care Plan for Resident #27 revealed a Focus Area for Behavior which stated on occasion refuses to come to dining room. Requires assistance with transfers, non-complaint, taking falls. History of being combative with cares as assisted, initiated 12/8/25 and revised on 3/4/26. The Care Plan further revealed a Focus Area of Antipsychotic Medication related to dementia, dated 12/11/25. It directed staff to administer medication as ordered and to monitor for adverse side effects. The Care Plan failed to reflect the targeted behaviors which indicated signs of psychosis personalized to Resident #27.The Care Plan for Resident #27 also revealed a Focus Area of Antianxiety Medication related to anxious/restlessness, dated 12/11/25. It directed staff to administer medication as ordered and monitor for adverse side effects. The Care Plan failed to reflect the targeted behaviors which indicated signs of anxiety personalized to Resident #27. The Care Plan further revealed a Focus Area of Antidepressant Medication dated 12/11/25. It directed staff to administer medication as ordered and monitor for adverse side effects. The Care Plan failed to reflect the target behaviors which indicated signs of depression personalized to the resident. On 4/2/26 at 12:29 pm, the Director of Nursing (DON) stated the facility does not have a broad documentation of target behaviors. She state the nurses monitor those things each shift but there is not specific routine. She added this would be addressed.On 4/2/26 at 12:30 pm, The MDS Coordinator stated some of the facility residents do have target behaviors on their care plans. She expanded by stating she would go through and update the needed care plans. The undated facility policy titled Care Plan, Comprehensive Person-Centered included the following documentation: A comprehensive, person-centered care plan that includes measurable objective and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The policy further revealed, The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .Care plan interventions are chosen after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making .Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's condition change. The interdisciplinary team reviews and updates the care plan when there has been a significant change in the resident's condition, when the desired outcome is not met, at least quarterly in conjunction with the required quarterly MDS assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165537	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hiawatha Care Center	405 North 15th Avenue Hiawatha, IA 52233

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 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, and resident and staff interviews, the facility failed to prevent an accident/hazard when a resident who required assistance with transfer fell trying to reach for the call light which was placed out of reach for 1 of 2 residents sampled (Resident #17). The facility identified a census of 104 residents. The facility corrected the deficient practice through past noncompliance through the following actions: -Staff education regarding call light placement. Findings include:Review of Resident #17's Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 13/15 indicating intact cognition. Resident #17 required the use of a walker, wheelchair and was dependent upon staff for chair/bed to chair transfers. The MDS listed diagnoses of Non-Alzheimer's Dementia and age-related osteoporosis. The MDS further documented Resident #17 with a fall history in the past month and 2-6 months prior to admission. A Fall Risk Evaluation completed 12/14/25 documented a score of 19. The Evaluation further detailed Resident #17 had 3 of more falls in the past 3 months, had intermittent confusion, was ambulatory and incontinent, required the use of an assistive device (walker, wheelchair) and took 1-2 medications that could increase fall risk. The Fall Risk Evaluation documented a score of 10 or higher indicated a high risk of falls. The Risk for Falls Care Plan revised 12/17/25 directed to be sure the call light was within reach and to encourage the resident to call for assistance. The Care Plan lacked documentation the resident used a cordless call pendant. A Long-Term Care Facility Visit Note dated 1/06/26 by the Provider documented Resident #17 resided previously at an assisted living and came to the nursing home needing more assistance with activities of daily livings and exhibited more confusion which seemed to be her new normal.An Un-Witnessed Fall Incident Report dated 1/15/26 at 6:43 AM documented Resident #17 was found on the floor by the head of the bed gripping her left arm. The Resident reported arm pain of 9/10. The Incident Report detailed Resident #17 stated she couldn't call for help because she could not find her call light. She was reaching for it when she fell to the floor. Resident #17 stated her arm was hurting really bad in the upper bicep. The Incident Report further detailed Resident #17 was ambulatory with assistance. The Un-Witnessed Fall Incident Report lacked documentation on where the resident fell from. An Incident Progress Note dated 1/15/26 at 7:06 AM documented by Staff A, Licensed Practical Nurse (LPN) documented Resident #17 was found in the room on the floor at the head of the bed gripping her left arm. Resident #17 reported she hit her arm on the side bed rail and was experiencing pain 9/10 (on a 1-10 scale). Resident #17 stated she was unable to find her call light and was searching for it to call for help when she fell. During an interview on 3/31/26 at 9:42 AM Resident #17 stated a Certified Nursing Assistant (CNA) had attached her call light above her bed where she couldn't reach it. She ended up having to get up on her own and fell. She hurt her left arm which she still had pain in, but she could use it. She needed assist of one aide to transfer and walk. Observation on 4/01/26 at 9:41 AM revealed Staff B, CNA removed Resident #17's wheelchair pedals to the side of the wheelchair (WC), locked the WC in place, placed a gait belt around the resident's waist and assisted the resident to stand up to the walker. Staff B assisted Resident #17 to walk approximately 8 feet into the bathroom. Resident #17 observed with a slow gait and difficulty lifting and swinging her right foot through as she walked. During an interview on 4/01/26 at 11:55 the Director of Nursing (DON) reported regarding an investigation, Resident #17's call light was not in reach. The resident's family had asked the facility to get the resident up around 5 AM as she was an early riser at the assisted living. They revised Resident #17's care plan to not leave unattended in the wheelchair after she fell on 1/15/26. The DON further explained Resident #17's call light had been clipped to the wall back by the head of the bed out of the resident's reach. Staff B had been written up for not leaving the call light in reach of the resident.An Employee Disciplinary Report dated 1/15/26 documented a Verbal Warning due to failure to follow instructions (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165537	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hiawatha Care Center	405 North 15th Avenue Hiawatha, IA 52233

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or company rule specifically citing improper call light placement for Resident #17. Staff B signed the write up along with the Administrator and DON. On 4/01/26 at 12:01 PM, Staff A reported she was orientating with Staff C, Registered Nurse (RN) when Resident #17 fell. She recalled Resident #17 was on the floor gripping her left arm in pain and she was so scared for her. Resident #17 kept stating, my arm! My arm! She had hit her arm hard. Staff A reported Resident #17's call light was not in reach, but she couldn't recall exactly where it was as it had been a while since the fall. Staff A reported she didn't know if the resident fell from the wheelchair or the bed. On 4/01/26 at 12:16 PM Staff C, reported Resident #17 fell trying to reach for her call light. It was clipped to the upper part of the call light cord by the wall. When queried if the resident fell from the bed or the wheelchair, Staff C reported she had not been in the room and didn't see Resident #17 until the resident in the wheelchair out in the dining room for breakfast to assess her arm. Staff A had performed vital signs and range of motion. She never assessed Resident #17 until she was in the dining room for breakfast. During an interview on 4/01/26 at 1:24 PM with Staff B, Staff B explained she couldn't recall if Resident #17 had been up in the wheelchair prior to the fall, but her call light was not in reach. She has a special paddle type call light that should be placed in reach right by her hand whether she was in the wheelchair or bed. On 4/01/26 at 1:28 PM, Staff J, CNA reported call lights had to be placed in easy reach for the resident. On 4/01/26 at 1:30 PM Staff K, RN reported call lights should be pinned to the resident or if a paddle right next to the resident. Call light have to be placed so residents have easy, accessible access to the call light for help. During an interview on 4/01/26 at 1:51 PM the DON reported they had a Quality Assurance and Performance Meeting everyday where they went over falls. Obviously knowing that Resident #17 could not reach her call light prompted more investigation. The DON verbalized Resident #17's fall could have been prevented.The Call Light System Policy, undated, provided by the facility stated residents would be provided with a means to call staff for assistance through a communication system that directly calls a staff member. The Policy Procedure directed each resident would be provided with a means to call staff directly for assistance from his/her bed, chair, toilet or bathing facilities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165537	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hiawatha Care Center	405 North 15th Avenue Hiawatha, IA 52233

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, dietary tray card review, policy review, and staff interview, the facility failed to ensure a resident did not receive a food item they were allergic to for 1 of 1 resident reviewed (Resident #60). The facility identified a census of 104 residents.Findings include:Resident #60's Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) Score of 14/15 indicating intact cognition. Resident #60 was independent in eating. The MDS documented diagnoses of heart failure, end stage renal disease, chronic obstructive pulmonary disease, and respiratory failure.A Nutritional assessment dated [DATE] documented a food allergy to bananas. The Care Plan revised 2/13/26 included a Focus for Actual Nutritional Risk noting food allergies, and the intervention revised on 1/2/26 revealed Resident #60 was allergic to bananas.During an interview on 3/30/26 at 1:57 PM, Resident #60 reported she was allergic to bananas and was served a banana that had been cut in half at breakfast that morning (3/30/26). She took it off her tray and laid it on the table. They took her back to her room. She said something to the Certified Nursing Assistant (CNA). The CNA got the nurse and the nurse gave her something and then she started to feel better. She felt she was having a reaction to the banana. On 3/31/26 at 2:13 PM, during another interview with the resident, the resident explained they brought her a fruit bowl Monday morning after she was done with her breakfast. She had already touched the banana and given it to Resident #112 at the table. She felt like she had a tight band around her waist and had nausea right after breakfast. She had a banana allergy for 50 years and that is typical of how she feels.A 3/30/26 review of Resident #60's Electronic Medical Record (EHR) Clinical Resident Profile under Allergies documented a Banana allergy in red print. A 3/31/26 review of Resident #60's March 2026 Electronic Medication Administration Record (EMAR) documented Staff D, Licensed Practical Nurse (LPN) administered Ondansetron (anti-nausea medication) 4 Milligrams (MG) on 3/30/26 at 10:00 AM for nausea. Review of the Dietary Seating Chart revealed Resident #60 sat at table #16 next to Resident #112.Interview on 3/31/26 at 1:44 PM Staff D, reported she was the nurse that worked on Monday 3/30/26. A CNA came and got her and reported that Resident #60 didn't feel good. She stated the resident complained of nausea. She gave her medication and she was fine. Staff D reported she did see Resident #60 give a half banana to Resident #112 who sat at the same table Monday morning. Staff D reviewed Resident #60's diet in the Electronic Health Record (EHR) and stated she was not aware Resident #60 had a banana allergy. Observation on 3/31/26 at 1:47 PM Resident #60 Dietary Card was clearly marked with a red Food Allergy Sticker in the middle of the Dietary Tray Card documenting an allergy to bananas.During an interview on 3/31/26 at 1:49 PM conducted with Staff E, Dietary Aide (DA), with the Dietary Manager present, reported everything regarding the resident's diet is listed on the dietary card. She served the food from the steam table in the main dining room and someone else gets the drinks. Staff E reported Resident #60 gets a banana every day. Then Staff E stated the bananas were rotten yesterday, and Resident #60 got a fruit bowl. Staff E reported the resident allergies are listed on the resident's dietary card in red at the bottom of the card. She served in the [NAME] dining room Monday where Resident #60 sits at table #[redacted] and she gave her a fruit cup. Interview on 3/31/26 1:58 PM the Dietary Manager revealed the following: After listening to Staff E's interview, stated there are so many staff serving, it would be possible that another server stated there was something missing off the tray and may have grabbed a banana for the resident.Interview completed on 3/31/26 at 2:28 PM Staff F, DA reported there was a red sticker on the dietary card that listed resident allergies that they checked before serving.Interview on 3/31/26 at 2:29 PM Staff G, DA explained they had a rack that held the dietary cards. The dietary cards were color coded to alert to certain diets and there was a red allergy sticker on the diet card that listed the resident allergies. During an interview on 3/31/26 at 2:30 PM Staff H, [NAME] voiced there was a red (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165537	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hiawatha Care Center	405 North 15th Avenue Hiawatha, IA 52233

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sticker at the bottom of the dietary cards that listed resident allergies. She reviewed each card before the meal tray went out to the dining room. Interview was completed on 4/01/2026 at 9:59 AM Staff B, CNA. Staff B reported she assisted with serving in the dining room. If a resident asks for a food item, she would check their diet card and ask the kitchen if the resident could have the items. She reported she had received redirection in the process in the past 24 hours from the Dietary Manager. She explained for example if a resident wanted a banana, and her diet card stated she couldn't have a banana, then she would check with the Dietary Manager. During an interview on 4/01/26 at 10:05 AM the Assistant Director of Nursing (ADON), the ADON reported dietary used diet cards that listed the resident's diet. Staff were to check with the dietary staff before taking any food items out to the resident tables. Staff cannot access any food. All food had to be provided by the dietary department so dietary has to check the diet card before giving the food out to the staff to serve to the table. The diet card goes with the meal to the resident's table and staff leave the diet card on the table once the meal is served to the resident. Interview on 4/01/2026 at 10:06 AM Staff L, CNA explained all resident allergies were listed on the diet card. After they served the tray, they put the diet card in the middle of the resident's table. She always looked at the diet card to ensure the resident did not have a food restriction. If it is something the resident couldn't have, she went back and checked with dietary. During an interview on 4/01/26 at 1:17 PM Staff I, CNA reported if a resident requested food items, they could check the dietary card if it was filled out. Sometimes when there was a new admission, the dietary card was not filled out. They did not have access to any food, so they had to check with dietary if the resident could have the food item and get the food items from the kitchen staff. During an interview on 4/01/2026 at 1:48 PM the Director of Nursing (DON) reported if a resident requested other food items, non-dietary staff would go back up to the dietary steam table. It would be dietary's responsibility to look at the dietary card and see if the resident can have the food item before serving the food item out. If the dietary staff didn't know, then they would check with the nurse.During an interview on 4/01/2026 at 2:07 PM the Dietary Manager reported food allergies were listed on the diet card. The Diet Cards are on a rack on the steam table. The person serving the food is to look at the dietary card, then prepare the plate according to likes, dislikes and preferences. The aide next to them will set up the drinks. The cards go out on the dietary tray by the server or the aide. The person delivering the tray would look at the resident's name and diet as they serve the meal. She couldn't know if servers or aides were actually looking at the food allergies on the diet card when the meals were served, but she had talked to all staff to pay attention to the allergy portion of the dietary cards in the past 24 hours. The Food Allergies and Intolerances Policy, undated, provided by the facility directed residents with food intolerances and allergies would be offered appropriate substitutions for foods that they cannot eat. The Policy lacked direction how the facility communicated food allergies for the meal service.