STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165541	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riceville Family Care and Therapy Center	915 Woodland Avenue Riceville, IA 50466

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews and policy review the facility failed to provide informed consent regarding the risk and benefits for as needed psychotropic medications (medications that affect brain activity, influencing mood, thoughts, behavior, and perception to treat mental health conditions) for 1 of 3 residents reviewed for psychotropic medications (Resident #7). The facility reported a census of 27 residents.Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #7 documented an admission date to the facility on [DATE]. The MDS identified a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. The MDS included diagnoses of atrial fibrillation (A-fib, occurs when the heart flutters and does beat correctly), dementia, insomnia, and mild cognitive impairment. The MDS reflected she took an antidepressant, antipsychotic and anticoagulant medications during the lookback period. Review of Resident #7's Nursing Home Notes Final Report written by her doctor on 12/16/25 documented to continue Seroquel (a psychotropic medication called an antipsychotic, that affects the brain) and trazodone (a psychotropic medication called an antidepressant, that affects the brain)Review of Resident #7's Medication Review Report signed by her doctor on 3/10/26 indicated she started taking two (2) antidepressant medications and one (1) antipsychotic medication on 12/9/26. Resident #7 continued to take them.Review of Resident #7's Medication Administration Record (MAR) for January and February 2026 documented she took her two (2) antidepressants and one (1) antipsychotic medications daily at bedtime. Review of Resident #7's Progress Notes from 12/9/25 to 3/18/26 lacked documentation of family consent and/or education of adverse side effects regarding the risk and benefits of receiving psychotropic medications.The Care Plan Focus revised 12/18/25 indicated Resident #7 had a medical need for medication due to multiple diagnoses. The Interventions instructed she used antidepressant and antipsychotic medications. The Interventions included what adverse side effects to monitor. In an interview on 3/19/26 at 12:28 PM the Director of Nursing (DON) revealed the facility didn't complete psychotropic medication consents with Resident #7's family until today (3/19/26). They should be completed upon admission or when they receive an order for them. In an interview on 3/19/26 at 12:33 PM the Administrator reported they recently reviewed psychotropic medication consents with the DON, but they have trained the floor nurses on it yet.Review of the facility's undated Drug Regimen Review policy lacked instruction on when to obtain informed consent and the facility's process to do so.

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
	165541	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riceville Family Care and Therapy Center	915 Woodland Avenue Riceville, IA 50466

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review the facility failed to obtain an International Normalized Ratio INR lab test (measures how quickly the blood clots and primarily used to monitor patients on blood thinners like warfarin, a normal range is typically 1.1 or lower for people not on anticoagulant medication, but for those taking anticoagulants, the target range is usually 2.0 to 3.0 to ensure a balance between preventing clots and minimizing bleeding is maintained) for 1 of 1 residents reviewed for anticoagulants (Resident #7). The facility also failed to have their INR policy and procedure reflect the facility's procedure for INR lab tests. The facility reported a census of 27 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #7 documented an admission date to the facility on [DATE]. The MDS identified a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. The MDS included diagnoses of atrial fibrillation (A-fib, occurs when the heart flutters and does beat correctly), dementia, insomnia, and mild cognitive impairment. The MDS reflected she took an anticoagulant medication (affects the thickness of the blood) during the lookback period. Review of Resident #7's Nursing Home Notes Final Report written by her doctor on 12/16/25 instructed to continue use warfarin (anticoagulant medication).Review of Resident #7's INR Lab Test dated 12/19/25 instructed to check her INR again in 2 weeks (1/2/26).Review of Resident #7's Progress Note on 12/19/2025 at 1:50 PM revealed the facility received a new order to take warfarin 10 milligram (mg) dose on Sunday and Thursday and a 5 mg dose on Monday, Tuesday, Wednesday, Friday, and Saturday. The next INR should be checked in 2 weeks (1/2/26).Review of Resident #7's Progress Notes from 1/2/26 to 1/22/26 revealed and INR lab test was not completed. Review of Resident #7's Progress note on 1/23/26 at 7:46 AM revealed she was ordered to have her INR drawn on 1/2/26, but due to a technical issue (order entered but did not trigger) her INR did not get checked on 1/2/2. She remained on the same warfarin dosage since her last order received on 12/19/25. Her INR result from that morning was 2.4. Review of Resident #7's INR Lab Test dated 1/23/26 instructed to check her INR again on 2/23/26 with no order changes made. Review of Resident #7 Medication Administration Record (MAR) for January 2026 revealed she took warfarin without an order from 1/2/26 to 1/23/26. The Care Plan Focus revised 12/18/26 indicated Resident #7 had a medical need for medication due to multiple diagnoses. The Interventions instructed she used anticoagulant medications. In addition, the Interventions listed the adverse side effect to monitor. In an interview on 3/19/26 at 12:28 PM the Director of Nursing (DON) revealed the nurse who put the order in the computer did it incorrectly and it did not alert the staff to check the lab. She explained she provided individual training to the nurse involved when the error occurred. She would expect it checked as the order read on 1/2/26. In an interview on 3/19/26 at 12:33 PM the Administrator reported they provided training to the nurse involved. They would expect the order to be completed as ordered and not late.Review of the facility's Finger Stick INR Procedure & Policy dated 9/24/20 instructed the local hospital will be in charge of obtaining INRs. The policy directed to check the Appointment calendar daily for INRs. The Care Coordinator will audit the INR's weekly for accuracy.