

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165546	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2025
NAME OF PROVIDER OR SUPPLIER Tabor Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 209 Main Street Tabor, IA 51653	

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, document review, staff interview, family interview and policy review the facility failed to notify the resident's representative / family / Power of Attorney (POA) for change in condition / transfer to Emergency Department (ED) when a resident fell from a full body mechanical lift for 1 of 3 residents (Residents #1) reviewed. The facility reported a census of 39 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] documented Resident #1 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. MDS documented Resident #1 required maximum assistance by staff for transfers. Review of Resident #1's Electronic Health Record (EHR) dated 11/5/25 titled, Progress Notes entered by Staff C at 12:29 PM documented Resident #1 fell from a full body mechanical lift to the floor and landed in the prone position. Emergency Medical Services (EMS) were called and arrived at the facility. Resident #1 was transported to the ED of her choice. Review of Resident #1's EHR dated 11/5/25 titled, Progress Notes entered by the Director of Nursing (DON) at 12:10 PM documented the DON called Resident #1's Daughter and notified her of the situation. Resident #1's Daughter had requested a meeting after the facility reviewed the fall to discuss the situation with the DON and the Administrator. Review of Resident #1's EHR dated 11/5/25 titled, Progress Notes entered by Staff C at 1:04 PM documented there was not a phone number for Resident #1's Daughter on the transfer/discharge paperwork so Resident #1's Daughter was not notified about Resident #1's transfer to the ED. Attempted to call after completed tasks and there was no answer. Repeated attempt to call after the lunch medication pass was over and Resident #1's Daughter answered. Resident #1's Daughter reported she was already at the hospital and would call with updates. Resident #1's Daughter was understandably upset that she had not been notified sooner. Review of Resident #1's document dated 11/10/25 titled, After Visit Summary documented Resident #1 entered the hospital on [DATE] and was diagnosed with neck fracture, thoracic compression fracture, a closed initial initial encounter and bleeding around the brain. Review of document dated 11/5/25 titled, Risk Management Witnessed Fall prepared by Staff C documented no family or POA notified of incident. On 11/10/25 at 10:16 AM Resident #1's Daughter stated she had not been notified that Resident #1 had fallen or was transferred to the ED until notified by the DON. Resident #1's Daughter explained there were no missed calls from the facility that day. Resident #1's Daughter said the DON told her she had just got on shift and called her. Resident #1 stated she told the DON she was already at the hospital with Resident #1. Resident #1 explained the staff at the hospital were the people that prompted the facility to call the family because no one had called her yet. On 11/10/25 at 1:38 PM Staff C, Registered Nurse (RN) stated EMS transferred Resident #1 to the hospital because of a fall out of a sling. Staff C stated she notified the physician of the fall. Staff C explained when she printed Resident #1's discharge information there was no phone number for Resident #1's POA / daughter. Staff C said she told the DON that there was no phone number for Resident #1's POA / daughter. Staff C stated the DON looked at the admission paperwork and found the phone number and called Resident #1's POA / daughter. Staff C acknowledged Resident #1's POA / daughter was upset she was not called earlier to notify that Resident #1 had been transferred to the ED related to a fall from a lift. On 11/10/25 at 11:52 AM the DON stated she did not come into the facility on [DATE] until 12:00 PM. The DON stated she was not at the facility when the fall occurred. The DON explained Resident #1 had a 2mm subdural hematoma and a fracture from C7 - T6. The DON stated she did not know if Staff C notified the physician of the transfer. The DON stated Staff C did not notify Resident #1's family about the fall or transfer to the ED. The DON acknowledged the fall had occurred around 10:00 AM on 11/5/25. The DON acknowledged Resident #1's family was not notified for 2 hours. The DON explained Staff C said she could not find Resident #1's POA phone number on the printed paper that she had. The DON said Resident #1's POA's phone number was under other and did not populate on the transfer face sheet. The DON explained education was provided to Staff C about other places to look for emergency contact information. The DON stated her expectation was that family / POA would have been notified earlier than when she notified. The DON stated the facility's expectation was family / POA would be notified immediately of any emergency incidents that require intervention. Review of policy updated 6/2/25 titled, Policy Notification of Family/POA documented the purpose was to ensure staff are informed of when to notify families, POA's and physicians of any changes. Nursing staff must notify families, POA's and physicians of any changes of condition, falls or incidents involving loved ones. Members of the nursing staff must document in the FHR of notification of</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and facility policy review, the facility failed to provide weekly skin assessments for 2 residents reviewed (Resident #2, #3) for pressure ulcers. The facility reported a census of 39 residents. 1. The Minimum Data Set (MDS) dated [DATE] for Resident #2 documented a Brief Interview for Mental Status (BIMS) of 4 indicating severe cognitive impairment. MDS also documented Resident #2 had 1 unstageable pressure ulcer. Review of Resident #2's EHR titled, Progress Notes documented an unstageable pressure ulcer to the left heel was discovered on 6/2/25. Progress Notes documented wound assessments with size and description were completed on 6/8/25, 9/15/25, 10/13/25, 11/6/25, and 11/11/25. Review of Resident #2's document printed on 11/12/25 titled, Hospice Wound Record Report documented wound assessments to the unstageable pressure ulcer located on the left heel with size and description were completed on 8/4/25, 8/12/25, 8/18/25, 8/25/25, 9/22/25, 10/2/25, 10/16/25, 10/23/25, 10/30/25 and 11/11/25. Review of Resident #2's documents titled, Progress Notes and Hospice Wound Record Report documented no weekly wound assessment completed to unstageable pressure ulcer on left heel from 6/8/25 - 8/4/25, 8/25/25 - 9/15/25 and 10/2/25 - 10/13/25. On 11/13/25 at 10:25 AM the DON stated hospice reported no skin assessments completed by them prior to 8/4/25. 2. The MDS dated [DATE] for Resident #3 documented a BIMS of 2 indicating severe cognitive impairment. Review of Resident #3's EHR titled, Progress Notes documented a Deep Tissue Injury (DTI) to the right lateral heel was discovered on 10/15/25. Progress Notes documented a wound assessment with size and description was completed on 11/7/25. Review of Resident #3's document printed on 11/12/25 titled, Hospice Wound Record Report documented wound assessments to the suspected DTI located on the right lateral heel with size and description were completed on 10/17/25, 10/22/25 and 11/11/25. Review of Resident #3's documents titled, Progress Notes and Hospice Wound Record Report documented no weekly wound assessment completed to DTI on right lateral heel from 10/23/25 - 11/6/25. On 11/12/25 at 10:58 AM the DON stated skin assessments were discussed during the mock survey. The DON explained a mock survey at the facility had been completed 11/3/25 - 11/7/25. The DON acknowledged during mock exit the team explained to the facility they noticed some potential documentation issues with skin assessments and Resident #2's name was brought up. The DON said there should have been documentation of the wound itself and what it looked like including the size and description of the wound. The DON explained no vitals would be required during the wound assessment according to the facility's policy. The DON stated there should be a more in-depth note in the progress notes for Resident #2 if not covered in the total body assessment. The DON stated the facility policy stated there had to be an update in the EHR Progress Notes or an assessment completed in the EHR. The DON stated the assessment would be found under progress notes or under assessments tab. The DON stated there should be a through wound assessment completed on Resident #2 weekly. The DON acknowledged there should be a wound assessment completed at least weekly. The DON explained the assessment should have included measurements and a description of the wound. The DON stated her expectation was between the hospice nurses and facility nurses a wound assessment should have been completed weekly. The DON stated if the hospice nurse had completed an assessment she would not expect that a nurse at the facility would complete a weekly wound assessment. On 11/12/25 at 1:17 PM Staff E, Licensed Practical Nurse (LPN) stated all wounds are monitored but it depended on the severity of the wound as to how often. Staff E stated if the dressing needed changed the nurse would assess the wound. Staff E explained wound assessments were documented on the MAR as to when they are completed. Staff E stated Resident #2 dressing is changed every day but would only measure the wound when the MAR indicated to measure the wound. Staff E stated measurements are an expectation for all skin assessments with a description of the wound. On 11/13/25 at 10:40 AM Staff C, Registered Nurse (RN) stated skin assessments are supposed to be completed weekly. Staff C stated the weekly skin assessment should include measurements and a description of the wound. On 11/12/25 at 3:09 PM the DON stated she would have expected there would have been more documentation in the Progress Notes with wound size and description. The DON stated it was discovered documentation could have been better related to wound assessments during the mock survey that was concluded 11/3/25 - 11/7/25. Review of policy dated 2/28/24 titled, Protocol for Wound Assessments documented when a skin concern arises, the nurse shall complete skin assessment in the EHR Physician notification for ongoing treatment/intervention, electronic medication administration record</p>		