STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165546	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tabor Manor Care Center	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, policy review, resident interviews and staff interviews the facility failed to provide dignity and respect by video recording a resident without notifying the resident or asking permission and by failing to remove food from the resident's face and cover the resident's right shoulder in a public area to 2 of 40 residents reviewed (Resident #36 and #24). The facility reported a census of 40 residents.Findings include:1.On 2/23/26 at 12:27 PM, Staff F, Certified Nurse Aide (CNA) transported Resident #36 to her room after eating lunch and positioned the resident beside her bed facing the room door. Resident #36 had mashed potatoes below her left lower lip. Resident #36's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 04 out of 15 which indicated severely impaired cognition. It included diagnoses of a stroke with reduced right side muscle strength, non-Alzheimer's dementia, and seizure disorder. It revealed she required supervision with eating, maximal assistance with upper body dressing and rolling left-to-right in bed, and was dependent with all other Activities of Daily Living (ADLs) and chair-to-bed and shower transfers. The Care Plan revised 12/11/25 revealed the resident required assistance with eating on days she was more tired. It also revealed the resident required staff to perform oral hygiene. On 2/23/26 at 1:06 PM, observed the resident sitting in her wheelchair, in her room, facing the door with mashed potatoes still on her face. On 2/24/26 at 8:27 AM, observed Resident #36 sitting in her wheelchair at the dining conference room table with 2 other residents while Staff F assisted her with eating. Resident #36's gown was positioned in a way which allowed full exposure of her right shoulder, collar-bone, and the nape of her neck. At 8:29 am, Staff F transported Resident #36 back to her room, faced the resident toward the opened door, pulled her gown over her right shoulder, and left the room. The resident's gown slipped back down and re-exposed her right shoulder, collar-bone, and the nape of her neck. On 2/24/26 at 9:16 AM, Staff F transported Resident #36 to the lobby in her wheelchair to participate in a group activity. Her gown was positioned below her right shoulder exposing her shoulder, collar-bone, and the nape of her neck with other residents in the lobby. On 2/25/26 at 1:51 PM, Staff G, Certified Medication Aide (CMA) stated it is a dignity concern to leave food on a resident's face because it could easily be removed when they are put in their room. She also stated a female's shoulder, collar-bone, and neck exposed in a public setting is a dignity concern. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/26 at 1:54 PM, Staff C, CNA, stated food left on a resident's face is a dignity concern. She also stated a female's shoulder, collar-bone, and neck exposed in a public place is also a dignity concern. On 2/26/26 at 11:30 AM, the Director of Nursing (DON) stated staff should have assisted the resident to clean her face and help her readjust her clothing to cover her shoulder. 2. The Minimum Data Set (MDS) dated [DATE] for Resident #24 documented a Brief Interview for Mental Status (BIMS) of 12 indicating moderate cognitive impairment. On 2/23/26 at 11:03 AM Resident #24 explained on 2/16/26 the Director of Nursing (DON) and Staff Q, MDS Coordinator came into her room. Resident #24 stated the DON and Staff Q got into an argument with her about and continued to accuse her of having cameras in the room and recording the staff. Resident #24 stated the facility staff accused her of having recording devices but they did not tell her that she could not have them. Resident #24 stated the Administrator came into her room and asked what time the incident occurred. Resident #24 stated she replied to the Administrator the incident happened around 1:20 PM and she told him he could just check the camera. Resident #24 stated the Administrator told her that he knew he had already reviewed the facility's video footage. Resident #24 said the police officer stated the DON had recorded their interaction. Resident #24 said if the DON had recorded her it was very upsetting to her. Resident #24 stated recording her without her knowledge was very disrespectful and the DON would not have been treating her with dignity. On 2/25/26 at 3:44 PM Staff R, Certified Nurse Assistant (CNA) stated on 2/16/26 Resident #24 had requested to speak with Staff Q and the DON. On 2/25/26 at 4:35 PM Staff Q, MDS Coordinator stated Staff R received a note from Resident #24 requesting for Staff Q to come talk to her. Staff Q explained staff had to enter Resident #24's room in pairs. Staff Q explained she entered the room with the Director of Nursing (DON) around 1:30 PM on 2/16/26. Staff Q stated the DON recorded the encounter with Resident #24. Staff Q stated the DON revealed to Staff Q as they were walking in the door. Staff Q stated she thought the DON should have told Resident #24 or asked Resident #24 if they could record the incident. On 2/25/26 at 10:27 AM the DON stated Resident #24 had sent a handwritten note to talk to Staff Q. The DON explained that Staff Q asked her to be the second staff to enter the room. The DON acknowledged she put her phone on record, placed it in her pocket and recorded the entire interaction. The DON stated she does not record residents frequently. The DON stated she did not ask Resident #24 if she could record their interaction. The DON explained there was not a policy at the facility for staff recording residents. The DON stated she did see an issue with dignity when she recorded Resident #24 without her knowledge. On 2/26/26 at 4:01 PM the DON sent the video recording from her personal phone of the incident between her, Staff Q and Resident #24 to the survey team. Review of a policy revised 11/16 titled, Abuse Prevention, Identification, Investigation, and Reporting Policy documented all residents have the right to be free from verbal, sexual, and mental abuse, neglect, misappropriation of resident property, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This includes prohibiting nursing facility staff from taking or using photographs or recordings in any manner that would demean or humiliate a resident, and prohibits using any type of equipment (e.g., cameras, smart (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	phones, and other electronic devices) to take, keep, or distribute photographs and/or recordings on social media or through multimedia messages. Review of a policy with an effective date of 11/26/13 titled, HIPAA / Privacy Safeguarding and Storing Protected Health Information documented the purpose of the policy was to ensure, to the extent possible, that Protected Health Information (PHI) is not intentionally or unintentionally used or disclosed in a manner that would violate the HIPAA Privacy Rule or any other federal or state regulation governing confidentiality and privacy of health information. The procedure was designed to prevent improper uses and disclosure of PHI that is or would be, contained in a resident's medical record.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, resident interview, policy review, and staff interview the facility failed to provide the residents with a homelike environment by serving meals on Styrofoam flatware to residents. The facility reported a census of 40 residents.Findings include:The Minimum Data Set (MDS) dated [DATE] for Resident #24 documented a Brief Interview for Mental Status (BIMS) of 12 indicating moderate cognitive impairment.On 2/23/26 at 11:03 AM Resident #24 stated the staff in the evening serve most of the meals on Styrofoam plates and bowls. Resident #24 explained she does not like being served on Styrofoam plates. Resident #24 stated she did not know why the facility does not use actual plates. On 2/24/26 at 11:32 AM Staff L, [NAME] stated she worked 3-4 days a week serving dinner meals of the day. Staff L stated if the dish machine was broken the cook would use Styrofoam for that meal. Staff L stated the dish machine had not been out of order when she had worked but she had heard the dish machine was down at least one day in the last 3 months. Staff L explained Staff M, PM shift [NAME] worked as the other evening shift cook. Staff L said she never used Styrofoam for meals. Staff L said Resident #24 had complained about cold food and not getting enough food. Staff L explained these concerns were reported to her by Staff N, Certified Dietary Manager (CDM).On 2/25/26 at 12:51 PM Staff E, CNA/CMA/Transport Driver stated she had heard residents complain about meals served on Styrofoam. Staff E stated Staff M was the cook that served meals on Styrofoam. On 2/24/26 at 1:15 PM Staff M stated residents had not voiced any concerns to him about the kitchen. Staff M acknowledged Staff L was the only other cook on pm shift and she had worked at the facility for about 6 months. Staff L stated he thought the dish machine had been down a couple of times in the last 3 months. Staff L explained he got his butt chewed today about serving all the room trays on Styrofoam plates. Staff L stated Staff N told him everything was supposed to be on regular plates and bowls. Staff L explained he served room trays and the assisting dining room with Styrofoam flatware. Staff L said there was no real reason he used Styrofoam for meal service.On 2/25/26 at 1:12 PM Staff N, (CDM) explained there was a sit down with Staff M a little while back about serving with Styrofoam plates and he acknowledged he understood not to use Styrofoam for meal service. Staff N stated she had spoken with Staff M yesterday about use of Styrofoam and he admitted to continued use of Styrofoam. Staff N explained the use of Styrofoam was a dignity issue. Staff N explained her expectation was meals would be served on regular plates and not utilize Styrofoam for resident meal service unless there was a need such the dish machine was not working appropriately or during a quarantine. Review of an undated policy titled, Disposable Dishware Use Policy documented the purpose of the policy was to define appropriate circumstances for the use of paper plates and other disposable dishware in order to maintain resident dignity, infection control standards and regulatory compliance. The facility will use reusable dishware for routine meal service. Disposable dishware may be used only under the conditions outlined below and shall not be used for staff convenience. Disposable dishware may be used for infection control during outbreaks or when directed by the Infection Preventionist and for residents on transmission-based precautions, as clinically indicated. During emergency situations such as during water service interruptions, dishwasher malfunction, or other utility failures and during natural disasters or other events impacting normal kitchen operations. During special events such as outdoor events or large facility-sponsored gatherings where reusable dishware is impractical and to meet individual care plan needs when identified by the interdisciplinary team as necessary for resident safety or behavioral reasons and documented in the care plan.Review of policy with effective date of 5/19/16 titled, Meal Delivery / Room Trays documented the purpose was to ensure all residents receive meals that are safe, palatable, and served in a dignified manner by maintaining CMS-compliant food temperatures during tray service, serving meals on plates rather than disposable containers when appropriate and promoting resident dignity and quality of life.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on clinical record review, facility document review, and staff interviews, the facility failed to report suspected abuse between two (2) residents (#2 & #37) to the State Agency after being made aware of the incident. The facility reported a census of 40 residents. Findings include:A grievance form dated 11/08/25 at 10:00 AM revealed Resident #37 informed Staff H, Restorative Aide (RA) that Resident #2 came in Resident #37's room and was bumping into everything. When he tried to stop Resident #2, Resident #2 grabbed Resident #37's shirt so Resident #37 grabbed Resident #2's shirt. Resident #2 let go of Resident #37's shirt and slapped at his hands. When Resident #37 let go of Resident #2's shirt, Resident #2 left the room.A document dated 11/08/25 titled Incident with <Resident #37 name> and <Resident #2 name> revealed the administrator interviewed Resident #37 and documented Resident #37 stated Resident #2 came in in his room and startled him and he spilt his coffee. He stated he tried to stop him by grabbing his merry walker (specialized walker with a seat to prevent falls while walking). He also stated Resident #2 grabbed his shirt and Resident #37 grabbed Resident #2's shirt tail and Resident #2 let go and swatted at Resident #37's hands with no contact.On 11/08/25 AM at 11:45 AM, Staff H entered a Restorative Program Note that documented Resident #37 stopped Staff H in the hallway to report that another resident came into his room bumping into everything. Resident #37 tried to stop him by grabbing his merry walker since there was coffee spilt everywhere he didn't want the other resident to fall. The other resident grabbed this resident by the shirt. This resident reacted by also grabbing the other resident by the shirt. The other resident began slapping at this resident's hands stating he's allowed to be in this room. This resident let go of the other resident and the other resident left the room. This resident also stated how upset he was since he's not able to stand or defend his self that he felt threatened. The nurse <Staff A, Registered Nurse (RN)> was notified by staff immediately.A document titled Self Reports did not include a facility reported incident dated within 48 hours of the aforementioned incident.On 2/25/26 at 5:00 pm, the Administrator stated the aforementioned resident-to-resident interaction was not reported to the state agency because there was no physical contact.On 2/26/26 at 8:29 AM, Staff H confirmed the resident reported the aforementioned events and she notified the Assistant Administrator. She stated she was instructed to complete the grievance form and asked her to provide close supervision for Resident #2 for the remainder of her shift, 2:00 PM.On 2/26/26 at 8:49 AM, Staff J, Certified Medication Aide (CMA) stated she was not present during the incident but was told about it. She also stated she was instructed to keep a closer eye on him when she came to work.On 2/26/26 at 8:55 AM, Staff K, CNA stated staff were instructed to keep eyes on Resident #2 as a collective group more vigilantly.On 2/26/26 at 9:31 AM, Staff I, Certified Nurse Aide (CNA) stated, when she came to work, the nurse told her to keep the two residents apart as best she could during her shift.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, resident interviews, staff interviews, and policy review the facility failed to provide the needed services in accordance with professional standards for 2 of 14 residents (Residents #26, #1). The facility failed to complete neurological assessments post falls, and failed to complete wound assessments to ensure healing. The facility reported a census of 40 residents. Findings include:1. The Minimum Data Set (MDS) admission for Resident #26 dated 1/2/26 provided a Brief Interview for Mental Status (BIMS) score of 10/15 indicating moderate cognitive impairment. The document revealed the resident had diagnoses of stroke, anxiety, depression, bipolar disorder, psychotic disorder and schizophrenia. The document revealed the resident had a fall in the last month prior to admission, a fall in the last 2-6 months prior to admission, fracture related to a fall in the 6 months prior to admission, and no falls since the admission to the facility. The MDS Discharge Return Not Anticipated dated 12/21/25 revealed the resident had sustained 2 falls without injury since the prior assessment. The MDS Quarterly dated 11/10/25 provided the resident scored 14/15 on the BIMS, indicating normal cognition. The document revealed the resident sustained 2 falls without injury during the previous reporting period. Resident #26's Care Plan dated 1/27/26 contained a focus area of high risk for falls dated 1/25/26 with interventions of call light within reach and encouraged the resident to use it for assistance as needed and prompt response to all requests for assistance. A focus area of actual fall with no injury related to poor balance, poor communication/comprehension and psychoactive drug use dated 1/4/26 contained interventions of previous Care Plan interventions of staff education/re-education, 2 assist with toileting, use of call light for assistance, resident education on reclining chair prior to attempting to reposition or use of the call light, anti-slide mat in recliner, seat belt on the wheelchair (w/c) and grabber initiated 1/5/26 and revised 1/17/26). The clinical record Progress Notes contained the following entries: 2/11/26 at 10:30 PM the resident put pillows on the floor and lowered herself to it. 12/4/25 at 5:22 PM the resident had an unwitnessed fall at the bedside. 12/3/25 at 11:12 AM the resident slid from her w/c while outside in a supervised smoking environment. 11/13/25 at 10:27 PM the resident fell from her recliner when attempting to recline. The resident had significant pain in her left shoulder and hip and was sent to the emergency room. 11/13/25 at 12:25 AM the resident had an unwitnessed fall transferring herself from her w/c to her bed. 11/10/25 at 10:30 AM the resident fell while staff was assisting with a toileting transfer in the bathroom. 11/9/25 at 1:57 AM the resident had an unwitnessed fall in her bedroom and was found beside the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed. 10/28/25 at 11:20 PM the resident had an unwitnessed fall when she put herself on the floor in an attempt to take herself to the bathroom. The clinical record Neurological Check List in the Assessment tab provided assessments were completed on the following dates: 2/11/26 at 10:30 PM, 12/5/25 at 4:39 PM, 11/16/25 at 10:10 PM, 11/13/25 at 12:25 AM, 11/9/25 at 1:48 AM, 10/28/25 at 11:20 PM. The facility provided documents related to falls on the following dates: 2/11/26 at 10:30 PM un-witnessed fall by placing pillows on the floor and placing self on the floor. 12/4/25 at 3:00 PM un-witnessed fall by reaching for the call light that was laying on the bed. 12/3/25 at 10:00 AM witnessed fall slide from w/c while outside smoking. 11/16/25 at 10:10 PM un-witnessed fall when the resident was using a reaching device while seated in the recliner to obtain a pillow from her bed. 11/13/25 at 12:25 AM un-witnessed fall self transferring from the w/c to the bed. 11/13/25 at 9:50 PM un-witnessed fall pushing back in recliner and falling. 11/10/25 at 8:00 AM witnessed fall transferring with staff in the bathroom. 11/8/25 at 11:50 PM un-witnessed fall reaching for call light and slipped from the side of the bed. The clinical medical record contained physician notifications for falls on the following dates: 2/11/26 notification of un-witnessed fall. 12/3/25 order for x-ray for resident thinking toes were broken. 12/3/25 notification for a witnessed fall outside. 11/16/25 notification for un-witnessed fall from a recliner. 11/10/25 notification for witnessed fall. 10/28/25 notification for un-witnessed fall. The clinical medical record contained an emergency room report following the fall sustained on 11/13/25 with an increase in pain. The document revealed no acute injuries. The clinical medical record contained neuro assessments for 2/11/26, 12/3/25, at 12/4/25. The clinical medical record contained 15 minute checks without assessments for 11/16/25. The medical clinical record did not contain neuro assessments for fall on 11/16, 11/13, 11/8 and 10/28/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/2/26 at 2:54 PM Staff Q, MDS Coordinator/Licensed Practical Nurse (LPN), stated she had looked through the medical record and acknowledged neuro assessments had not been completed on 11/16/25, first fall on 11/13 and 11/8/25. The staff stated she expected the staff to complete neurological assessments following unwitnessed falls. On 3/2/26 at 3:55 PM the Director of Nursing, DON, stated her expectation was for staff to complete Risk Assessments, Neurological Assessments, and notification to the physician following falls with the Neurological Assessments for unwitnessed falls. 2. The Minimum Data Set (MDS) dated [DATE] for Resident #1 documented a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. The MDS documented diagnoses of chronic venous hypertension with ulcer and inflammation of the right lower extremity. On 2/23/26 at 12:36 PM Resident #1 said a van ran over him before he got to the facility and broke his leg in 9 places. Resident #1 pulled his sock on the right foot down to reveal wounds on inner ankle. On 2/23/26 at 12:40 PM an observation of Resident #1's inner right lower extremity revealed 5 areas with dark red scab covering the wound all approximately 0.3cm in diameter. Review of Resident #1's document dated 5/21/25 titled fax documented to send Resident #1 to a wound care clinic. Review of Resident #1's document dated 5/23/25 titled Physician's Orders Wound Care Clinic documented the wounds on Resident #1's right lower extremity probes down to the hardware. Resident #1 needs ortho. Request for Ortho consult for exposed hardware. Review of Resident #1's document dated 7/3/25 titled Physician's Orders Ortho Consult documented to continue current wound care with chronic implant related infection to right leg. Review of Resident #1's wound assessments for the last year in EHR titled, Assessments documented no assessments with measurements or descriptions of the wound on the right lower extremity. Review of Resident #1's Electronic Health Records (EHR) titled, Progress Notes for last 12 months documented wound assessment with measurements on 2/19/26, 6/21/25, 5/30/25 and 5/25/25. Progress Notes documented only monthly skin assessment on 2/3/26, 1/19/26, 12/22/25, 9/21/25, 8/4/25 and 7/21/25 with no wound description or measurement. On 2/26/26 at 12:00 PM Staff A, Registered Nurse (RN) stated she did not know when a skin assessment was supposed to be completed. Staff A acknowledged she cared for Resident #1 frequently. Staff A explained she was the nurse that completed the treatment to Resident #1's wound to the lower right extremity most days that she had worked since September of 2025. Staff A stated since caring for Resident #1 his wound had not gotten any worse. Staff A stated the wound remained about the same. Staff A explained stated if the wound had gotten worse she would have notified the DON and Resident #1's physician. On 2/26/26 at 12:15 PM Staff P, Licensed Practical Nurse (LPN) stated the skin assessments were to be completed weekly and should contain both measurements and a description of the wound. Staff P stated she completed the treatment today and had measured the wound then and entered the (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	measurements. Staff P stated she would put the assessment under weekly skin assessments and would contain measurements and a description. On 2/26/26 at 12:32 PM the Director of Nursing (DON) presented 2 photo assessments that determined the wound had been resolving over the last 6 months. On 2/25/26 at 10:59 AM the DON stated there were no progress notes with regards to an assessment to Resident #1's right leg since 2/19/26. The DON explained she would like to see a wound assessment every time a dressing was changed. The DON acknowledged there was not the amount of assessments she would expect to see in progress notes for Resident #1's wound on his right lower leg. Stated she would expect s/s of infection, dressing, measurements and description of the wound on the wound assessments. The DON explained Resident #1's wound comes and goes and he has had them for years. The DON acknowledged assessments were not completed appropriately by the nursing staff. On 2/26/26 at 10:41 AM Resident #1's Primary Care Physician (PCP) stated he could not tell for sure if the wound was resolving or worsening as he had not looked at the area recently. Resident #1's PCP stated in July of 2025 Resident #1 had right ankle pain and the AFO was rubbing. Resident #1's PCP stated on 5/21/25 at fax he sent to refer Resident #1 to a wound care clinic. Resident #1's PCP stated Resident #1 was having more problems with the wound. Resident #1's PCP stated once the referral was sent he assumed the wound care clinic would complete the determination. Resident #1's PCP stated he has no notes from the wound care clinic. Resident #1's PCP stated he would expect the facility would notify the wound clinic if there was any change. Review of a policy updated 3/18/25 titled, Protocol for Documentation documented the purpose was to ensure all patients information was being documented. Wound care notes should state the treatment provided, the appearance of the wound in detail, and any new concerns noted during treatment. Review of a policy updated 2/28/24 titled, Protocol for Wound Assessments documented the purpose was to ensure that wound and skin concerns are tracked and evaluated to ensure that interventions are working in a timely manner and to prevent further breakdown. When a skin concern arises, the nurse shall complete skin assessment in the EHR, physician notification for ongoing treatment/intervention, EHR updated to reflect current treatment/intervention, weekly measurements obtained by a nurse and reflected in the residents EHR. The policy was to ensure all patient information was being documented. The document disclosed that telephone orders were to be documented in the nurse's notes with any clarification required as well as additional notifications made. The document included all wound care notes that would state the treatment provided, appearance of the wound in detail and any new concerns regarding the wound.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165546	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tabor Manor Care Center	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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility document review, clinical record review, policy review, resident interviews and staff interviews the facility failed to provide nursing staff to assure residents safety by not responding to call lights in a timely manner for 3 of 16 resident reviewed (Resident #3, #24, and #26). The facility reported a census of 40 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] for Resident #3 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. The MDS documented diagnoses of acute and chronic respiratory failure with hypoxia, unspecified nondisplaced fracture of seventh cervical vertebra, unspecified fracture of first thoracic vertebra, functional quadriplegia and need for assistance with personal care. On 2/23/26 at 1:07 PM Resident #3 stated on the 2:00 PM - 10:00 PM shift and the overnight shift it can take much longer than 15 minutes to answer the call light. Resident #3 explained on the overnight shift it had taken over an hour to answer her call light. Review of Resident #3's Electronic Health Record (EHR) documented Resident #3 resided in room [ROOM NUMBER]. Review of the document titled, Call Light Report for room [ROOM NUMBER] documented call lights longer than 15 minutes from 2/16/26 - 2/23/26 on: a. 2/16/26 at 5:57 PM - 50 minutes 19 seconds. b. 2/16/26 at 7:01 PM - 26 minutes 43 seconds. c. 2/16/26 at 10:21 PM - 22 minutes 35 seconds. d. 2/17/26 at 12:54 PM - 29 minutes 10 seconds. e. 2/17/26 at 11:04 PM - 43 minutes 1 second. f. 2/20/26 at 7:43 PM - 19 minutes 14 seconds. g. 2/21/26 at 6:09 PM - 36 minutes 24 seconds. h. 2/21/26 at 10:42 PM - 26 minutes 33 seconds. i. 2/22/26 at 8:17 PM - 32 minutes 5 seconds. j. 2/23/26 at 8:14 PM - 20 minutes 4 seconds. 2. The MDS dated [DATE] for Resident #24 documented a BIMS of 12 indicating moderate cognitive impairment. Review of Resident #24's EHR documented Resident #24 resided in room [ROOM NUMBER]. Review of document titled, Call Light Report for room [ROOM NUMBER] documented call lights longer (continued on next page)

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	165546	A. Building B. Wing	03/04/2026

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	than 15 minutes from 2/16/26 - 2/23/26 on: a. 2/16/26 at 3:28 PM - 18 minutes 8 seconds. b. 2/16/26 at 5:58 PM - 18 minutes 9 seconds. c. 2/18/26 at 7:04 AM - 20 minutes 44 seconds. d. 2/18/26 at 8:47 PM - 48 minutes 58 seconds. e. 2/20/26 at 3:45 PM - 30 minutes 17 seconds. f. 2/21/26 at 9:50 AM - 20 minutes 33 seconds. g. 2/23/36 at 8:49 PM - 23 minutes 12 seconds. 3. The MDS admission for Resident #26 dated 1/2/26 provided a BIMS score of 10/15 indicating moderate cognitive impairment. The document revealed the resident had diagnoses of stroke, anxiety, depression, bipolar disorder, psychotic disorder and schizophrenia. The document revealed the resident had a fall in the last month prior to admission, a fall in the last 2-6 months prior to admission, fracture related to a fall in the 6 months prior to admission, and no falls since the admission to the facility. Resident #26's Care Plan dated 1/27/26 contained a focus area of high risk for falls dated 1/25/26 with interventions of call light within reach and encouraged the resident to use it for assistance as needed and prompt response to all requests for assistance. The facility provided Call Light Report for 2/16-2/23/26 contained the following entries: 2/16/26 at 5:42 PM - 28 minutes 8 seconds 2/16/26 at 6:52 PM - 24 minutes 21 seconds 2/17/26 at 6:32 PM - 21 minutes 6 seconds 2/18/26 at 6:42 PM - 24 minutes 32 seconds 2/18/26 at 10:54 AM - 16 minutes 14 seconds 2/19/26 at 1:01 PM 27 - minutes 59 seconds 2/19/26 at 5:38 PM - 16 minutes 18 seconds 2/20/26 at 7:39 AM - 40 minutes 28 seconds 2/20/26 at 9:28 AM - 18 minutes 44 seconds 2/21/26 at 5:13 AM - 29 minutes 13 seconds (continued on next page)

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	165546	A. Building B. Wing	03/04/2026

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/21/26 at 6:09 AM - 47 minutes 30 seconds 2/21/26 at 8:44 AM - 20 minutes 45 seconds 2/21/26 at 9:18 AM - 30 minutes 23 seconds 2/21/26 at 5:51 PM - 18 minutes 56 seconds 2/22/26 at 6:59 AM - 17 minutes 12 seconds 2/22/26 at 12:20 PM - 24 minutes 21 seconds 2/23/26 at 5:58 AM - 19 minutes 12 seconds 2/23/26 at 3:24 PM - 16 minutes 58 seconds 2/23/26 at 4:17 PM - 37 minutes 13 seconds 2/23/26 at 6:02 PM - 26 minutes 28 seconds 2/23/26 at 6:46 PM - 17 minutes 53 seconds 2/23/26 at 7:43 PM - 29 minutes 57 seconds 2/23/26 at 9:13 PM - 30 minutes 45 seconds On 2/24/26 at 10:30 AM Resident #26 stated she felt there was not enough staff as she had to wait a long time for call lights at times. On 2/26/26 at 12;40 PM Staff C, Certified Nurse Assistant (CNA), stated they need another staff on the floor, as call lights can take longer than 15 minutes to answer. The staff stated she had call lights that took longer than 15 minutes to answer. On 2/26/26 at 12:50 PM Staff H, CNA/Restorative Nursing Assistant (RNA) stated there have been times when call lights run long, but the staff as a whole try to work together to ensure no lights run longer than 15 minutes. The staff acknowledged she had lights that had run longer than 15 minutes. On 3/2/26 at 11:06 AM Staff T, Registered Nurse (RN), stated she had heard residents complain about call lights and the length of time it takes for staff to answer them. On 3/4/26 at 9:45 AM the DON stated the expectation on call lights was under 15 minutes. On 3/4/26 at 11:25 AM the Administrator stated the facility had changed the call light system in the past year to a phone system and acknowledged the facility needed to continue to work on answering the call lights in a timely manner. The facility's Call Light Policy dated 7/31/2014 disclosed that residents need to have call lights within reach. The document did not include an expectation of length of time for answering a call light.