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

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, staff interviews and policy review, the facility failed to secure prescribed medications from the possibility of unauthorized access. The facility reported a census of 40 residents.Findings included:On 2/25/26 at 3:38 PM, a medication cart was observed unlocked at the nurses' station facing the lobby. Staff A, Registered Nurse (RN) was on the opposite side of the lobby, facing a resident with her back partially positioned toward the medication cart. A vase of flowers was blocking the line-of-site between Staff A and the medication cart. The cart contained gabapentin (anticonvulsant), escitalopram (antidepressant), and multiple blood pressure medications.At 3:40 PM, a confused resident wandered toward the nurses' station as Staff B, RN approached the nurses' station from the other side and confirmed she was not assigned to the cart. She redirected the resident's attention to an activity device on the counter and stated she wasn't going to leave the medication cart unsecured.At 3:42 PM, Staff A stated the medication carts are not typically left unlocked when staff walk away from the cart. She stated she was giving medications to a resident who was yelling that her taxi was waiting on her to go to an appointment. She admitted the cart should not have been left unlocked.On 2/26/26 at 11:28 AM, the Director of Nursing (DON) stated staff should lock the cart if they are going to leave it unattended.An undated document titled Protocol for Medication Administration indicated the carts must be in possession of the Nurse or Medication Aide at all times. When unlocked, the cart must be within eyesight of the nurse or medication aide at all times.

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interview, staff interviews and policy review the facility failed to provide food at an appetizing temperature to 1 of 10 residents reviewed (Resident #24). 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 food was served very cold most of the time. Resident #24 explained she had asked the staff to reheat the food and the staff say they would get the food reheated and the staff would not return. On 2/24/26 at approximately 12:15 PM an observation of the lunch meal room tray plating and delivery revealed:The first room tray was an alternate meal. At 12:16 PM the second room tray was plated with a regular lunch meal.Test plate plated at 12:18 PM and replaced with the second plate that was placed on the delivery cart.Test plate picked up by CNA at 12:20 PM.The plate was delivered to the room for the Resident who originally had the second plate placed on the delivery cart. The test plate was immediately removed from the delivery cart as staff took the residents tray into the room at 12:24 PM and returned to the lunch service to check the temperature of the food by the Staff O who was still serving the lunch meal. One room tray remained on the delivery cart to still be delivered at the time the test plate was removed and taken for temperature check (the second plate that was plated was the second to last plate delivered during room tray delivery). Test plate temperature checked at 12:25 PM.Temperatures of test tray food items: pulled pork 114, french fries 105 and green beans 108On 2/24/26 at 12:40 PM Staff O, Assistant Dietary Manager / [NAME] acknowledged all of the food from the test tray was under temperature. Staff O explained she would like the food to be delivered to the residents room at 135 degrees or higher.On 2/24/26 at 11:32 AM Staff L, [NAME] 1 PM shift stated Resident #24 had complained about cold food and not getting enough food. Staff L explained these concerns were reported by Staff N, Certified Dietary Manager (CDM).On 2/24/26 at 1:15 PM Staff M, [NAME] 1 PM shift stated the holding temperature for food was 145 degrees. Staff M explained there were usually 4 room trays. Staff M stated the temperature of the food arriving in the residents room should also be 145 degrees. On 2/25/26 at 1:12 PM Staff N, CDM stated the temperature of the items of food should be out of the danger zone. Staff N explained the facility does temperatures on test trays frequently. Staff N stated she checked the temperature of the tray for the food that had to travel to the furthest resident room away. Staff N stated she would like the temperatures above 135 degrees when delivered to the residents in the room. 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. Hot foods must be greater than or equal to 135 degrees when served to residents. Trays must be delivered to resident rooms within 5 minutes of plating. If delivery exceeds, temperatures must be rechecked.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interviews, and policy review the facility failed to transport food in accordance with professional standards by stacking food uncovered in bowls on top of each other contaminating the uncovered food. The facility reported a census of 40 residents.Findings include:On 2/24/26 at 11:15 AM an observation of Staff O, Assistant Dietary Manager / [NAME] preparing pureed chocolate gooey cake revealed Staff O obtained chocolate gooey cake from the walk in refrigerator from trays stacked on each other in styrofoam bowl with clear plastic wrap cover, Staff O removed bowls of cake from trays, stacked 2 cakes on each other in one hand, stacked 3 cakes on top of each other in the other hand, cakes had no cover when brought to the table to be processed, cake processed to appropriate consistency and utilized appropriate scoop to replace puree cake in styrofoam bowl.On 2/24/26 at 11:25 AM Staff O acknowledged she should not have stacked the chocolate cakes on top of each other without a protective cover between each. Staff O stated the outside of the bowl should not have come in contact with the item of food. On 2/25/26 at 1:12 PM Staff N, Certified Dietary Manager (CDM) stated when the food was removed Staff O she should not have stacked because the bottom of the bowl would contaminate the food item. Staff N stated she expected the food would have been covered if it was going to be stacked with a lid or a plastic wrap cover. Staff N acknowledged the food should not come in contact with any surfaces that would contaminate the food.Review of an undated policy titled, Meal Preparation documented the purpose of the policy was to establish procedures that ensure food was prepared, handled, and stacked in a manner that maintained food safety, prevents contamination, and complies with Iowa Food and Drug Code requirements. Stacking food items during preparation must follow safe practices to prevent cross contamination and ensure temperature control. If foods are plated and stacked before service, stacking must not compromise hygiene.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews and policy review, the facility failed to maintain medical records that are complete and accurately documented for 1 of 14 residents (Resident #4). The facility also maintain confidentiality of residents' records during medication administration. The facility reported a census of 40 residents. Findings include:1. The Minimum Data Set (MDS) dated [DATE] for Resident #4 revealed a Brief Interview for Mental Status (BIMS) score of 4/15 indicating severe cognitive impairment. The document included resident diagnoses of Alzheimer's, Non-Alzheimer's Dementia, and depression. The resident did not have any falls in the previous reporting period. Resident #4's Care Plan last revised 2/13/26 contained a focus of high risk for falls (10/30/25) with interventions of call light within reach and follow facility fall protocol (10/30/25). A focus area of having an actual with no injury dated 10/30/25 contained staff interventions of chair/bed alarm (12/12/25), continue interventions on the at-risk plan (10/30/25), and hospice fall mat (2/13/26). The clinical record's Progress Notes entry on 2/24/26 at 9:05 PM revealed Staff V, Licensed Practical Nurse (LPN) was summoned to Resident #4's room and observed the resident sitting on the floor with her back against the bed. Temperature, pulse and respiration checks 97.5-68-18 and the resident refused blood pressure (B/P). The staff noted approximately 1 inch x .25 inch abrasion to mid left side of back, area cleansed with soap and water. The entry included the resident was assisted onto her bed with dependent full body lift and 3 staff assistance, the bed was in lowest position prior to fall, and neuro checks were initiated due to fall being unwitnessed. Staff V entered the note on 2/24/26 at 10:55 PM.Staff V completed the facility's Un-witnessed Fall document with indication of a fall on 2/25/26 at 9:05 PM. The document provided a Certified Nurse Assistant (CNA) summoned the nurse to the room at 9:05 PM and the resident was observed sitting on the floor next to the bed, back to the mattress with legs extended. The staff noted a 1 x .25 abrasion-like area to the mid left back which was cleansed with soap and water, full range of motion (ROM) to extremities and no complaints of pain. The resident refused B/P, temperature, pulse and respiration checks 97.5-64-18. The document included the resident was lifted from the floor with a dependent mechanical lift with the assistance of 2 staff, the bed was in the lowest position at the time of the fall, a fax was sent to the physician for notification and neuro checks were initiated. The Neurological Flow Sheet provided the following:Staff V completed the first entry at 9:05 PM with pupil size equal and reactive equally, hand grasp equal and strong, speech clear, refused B/P and pulse, respiration 18, and temperature 97.5.Staff V's entry at 9:20 PM included refusal of B/P, pulse 68, respiration 18, and temperature 97.5.Entries beginning at 10:50 PM for level of consciousness indicated the resident was sleeping until 7:00 AM with hand grasps, pupil size, reaction and speech assessed and documented. Entries beginning at 11:20 PM for speech, B/P, Pulse included the resident was sleeping and not assessed. On 3/3/26 at 2:52 PM Staff V stated she did not actually respond to the call for assistance as she was down the hall. The staff stated Staff W, LPN, responded to the call. Staff V stated by the time she got there, Staff W had completed the assessment, got Resident #4 back into bed and gave the report of what had happened. Staff V stated she did not witness the fall or assess Resident #4.On 3/3/26 at 3:10 PM Staff W stated she was notified by Staff S, CNA, of need for assistance as Resident #4 was on the floor. The staff stated upon entry the resident was seated on the floor mat with her back against the bed and the bed was in a low position. Staff W stated she completed the assessments of ROM and pain with no abnormal findings. The staff stated then she and 2 CNAs assisted the resident back into bed. Staff W acknowledged she had Staff V complete the documentation of the assessment and fall, but could not give justification as to why. On 3/3/25 at 4:22 PM Staff S stated she heard Resident #4's bed alarm going off with the resident calling for help. The staff stated she found the resident seated on the floor mat with her back against the bed with her (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	legs stretched out. Staff S stated she did observe the bed control on the bed and the bed higher than what she had placed it around 8:00 PM when she put the resident to bed. The staff stated when putting the resident to bed she placed the bed in the lowest position with a fall mat present and upon entry into the room the resident was no longer in that position. Staff stated she called for assistance with Staff W and Staff X, CNA, responding. Staff S stated Staff W did some assessment while the resident was on the floor, and then the 3 staff assisted the resident back into bed. Staff S stated Staff W left the room and came back and completed vital assessments. Staff S stated Staff V did not assess the resident at the time of the fall. Staff S stated she witnessed Staff V talking with Staff W at the nurses station discussing the documentation of the fall. On 3/3/26 at 4:26 PM Staff X stated she could not remember all the details of the fall but did acknowledge she, a nurse and CNA S picked the resident up and put her into bed. On 3/4/26 at 9:40 AM the Director of Nursing (DON) reviewed the neuro assessments and stated if the resident was documented as sleeping the staff should not have documented hand grasp and pupil size/reaction as the resident would need to be awake for those assessments. The DON stated the documentation in the medical record needs to be completed by the nurse who is completing the assessment.On 3/4/26 at 12:00 PM the Administrator stated he felt a licensed nurse would want to complete the documentation of her assessments and not depend on someone else to document correctly what was completed. 2. Continuous observation of Staff A, Registered Nurse (RN), on 7/24/26 beginning at 7:00 AM - 7:35 AM completing medication administration. Observed the staff enter Resident #22's room leaving the laptop computer on the medication cart open and the screen not locked. Observed the nurse's paper notes face up on the cart with documentation readable. Staff A entered Resident #27's room not locking the computer and leaving documentation papers readable to others on the medication cart. On 2/26/26 at 12:30 PM the Administrator acknowledged that computers were not to be left open and nurse's documentation papers were not to be left open and viewable by others.On 2/26/26 at 1:15 PM the DON stated nurses cannot leave computers unlocked and documentation pages uncovered on the medication carts when walking away from the carts. The facility's Health Insurance Portability and Accountability Act (HIPAA)/Privacy Safeguarding and Storing Protected Health Information Policy and Procedure revealed active medical records should not be left unattended in any areas where residents, visitors and unauthorized individuals could easily view the records.

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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. 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 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevent improper uses and disclosure of PHI that is or would be, contained in a resident's medical record.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on clinical record review, interviews and policy review the facility failed to provide a Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN), Form Center for Medicare Services (CMS)-10055 or Notice of Medicare Non-Coverage (NOMNC), Form CMS 10123-NOMNC, for 2/3 residents reviewed (Resident #26, #11). The facility failed to provide the residents notification of the changes as soon as the change in coverage was made available. The facility reported a census of 40. Findings include:1. The Discharge Notification from therapy dated 8/31/25 for Resident #26 indicated the last treatment date for therapy would be on 9/4/25 and the discharge date would be 9/5/25. Resident #26 signed a NOMNC, Form CMA 10123-NOMNC approved 12/31/11, on 9/2/25 indicating coverage of therapy services would end on 9/5/25. Resident #26 signed the SNF-ABN form on 9/5/25 indicating the resident would begin occurring costs for therapy on 9/6/25 if electing to continue therapy services. The facility failed to provide the resident the document the charges that would occur prior to the last date of covered services. The facility failed to provide consistent dates on the last date of therapy services and discharge based on the notification from the therapy department. 2. The Discharge Notification from therapy dated 1/13/26 for Resident #11 indicated the last treatment date for therapy would be on 1/20/26 and the discharge date would be 1/20/26 as all goals were met and the resident was discharging home at prior level of function.Resident #11 signed a NOMNC, Form CMA 10123-NOMNC approved 12/31/11, on 1/20/26. The facility failed to provide the resident with the documentation of notification of ending of services prior to the discharge date . On 3/3/26 at 12:25 PM the Assistant Administrator/Billing Manager stated he had been completing audits since the last annual survey to improve the process, and had begun to decrease the audits. On 3/3/26 at 12:45 PM the Administrator stated audits were being completed in several areas with hopes to improve the processes in the facility.On 3/3/26 at 4:00 PM the Assistant Administrator/Billing Manager acknowledged documents regarding NOMNC and SNFABN needed to be provided as soon as notification for discontinuation of therapy services was made. The facility's ABN Policy, revised 3/25/25, revealed the facility must issue a SNFABN before providing services may not be covered ensuring the resident understands their financial liability. The document further included that the ABN must be given before reducing services that the facility believes Medicare will not pay for and allow the beneficiary time to sign the form and ask questions.

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, clinical record review, staff interviews, and policy review, the facility failed to complete an accurate comprehensive assessment for 1 of 1 resident (#29). The facility reported a census of 40 residents.Findings include:On 2/23/26 at 11:48 AM, Resident #29 stated she was hard of hearing and has been trying to get hearing aids but her insurance would not cover them.The Baseline Care Plan dated 3/27/25 revealed the resident was hearing impaired.The Care Plan dated 3/31/25 included a hearing deficit focus category and directed staff to validate the resident's message by repeating aloud.The Appointment Note dated 10/21/25 at 2:33 PM revealed the facility was waiting for the resident's Ear, Nose, and Throat (ENT) provider to supply a phone number for the facility to contact the resident's insurance company about hearing aids.Resident #29's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 07 out of 15 which indicated severely impaired cognition. It included diagnoses of heart failure, depression, and bilateral hearing loss. It indicated she required supervision with bathing and shower transfers, dressing, personal hygiene, and ambulating 150 feet and was independent with all other Activities of Daily Living (ADLs) and mobility. It documented she had adequate hearing without hearing aids or other hearing appliances.The Appointment Note dated 12/17/25 at 11:49 AM revealed the facility was waiting for a mobile hearing service response to schedule a hearing test.On 2/24/26 at 2:07 PM, the MDS Coordinator stated she coded the MDS as adequate hearing because the resident did not say she had a hard time hearing her and resident responded as though she was able to hear. She confirmed her assessments are based solely on her interactions with the residents unless there is something in the progress notes. She stated she did not catch the prior notes about the resident's hearing deficit.On 2/24/26 at 2:20 PM, Staff C, Certified Nurse Aide (CNA) stated she has to talk to Resident #29 with an elevated voice because she doesn't think the resident can hear very well.On 2/26/26 at 11:32 AM the DON stated the MDS should be accurate and follow the diagnoses.An undated policy titled Minimum Data Set (MDS) Accuracy and Documentation Integrity indicated every MDS item must accurately reflect the resident's status during the defined look-back period (observation period) ending at 11:59 PM on the Assessment Reference Date (ARD). It also directed staff before transmission, the RN Coordinator will verify that encoded data matches clinical documentation. Any discrepancies must be corrected during the 7-day encoding period.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, and policy review the facility failed to provide the needed services in accordance with professional standards for 1 of 14 residents (Residents #45). The facility failed to complete/document wound treatments per physician orders and failed to administer oxycodone per physician orders. The facility reported a census of 40 residents. Findings include:The Minimum Data Set (MDS) admission for Resident #45 dated 2/21/26 provided a BIMS score of 15/15 indicating normal cognition. The document revealed the resident had diagnoses of severe life threatening blood infection, diabetes and a rare flesh eating bacterial infection. The document revealed the resident had an open lesion and had the interventions of a pressure reducing device for the bed, repositioning program and application of nonsurgical dressings. Resident #45's Care Plan dated 2/24/26 contained a focus area of wound management dated 2/20/26 with interventions of measuring wound on regular intervals, monitoring for signs of infections, and wet to dry dressing changes twice daily dated 2/20/26.The clinical record contained a verbal order on 2/18/26 at 8:40 AM for wet to dry dressing 2 times daily to affect area and wound care clinic referral. The order was signed by the physician and noted on 2/18/26. The clinical record's Physician Orders revealed wet to dry dressing 2x daily to perianal. Pack wound with wet (Dakins/[NAME]) kerlix/gauze, cover with ABD secure with tape every day and night shift for perianal wound. The document disclosed entry at 4:53 PM with a start of 2/18/26 at 5:00 PM.The clinical record's Progress Notes did not contain the verbal order received from the physician for wound care/dressing changes that occurred on 2/18/25 at 8:40 AM. The Progress Notes contained an entry at 2/18/26 at 4:56 PM indicating receiving the returned fax from the physician for the wound care treatment. The entry further contained an entry regarding treatments provided and the appearance of the wound, as well as its size. The Treatment Administration Record (TAR) 2/26 revealed the entry for the order of dressing changes for day and HS (evening). The document disclosed the following:2/18 hour of sleep (HS) no entry for treatment.2/19 day and HS no entries for treatment.2/20 day and HS no entries for treatment.2/25 HS no entry for treatment.2/26 HS no entry for treatment.The Medication Administration Record (MAR) 2/26 revealed an order for Oxycodone/APAP Tab 5-325 mg, 1 tab twice daily as needed. The order disclosed on 2/20/26 Resident #45 received the medication at 4:23 AM, 3:54 PM, and 8:23 PM for a total of 3 doses in 1 day.On 2/25/26 at 11:30 AM Staff B, Registered Nurse (RN) stated as staff she cannot see all missed treatments/medications on clinical record (electronic). The staff acknowledged she had seen items in red when opening the Medication Administration Record (MAR)/TAR meaning something had not been completed on the previous shift. Staff B stated she did not see Resident #45 for the first few days he was in the facility past the day of admission as she was off. The staff stated the day of admission the resident did not have wound orders. Staff B stated when she returned she knew the resident did not have orders on his TAR for wound treatments. The staff stated she did provide a treatment for the resident as she had been told to do a wet to dry dressing with saline on the resident. The staff then stated she saw the resident for the first time with the DON as the DON was going to complete the treatment and take measurements of the area. The staff acknowledged she should have put an order onto the TAR when she saw there wasn't one present but she didn't. The staff stated the resident should not have gotten the pain medication 3 times in a day when only ordered for twice as needed. On 3/2/26 at 11:06 AM Staff T, RN, stated she recalled entering the order for the dressing change and was then off for the next couple of days. The staff stated when she returned she noted the order was not on the TAR as it had not been populated. Staff T stated she was able to go into the medical orders and populate the order to the TAR.On 3/4/26 at 9:50 AM the DON stated she did not know why the documentation was not completed for Resident #45 on the TAR for wound treatments for the 18th-20th as she had been present for one of the treatments and no entries for the 25th and 26th. The staff stated the resident should not have been provided 3 Oxycodone when the order was (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	written for 2. The DON stated the expectation was to provide and document orders as written.On 3/4/26 at 11:15 AM the Administrator stated that orders should be followed and documentation should be completed without holes reflected in the record. The policy titled Protocol for Medication Administration dated 1/8/26 documented the purpose is to assure all medication is administered within state and licensing guidelines/regulations and in accordance with policy and procedures and physician orders. Review of a policy updated 3/18/25 titled, Protocol for Documentation documented the purpose was to ensure all patients information was being documented. All new orders shall be documented in the nurses notes along with the following information: any clarifications that may need to be made, notification of responsible party, notification of the pharmacy, notification of therapy or other documentation if applicable. Wound care notes should state the treatment provided, the appearance of the wound in detail, and any new concerns noted during treatment.

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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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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.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and provider interview, the facility failed to assist the resident to obtain hearing devices through possible available resources for 1 of 1 resident (#29). The facility reported a census of 40 residents.Findings include:On 2/23/26 at 11:48 AM, Resident #29 stated she was hard of hearing and has been trying to get hearing aids but her insurance would not cover them.The Care Plan dated 3/31/25 included a hearing deficit focus category and directed staff to validate the resident's message by repeating aloud.The Appointment Note dated 10/21/25 at 2:33 PM revealed the facility was waiting for the resident's Ear, Nose, and Throat (ENT) provider to supply a phone number for the facility to contact the resident's insurance company about hearing aids.Resident #29's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 07 out of 15 which indicated severely impaired cognition. It included diagnoses of heart failure, depression, and bilateral hearing loss. It indicated she required supervision with bathing and shower transfers, dressing, personal hygiene, and ambulating 150 feet and was independent with all other Activities of Daily Living (ADLs) and mobility. It documented she had adequate hearing without hearing aids or other hearing appliances.The Appointment Note dated 12/17/25 at 11:49 AM revealed the facility was waiting for a mobile hearing service response to schedule a hearing test.On 2/24/26 at 8:44 AM, Staff D, Certified Nurse Aide (CNA) stated Resident #29's insurance would not pay for her hearing aids.On 2/24/26 at 1:37 PM, the Assistant Administrator (Asst Admin) stated he was not aware of the hearing aid process delay in the aforementioned progress note until he spoke to the Director of Nursing earlier in the day. He also stated the process for insurance related communication was for staff to notify him directly.On 2/24/26 at 1:52 PM, Staff E, Certified Medication Aid (CMA) stated the resident's ENT provider did not state they could not provide the resident with hearing aids but supplied her with a list of hearing aid providers contracted by the resident's insurance. Staff E stated she made multiple attempts to contact the resident's insurance provider on 12/17/25 and was informed they would call her back, but never did. She further stated she forgot about it until the date and time of this communication. She revealed she usually talks to the Director of Nursing (DON) or the MDS Coordinator when she is communicating with insurance providers and is expecting return calls. She also stated she does not know of any official process in place for communication of insurance barrier situations.On 2/24/26 at 2:02 PM, the MDS Coordinator stated she knew the resident had gone for a hearing test but was not aware of the hearing aid insurance barrier until the DON asked her to contact the hospital on 2/24/26.On 2/24/26 at 2:13 PM, the DON stated she was not aware of the hearing aid insurance barrier until 2/24/26.On 2/24/26 at 2:20 PM, Staff C, Certified Nurse Aide (CNA) stated she has to talk to Resident #29 with an elevated voice because she doesn't think the resident can hear very well.On 2/26/26 at 11:32 AM, the DON stated staff should've notified her or the MDS coordinator of the ongoing hearing aid communication attempts.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tabor Manor Care Center	209 Main Street Tabor, IA 51653

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, interviews, and policy review, the facility failed to monitor a pressure area in a manner to reduce the risk of wound development and failed to implement offloading procedures to decrease pressure for 1 of 1 residents reviewed (Resident #4). The facility reported a census of 40 residents.Findings include:Resident #4's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 4/15 indicating severe cognitive impairment. The document included resident diagnoses of Alzheimer's, Non-Alzheimer's Dementia, and depression. The document disclosed the resident had an unstageable pressure ulcer due to coverage of the wound bed by dead hard tissue. The MDS included skin treatments including a pressure reducing device for chair, bed, pressure ulcer/injury care, application of dressings to feet and the resident utilized a wheelchair (w/c)The resident's Care Plan dated 2/13/26 contained a focus area of potential/actual impairment to skin integrity revised on 11/8/25 with staff interventions of monitoring/documenting location, size and treatment of skin injury, dependence on staff for wound care, assistance to apply protective garments (cushion boot) dated 11/8/25. The 2/26 Treatment Administration Record (TAR) contained an order to apply Betadine to the right lateral heel every night shift with a start date of 12/2/25 at 10:00 PM. The document provided the following entries for the order:No documentation on 2/3/26 indicating the treatment was completed. The M line contained 10 entries with measurements, 7 entries with Y, 8 entries with X, 2 entries with NA.The Note line contained 22 entries of yes or Y, 3 entries of no or N, 2 entries with NA.The Night line contained staff initials with completion indicated, 1 entry for refused, 2 entries for sleeping. The clinical record document Skin Issues dated 2/19/26 - in progress disclosed the resident had a new issue on the right heel, pressure - Kennedy terminal ulcer/End of Life that was improving and unstageable. The document included it was inhouse acquired, chronic over 3 months and measured length .75 cm x width 1.16 cm, no depth and area .65 cm squared. The clinical record document Skin Issues dated 2/27/26 - in progress disclosed the resident had a new issue to the right heel, pressure ulcer/injury that was improving and unstageable. The document included it was inhouse acquired, chronic over 3 months and measured length 1.5 cm x width 3.5 cm, no depth, no area. The clinical record Skin and Wound - Total Body Skin assessment dated [DATE] identified a new wound but did not provide measurements. The clinical record Skin and Wound - Total Body Skin assessment dated [DATE] did not identify a pressure ulcer or provide measurements. The clinical record Skin and Wound - Total Body Skin assessment dated [DATE] did not identify a pressure ulcer or provide measurements. The clinical record Skin and Wound - Total Body Skin assessment dated [DATE] did not identify a pressure ulcer or provide measurements.The clinical record Progress Notes reviewed from 10/15/25 - 3/3/26 contained the following entries: 10/15/25 2:37 PM Resident #4 had a deep tissue injury to the right lateral heel measuring 1.5 cm x 3 cm; the heels were floated in bed and a boot was applied. The entry included notification to the physician for treatment orders.10/29/25 9:00 AM the resident continued to wear a pressure relieving boot.11/21/25 11:47 AM the right lateral heel measured 1.5 inches x1 inch and was hard, dark black/brown.1/10/25 5:16 AM dark coloring of the heel and measured 1.5 inches x1 inch.2/9/26 4:17 AM the right lateral heel is brown, flaky in appearance and measured 2 cm x 1.5 cm circular in shape. 2/19/26 at 3:43 PM light brown scabbed area on right heel, no pain 0.75 cm x 1.16 cm. 3/3/26 at 4:55 AM the right heel measured 2 cm x1.5 cm. Observed on 2/23/26 at 1:36 PM the resident's picture cue card above the bed indicated a pressure boot for the right foot. The resident was seated in her w/c. Observed on 2/24/26 at 2:05 PM Staff D, Certified Nurse Assistant (CNA)/Restorative Nursing Assistant (RNA) and Staff J, Certified Medication Aide (CMA) bring the resident in her w/c wearing only socks to her room for personal care and repositioning. Following personal care, the resident was positioned in bed without the use of heel protector/boot. Observed on 2/25/26 at 10:55 AM observed a heel protector (blue foam bootie) on the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's recliner. Observed on 2/25/26 at 11:13 AM observed the resident seated in her w/c wearing only socks with her feet touching the footrests. Observed on 2/25/26 at 2:39 PM the resident was wearing only socks while seated in her w/c. Observed on 2/26/25 at 12:22 PM 2 foam heel protectors on the resident's recliner and the resident seated in her w/c without a foot protector. Observed on 3/4/26 at 10:35 AM the resident seated in her w/c without wearing a heel protector. On 2/25/26 at 11:10 AM Staff D stated she did not typically work with Resident #4. The staff stated to know about a resident she would look at the Care Plan. The staff stated the picture diagram on the walls in the residents' rooms assists the staff know what kind of assistance a resident needs with transfers, care. Staff D stated Resident #4 had had a heel protector and did not know if one was still required. The staff stated she was not aware of any pressure areas on the resident and had not observed any pressure areas when completing care the previous day. On 2/25/26 at 11:30 AM Staff B, Registered Nurse (RN), stated she was not sure if orders were obtained for the use of pressure relief boots. The staff stated it would make sense to be on the TAR to ensure they were used. The staff stated she did not know if Resident #4 had heel protectors and could not speak to the resident's treatment as it was completed on the night shift. On 2/25/26 at 1:50 PM Staff A, RN, stated if a resident had a heel protector it would typically go on the Medication Administration Record (MAR)/TAR ensuring nursing could monitor the protective equipment being used with the staff giving examples of other residents who utilized pressure relieving devices. On 2/25/26 at 3:44 PM Staff R, CNA, stated she would know if a resident needed a heel protector by looking at the picture diagram/chart posted in a resident's room.On 2/26/26 at 9:10 AM Staff H, CNA/RNA, stated she would know if a resident required a heel protector by the picture system on a resident's wall. When asked when the device would be used, the staff stated she would assume on in the morning and off at night or would ask the nurse. On 2/26/26 at 9:30 AM Staff C, CNA, stated she would know to use the heel protectors if it was represented on the wall. The staff stated she would think the heel protectors would be used when the resident is in bed. On 3/3/26 at 9:50 AM and 12:15 PM the Director of Nursing (DON) stated the resident's heel initially was all black and covered the heel. The DON indicated she would look at the Progress Notes for monitoring the progress of the heel with the notes coming from the Electronic Medical Administration Record (EMAR). The DON stated she had recently started completing Skin Issues Assessments in the past few weeks due to concerns raised by herself and the Administrator regarding the consistency of measurement and documentation of the wounds. The staff stated the assessments she completed included photos of the wounds and with a recent update to the electronic record it showed documents that contained photos as in progress versus completed. The DON stated with the use of the photo program it automatically completed the measurements of the wound and was still working to get the consistency with the program. The staff stated the resident's pressure ulcer was improving and not regressing as indicated by the most recent automated measurement. The DON stated interventions for the pressure ulcer included the iodine treatment, no shoes and heel cushion. The staff stated the heel cushion was supposed to be on the right foot and the resident had a history of messing with it. The DON stated it was suspected the issue with Resident #4's heel came from either her shoe or hitting her foot on the w/c pedal. The DON stated the resident was supposed to wear the heel boot while she was up in her w/c. The DON indicated the boot was referenced on the Care Plan, but acknowledged it did give staff directions on when to use it. The DON further concurred the picture system on the resident's wall did not give directions as to what times the boot should be worn. The DON stated the facility did not typically get physician orders for use of pressure devices as they were considered nurses orders. The staff stated without it being on the TAR it would be difficult for staff to monitor the use of the device and other residents did have pressure devices on their TARs. The DON stated she could not speak to why Resident #4 did not have her boot placed on the TAR and the boot should still be used. The DON stated her expectation was the treatments be completed as ordered and the resident's TAR was to have daily measurements of the wound, and a note entered. On 3/3/26 at 12:45 PM the Administrator stated he had been made aware (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the concern with Resident #4's pressure ulcer. The Administrator stated the facility was making a change in monitoring of the wounds and would continue to complete audits to improve this area of concern. The facility's Policy and Procedure for Skin Inspection and Pressure Injury Prevention, updated 11/25, provided there would be documentation of all assessments in the resident's medical record with inclusion of date, time, interventions, reassessment schedule and staging. The document included the daily dressing changes required descriptive wound note from the nurse and interventions included repositioning schedules based on the risk level, use of pressure relieving devices, skin care protocols and nutrition/hydration support. The facility's Protocol for Wound Assessments, updated 2/28/24, included that wound and skin concerns were tracked and evaluated to ensure interventions were working in a timely manner and to prevent further breakdown. The document included skin assessment would be completed in the clinical record weekly with measurements.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review the facility failed to develop programs maintaining residents strength, range of motion (ROM), mobility needs based on the comprehensive assessment and under the direct guidance of a Registered Nurse (RN) for 2 of 14 residents reviewed (Resident #26, #45). The facility reported a census of 40.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 included the resident had functional limitations of ROM in both the upper and lower extremities. The document further disclosed the resident received 4 days of passive range of motion (PROM), 3 days of active range of motion (AROM), 2 days of splint or brace assistance, 5 days of bed mobility, 5 days of transfers and 1 day of dressing and/or grooming of least 15 minutes in the last 7 calendar days.Resident #26's Care Plan dated 1/27/26 contained a focus area related to the Restorative Nursing Program initiated and revised on 1/5/26 by the Director of Nursing/RN. The interventions for staff to follow included specific resistive exercises, bed mobility, PROM, splint/brace,and transfers revised by Staff Y, Restorative Nursing Assistant (RNA) on 1/19/26. On 2/23/26 at 3:02 PM Resident #26 stated she wanted to be walking more and she was supposed to be getting a new leg brace and the staff had told her they would work with her on the uneven bars.On 2/26/26 at 8:33 AM Staff D, Certified Nurse Assistant (CNA)/RNA stated Resident #26's Restorative Nursing Program included PROM to the left upper extremity (LUE) and left lower extremity (LLE), splint for the LUE, brace for LLE, attending morning group exercise, and use of the NuStep (low impact seated upper and lower extremity exercise machine). The staff stated she was not aware of the resident getting a new brace for her leg. Staff D stated she created Resident #26's Restorative Nursing Program on 12/28/25 when the resident re-admitted to the facility. The staff stated if a resident presented without AROM of an extremity, she would immediately go to PROM. When asked how far she would passively stretch a resident, Staff D replied go until you feel resistance. Staff D stated the training she had received for completing Restorative Nursing Programs was by Staff Y and Staff U, Administrative Assistant, who used to complete Restorative Nursing Programs. The staff stated she had been working in Restorative Nursing for almost a year. The staff stated she referred to the resident's Care Plan for the Restorative Nursing Program. 2. Resident #45's MDS Export Ready dated 2/21/26 revealed a BIMS score of 15/15 indicating normal cognition. The document revealed the resident had diagnoses of severe life threatening blood infection, diabetes and a rare flesh eating bacterial infection. The document disclosed the resident was independent with dressing, toileting, bed mobility, transfers and required supervision for walking distances of 150'. The document included the resident did not have limitations in ROM. The document disclosed the resident received at least 15 minutes of AROM 3 days, bed mobility 4 days, transfers 4 days and dressing and/or grooming 4 days in the last 7 calendar days. The resident's Care Plan dated 2/24/26 included a focus for restorative initiated 2/18/26 with staff interventions of ambulation, AROM, bed mobility, dressing and/or grooming, and transfers initiated and revised by Staff Y on 2/18/26. The self-care performance deficit focus area initiated and revised 2/23/26 included staff interventions of independence with bed mobility, dressing, toileting, and personal hygiene initiated and revised 2/23/26.The clinical record provided the resident was admitted on [DATE].On 2/25/26 at 12:51 PM Resident #45 stated he had only attended Restorative Nursing 1 time since his admission on [DATE]. The resident stated he had an exercise band in his room that he had brought with him that he used for independent exercise and that the facility staff had given him a stronger resistance band for him to use and could get a stronger one if he wanted. On 2/26/26 at 8:27 AM Staff D stated Resident #45 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	used overhead pulleys for 1-5 minutes, bicep curls with and without weights (1-2#), and AROM for his LEs. The staff stated the resident was independent in his room. The staff stated Staff Y wrote the Restorative Nursing Program on the Care Plan on 2/18/26. On 2/26/26 at 9:45 AM Staff Y stated if a resident came into the facility with skilled orders for therapy, Restorative Nursing would wait until the resident was finished and then therapy would give directions on what the resident could do. Staff Y stated if a resident did not have therapy orders, she would do an assessment to determine what the resident can and can't do for basic exercises, ambulation. The staff stated she would give the ideas to the MDS Coordinator or the DON if the MDS Coordinator wasn't available, and then start the program. The staff stated she received training on the completion of Restorative Nursing Programs from Staff U. On 2/26/26 at 1:20 PM Staff U stated she was self taught on the Restorative Nursing Program many years ago. The staff stated she did a lot of internet searches to learn about exercises and ROM. The staff stated when she was completing Restorative Nursing therapists were more prevalent in the building and she may observe them. However Staff U stated her primary knowledge was obtained from books and the internet without any formal training on Restorative Nursing. On 3/3/26 at 10:10 AM the DON stated the MDS Coordinator works more directly with the RNAs and oversees the staff. The DON acknowledged the MDS Coordinator was a Licensed Practical Nurse (LPN). The DON stated the RNA will write the programs, take to the MDS Coordinator and then give to the DON. The DON stated the RNAs can write programs and put them in the residents' Care Plans. The staff stated when developing the programs they use feedback from the RNAs and the residents. When asked about residents who may not be able to provide feedback, the DON indicated that more of the feedback was taken from the RNAs. The DON stated if a resident had specific needs, the facility would request therapy orders for assistance in developing a program. When asked for documentation indicating the DON had been actively involved with the program development and not done by a RNA, the DON acknowledged the documentation did not provide that information. The DON stated she reviewed the Care Plans quarterly. The DON stated she was not aware of the training the staff had for working in the Restorative Nursing Program. The DON stated RNA's should not be assessing residents for program development and changes, and there needed to be more formal training for RNA staff.The facility's Restorative Policy dated 1/24/23 revealed a restorative program would be started upon admission for AROM, PROM, strengthening and self care. The document disclosed the programs would be set up by the restorative supervision and MDS/Care Plan Coordinator. The programs will include 3 days a week and 7 days a week upon Care Plans and Skilled Care.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, policy review, resident interview and staff interviews the facility failed to provide respiratory services in accordance with professional standards of practice for 1 of 2 residents reviewed (Resident #24) who required the use of a Continuous Positive Airway Pressure (CPAP) machine. 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. The MDS documented Resident #24 had a diagnosis of obstructive sleep apnea.On 2/23/26 at 11:03 AM Resident #24 stated none of the facility's staff have ever cleaned her CPAP machine. Resident #24 stated she had not had her CPAP mask or machine cleaned at all since admission to the facility.On 2/23/26 at 11:10 AM an observation of Resident #24's CPAP machine revealed speckled white sediment covered the outside of the machine. [NAME] haze colored water present in the reservoir. The CPAP machine's mask had cloudy white sediment and film on the inside with dry red [NAME] on areas of the mask.Review of Resident #24's Care Plan revealed no documentation that Resident #24 would clean her own CPAP machine or mask.Review of Resident #24's Treatment Administration Record (TAR) revealed no orders for cleaning of Resident #24's CPAP machine or maskOn 2/26/26 at 12:00 PM Staff A, Registered Nurse (RN) stated she had never cleaned Resident #24 CPAP machine or mask. Staff A stated she thought that Resident #24 cleaned her own machine. Staff A acknowledged if Resident #24 cleaned her own CPAP that would be documented on the care plan and the TAR. Staff A stated she thought CPAP masks were cleaned every am shiftOn 2/26/26 at 12:15 PM Staff P, Licensed Practical Nurse (LPN) stated she had never cleaned Resident #24 CPAP machine or mask. Staff P stated she thought that Resident #24 cleaned her own machine. Staff P stated Staff B usually worked with Resident #24 in the morning.On 2/26/26 at 2:03 PM Staff B, RN stated she had never cleaned the CPAP machine. Staff B stated Resident #24 does all of that herself. Staff B explained typically for all the other residents she would complete that task for them on the am shift every morning. Staff B stated if the resident completed her own cleaning of the CPAP it would be in the care plan. Staff B acknowledged she worked with Resident #24 frequently. On 2/26/26 at 12:57 PM the Director of Nursing (DON) stated Resident #24 told her that she would clean her own CPAP machine and did not need nursing staff help. The DON stated the resident should have a care plan that indicated Resident #24 would complete the cleaning of the CPAP machine on her own. The DON acknowledged Resident #24's care plan did not have any documentation that she would clean her own CPAP machine. The DON explained the TAR would also have an order to clean Resident #24's CPAP mask if facility staff were going to clean it. The DON acknowledged the TAR did not have an order.Review of policy revised on 6/26/23 titled, CPAP and Nebulizer Cleaning and Storage documented the policy was developed to ensure all CPAP and nebulizer equipment was cleaned and disinfected according to manufacturer instructions for use. Stored in a manner that prevents contamination. Assigned to individual residents when required. Maintained and documented per CMS and facility Infection Prevention and Control Program.

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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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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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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.

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

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, interviews and policy review the facility failed to ensure medication error rates were not 5 percent or greater by having a medication error rate of 8.33 percent. The facility reported a census of 40 residents.Findings include: 1. The Minimum Data Set (MDS) dated [DATE] documented Resident #22 had a Brief Interview of Mental Status (BIMS) score of 11/15 indicating moderate cognitive impairment. The resident's Care Plan 2/15/26 did not contain a focus area or intervention for independent medication administration. Observed on 2/24/26 at 7:00 AM Staff A, Registered Nurse (RN), obtained the following medications: 1 vial of Ipratropium-Albuterol Inhalation Aerosol Solution 20-100 MCG/ACT, Milvexian 25 mg, Levothyroxine 88 MCG, acetaminophen 500 mg (2), aspirin 81, Cymbalta 30 mg, Levetiracetam 500 mg, Meloxicam 15 mg, Pantoprazole 40 mg, Senna 8.6 mg and Cholecalciferol 25 mcg and took them with a cup of water to the Resident #22's room. The staff provided the medications to the resident, and poured the vial into the canister of the nebulizer. Staff A did not start the nebulizer. The staff exited the room and completed the documentation on the electronic medical record.Review of the Resident #22's Medication Administration Record (MAR) 2/26 on 2/24/26 at 7:20 AM revealed the following:Ipratropium-Albuterol Inhalation Aerosol Solution 20-100 MCG/ACT 1 vial inhale orally 3 times a day for wheezing with a start date 1/31/24 at 8:00 PM. The order was marked as completed taking 15 minutes to complete.Meloxicam 15 mg tablet - take 1 tablet by mouth daily, take with food for other specified disorders of bone density and structure right shoulder, fibromyalgia with a start date of 12/17/25 8:00 AM. Observed on 2/24/26 at 7:23 AM Resident #22 turn the nebulizer on and place the mouth piece in her mouth. Observed on 2/24/26 at 7:24 AM Resident #22 turn the nebulizer off and walk to the bathroom.Observed on 2/24/26 at 7:27 AM Resident #22 returned to her bedside, threw some trash away and sat on the edge of the bed.Observed on 2/24/26 at 7:35 AM Resident #22 had not turned the nebulizer back on.Observed on 2/24/26 at 8:00 AM Resident #22 was at breakfast. Observed 2/24/26 at 8:10 AM Resident #22's nebulizer canister contained the Ipratropium-Albuterol Inhalation Aerosol Solution. On 2/24/26 at 8:13 AM the Director of Nursing (DON) observed the nebulizer canister and acknowledged the resident had not completed nebulizer treatment. Staff stated the resident did not have an order for self administration of medication. The DON stated to self administer a medication, a resident must have an assessment and it would be in the Care Plan that the resident could self administer medications. The DON stated the staff should not set up the medication, walk away and document that the medication was completed when it was not completed.On 2/24/26 at 11:10 AM the DON stated if a medication (Meloxicam) contained an order to provide with food then the medication should have food. The DON stated that providing the medication at 7:00 AM and breakfast not served until 8:00 AM was too long without food, especially if the medication was only provided with water. 2. Resident #27's MDS dated [DATE] revealed a BIMS score of 10/15 indicating moderate cognitive impairment. Observed on 2/24/26 at 7:10 AM Staff A prepare Resident #27's medications including Omeprazole 20 mg, aspirin 81 mg, Dulera 200/5 inhaler, Fluticasone, Duloxetine 60 mg, Guaifenesin 20 mg, PreserVision ARED 2+ Multi Vital, Torsemide 20 mg and Cholecalciferol 125 mcg. The resident was provided her medications with a glass of water followed by her nasal spray and inhaler. Staff A did not provide Resident #27 with a glass of water or an empty cup for rinsing her mouth. Resident #27's [DATE]/26 contained an order for Dulera 200/5 Inhale 2 puffs by mouth twice daily - Rinse mouth after each use for pulmonary with a start date of 11/25/25 at 8:00 PM. On 2/24/26 at 11:10 AM the DON stated if an inhaler order stated to rinse mouth after each use, the expectation was to provide the resident with water to rinse their mouth after each use. The facility's Medication Administration Protocol, updated 1/8/26, revealed all medication must be administered by a nurse or medication aide in accordance with the Physician's Order. The document further disclosed a nurse or medication aide must never document a medication prior to the (continued on next page)

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	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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration of the medication, leave medication on the bedside, and assure the resident has taken the medication prior to leaving the resident.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review and staff interview the facility failed to provide appropriate infection prevention practices when providing care for a resident with a catheter for 1 of 3 residents reviewed (Resident #3). The facility reported a census of 40 residents.Findings include: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. The MDS documented the resident had an indwelling catheter. The Care Plan initiated 6/25/24 documented the resident has an indwelling catheter related to obstructive uropathy. The care plan interventions directed staff to position the catheter bag and tubing below the level of the bladder and away from the entrance room door, and to monitor for symptoms on infection. On 2/25/26 at 10:20 AM an observation in Resident #3's room with the Director of Nursing (DON) present of Resident #3's catheter bag hanging from garbage can next to Resident #3's recliner without a cover or dignity bag.On 2/25/26 at 10:20 AM the DON stated the catheter placed on the garbage can for Resident #3 during the observation at 10:20 AM was an infection control issue. The DON stated she would expect the catheter bag to be hung somewhere else that was not the side of the garbage can.