STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. Building B. Wing	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Oaks Nursing and Rehabilitation Center	4614 NW 84th Street Urbandale, IA 50322

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on clinical record review and staff interviews, the facility failed to complete follow up assessments following a fall for one of four residents (Res #18) reviewed for falls. Findings include:The Progress Note of Resident #18 dated 8/22/25 at 11:44 am, authored by Staff O, Registered Nurse noted IDT (interdisciplinary team) met to discuss fall on 8/21/25. RCA (root cause analysis) performed. Hoyer (full body mechanical lift) sling to be tucked into sides of wheelchair. Review of subsequent progress notes failed to reveal any fall follow up was completed for Resident #18. On 10/21/25 at 3:44 pm, the Director of Nursing (DON) stated no incident report could be located for Resident #18 for a fall on 8/21/25. She agreed there was no documentation in the resident record of staff having followed up with pain assessments, vital signs or neurological checks as is protocol when there is a resident fall. On 10/21/25 at 4:16 pm, Staff O, RN stated she recalled the fall on 8/21/25 was in the morning. She stated the nurse that was on duty that morning for Station 2, where Resident #18 resides, had walked out on the job later in the morning, after the fall. She stated the clinical team met and discussed the fall and an appropriate intervention to be put into place. She stated the DON at the time, who is no longer employed at the facility, was to document in the resident chart what had happened. On 10/22/25 at 1:40 pm, the DON stated it appeared the nurse on duty at the time of the fall failed to open up an incident report for the fall. She stated the facility at this time would provide education for documentation and follow up. The Administrator stated the facility had no policy for follow up documentation after a fall.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Based on clinical record review, staff and resident interviews, official city records, facility policy review, and guidance from the Centers for Medicare & Medicaid Services (CMS), the facility failed to provide necessary nursing coverage for approximately four hours on two nursing units housing a total of 53 residents, after one of two on duty nurses left the facility unscheduled. During this period of time, the facility failed to provide requested medications to three residents (Res #3, #6, #9). As a result, one resident's pain (Res #3) became so severe that she contacted 911 (emergency services) to obtain assistance with receiving her pain medication. Additionally, the facility failed to assess another resident (Res #6), who had a documented history of multiple anaphylactic reactions requiring intubation, when she reported symptoms of an allergic reaction.On 10/14/25 at 10:10 am, the State Survey Agency informed the facility the failure to assess the residents, provide needed medications, and take action to ensure resident care and safety needs were met created an Immediate Jeopardy situation. The facility removed the immediacy prior to the survey on 10/09/25 when the facility staff implemented the following Corrective Actions: Facility attendance policy, nurse job description, and scheduling process were reviewedFacility review of current and future staffing patterns to ensure an adequate number of competent licensed nurses and nurse aides being scheduled to meet the needs of the residentsFacility assigning one person from the leadership team to monitor staffing levels daily to ensure adequate nursing staff are availableFacility developed an orientation tool for agency nurses to include procedure for notifying facility leadership for staffing adjustmentsFacility's Regional Director of Operations began providing oversight of staffing and providing weekly facility visits for three monthsOn-Call and emergency staffing process education to all staffEducation to all nursing staff (nurses, medication aides, nurse aides) of the expectation to communicate directly with nursing leadership or administration of emergent staffing changes or when circumstances require a reassignment of staff to cover absences. Additional education to licensed nurses regarding procedure to follow prior to exiting the facilityEducation to all nurse aides of the expectation to report resident needs immediately to licensed nurses onsite, nursing leadership, or administration. Posting of the Director of Nursing's phone number visibly at each nursing station for all staff to contact in emergenciesPain assessments conducted on all facility residentsPlan for audits to be conducted with staff and residents of staffing processAn unplanned Quality Assurance and Performance Improvement meeting conducted to review staffing and medication administrationThe scope and severity was lowered from a K to an E at the time of the survey after ensuring the facility implemented the education, assessments, audits, policy reviews/updates, orientation tools and staffing oversight procedures. Findings include:1.The Minimum Data Set (MDS) Assessment of Resident #3, dated 8/28/25 identified a Brief Interview for Mental Status (BIMS) score of 15, which indicated cognition intact. The MDS documented diagnoses that included: incomplete paraplegia, renal insufficiency, and chronic pain. The MDS recorded the resident received both scheduled and as needed pain medication during the look-back period, as well as non medication pain intervention. The MDS recorded the resident reported they experienced pain on a frequent basis and rated the worst pain at a 5 on a 0 to 10 pain scale, with 10 being the worst pain imaginable. The Care Plan of Resident #3 documented a Focus Area of refusal of care due to her pain tolerance, dated 4/22/25. The Care Plan documented an additional Focus Area of chronic pain, dated 6/10/24. The Care Plan directed staff to administer scheduled and as needed pain medications as ordered. The Care Plan additionally directed staff to assist in being timely with medication delivery per the resident specific interval requests. 2. The MDS of Resident #6 dated 10/12/25 documented a BIMS score of 15, which indicated cognition intact. The MDS documented diagnoses which included unspecified immunodeficiency. An encounter note by the facility's Advanced Registered Nurse Practitioner (ARNP), dated 10/13/25 documented Resident #6's medical history to include a diagnosis of systemic mastocytosis (a rare condition where the body makes too many abnormal mast cells, a type of immune cell, which build up in the body's organs. The buildup causes various symptoms, as excess cells release too many chemicals, similar to a severe allergic reaction. Treatment is symptom management as there is no cure), and noted she had been intubated (mechanical ventilation for a patient who is unable to breathe on their own) several times as a result of anaphylaxis (severe, potentially life-threatening allergic reaction).Hospital referral information for Resident #6 dated 9/29/25 listed greater than 30 medications Resident #6 is allergic to. The reaction listed for these allergies noted anaphylaxis for greater than 10 of these allergies.3. The MDS of Resident #9 dated 10/1/25 documented a BIMS score of 15, which indicated cognition intact. The MDS documented the

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on clinical record review, staff interviews and review of facility policy, the facilty failed to maintain complete medical records in accordance with professional standards for three of four residents reviewed (Res #1, #13, #18). Findings include: The Progress Note for Resident #1 dated 2/20/25 identified a witnessed fall and indicated neurological checks were initiated. Additional Progress Notes dated through 2/23/25 referenced continued neurological monitoring.Similarly, an Incident Report for Resident #13 dated 2/19/25 reported a fall. The corresponding Nursing Note dated 2/19/25 at 12:03AM documented neurological checks were initiated at the time of the fall. On 10/20/25 at 10:58 am, the Administrator stated the facility was unable to produce the neurological check sheets for Res #1 or Res #13. She stated the neuro checks were done on pen and paper and were lost.The Progress Note of Resident #18 dated 8/22/25, authored by Staff O, Registered Nurse noted IDT (interdisciplinary team) met to discuss fall on 8/21/25. RCA (root cause analysis) performed. Hoyer (full body mechanical lift) sling to be tucked into sides of wheelchair. On 10/21/25 at 3:44 pm, the Director of Nursing stated no incident report could be located for Resident #18 for a fall on 8/21/25. She stated she could see one incident report for May and another later in August, neither being related to a fall. On 10/21/25 at 4:16 pm, Staff O, RN stated she recalled the fall on 8/21/25 was in the morning. She stated the nurse that was on duty that morning for Station 2, where Resident #18 resides, had walked out on the job later in the morning, after the fall. She stated the clinical team met and discussed the fall and an appropriate intervention to be put into place. She stated the DON at the time, who is no longer employed at the facility, was to document in the resident chart what had happened. She stated Staff P, LPN was the nurse who was on duty, who quit employment that day. On 10/21/25 at 4:26 pm, Staff P, LPN (former employee) stated the fall happened before she left. She stated she assessed the resident immediately after the fall to monitor for pain or any injury, and took her vital signs. She stated the resident had no bruising and no sign of injury and following her assessment, two CNAs transferred the resident off the floor. She stated she had an incident with the DON at the time and stated she was over stimulated and chose to quit employment. She stated after her conversation with the DON she went to Human Resources and resigned her position immediately. She stated as she was leaving, she gave the assessment information of Resident #18 to Staff O, RN and told her she had to leave. On 10/22/25 at 1:40 pm, the DON stated it appeared the nurse on duty at the time of the fall failed to open up an incident report for the fall. She stated the facility at this time would provide education for documentation and follow up. The facility policy titled Medical Records Organization dated 3/2015 documented a policy statement of:Resident medical records will be organized so that information can be easily retrieved. Electronic format is acceptable. Resident Record Order documented records that are not electronic may be maintained in paper format. These items included Resident Assessment Forms.