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	02/11/2026

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

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on electronic health record review (EHR), observations, staff interview, and policy review, the facility failed to supervise resident administration of medications for 1 or 4 residents reviewed for medications (Resident #4). The facility reported a census of 88.Findings include:The Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 with a Brief Interview for Mental Status score of 15, indicating intact cognition. Diagnoses atrial fibrillation (irregular heart rhythm), anxiety, arthritis, depression, diabetes, edema, and high blood pressure.The Care Plan, last revised on 10/20/25, documented that Resident #4 was resistive to cares and had a history of refusing medications if they did not feel the medications were necessary. Interventions for staff include education for the resident of possible outcomes of not complying. The Care Plan lacked documentation that the resident could self-administer medications.The Medication Administration Record (MAR) directed staff to offer 2 different medications mid-morning for a total of 3 pills to Resident #4. The MAR as well as current Physician Orders did not indicate Resident #4 may self-administer medications. During an observation on 2/4/26 at 11:22 AM, Staff J, Certified Medication Aide (CMA), entered Resident #4's room with a small cup of medications (3 pills total) and placed it on the bedside table in front of the resident. Staff J visited with Resident #4 for a few minutes and then left the room without acknowledging or administering the medications which were still sitting on the bedside table. On 2/4/26 at 1:00 PM, the Director of Nursing (DON) explained that staff need to stay with residents when administering medications. Staff should not leave residents alone with medications. On 2/4/26 at 2:15 PM, Staff J stated they were not aware of any residents who may independently keep mediations in their room. Staff J noted they typically stay with residents to ensure medications are taken and do not leave medications in resident rooms. On 2/4/26 at 3:15 PM, Resident #4 acknowledged the medications left in the their room by Staff J. Resident #4 reported this happens periodically.On 2/5/26 at 10:20 AM, Staff R, CMA reported that no residents are independent to keep medications in their room, and reported she would not leave medications with a resident in their room.The policy Administrating Medications, version 2.0 (H5MAPL0028), stated medications shall be administered in a safe and timely manner and as prescribed. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined the resident has the decision-making capacity to do so safely.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations, staff interviews, and policy review, the facility failed to maintain a home-like environment for residents due to persistent pungent odors throughout 2 of the 3 nursing units (Station 1 and Station 2). The facility reported a census of 88. Findings include: During an observation on 2/4/26 at 10:45 AM, an unpleasant strong odor was noted on the Station 2 nursing unit, especially near the shower room and the environmental service door. During an observation on 2/4/26 at 11:00 AM, a strong pungent odor was detected down the Station 1 nursing unit East hallway. It became stronger as one walked further down the hall. Approximately four hours later, at 2:00 PM, the same pungent odor was still present but not as strong.During an observation on 2/5/26 at 7:50 AM, a pungent odor was noted on the Station 1 nursing unit down the East hallway. There was evidence the facility attempted to combat the odor with the use of an air freshener. At 11:00 AM on this day, Staff O, Housekeeping Director, was seen using a deodorizing machine down the Station 1 East hallway. The pungent odor was mildly detected afterwards. At approximately 3:15 PM, the pungent odor returned and was present down the hallway. During an observation on 2/9/26 at 7:40 AM, a lingering pungent odor was noted on the Station 1 nursing unit East hallway. At 7:50 AM, on the Station 2 nursing unit, an unpleasant odor was noted. An uncovered trash and linen cart, noted with trash, soiled briefs, and soiled linens, was observed in the hallway. On 2/5/26 at 11:00 AM, Staff O reported using a deodorizing machine throughout the facility approximately 2 times per week and as needed. There is no set schedule when the deodorizing machine is used on a specific unit. When asked, Staff O used the machine on Station 1 this day as they could detect a strong pungent odor. Staff O acknowledged the odor is present daily. Staff O suspects the odor may be related to personal habits of several residents. Staff instructed to change bedding daily and ensure trash is emptied timely. On 2/10/26 at 10:30 AM, Staff P, Maintenance Assistant, acknowledged the pungent odors, especially on Station 1 and down the East hallway. Staff P suspects the carpets may be the source of the odors and reported they are shampooed one time per month. On 2/11/26 at 12:15 PM, the Administrator acknowledged the pungent odors throughout the building. The policy Quality of Life-Homelike Environment, version 1.2 (H5MAPL1202), stated facility staff and management shall maximize, to the extent possible, a personalized, home-like setting which include pleasant, neutral scents. The policy also stated to minimize, to the extent possible, a depersonalized, institutional setting which include institutional odors.

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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 review, staff interviews and policy review the facility failed to follow the physician's orders for 1 of 4 residents reviewed (Resident #3). The facility staff failed to return a [NAME] Monitor in a timely manner to the vendor after resident use which delayed downloading and analysis of the heart monitor data, follow up with the physician, and the potential treatment required. The facility reported a census of 88 residents. Findings include: The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 admitted to the facility on [DATE] from an inpatient psychiatric facility and had diagnoses of atrial fibrillation, hypertension, catatonic disorder, and major depressive disorder. The MDS revealed the resident had a Brief Interview for Mental Status score of 15 out of 15, indicating cognition intact. The Inpatient Adult Psychiatry Discharge summary dated [DATE] revealed Resident #3 admitted to the medical-psych unit for management of the severe catatonic, depressive symptoms. During this hospitalization, noted to have EKG changes, suspected to be due to her baseline tremors. EKG changes concerning for atrial flutter on admission. Cardiology reviewed EKG data and thought that the tremor may be cause for what appeared to be flutter. They recommended a 2-week [NAME] monitor at discharge with EP to follow-up. The Care Plan revised 12/29/25 lacked information about a [NAME] monitor. The Order Summary Report revealed an order start date 1/3/26 to monitor the heart monitor for placement every shift. Mail the monitor back on Friday and discontinue the order when done. The Clinical Physician Orders revealed an order entered on 1/3/26 at 6:00 PM by Staff T, Licensed Practical Nurse (LPN) to monitor the heart monitor for placement every shift for heart health. Mail the monitor back on Friday and discontinue the order when done. The order end date was 1/6/26. The Medication Administration Record and Treatment Administration Record dated 1/2026 lacked documentation for monitoring the placement of the heart monitor. The Progress Notes revealed the following: a. On 12/17/25 at 2:11 PM, resident arrived to facility.b. On 12/24/25 at 9:02 AM, a family member requested to inform nursing staff that resident needs her [NAME] monitor placed on today.The Progress Notes lacked any other information about application of a [NAME] monitor, monitoring that the monitor was on over a 2 week period of time, when the monitor was removed, or who removed the [NAME] monitor. The facility records lacked a process for tracking or the disposition of a [NAME] monitor being sent back to the appropriate vendor or the provider facility. In an interview on 2/4/26 at 10:30 AM, a family member voiced concern the resident was discharged from the hospital and was to wear a [NAME] monitor for 2 weeks. The monitor was not placed on the resident until about one week later. The monitor was on the floor for quite a while before the staff put it back on. Last week, the hospital called and asked about the monitor because it was 3 weeks past due. He had no idea where the monitor was or where it went. The resident was transferred to another facility on 1/23/26. In an interview on 2/4/26 at 11:10 AM, Staff J, certified medication assistant (CMA) reported she was unaware of a [NAME] monitor for Resident #3. In an interview on 2/4/26 at 2:12 PM, Staff N, CMA, reported Resident #3 was dependent on staff for all cares and used a mechanical lift for transfers. Staff N reported she did not recall Resident #3 wearing a [NAME] monitor. In an interview 2/9/26 at 11:35 AM, Staff D, LPN, reported Resident #3 had a [NAME] monitor on at one time. She recalled because of who Resident #3's roommate was at that time. Staff D reported she had to put the [NAME] monitor back on Resident #3 because it came off, she thought when the resident got a shower. Staff D stated she was told about the monitor during report and went to put the monitor on the resident. The monitor was believed to be off from the evening/overnight shift and put back on in the AM. In a follow up interview on 2/9/26 at 2:10 PM, Staff D reported she was not sure what happened to Resident #3's [NAME] monitor. Staff A (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was the Assistant Director of Nursing (ADON) at that time and was the one who handled the [NAME] monitor. Staff A no longer worked at the facility though. In an interview on 2/10/26 at 8:22 AM, Staff B, LPN, reported she started to work at the facility on 12/24/25 and only worked at the facility for 3 1/2 weeks. Staff B stated she took a phone call from someone who was checking on a heart monitor for Resident #3. She took his name and number and said she would look into it. She talked to people at the facility to see if anyone knew about the monitor. Everyone was looking for the monitor. Then one day, she went into the unit's Medication Room and it was sitting on top of the refrigerator. The monitor was in a box and the box had a label on it. Staff B recalled she gave the box to the ADON on the unit where the resident resided. She did not know the name of the ADON, but the ADON no longer worked at the facility. In an interview on 2/10/26 at 9:00 AM, Staff A, LPN, reported she worked at the facility from 8/2025 to 12/27/25. She applied the [NAME] monitor on Resident #3 but she did not know who took the [NAME] monitor off or when it was removed. Staff A reported orders are entered into the computer by the nurses and ADON's. Whenever there was a new admission, she obtained the orders and entered the orders. Staff A recalled she entered orders for Resident #3's [NAME] monitor because the nurse did not know how to do it, so she showed the nurse what to do. In an interview on 2/10/26 at 9:55 AM, the Director of Nursing (DON) stated she did not believe Resident #3 had a [NAME] monitor. She did not know if they ever received a [NAME] monitor for Resident #3. The DON stated Resident #14 had a [NAME] monitor but could not say for sure that Resident #3 had one. In an interview on 2/10/26 at 12:00 PM, Staff M, Registered Nurse (RN), reported she was only familiar with Resident #3 for MDS assessment purposes only. There was no [NAME] monitor on Resident #3 upon admission or when Staff M completed her MDS assessment. Staff M reported Staff A, Staff D, Staff J, and Staff Q worked in the area where the resident resided and she thought those staff would by more familiar with the resident. In an interview on 2/10/26 at 12:10 PM, Staff J, CMA, reported Resident #3 was not at the facility very long. Staff J stated she was not able to recall if Resident #3 had a [NAME] monitor when she first came in. The first time she became aware that the resident had a monitor is when the resident's husband asked for it to be put on. In an interview on 2/10/26 at 12:35 PM, Staff Q, CNA, reported he recalled Resident #3 was only at the facility for about a month. She did not have a monitor when she first came in but she did have a heart monitor put on while she was at the facility. One day the monitor was off and he gave it to Staff B, LPN. Staff B no longer worked at the facility though. In an interview on 2/10/26 at 2:35 PM, the DON reported she vaguely remembered Staff T coming to her and telling her about a resident's monitor. Staff T boxed it up and brought it to her office. The box had a return label but she did not know where it was being shipped to. The DON stated she could not recall who would have taken the box from her office. There is not a specific person or department that picked up the packages or mail. There was not a process for who took the mail packages out of the facility nor for tracking when things were shipped. In an interview on 2/10/26 at 2:40 PM, the Regional Director of Operations (RDO) reported she had looked in the ADON's office and the medication rooms and carts. She did not find any kind of monitor. Staff A told the RDO she put the monitor on the resident. At 2:44 PM, the RDO said she found the monitor. She had just talked to the DON who said the box was in her office and she took the box to the post office and mailed it. On 2/10/26 at 2:45 PM, the DON reported she took the box and dropped it off at the Post Office downtown as that Post Office was on her way home. The DON claimed she did not know what was in the box, she just mailed it. When the surveyor inquired why she did not tell the surveyor this during a recent interview. The DON stated she had to process it. In an interview on 2/10/26 at 3:25 PM, Staff T, LPN, reported she took the [NAME] monitor off of Resident #3 at least 3-4 weeks ago. There were instructions (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to put the monitor on and a certain number of days the monitor needed to be on. She had talked to the resident and family during the resident's stay because she did not see an order in the computer about the monitor. Staff T stated she called the 800 number to find out what they needed to do about the monitor. The ADON at the time took over and was supposed to take care of the monitor but when Staff T came back to work a few days later, the resident still had the monitor on. The ADON that took over for her and knew about the monitor had quit or got fired. Staff T said she then went to talk to the DON and told her the monitor needed to be removed. Staff T removed the monitor from Resident #3, packed up the monitor, and took the box with the monitor to the DON's office. That was 3-4 weeks ago. Staff T stated she put an order in the computer about the monitor and that it had been discontinued. In an interview on 2/11/26 at 9:18 AM, the Nurse Practitioner (NP) reported she wrote orders out and let the staff know. The facility managers then entered the order in the computer. She expected orders to be processed and followed. She let facility management know if an order was not followed. This happened a lot. Sometimes when the order is not carried out it was not a huge deal but she expected orders to be done. In an interview on 2/11/26 at 10:35 AM, the University Hospital Clinic nurse confirmed no [NAME] monitor or data received yet for Resident #3. The computer showed they were still waiting for the data. The surveyor advised the clinic staff that the facility staff (where the resident resided) had reported they took the monitor in a box and dropped it off at the main Post Office. The clinic staff reported the box needed to be shipped by UPS, and that was most likely why they had not received the monitor back yet. The clinic nurse confirmed since the monitor had not been received, they are not able to download the information to determine if there is any kind of arrhythmia. This had led to a delay in the physician getting the report and being able to make a treatment plan. Also, if the monitor was not found, the physician would have the resident repeat the study. The clinic nurse reported they often had trouble getting the monitor returned when a resident resided at a facility. They also had trouble with the staff at care facilities not knowing what to do with the monitor and doing what needed to be done to get the monitor back timely. In an interview on 2/11/26 at 11:00 AM, the DON reported she does not know the date she took the box to the Post Office to drop it off, but whatever day Staff T brought the box to her office is the day the DON took the box with the monitor to the Post Office. She just dropped it off in the mailbox. Staff A was the ADON at the time and should have put the orders in for the [NAME] monitor. The surveyor advised the DON the vendor had not received the monitor yet, and understood that the box was supposed to be mailed by UPS. The DON stated she did not know that. She planned to let Staff M (the new DON) know to follow up with the Post Office. On 2/11/26 at 11:10 AM, the RDO and Administrator stated they would check with the Post Office to see if they could locate the missing monitor. In an interview on 2/11/26 at 11:40 AM, the University Hospital Clinic staff confirmed Resident #3 should have received the [NAME] monitor on 12/17/25. The monitor ran for 15 days. If the monitor was applied on 12/17/25, then it should have been done and removed on 1/1/26. The monitor would have been done recording by that date. If it was mailed via UPS right away after the monitoring was completed, then the results would have been obtained within 2 weeks. In an email, 2/11/26 at 9:02 AM the Administrator wrote they do not have a policy for the mail. In an email 2/11/26 at 9:35 AM, the surveyor requested a policy for physician's orders. At 10:35 AM, the Administrator wrote they just have a medication order policy. A Resident Assessment policy revised 10/2023 revealed the resident assessment coordinator is responsible for ensuring timely and appropriate resident assessments are conducted. Information in the assessments will consistently reflect information in the progress notes, plans of care, and resident observations/interviews. The results of the assessments are used to develop, review, and revise the resident's (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comprehensive care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility bath records, resident interviews, staff interviews and policy review, the facility failed to offer and provide resident bathing on a consistent basis for 3 of 5 resident reviewed for bathing (Resident #1, #3, and #5). The facility reported a census of 88. Findings include: Resident Council meeting minutes from 11/24/25 noted 6 residents voiced not receiving showers consistently. 1.The Annual Minimum Data Set (MDS) Assessment completed on 1/21/26 revealed Resident #5 with a Brief Interview for Mental Status (BMIS) score of 15, indicating intact cognition. Diagnoses include arthritis, chronic pain syndrome, and heart failure. The Care Plan, last updated on 1/29/26, noted Resident #5 requires staff assistance with bathing and showers. During an interview on 2/4/26 at 11:10 AM, Resident #5 reported going over two weeks in-between showers. On many occasions, a bath or shower was not offered. At one point, the resident had to ask about receiving a shower. Resident #5 explained this mainly occurred in January. The Dec'25 Documentation Survey Report v2 revealed Resident #5 should be offered bathing two times per week on Tuesdays and Fridays. Between this report and the Resident Bath/Skin Assessment paper documentation, bathing was documented as complete four times out of nine scheduled days. No further documentation identified as to the status of the other five scheduled bath days (completed, not offered, offered but resident refused). The Jan'26 Documentation Survey Report v2 revealed Resident #5 should be offered bathing two times per week on Tuesdays and Fridays. Between this report and the Resident Bath/Skin Assessment paper documentation, bathing was documented as complete two times out of nine scheduled days. No other documentation identified as to the status of the other seven scheduled bath days (completed, not offered, offered but resident refused). 2. The MDS for Resident #3, dated 12/23/35, revealed the resident was admitted to the facility on [DATE] with diagnoses of Osteoporosis (bones become fragile and brittle) and Major Depressive Disorder, and dependent on staff for bathing. A BIMS score of 15, indicated no cognitive impairment for decision-making. During an interview on 2/4/26 at 10:30 AM, Resident #3's family member stated the resident was admitted to the facility on [DATE] and did not receive her first shower until 19 days after being admitted . The family member stated during a meeting with the facility care team, after the first shower, he was promised the resident would receive a shower two times per week. The family member stated the resident went 8 days before receiving her next shower. The family member stated the resident received 2 showers total in 30 days. Resident #3's Document Survey Report v2 for Showers for 12/25 and 1/26 revealed from 12/17/25 – 1/17/25, the resident received a shower on 12/31/25 and 1/8/26. 3. The admission MDS dated [DATE] for Resident #1 revealed preferences for customary routine and activities such as the resident's preference for receiving a bath or shower was left blank. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly MDS assessment dated [DATE] revealed Resident #1 had diagnoses of urinary tract infection and hip pain. The MDS recorded the resident had a BIMS score of 15 indicating intact cognition. The MDS documented the resident had no behaviors and had no days when he rejected care. The MDS revealed the resident had dependence on staff for transfers and bathing. The Care Plan revised 8/11/25 revealed Resident #1 had an ADL (activities of daily living) self-care performance deficit related to pain and impaired balance and mobility. The Care Plan directives staff to provide assistance of one for bathing activities. Review of the Generations Hall Bath Schedule in a binder at the nurse's station revealed baths for Resident #1's room were scheduled on Tuesday and Friday mornings. Review of facility's paper bath sheets for Resident #1 reviewed 11/1/2025 to 1/31/2026 revealed baths documented on 11/1/25, 11/7/25, and 12/19/25. The documentation revealed the resident did not receive a shower on 12/30/25 because he was hospitalized . The bath sheet dated 1/16/26 revealed the resident refused a shower/ bath. Review of the Documentation Survey Report revealed an X indicated on non-bath days but an area to document a bath or shower on Tuesdays and Fridays. The Documentation Survey Reports dated 11/1/25 to 1/31/26 revealed bathing was documented as complete two out of nine times in 11/2025 (on 11/7/25 and 11/14/25), one out of nine times in 12/2025 (on 12/19/26), and two of nine times in 1/2026 (on 1/13/26 and 1/30/26). Refused was documented on 1/16/26. In an interview 2/4/26 at 11:10 AM, Staff J, Certified Medication Aide (CMA) reported the Certified Nursing Assistant's (CNA's) were responsible for giving the residents a showers. They had a book with the resident rooms listed and the days each room was assigned to get a bath. The CNA's filled out a shower sheet every time a resident's shower was completed. The bath schedule did not change usually as it was assigned by room numbers but a change could be made based on a resident's preferences. Whenever they had a new resident admission, the resident was assigned to get a shower based on the schedule. This process just started a couple of weeks ago. The previous process was by assigning the residents based on how many residents they had each day. In an interview on 2/4/26 at 11:25 AM, Staff K, CNA, reported the facility did not have a bath aide. The CNA's that were working were responsible for getting the residents' baths done. Staff K reported she looked at the list with resident rooms and who was supposed to get a bath that day. Staff K reported she documented the resident's bath in the computer whenever she gave a resident a bath or a shower. In an interview 2/4/26 at 11:25 AM, Staff Q, CNA, reported the residents were scheduled to receive a shower twice a week. The shower list went by room numbers, so that is how he knew which resident got a shower on that day. Staff Q reported a paper shower form filled out and he gave it to the charge nurse, but he also documented in the computer whenever he gave a shower or a bath. On 2/4/26 at 2:50 PM, the Director of Nursing (DON) stated she wanted to talk to the surveyors about baths. She had only been at the facility since 9/2025. She reported she had started a PIP (performance improvement plan) for bath and skin assessments. There had been grievances and complaints from residents and family members that baths/showers were an issue. Once she identified a concern about baths, she implemented some things so staff knew who bathes when. She felt there had been progress and she had tried to undertake an improvement in getting the residents' baths done. They had (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implemented bathing sheets and managers were auditing if a resident had a bath. If no bath had been given then the resident was scheduled for the next day or the following day. The DON stated there was not a process in place before. They had a bath schedule in place but it was overwhelming for staff to get things done, so they split up the baths so it was fair to everyone and staff don't get overwhelmed. The Assistant Director of Nursing (ADON) was monitoring if baths got done but there had been a turnover in the ADON's. Three ADON's had been termed in a timeframe of a couple of months. The facility only had one ADON currently. In an interview on 2/10/26 at 9:00 AM, Staff A, Licensed Practical Nurse (LPN), reported the CNA's gave the baths at the facility. When she worked at the facility, the facility had a problem with the water heater and they did not give baths because there was no hot water. She had put together a schedule for residents to get baths twice a week. The CNA's documented the baths in the computer and filled out a (paper) bath sheet. Nine times out of ten, the paper bath sheet did not get done. The facility's Supporting Activities of Daily Living (ADL's) policy revised 3/2018 revealed residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who are unable to carry out ADL's independently will receive the services necessary to maintain good grooming and personal hygiene such as bathing.

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	165580	A. Building B. Wing	02/11/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on electronic health record review (EHR), staff interviews, and policy review, the facility failed to complete and document neurological exams (neuro-checks) and skin assessments for 1 of 4 residents reviewed for assessment and intervention (Resident #2). The facility reported a census of 88. Findings include: The Significant Change Minimum Data Set (MDS) Assessment completed 10/9/25 reviewed Resident #2 with a Brief Interview for Mental Status score of 13, indicating intact cognition. Diagnoses included anxiety, aphasia (communication disorder), diabetes, heart failure, hemiplegia, and stroke. Resident #2 noted to be dependent on staff for all cares and transfers. The MDS documented two or more falls since prior assessment. Resident #2 at risk of developing pressure injuries and was reported with a diabetic foot wound and an open foot lesion. The Care Plan, last revised 10/17/25, reported Resident #2 with falls. Interventions include neuro-checks per facility policy. Due to self-care performance deficits, skin inspections are care planned. Staff directed to observe for redness, open areas, scratches, cuts, bruises, and to report changes to the nurse. Review of Facility Incident Reports showed Resident #2 with a total of 21 unwitnessed falls between 9/1/25 and 12/14/25. Of the 21 unwitnessed falls, neuro-checks were initiated and documented for 13 of these falls. For the 13 documented neuro-checks, 8 of neuro-check forms were incomplete and missing one or more of the scheduled assessments. The EHR form Weekly Skin Reviews-v 3, which documents nursing full body skin assessments, were completed on a regular basis from 7/21/25-11/11/25. No further full-body skin assessments, either electronically or paper, identified from 11/11/25 to 12/31/25. The only documented skin assessment identified after 11/11/25 was the Weekly Non-Pressure Diabetic/Neuropathic Injury Evaluation. The assessment focused on the right foot or left toes and did not address full-body. The Progress Note dated 11/20/25 at 7:11 PM documented a small bruise to Resident #2's left upper eye area. No further documentation regarding this injury identified in the Progress Notes or skin assessments. The Incident Report #3190, dated 12/14/25, documented Resident #2's injuries related to a fall that occurred. Injuries included a bruise and skin tear to the right elbow. No further documentation identified in the Progress Notes or skin assessments identified tracking the injuries. Nursing Note dated 12/17/25 at 11:03 AM documented as follows; resident was restless this morning. Gave resident his meds and noticed gauze in residents hand, removed it and cleaned area and noticed finger nail cutting into his hand, so this nurse cleansed area with wound cleanser. Then cut residents fingernails, applied a Derma Foam, and wrapped with Kerlix at this time.The Progress Note dated 12/17/25 at 11:15 AM documented cuts on Resident #2's hand related to their fingernails cutting into the skin. Orders to apply Silvadene cream, a foam bandage and to wrap with gauze initiated. No further documentation identified in the Progress Notes or skin assessment identified tracking the injury. During an interview on 2/10/26 at 9:00 AM, Staff A, Licensed Practical Nurse (LPN), explained neuro-checks completed with all unwitnessed falls for up to 72 hours. Neuro-checks are documented on paper. The nurse who initiates the neuro-check form should fill out the dates and times when the checks are needed so upcoming staff know when to assess. During an interview on 2/10/26 at 9:30 AM, Staff D, LPN, explained skin assessments are completed during bath days. The Certified Nurses Aide (CNA) would notify the floor nurse when bathing is complete so a full-body skin assessment can be performed. The nurse would then document the assessment in the EHR. During an interview on 2/10/26 at 1:25 PM, Staff U, Assistant Director of Nursing, acknowledged Resident #2's frequent falls and overall skin condition. Weekly rounds were made with the Wound Care Provider with the focus mainly to the resident's foot. Full-body checks would not have been completed during this time. Staff U believes there may have been some bruises on the resident's arm towards the end of December. Staff U would expect the CNAs to notify (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing staff of any skin abnormalities during scheduled bathes. Staff U would also expect skin abnormalities, including bruises, to be documented during weekly skin assessments. The facility document Falls Management System, revised 2016, noted any fall that involves an actual head injury and all unwitnessed falls will include follow-up neurological checks. Neurological checks will be documented. The Neurological Assessment form noted checks should be performed every 15 minutes x4, every 30 minutes x4, every 4 hours x4, and every shift x3.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, consultant pharmacy interview and staff interviews, the facility failed to complete routine urinary catheter care, monitor urinary output and administer an antibiotic to treat an urinary tract infection (UTI) per physician order for 2 of 3 residents (Resident #1 and Resident #11) reviewed for urinary catheter. Resident #1 did not receive a full nine-day course of antibiotics to treat an UTI which resulted in a hospitalization. The facility reported a census of 88 residents Findings include: 1.The Quarterly Minimum Data Set (MDS) Assessment completed on 11/19/25 revealed Resident #11 with a Brief Interview for Mental Status (BIMS) score of 10, indicating a moderate cognitive impairment. Diagnoses include multiple sclerosis and neurogenic bladder (bladder dysfunction contributing to incontinence). The MDS confirmed the use of a urinary catheter. The Care Plan, last revised 6/3/25, documented the following; the resident was at risk for urinary tract infections, also noted the presence of a catheter. The Care Plan directed staff to empty the catheter bag every shift and as needed. The Physician's Order, initiated on 4/6/25, directed staff to record catheter output every shift for monitoring. The Treatment Administration Record (TAR) for December 2025 showed catheter output was recorded 47/62 entries. The TAR for January 2026 showed catheter output was recorded 52/62 entries. The TAR for February 2026, thus far, showed catheter output was recorded 12/16 entries. 2. The admission MDS assessment dated [DATE] revealed Resident #1 had diagnosis of obstructive uropathy (a condition when urine cannot drain through the urinary tract). The MDS indicated the resident had an indwelling catheter and had dependence on staff for toileting hygiene. The MDS assessment dated [DATE] revealed the resident readmitted to the facility from the hospital on [DATE], and had a diagnosis of a urinary tract infection (UTI) in the past 30 days. The MDS indicated the resident had indwelling catheter and took an antibiotic. The Care Plan initiated on 8/9/25 and revised on 1/6/26 revealed the resident had an indwelling catheter. The staff directives included to encourage fluids and check the catheter tubing for kinks each shift. The Care Plan lacked directives for the provision and/or frequency for catheter care. The Order Summary Report revealed the following orders: a. Provide catheter care every shift and as needed (PRN) for soilage (start date 7/28/25). b. Change the catheter PRN for leakage, dislodgement or occlusion (start date 7/28/25). c. Administer Amoxicillin (an antibiotic) 500 mg (milligrams) two times a day (BID) by mouth (PO) for a UTI started on 10/22/25, and continued 10/23/25 until 11/1/25 (for a total of 9 additional days). (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	d. UA (urinalysis) with C & S (culture and sensitivity) ordered on 10/16/25 related to UTI was discontinued on 10/21/25. A UA was ordered again on 10/27/25 for agitation, elevated temperature and an upset stomach. e. Record output BID (start date 1/8/26) f. Use enhanced barrier precautions (EBP) (start date 1/19/26) g. Cephalexin 500mgs by mouth four times a day for infection start 12/31/25 and date 1/4/26 h. Tamsulosin HCL 0.4mg (2 capsules) by mouth two times a day (medication commonly used for enlarged prostate, and kidney stones) The Census Report revealed Resident #1 hospitalized from [DATE] - 10/22/25 and 12/28/25 - 12/31/25. The Interact Transfer Form revealed Resident #1 transferred to the hospital on [DATE] due to urinary retention and also transferred to the hospital on [DATE] due to uncontrolled pain. The transfer form documented the catheter was last inserted on 9/1/25. The Nurse Practitioner (NP) Encounter Note dated 10/23/25 revealed the resident was hospitalized for sepsis secondary to a UTI and urinary retention. Resident currently on Amoxicillin and had a Foley (catheter) due to urinary obstruction. The NP ordered to administer medications as ordered and encourage fluids. The NP Encounter Note dated 1/5/26 revealed the resident recently hospitalized for increased pain and was found to have a UTI. He returned to the facility on Cephalexin (an antibiotic). The Hospital Discharge Orders revealed the following diagnoses: 7/22/25 - Obstructive uropathy nephrolithiasis (obstruction of urine flow caused by kidney stone) 10/17/25 - Sepsis (a life threatening response to an infection) secondary to UTI 10/18/25 - Enterococcal bacteremia (a serious bloodstream infection) 12/28/25 - Complicated UTI The Progress Notes revealed the following: a. On 7/28/25 at 7:50 PM, resident admitted to the facility from the hospital. b. On 7/30/25, catheter patent and draining yellow urine. c. On 9/1/25 at 2:55 PM, resident demonstrated intermittent confusion and forgetfulness. Moisture-associated skin disorder (MASD) noted to the groin area. Area cleansed with soap and water and treated with Nystatin (an antifungal) powder. Indwelling catheter present, patent, and draining well. d. On 10/17/25 at 6:38 AM, off-going nurse reported a UA needed for this resident. New drainage bag changed. A 5:30 AM the nurse went to collect a urine sample only to find zero (amount) in the (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	catheter. No kinks noted. Resident complained of pain. Abdomen distended. PRN pain medication given. e. On 10/17/25 at 6:57 AM, the oncoming nurse evaluated resident. Abdomen distended and tender when area palpated. Catheter was patent. A scant amount of yellow urine observed in the bag. The NP was contacted and provided an order to send the resident to the Emergency Department (ED). f. On 10/18/25 at 7:18 PM, resident admitted to the hospital with sepsis and urinary retention. g. On 10/22/25 at 1:09 PM, resident returned to the facility. h. On 10/24/25 at 2:53 PM, resident continues on ATB. i. On 10/29/25 at 1:53 PM, resident seen by NP. New order received for a UA with C & S. j. On 12/28/25 at 3:35 PM, at 3:30 PM this nurse was alerted by assigned CNA that resident was in pain and having discomfort, and in the process of contacting 911. Once the nurse arrived in the resident's room, resident was informed that a pain medication was available for him. Resident stated that he does not feel as though his Hydrocodone (narcotic pain med) was effective and continued to communicate on the phone with dispatch. The EMTs (Emergency Medical Technicians) arrived at 3:35 PM. k. On 12/31/25 at 3:08 PM, resident returned from the hospital. The Medication Administration Record (MAR) dated 10/2025 revealed an order to administer Amoxicillin 500 mg PO BID for 10 days for a UTI started on 10/22/25. The MAR lacked documentation that the medication was administered on 10/27/25 for one dose, 10/28/25 for 2 doses and 10/29/25 for one dose. Medication Administration Note 10/27/25 at 7:17 PM documented Amoxicillin oral tablet 500 mg by mouth two times a day for UTI for 9 days, medication on order waiting for pharmacy delivery, author of note Staff L, Certified Medication Aide (CMA). Review of the TAR dated 9/2025 to 11/2025 revealed an order for catheter care every shift started on 7/28/25. The TAR indicated catheter care on hold 10/18/25 to 10/22/25 (when the resident was in the hospital). The TAR lacked documentation for catheter care on the following dates: 9/1, 9/3, 9/11, 9/17 x 2, 9/18, 9/19, 9/21. 10/5, 10/10, 10/26, 10/27 11/2, 11/13, 11/15, 11/27 x 2, 11/29 The TAR also revealed on order to Record Output (started on 11/5/25). Review of the TAR dated 11/2025 to 1/2026 revealed Urine Output not recorded on the following dates: 11/13, 11/15, 11/17, 11/27, 11/29 x 2 12/9, 12/14, 12/15, 12/18, 12/25 (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	1/20, 1/21, 1/22, 1/26, 1/27, 1/28, 1/29, 1/31 The TAR also revealed an order to change the catheter PRN for leakage, dislodgement or occlusion. Review of the TAR dated 10/1/25 to 1/31/26 revealed no catheter change documented. In an interview on 2/9/26 at 10:45 AM, Staff I, Certified Medication Aide (CMA), reported the CMA's could reorder medications in the computer except for the narcotics. She also faxed the order to make sure the order went through when the prior pharmacy was the vendor for the facility. She requested the nurse to obtain medication through the E-kit (emergency kit) if the medication was available. In an interview on 2/9/26 at 11:35 AM, Staff D, Licensed Practical Nurse (LPN), reported the facility switched to a different pharmacy vendor in 11/2025. Medications are ordered through the computer, except for narcotics and IV meds. An order was faxed to the pharmacy for narcotics and IV meds. Staff D explained the process for ordering medications in the computer: click on the medication needed, go to the summary, and click on reorder to order the medication that was needed. The last reorder date and the date when the medication was received could be viewed on the computer. If it showed ordered that meant the medication had been ordered from the pharmacy. If the medication had not been received in a couple of days from the ordered date, she called the pharmacy to let them know. The pharmacy did not deliver on Sundays though. Staff D reported she obtained an antibiotic (ATB) medication from the E-kit to start the medication right away when she got an order for an ATB medication. In an interview on 2/9/26 at 11:40 AM, Staff G, LPN, reported she recalled sending Resident #1 to the ED for an evaluation because she tried to flush the catheter but it wouldn't flush and he complained of difficulty voiding. At that time, he did not have any other symptoms such as a fever. Staff G reported whenever she found a medication card in the medication cart without any medication left, she called the pharmacy and called the doctor. Staff G explained she reordered medication when she noted there were less than 5 days of medications left on the card. Staff G stated staff do not always do this though. Medications are ordered on the computer. She obtained medication such as an antibiotic from the E-kit and gave the medication to the resident while waiting for the pharmacy to deliver the medication. Staff G was unsure how long it took for the pharmacy to deliver the medications from the date/time it was ordered. On 2/9/26 at 11:45 AM, the pharmacist reported no Amoxicillin dispensed from their pharmacy for Resident #1. The original order for Amoxicillin was for 9 days and the facility should have received the entire ATB course from the previous pharmacy vendor. The pharmacist stated the facility began to use their pharmacy on 11/1/25. The pharmacist was unsure who the prior pharmacy vendor was for the facility. In an email on 2/9/26 at 12:37 PM, the Administrator wrote the facility switched to new pharmacy vendor on 11/1/25. The former pharmacy vendor's contact information was provided to the surveyor. In an interview on 2/9/26 at 12:40 PM, a pharmacy technician from the pharmacy vendor used prior to 11/1/25 reported their pharmacy dispensed Amoxicillin on 10/22/25 for Resident #1. The pharmacy technician stated 10 amoxicillin tablets dispensed for a 5-day supply. She stated the amoxicillin was supposed to be for one tablet BID for 9 days for a UTI. She is not seeing anything else that showed additional Amoxicillin was dispensed other than the 10 pills for a 5-day supply. In an interview on 2/9/26 at 1:00 PM, Staff F, CMA, reported she had no training when she started to work at the facility. She was just thrown to work on the floor. She had worked as a CMA for a (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	number of years before and knew the proper way to set up and give medications. When she started working at the facility, there were a lot of medications left in the drawer that were not supposed to be there, like blood pressure medications that had been discontinued. She also had to pull cards and reorder a lot of medications when she worked because the medications had not been reordered from the pharmacy. Staff F reported she was told they could not document that a medication was not available or a medication was ordered from the pharmacy. Staff F reported there was a resident that was sick. A family member came in and was upset so she contacted the DON. Staff F asked Staff H, LPN, to come and evaluate Resident #1 until the DON came in. Staff H did not do it. It was a hot mess. There was a situation when Resident #1's ATB did not come in. She told Staff H and Staff V, LPN, about it but they said it's fine and not to worry about it. The ATB kept popping up on the MAR though. It was supposed to be given for 6-10 days but they did not have the medication even for 6 days. He only had 4 tabs of the ATB and it was supposed to be given BID. He was started on the ATB to help with an infection. Whenever a medication was not in the drawer, she checked the MAR, pulled the sticker off the card, and faxed it to pharmacy. The nurse could go to kiosk to get a medication out of the E-kit, but she was a CMA and did not have any access to the kiosk / E-kit. The ADON's Staff V and Staff A were the ones who told her not to document that a medication was not available or waiting for delivery from pharmacy. In an interview on 2/9/26 at 2:05 PM, the DON reported that no longer had paper charts, the residents' records were in the computer. The diagnostic tests such as labs and x-rays could be viewed under the results tab in the computer. In an interview on 2/9/26 at 2:10 PM, Staff D, LPN reported all of the labs that had been done on a resident would be in the computer under the results tab. If no UA results listed then no UA was done. In an email 2/9/26 at 4:09 PM, the former pharmacy vendor wrote the last date of service at the facility was on 10/31/25. A report was attached that reflected the medications that were available in the E-kit for the facility prior to 10/31/25. The Inventory Snapshot revealed medications stocked in the E-kit. Amoxicillin 250 mg capsules for a quantity of 6 doses was listed as in stock. In an email, 2/9/26 at 4:34 PM, the pharmacy manager confirmed if a resident had an order for Amoxicillin 500 mg, the facility staff could take 2 tabs of the Amoxicillin 250 mg from the E-kit and give the medication until the pharmacy delivered the supply of medication (per the Dr's order) for a resident. In an interview 2/9/25 at 4:40 PM, Staff H, LPN, reported she removed the sticker on the medication card usually within 7-10 days from when a medication would run out and reordered the medication in the computer system. Previously (before using the new pharmacy vendor), the sticker from the medication card was sent to the pharmacy to reorder the medication. Staff H reported the process for when a new medication order such as an antibiotic was received. She checked the E-kit to see if the medication was available and pulled the medication from the E-kit. Otherwise, she requested a Stat order for the pharmacy to deliver the medication. Staff H stated there was no pharmacy delivery on Sundays though. Staff H confirmed she was working on the day Resident #1 was sent to the hospital. He was complaining of pain. Staff I, CMA, told her he had requested something for pain and she was waiting for the timeframe to give him the pain medication. Staff H checked to see what was on hand and what Resident #1 could have for pain, then she told Staff I to give the medication. Staff H stated when she (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	went to assess Resident #1, he had already called 911. Staff H reported the resident was not complaining of pain earlier in the day when she evaluated him. Staff H reported she would have entered her assessment in a progress note. Staff H reported Resident #1 was compliant but not if he was really, really anxious. His mind got set on something and it was hard to get him back. Resident #1 had his mind made up that the medication was not going to help and he wanted to go to the hospital. In an interview on 2/10/26 at 8:00 AM, Staff L, CMA, reported she clicked on the medication that needed ordered and checked to see if the medication had been reordered and the date it was ordered. If the medication had not been ordered, she clicked on the reorder button, and entered a nursing note such as waiting for pharmacy to deliver, or that the medication was on order. The pharmacy delivered every day except on Sundays. Staff L reported she had not been told not to document waiting for pharmacy to deliver or that the medication was on order. In an interview on 2/10/26 at 9:00 AM, Staff A, LPN, reported the ADON's and nurses processed and entered orders in the computer and faxed the orders to the pharmacy. The pharmacy delivered the medications. The process could be lengthy putting the orders in so she faxed the orders so the pharmacy would deliver the medications by that evening or the next day. When they switched to a new pharmacy (in 11/2025), a STAT order would be at the pharmacy's discretion. She would call the pharmacy to see if the medication could be sent over STAT. The pharmacy would say they would deliver the medication within 2 hours but a lot of the time it was not delivered in 2 hours. If the medication was in the E-kit, she got the medication from the E-kit but they had to call the pharmacy first. The pharmacy needed the doctor's order first. It was a fiasco with the new pharmacy. Staff A stated she filled out a paper and put it in the E-kit box whenever she took a medication from the E-kit. Staff A reported whenever they were out of a medication, she entered a note awaiting pharmacy in a pop-up box on the computer or wrote waiting for pharmacy to delivery in the progress note. She never told staff they could not document not available or waiting for delivery from pharmacy. However, the DON told her not to document not available because it was an unacceptable reason. The nurse told the CNA if a UA needed to be collected on a resident whenever a UA was ordered. She contacted the lab after the UA was collected. UA results would be listed under the results tab in the computer. The facility also received a fax for the Dr to review the results. The DON told staff a resident's catheter only needed to be changed if there was a problem such as the catheter was leaking or not draining. Prior to the new DON, they changed the resident's catheter monthly but the new DON said they only needed to change catheter as needed. In an interview on 2/10/26 at 9:55 AM, the DON reported she expected staff to document on the MAR/TAR or the plan of care. The CNA's documented in POC, and the nurses documented in the EHR or on the nursing notes. The DON stated a urinary catheter was changed per the Dr's order. It was best practice only to change the catheter PRN such as if the catheter was plugged or leaked. The staff should let the charge nurse know if a medication was not available so the charge nurse could follow up with the pharmacy. The nurse could get a medication from the E-kit if the medication was in the E-kit. She also expected staff to call the Dr to let the Dr know the medication was not available or why the medication was not given. Staff could enter a comment or the reason why a medication not available, or document the medication was on order or unavailable. The DON reported the pharmacy usually delivered medications once a day. The pharmacy delivered medication the following day if the medication was ordered after a certain time. In an interview on 2/11/26 at 9:18 AM, the NP reported she wrote orders out and let the staff know (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	about the orders. The facility managers then entered the order in the computer. If the order is for lab to be drawn in a couple of days, she entered the order in her notes, then the Manager entered the order in the computer. She expected orders to be processed and followed. She let facility management know if an order was not followed. This happened a lot. Sometimes when the order is not carried out it was not a huge deal but she expected orders to be done. Sometimes there had been times when a medication such as an ATB had not been given, but sometimes it was because pharmacy had not delivered the medication. The facility used to have a Hot Chart but they no longer had a hot chart. She told the manager they needed to bring the hot chart back. Staff can pull medication from the E-kit but they had problems with not having the medication in the E-kit because someone had used it. She spoke with the manager to make sure they have the medications available for weekend staff. There was a lot of education and follow up that needed to be done. In an email 2/11/26 at 9:35 AM, the surveyor requested a policy for physician's orders. At 10:35 AM, the Administrator wrote they just have a medication order policy. A Resident Assessment policy revised 10/2023 revealed the resident assessment coordinator is responsible for ensuring timely and appropriate resident assessments are conducted. Information in the assessments will consistently reflect information in the progress notes, plans of care, and resident observations/interviews. The results of the assessments are used to develop, review, and revise the resident's comprehensive care plan. The Administering Medications Policy revised 12/2012 revealed medications shall be administered in a safe and timely manner, and as prescribed, including any required time frame. The attending physician or Medical Director shall be contacted to discuss the concern. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. A Pharmacy Services Policy revised 11/28/16 revealed the facility will provide routine and emergency drugs and biologicals to its residents. A drug, whether prescribed on a routine, emergency, or a PRN basis, will be provided in a timely manner. The nursing home shall have pharmaceutical services that meet the needs of the residents and are in accordance with the Board of Pharmacy statutes and rules. The medical staff is responsible for developing policies and procedures that minimize drug errors. A facility shall have at least one emergency medication kit or automated dispensing system with emergency medications (kit). The kit used in the facility shall be governed by the following: The kits shall be kept readily available to staff. If a prescribed medication is not given, the reason shall be recorded on the resident's medical record.

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	165580	A. Building B. Wing	02/11/2026

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff interview and policy review, the facility failed to follow infection control measures in order to prevent the spread of infection for 2 of 3 residents who received insulin(an injectable medication used to lower blood sugar) (Resident #6 and #14). The facility failed to ensure staff did not utilize multiple dose insulin pens for more than one resident. The facility staff failed to perform hand hygiene and change gloves before, during, and after resident cares for 2 of 5 residents observed for cares (Resident #7 and #11). The facility also failed to ensure staff followed infection control practices to protect against cross contamination and potential spread of infection for 2 of 3 residents on Enhanced Barrier Precautions (EBP's) (Resident #7 and #11). The facility staff also failed to use a barrier when a catheter was emptied and failed to properly disinfect a graduate container after use for 1 of 3 residents observed for catheter care (Resident #7). The facility reported a census of 88 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) assessment tool, dated 10/22/25, listed diagnoses for Resident #6 which included diabetes mellitus (a condition which caused abnormal blood sugars), anxiety disorder, and heart failure. The MDS stated the resident received insulin and listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. The facility policy Administering Medications, revised December 2012, stated insulin pens containing multiple doses were for single-resident use only. The policy stated changing the needle did not make it safe to use insulin pens for more than one resident. Resident #6's December 2025 Medication Administration Record (MAR) documented Staff A, Licensed Practical Nurse(LPN)/former Assistant Director of Nursing (ADON) administered the resident's insulin Lispro(a type of fast-acting insulin) on dates which included 12/23/25 and 12/24/25 and administered her insulin Aspart (a type of fast-acting insulin) on dates which included 12/15/25, 12/17/25, 12/18/25, 12/19/25, and 12/22/25. 2. The MDS assessment tool, dated 10/25/25, listed diagnoses for Resident #14 which included diabetes mellitus, muscle weakness, and cognitive communication deficit. The MDS stated the resident received insulin injections and listed her BIMS score as 15 out of 15, indicating intact cognition. The resident's Care Plan did not address the resident's insulin. Resident #14's December 2025 MAR documented Staff A administered the resident's insulin Glargine(a type of long-acting insulin) on dates which included 12/22/25 and administered the resident's insulin Lispro on dates which included 12/23/25 and 12/24/25. A 12/26/25 Corrective Action form stated that Staff A did not dispose of insulin pens from discharged residents and reused the pens and other current resident pens for multiple residents who used the same type of insulin. This was an infection control violation and placed residents at risk for infection. The form stated the facility would discharge Staff A. On 2/4/26 at 3:50 p.m., via phone, Staff B Licensed Practical Nurse(LPN) stated she observed an insulin pen in the top of a cart and it had a used needle attached which had blood on it. She stated there was a bag of insulin pens with multiple resident names on them. She stated Staff A told her to utilize those pens until they ran out. Staff B stated the pens were from discharged residents. Staff (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B stated she discharged residents on the rehabilitation wing and then the resident's pens appeared in the bag. Staff B stated she removed the bag but Staff A put them back in the cart and directed her to use them as they were saving the company money. Staff B stated she did not use any of the pens and reported this to the Director of Nursing(DON). On 2/5/26 at 8:41 a.m., via phone, Staff A , LPN stated she did not have insulin to administer to residents so she borrowed from other residents. She stated she did not know which residents the pens belonged to but she borrowed from residents who used the same type of insulin. She stated she did this with Resident #14 and her roommate(Resident #6). She stated she was on work overload and panicked. She stated she did this for approximately one to one and a half weeks during which she worked 50-70 hours over 8-10 shifts. She stated she did not report that she had no insulin to use to the DON or anyone else in management. On 2/5/26 at 9:21 a.m., Staff A stated she utilized other resident's insulin during the time frame of late December 2025. On 2/5/26 at 10:32 a.m., the DON stated that Staff B came to her with a bin of insulin pens. Staff B told her Staff A instructed her to use the pens for those who didn't have their own. The DON asked Staff A why she did that and stated Staff A told her because that was how they had done it since she started there. The DON stated the facility terminated Staff A that night. On 2/5/26 at 12:55 p.m. the DON stated staff should not share insulin needles and should administer per physician's order. She stated if staff didn't have insulin, they could obtain it from the emergency pharmaceutical kit. 3. The admission MDS assessment dated [DATE] revealed Resident #7 had diagnoses of benign prostatic hyperplasia (BPH) (an enlarged prostate), diabetes, and cerebrovascular accident (stroke) (CVA). The MDS revealed the resident had an indwelling catheter and had dependence on for toileting. The Care Plan revised 1/19/26 revealed Resident #7 had an indwelling urinary catheter. The Care Plan directed staff to use Enhanced Barrier Precautions (EBP) and monitor urine output The Order Summary Report dated 2/2025 revealed catheter care every shift. During observations on 2/9/26 at 11:20 AM, Staff C, certified nursing assistant (CNA), wheeled Resident #7 in a wheelchair to his room. An EBP sign hung on the door along with a pocketed device containing personal protective equipment supplies with gowns and gloves. Staff C donned a yellow gown and a pair of gloves. Staff C did not use hand sanitizer or wash her hands. Staff C obtained a graduate container from the bathroom and placed the graduate directly on the tile floor by the resident's wheelchair. No barrier was used when the graduate was placed on the floor. Staff C took the catheter bag from under the wheelchair, unclamped the catheter port, and drained the urine contents into the graduate. Staff C clamped the port on the catheter, touched and pulled her yellow gown toward the side of her uniform, reached her other hand wearing a contaminated and dirty glove into her uniform pocket, and pulled out an alcohol swab. Staff C took the alcohol swab and cleansed the catheter port, and then attached the catheter bag under the wheelchair. Staff C picked up the graduate with urine from the floor, opened the bathroom door with her hand wearing the same gloves, and emptied the graduate contents into the toilet. Staff C then tipped the graduate over and placed the graduate on a paper towel by the toilet. Staff C removed her gown and gloves, pulled the divider / privacy curtain back, then pushed the resident in the wheelchair to the dining room. Staff C then walked down the 100 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hallway into another resident's room and answered the call light. At 11:28 AM, Staff C stood near the nurse's station and placed a handful of gloves into her uniform pockets. In an interview 2/10/26 at 9:55 AM, the Director of Nursing (DON) reported she expected staff changed gloves whenever they went from a dirty to a clean task or area and washed their hands before, during and after cares. The DON stated she also expected staff rinse the graduate with water after contents were emptied and place the graduate on the back of the toilet. The DON also stated she expected a gown and glove worn whenever staff provided cares, wound care or catheter care for EBP's. Staff reaching into their pocket after they emptied a catheter is not ok. She would expect staff to make sure supplies are available prior to provided cares or performed catheter care. Staff needed to remove the dirty gloves and then apply clean gloves. An Infection Prevention and Control Program policy dated 12/23 revealed an infection prevention and control program is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility was responsible for ensuring that staff adhere to proper techniques and procedures for prevention of infection. An undated Catheter Care policy revealed the following steps: a. Gather supplies needed. b. Perform hand hygiene. c. [NAME] gloves. d. Perform perineal/catheter care e. Perform hand hygiene. A Hand Hygiene document dated 5/15/20 revealed hand hygiene is the single most important procedure in preventing infection. Hands washed with soap and water when hands are visibly soiled or contaminated with body fluids. Using an alcohol-based hand rub is appropriate for decontaminating the hands before direct patient contact, before putting on gloves, after contact with a resident or touched an inanimate object in the resident's environment, and after removing gloves. A Personal Protective Equipment: Gloves policy revised 7/2009 revealed hands washed after gloves removed. 4. The Quarterly MDS Assessment completed on 1/14/26 revealed Resident #13 with a BIMS of 3, indicating severe cognitive impairment. Diagnoses include dementia and bowel/bladder incontinence. Resident #13 noted as dependent on staff for all personal cares. The Care Plan, last revised 10/22/25, documented that Resident #13 required the assistance of one to two staff members for personal hygiene and toileting. During an observation on 2/5/26 at 11:25 AM, Staff R, CNA, and Staff S, CNA, donned on gloves, and transferred Resident #13 from a wheelchair to their bed via a mechanical lift. Once situated in bed (laying flat with staff rolling the resident on their side) Staff S initiated personal cares. A (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	soiled incontinence brief was removed. Staff S voiced the resident had a small bowel movement and used several wipes to clean the gential areas. Once finished and still with gloved hands, Staff S assisted Staff R to roll the resident on their back, used the bed control to elevate the head of the bed, resituated blankets to ensure privacy, and proceed to change Resident #13's clothing. Staff S & Staff R both lifted the soiled shirt off with Staff S repositioning the resident's head/face area with their gloved hands. Staff S handed Staff R a clean shirt for the resident. Staff S took the soiled shirt as well as a soiled mechanical lift sling, opened the door and left the room, all with gloved hands. Staff R remained in the room and finished dressing Resident #13. At no point during the completion of personal cares and prior to leaving the room did Staff S perform hand hygiene or change gloves. Staff S returned to the room, donned a new pair of gloves and assisted Staff R with transferring Resident #13 back into the wheelchair via a mechanical lift. Once the resident was situated and ready to be assisted into the lunch room, both staff members removed their gloves and completed hand hygiene. During an interview on 2/5/26 at 1:00 PM, the DON, explained hand hygiene and glove change should be performed at the start of cares, anytime ending a dirty or contaminated care/task to a clean care/task, if need to step away during the middle of a cares, and at the end. The policy Administering Medications, version 2.0 (H5MAPL0028), stated insulin pens containing multiple doses of insulin are for single-resident use only. Changing the insulin needs does not make it safe to use insulin pens for more than one resident. Insulin pens will be clearly labeled with the resident's name. Prior to administering insulin with an insulin pen the nurse will verify the correct pen is used for that resident. The policy Personal Protective Equipment-Gloves, version 1.0 (H5MAPL0622) and revised July 2009, stated staff must wear gloves when touching blood, bodily fluids, secretions, mucous membranes and/or non-intact skin. Gloves shall be worn only once and discarded. The facility document Hand Hygiene, revised 5/15/20, noted hand hygiene should be completed before touching the patient, before clean/aseptic procedures, after body fluid exposure, after touching the patient and after touching patient surroundings.