STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026
NAME OF PROVIDER OR SUPPLIER Royal Oaks Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. Based on observation, clinical record review, staff, resident, and family member interviews, the facility failed to provide necessary assistance with eating and failed to implement ordered nutritional interventions to address significant weight loss for 2 of 3 sampled residents (Resident #24 and Resident #28). Specifically, staff failed to assist residents during meals, leaving them with untouched food for extended periods, and failed to provide ordered supplements even as the residents experienced significant weight declines. The facility reported a census of 83 residents. Findings include:1. The Minimum Data Set (MDS) Assessment with reference date 1/7/26 revealed Resident #24 had diagnoses that included non-Alzheimer's dementia, anxiety and abnormal weight loss, weight 135 pounds with mechanically altered diet provided. The resident required substantial staff assistance for all activities of daily living including eating, reposition in bed, transfer to and from bed or chair, dressing and hygiene, unable to stand or ambulate, cognition not assessed and symptoms of delirium present. Physician orders included; Provide House Supplement (a liquid protein supplement) 6 milliliters (ml) (2 ounces) 3 times daily, with start date of 4/30/26. Resident #24's recorded weights included:4/3/2026 127.6 pounds4/1/2026 129.2 pounds3/17/2026 128.7 pounds2/18/2026 130.2 pounds12/3/2025 134.6 pounds11/11/2025 136.8 pounds10/15/2025 137.6 pounds9/29/2025 146.0 pounds The resident's recorded weights indicated a weight loss of 5.75 percent in 1 month, and an 11.5 percent weight loss in 6 months, both defined as significant weight losses. Notes recorded by the facility's Registered and Licensed Dietician (RDLD) Staff EE, revealed, in part:1/6/26: Quarterly Assessment: Diet is mechanical soft, intakes are fair. Resident is assisted with meals as needed/accepted. Will indicate when she does not want more. Weight 135 pounds, a loss of 8 pounds in past 6 months. House supplement given 3 times a day, shakes provided twice a day. Intakes are adequate to maintain weight, no changes. 2/19/26: Weight 130 pounds, a loss of 12 pounds in past 6 months, loss of 5 pounds in past 2 months. Weight is stabilizing. Resident tolerates mechanical soft diet well, Hospice care continues. Resident dines on assisted side of Dining Room. Shakes given twice daily, house supplement provided 3 times a day. No changes.3/19/26: March weight of 129 pounds is a significant loss of 17 pounds in past 6 months, Intake of mechanical soft diet are fair, supplement intake varies also. Res assisted as accepted. Continue current interventions. The April, 2026 Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not reveal documentation that shakes were ordered or provided, and there were no additional physician orders that addressed the resident's significant weight loss as identified by the RDLD on 3/19/26. The resident's Nursing Care Plan included a problem labeled (Resident's name redacted) requires assistance with activities of daily living (ADL's) and is at risk for late loss ADLs due to: Venous insufficiency and the aging process, initiated 3/9/20, revised 11/2/23.The 4/12/26 goal listed in the care plan was (resident's name redacted) wishes to maintain current level of physical function through the next review, initiated 3/9/20, revised 3/28/25.The Nursing Care Plan directed staff to provide 1 staff assistance for resident eating, initiated 3/10/2020, revised 2/17/25. Another care problem listed on the Nursing Care Plan was labeled, in part (resident name redacted) is at risk for weight loss related to decreased cognition, need for a mechanical soft diet and assist with meals, initiated 2/12/24, revised 4/8/26.The 4/12/26 goal listed in the care plan was (resident's name (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	redacted) will have 3 meals offered daily, intake as she desires through next review, initiated 4/11/25, revised 5/12/25.The Nursing Care Plan directed staff:Monitor at meals for signs of aspiration, choking, runny nose/eyes and report to physician as indicated, initiated 2/12/24.Monitor weight, notify Doctor of any significant change, initiated 2/12/2024, revised on 6/16/24.Monitor/document/report as necessary to physician any signs or symptoms of dysphagia: Pocketing food in cheeks, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals, initiated 2/12/24.Resident dines with supervised/assisted. Please assist as she needs/allows, initiated 2/12/24, revised 6/16/24.Resident has a chocolate shake with lunch/supper. Res will drink if they are called B-Bop shakes, initiated 4/5/24, revised 10/2/25.Serve supplement per orders, initiated 11/13/24. The nursing schedule for the 6 a.m. to 2 p.m. day shift on 4/8/26 revealed the following staff scheduled and present:Three (3) nurses including Staff V, Licensed Practical Nurse (LPN), Staff Q, LPN, and Staff I, LPN.Seven (7) Certified Nursing Assistants (CNA's) including Staff G, CNA, Staff H, CNA, Staff T, CNA, Staff U, CNA, Staff Y, CNA, Staff Z, CNA and Staff FF, CNA.Three (3) Certified Medication Aides, that are also CNA's, including Staff K, CMA, Staff GG, CMA, Staff HH, CMA, and 1 new hire CMA assigned to train with Staff HH. In all, 11 CNA's were present in the facility during the 4/8/26 day shift. Observations in the Dining Room revealed: On 4/8/26: 11:36 a.m. Resident #24 seated at a table right next to a window that was open, sheer curtain over the window that blew towards the table. The temperature outside was 45 degrees Fahrenheit at the time. A glass of orange juice with a straw was on the table, about 12 inches from the edge of the table. A blanket covered the resident from mid-chest to over her feet, her arms under the blanket. 11:44 a.m. Resident #24 remained seated in the same position, Staff K, CNA seated next to the resident approximately 3 feet from the open window. The glass of orange juice was positioned approximately 3 inches from the edge of the table, there was no visible amount of orange juice out of the glass, the resident's arms remained covered under the blanket. 11:55 a.m. Resident #24 received a grilled cheese sandwich and a yellow cake dessert, Staff K removed the crust/edges from the sandwich, did not cut the sandwich or attempt to break the sandwich into smaller pieces and placed a spoon in the bowl of dessert. 12:02 p.m. Resident #24 at the table alone, sandwich untouched on the plate, the resident's arms uncovered and rested on her lap area. Staff K now seated at the next table and assisted a different resident, turned 180 degrees around from her position at Resident #24's table, approximately 4 feet from the open window. 12:04 p.m. Resident #24 remained seated alone at the table without feeding assistance, her food untouched, Staff K remained positioned in the same seat and assisted the same resident. 12:07 p.m. Resident #24 remained seated alone, without feeding assistance, food untouched, Staff K continued to assist a resident at the next table, remained approximately 4 feet from the open window. 12:09 p.m. Staff FF, CNA brought Resident #28 into the Dining Room and positioned her across from Resident #24 at the same table, then left the Dining Room. Resident #24 remained seated with her arms in her lap, food untouched and without feeding assistance. 12:11 p.m. Staff Y, CNA was seated at the Nurses Station next to the Dining Room, and not engaged in any activity as 2 medication aides, Staff HH and a trainee were positioned at a medication cart next to the Nurses Station, and not in process of medication administration. 12:12 p.m. Resident's #24 and #28 remained seated at the table, Resident #24's food untouched and Resident #28 held a cup of milk or supplement to her own mouth, no staff assistance at the table. Staff K remained seated at the same table next to the 2 resident's table, assisted a resident at that table, the window remained opened. 12:14 p.m. Resident #28 received a divided plate of pureed food, Resident #24 remained at the table without assistance and food untouched, and Staff K moved to a different table along the opposite wall of that section of the Dining Room and provided assistance to a resident. There were 3 CNA's in the Dining Room at that time, with at least 9 residents seated that required feeding assistance. 12:15 p.m. No change at the 2 resident's table, 3 CNA's remained in the Dining Room and assisted other residents. 12:17 p.m. Staff U, CNA moved from a different feeding assistance table to Resident #24's table, closed the window, sat next to Resident (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#24 and attempted to feed the resident cake. Staff K left the Dining Room with a different resident after a Hospice aide arrived in the Dining Room and started to assist a different resident. 12:22 p.m. Staff U continued to assist Resident #24 with the same food, approximately 2 bites of dessert and 1 to 2 ounces of orange juice consumed by the resident, Resident #28 remained without feeding assistance at the same table. 12:23 p.m. Staff K returned to the Dining Room, sat next to Resident #28 and provided feeding assistance to the resident (9 minutes after her food was served and remained at the table uncovered). 12:31 p.m. Staff's K and U remained seated at the 2 resident's table, Resident #24 without further intake, no other food offered to the resident, Resident #28 had ate approximately 1/2 of the food served. Staff Y observed seated at the Nurses Station, not engaged in any activity. 12:33 p.m. Staff K removed Resident # 24 from the Dining Room, Staff U switched to the chair next to Resident #28 and provided feeding assistance to the resident. 12:36 p.m. Resident #24 positioned in the Broda chair near the doorway in her room, Staff U remained next to Resident #28 and attempted feeding assistance, no observed change in the amount of food eaten by the resident. On 4/9/26 revealed: 11:36 a.m. Resident #24 seated at the table covered with a blanket from her waist area to over her feet. Glass or orange juice on the table, no food and no staff assistance. 11:58 a.m. Resident #24 fed by a Hospice CNA seated next to her. A grilled cheese sandwich that was cut into small bite-sized pieces was fed to the resident with a fork, at times the resident nodded her head back and forth to indicate no, and at the same time opened her mouth, accepted the food and chewed the food, willingly accepting additional bites as served by the aide. The resident was offered a drink with a straw in between the bites. Resident #28 was now seated at the table, did not have food or drink. 12:13 p.m. Resident #24 continued to be fed by the Hospice CNA, Resident #28 had pureed food on a divided plate in front of her, no feeding assistance provided to the resident. There were 2 other facility CNA's seated in the Dining Room at the time and provided feeding assistance to other dependent residents. 12:18 p.m. Resident #24 continued to be fed by the Hospice CNA, has ate over 1/2 the sandwich and at least 6 ounces of orange juice. Another CNA sat down next to Resident #28 at this time and began to provide feeding assistance, the resident had not attempted to feed herself. On 4/3/26 revealed: 8:34 a.m. Resident #24 seated in Broda chair in the Dining Room covered with blanket from waist to feet waiting to be served breakfast. Staff DD, CNA stood beside her. 8:40 a.m. Staff DD pushed resident out of Dining Room to the TV room, when asked if she ate breakfast, he reported she did not want to eat anything this morning. Resident family interview revealed: 4/7/26 at 7:22 p.m. a family member stated they had a relative that visited Resident #24 nearly daily during a meal time, and they went at least twice a week on days that their relative couldn't visit Resident #24. The family member reported they always found the resident seated at a table with cold food, without any staff assistance and the resident unable to feed herself. If there were staff in the Dining Room they were on their cell phones, didn't assist residents that needed help, there were several residents that needed help, and nobody there would do anything about it. Their family brought milk shakes to the resident daily that they fed the resident, they also brought tuna salad sandwiches as they were soft and the resident ate them. The family member believed the only reason the resident hasn't lost very much weight was from their family's support, because the resident did not get assistance from the staff. They reported their concerns to management staff at least 3 times and nothing changed. They would move the resident to another facility where the staff actually assisted the residents but feared the resident would further decline due to the sudden change and her dementia diagnosis. 2. The Minimum Data Set (MDS) Assessment tool with 2/23/26 reference date revealed Resident #28 had diagnoses that included anemia, thyroid disorder and non-Alzheimer's dementia, scored 6 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment that indicated severe cognitive impairment, without symptoms of delirium present, and weight of 133 pounds identified as a significant weight loss of 5 percent or greater in 1 month or 10 percent or greater in 6 months that preceded the assessment. The MDS document revealed the resident required substantial/maximal staff assistance to reposition in bed, transfer to and from bed or chair, dressing, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	toileting and bathing, and required staff supervision or touch assistance for eating. Physician orders included; Provide House Supplement (a liquid nutritional supplement) 60 milliliters (ml) (2 ounce serving) 3 times daily, ordered 6/19/25. Weights recorded in the clinical record included: 12/5/25 151.2 pounds2/2/26 150.0 pounds3/3/26 147.2 pounds3/17/26 143.2 pounds4/6/26 128.4 pounds The resident's recorded weights indicated a weight loss of 13.9 percent in 6 months, identified as a significant weight loss by the Centers for Medicaid/Medicare Services (CMS) Notes recorded by the facility's Registered and Licensed Dietician (RDLD) Staff EE, revealed, in part: 1/15/26 - Resident dines in Dining Room for assist as needed. Intakes ~75 percent. Weight 151pounds, stable. Resident accepts 60 milliliters (ml) house supplement TID (3 times daily) intakes vary. Est Needs (68 Kg) 1836-2176 Kcals, 68-88 grams protein 2040 ml fluids(30ml/Kg). Intake of meals & supplements adequate to meet estimated needs. Recommended 500mg L-Arginine TID to support wound healing, continue weekly weights. 1/29/26 - Weekly meeting completed with IDT (interdisciplinary team) area to foot classified as stage III pressure sore. 1+ pitting edema of bilateral lower extremities per notes. Recommend Prostat daily, to add 100 Kcals and 15grams protein to diet,January weight of 153.6 pounds is stable past 6 mos. Interventions in place/accepted for healing. 2/13/26 - Weekly weight 133.2 pounds, a significant loss of 17 pounds in past week. Diet is puree, intakes ~50%. Interventions in place as above. Stage III pressure sore to Rt foot continues. Wound has declined. Per nursing resident has admitted into Hospice care. Will transition to monthly weights for comfort. Nutrients are provided in-excess ofestimated needs, but are not adequately consumed. 3/5/26 - Met with IDT to review monthly weights. Weight 144 pounds is a loss of 6 pounds in past month, 4pounds in past 6 mos. Resident continues on Hospice care and staff assist with meals as accepted. Continue current interventions as weight is stable. The resident's Nursing Care Plan included a problem labeled (Resident's name redacted) requires assistance with ADL's (activities of daily living) and transfers related to her dementia and impaired gait, initiated10/7/2021, revision on 4/22/2025, with 6/3/26 goal(resident's name redacted) wishes to remain well-groomed and free of odors daily through the next review. The Nursing Care Plan directed staff:(Resident's name redacted) prefers to feed self independently with set up assistance, initiated11/26/2021, revised on 9/10/24. Another Nursing Care Plan problem labeled (resident's name redacted) is at risk for impaired nutrition related to: moderate protein calorie malnutrition, dementia, adult FTT (failure to thrive), altered diet, significant weight loss past month, initiated 10/7/2021, revised 4/99/2026, with 6/3/26 goals:(Resident's name redacted) will have 3 meals served daily, intake as desired through next review date, initiated 4/15/2025, revised 4/9/2026.(Resident's name redacted) will weigh 145-155# through next review date, initiated 4/15/2025, revised 3/15/2026.The Nursing Care Plan directed staff:(Resident's name redacted) set up/assist as needed, initiated 7/13/2023, revised 4/9/26.Offer ice cream PRN (as needed), initiated 1/19/2023, revised 9/10/2024.Provide alternates at meals as needed, initiated 10/12/2021, revised 9/10/2024.RD (registered dietician) to evaluate as needed, initiated10/12/2021, revised 9/10/2024.Serve diet as ordered, initiated 4/20/2023, revised 7/2/2025.Serve supplements per orders, extra foods per tray ticket, initiated 4/9/2026.Weights as directed, notify Dr of any significant change. Weights may fluctuate due to diagnoses CHF (congestive heart failure), CKD (chronic kidney disease), initiated 10/12/2021, revised 9/10/24. Staff interviews revealed: 4/8/26 at 2:06 p.m. the Director of Nursing (DON) stated she expected staff to be present and assist residents that required feeding when meals were served in the Dining Room. Staff should tell them what is on their plates and offer/accommodate the resident's preferences. There were residents that received room trays and required feeding assistance, she expected staff that passed the trays to provide the assistance needed to the resident. Resident #24 liked egg salad, grilled cheese sandwiches, ice cream, the dietary department makes their own protein shakes that she will drink. If the resident did not eat the food offered, she expected staff to offer other foods that the resident preferred to encourage her food intake. The DON stated there were 7 residents that required feeding assistance and 10 residents that required staff supervision and coining assistance for meals. 4/9/25 at 8:38 a.m. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff EE, Registered and Licensed Dietician (RDLD) stated staff should provide the supplements that are ordered for Resident #24, dietary serve her shakes twice a day and fortified ice cream. She should be brought to the Dining Room and staff should encourage and assist her to eat. Staff EE is included in a weekly interdisciplinary meeting where they review monthly and weekly weights, and how she is notified of recent changes. Staff EE made recommendations for the residents identified with weight loss/gain and communicated the recommendations to staff for implementation. 4/9/26 at 11:34 a.m. Staff Z, CNA, stated on the day shift 3 CNA's were to be in the Dining Room to provide feeding assistance to residents, the other CNA's on duty were to pass room trays provide feeding assistance to those residents if needed.

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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 observation, record review, and staff interviews, the facility failed to provide proper wound care for two of two residents reviewed with pressure ulcers and failed to document a total of 9 treatments for 3 different pressure ulcers for Resident #21 and failed to document a total of 7 treatments for 3 different wounds as being completed and failed to utilize proper infection control techniques while providing wound care to Resident #22. The facility reported a census of 83 residents. Findings include:The Minimum Data Set (MDS) dated [DATE] identified Resident #21 as severely cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 2 and had the following diagnoses: Coronary Artery Disease, Heart Failure and Alzheimer's Disease. The MDS also identified Resident #21 to be totally dependent on staff for assistance with all activities of daily living except for eating. The MDS also identified Resident #21 with two unstageable pressure ulcers. A review of the Physician Orders revealed the following:1/25/26 heel boots on at all times as tolerated.2/5/26 Left Heel: cleanse with wound cleanser, pat dry, apply betadine moistened gauze secure with gauze roll and tape QD and PRN one time a day for pressure sore and as needed.2/22/26 Weekly Skin Assessment in the evening every Saturday for monitoring.2/25/26 Right Coccyx: cleanse wound with quarter strength Dakins, loosely pack wound bed with Dakins moistened calcium alginate, cover with ABD pad daily and PRN if becomes loose or soiledevery day shift for coccyx wound care and as needed for if becomes loose or soiled On 3/7/26, The Care Plan identified Resident #21 with the problem of a pressure ulcer or potential for pressure ulcer development and directed staff to administer treatments as ordered and observe for effectiveness A review of the March 2026 TARs (Treatment Administration Records) revealed the following:Left heel: cleanse with wound cleanser, pat dry, apply betadine moistened gauze secure with gauze roll and tape QD (once daily) and PRN (as needed) one time a day for pressure soreTreatments were not signed out as completed on March 18, 25, and 29Right Coccyx: cleanse wound with quarter strength Dakins, loosely pack wound bed with Dakins moistened calcium alginate, cover with ABD pad daily and PRN if becomes loose or soiled every day shift for coccyx wound careTreatments not signed out as completed on March 2, 10, 14, 21, 25 and 30LT Buttock: Cleanse with cleanser of choice apply magic butt paste BID and PRN two times a day related to unstageable pressure ulcerTreatments not signed out as completed on March for 8:00 AM dose on March 18 and 25 and for 4:00 PM dose on March 2, 3, 4, 10, 17, 25, 29, and 30.RT Buttock: Cleanse with Cleanser of choice apply magic butt paste BID and PRN two times a day of woundTreatments not signed out as completed on March for 8:00 AM dose March 18, 25 and for 8:00 PM dose 15, and 25. An observation of wound care on 4/1/26 at 10:33 AM revealed staff donned isolation gown and gloves, changed gloves and sanitized hands appropriately between wounds which all appeared without signs of infection. A review of the April 2026 TARs revealed the following:Left Heel: cleanse with wound cleanser, pat dry, apply betadine moistened gauze secure with gauze roll and tape QD and PRN one time a day for pressure soreTreatments not signed out as completed on for 8:00 AM on April 3 and 7Right Coccyx:: cleanse wound with quarter strength Dakins, loosely pack wound bed with Dakins moistened calcium alginate, cover with ABD pad daily and PRN if becomes loose or soiled every day shift for coccyx wound careTreatments not signed out as completed on for day shift on April 3, 5, 7Sacrum: cleanse with Vashe soaked gauze and allow to dwell for 3-5 minutes, pat dry. Apply xeroform gauze, cover with ABD pad and secure with tape QD (daily) in the morning for wound.Treatments were not signed out as completed on for the morning dose on April 1. In an interview on 4/8/26 at 12:29 PM, the DON (Director of Nursing) reported after a nurse completes a treatment for a pressure ulcer, she would you expect the nurse to initial the TAR (Treatment Administration Record) to show it had been completed, right after the treatment had been completed. In an interview on 4/8/26 at 1:00 PM, the DON reported the following regarding Resident #21's treatments not signed out: she could not speak to the specific reason the treatments were not (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed throughout March/April. She did confirm is that this has been identified as a concern. The facility is reviewing the documentation and processes with staff, reinforcing expectations for completing and documenting treatments per physician orders, and implementing increased auditing to ensure compliance moving forward. A review of the Facility Policy Titled: Administering Medications with the last revision date of December 2012) had documentation of the following:Medications must be administered in accordance with the orders, including any required time frame.The individual administering the medication must document such in the eMAR (electronic Medication Administration Record) system after giving each medication and before administering the next ones.Topical medications used in treatments must be recorded on the resident's treatment record (TAR). The MDS dated [DATE] identified Resident #22 as cognitively intact with a BIMS score of 13 andhad the following diagnoses: Renal Insufficiency (Kidney Failure), Diabetes Mellitus and Spina Bifida. The MDS also identified Resident #22 to be totally dependent on staff for assistance with most activities of daily living except for oral hygiene and eating. The MDS also identified Resident #22 with an indwelling urinary catheter and had one Stage IV pressure ulcer. An observation of wound care on 4/3/26 revealed the following:10:35 AM both Staff B, LPN and Staff C, LPN used hand sanitizer, donned isolation gowns and gloves11:00 AM Staff B, LPN used scissors to cut through the kerlix dressings from each foot. Staff C, LPN then lifted up Resident #22's left foot, which had open area to left heel with necrotic area in the middle, surrounding skin appears reddened. Staff B, cleansed the left heel wound with VASHE wound cleanser then applied betadine soaked 4x4s and wrapped with kerlix dressing. Staff B did not disinfect scissors before cutting the new kerlix dressing.11:11 AM Staff B then cleansed the wound to the right medial calf with VASHE soaked gauze. She did not change gloves after cleansing the wound and before she picked up the new calcium alginate dressing. She did not disinfect the scissors before she cut the calcium alginate dressings. She then applied the calcium alginate dressings to the wound followed by the soft silicone dressing. Staff B then removed her gloves, used Alcohol Hand Rub and pointed to the dressing to Resident #22's right foot and said to the surveyor I don't know what's going on with that foot Staff B asked Staff C to check to see TAR (Treatment Administration Record). Staff C left the room.11:16 AM Staff B did not disinfect the scissors before she cut the kerlix (which was dated 4/2/26) off the right foot then placed the scissors in a plastic bag beside the resident. She found an open area with a necrotic center approximately quarter sized and removed the dressing from the foot and verified the surveyor's observation.11:18 AM Staff C returned to the room wearing isolation gown and gloves and reported the wound nurse came yesterday and healed that area out and discontinued the dressing. Staff B then placed the soiled dressings into trash and did not cleanse the wound to the right heel or apply a new dressing. Both used correct technique to doff both gown and gloves and washed hands. A review of the physician orders and April 2026 TARs revealed the following:Left heel: cleanse with Vashe, pat dry apply betadine moistened gauze and cover with roll gauze daily. in the morning for wound.Treatments were not signed out as completed on April 5 and 6.Right foot lateral cleanse with wound cleanser of choice, pat to dry, apply calcium alginate to wound bed, cover with abd pad and roll gauze, secure with tape. Change daily and as needed if becomes soiled or falls off. one time a day for wound.Treatments were not signed out as completed on April 2, 5, 7.Right medial lower leg and left posterior thigh) cleanse with Vashe soaked gauze and allow to soak for 3-5 minutes, pat dry apply TRIAD paste to wound bed and cover with Allevyn foam change Monday, Wednesday, Friday in the morning every Mon, Wed, Fri for wound.Treatments were not signed out as completed on April 1.Right medial lower leg and left posterior thigh) cleanse with Vashe soaked gauze and allow to soak for 3-5 minutes, pat dry apply TRIAD paste to wound bed and cover with Allevyn foam change Monday, Wednesday, Friday in the morning every Mon, Wed, Fri for woundTreatments were not signed out as completed on April 1. On 4/2/26, the Care Plan identified Resident #22 with an unstageable pressure ulcer on the left heel and a stage 3 pressure to the Coccyx and directed staff to:Administer medications as ordered. Observe for/document side effects and effectiveness.Administer treatments (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as ordered and observe for effectiveness.Pressure reduction mattress to prevent skin breakdown as ordered In an interview on 4/8/26 at 10:45 AM, Staff B, LPN reported the following:When asked when she would you need to disinfect her scissors during wound care, sheadmitted she knew she forgot to do that after she cut the dressing off. She should have disinfected them afterward and before she cut the new dressings.When asked when she would need to change gloves during wound care, she reported fromclean to dirty. She would remove the bandages, remove the gloves, sanitize her hands and put on clean glovesWhen asked about the wound Resident #22 had on the bottom of her right foot, she did verifythere was a necrotic area there. She discussed it with the DON as there was no order to treat that wound on the TAR. The order was in a different place and did not get transcribed to her TAR. She returned to Resident #22's room later and completed the treatment after she found the order. The DON found the order under other. In an interview on 4/8/26 at 12:29 PM, the DON reported the following:She would expect the nurses to disinfect their scissors during wound care anytime they go from dirty to clean She would expect nurses to change gloves during wound care between areas and between dirty to clean.When asked about the wound to the right foot and that Staff B, LPN could not find orders to treat the wound on the right foot, the DON explained that wound had not healed out as Staff C had originally stated. The order to treat that area on the bottom of the right foot was in the physician orders, but it did not get transcribed to the TAR. When the nurse enters an order in the system, there is a box on the bottom of the screen where the nurse should choose where it should appear at: the MAR, TAR or standard other. It had shown up on standard other. Staff P, LPN/ADON, made rounds with the Nurse Practitioner, entered the orders into PCC (Point Click Care electronic medical records), however, the orders did not get transcribed on to the TAR. In an interview on 4/8/26 at 12:55 PM, Staff C, LPN/ADON reported the following:She would disinfect her scissors during wound care after cutting one dressing off and before cutting the new one.She would change her gloves during wound care when going from one area to the next area or moving from one piece of the treatment to the nextWhen asked if she could verify that Resident #22 did have a wound to the bottom of her right foot, she verified she did report that wound had been healed out. She also reported the order appeared on the TAR that NP discontinued the order to treat that wound and then she started a new treatment to it, but instead of it being transcribed to the TAR, it went to standard other. They never use that option standard other, when putting the order it, the nurse needs to physically change it from standard other to the standard TAR. She would need to clarify what kind of wound it is, pressure or otherwise. A review of the Facility Policy titled: Skin and Wound Management System dated as last revised September 2022 had documentation of the following:Residents identified with skin impairments will have appropriate interventions, treatment and services implemented to promote healing and impede infection. Wound location, characteristics and a physician's order for treatment are documented in the medical record. Wound status will be evaluated and documented in PCC on the Wound Evaluation Flow Sheet form.

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F 0690 Level of Harm - Minimal harm or potential for 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 observation, clinical record review, facility policy review, and staff and resident interviews, the facility failed to ensure residents had physician orders for urinary catheters for 1 of 5 residents reviewed for urinary catheters (Resident #25), and failed to ensure staff provided appropriate catheter care that included infection control precautions for 2 of 5 residents reviewed for urinary catheters (Resident's #25 and #27). The facility reported a census of 83 residents.Findings include:1.The Minimum Data Set (MDS) Assessment tool with 1/07/26 reference date revealed Resident #27 had diagnoses that included obstructive uropathy, urinary tract infection, hemiplegia (paralysis on 1 side of the body), sepsis from unspecified organism, gross hematuria (blood in the urine) and bacteremia (infection in the blood). The assessment revealed a urinary catheter used for urination. The Care Plan for Resident #27 identified a focus with initiated date of 3/18/22 as follows; resident had a urinary catheter with diagnoses of hydronephrosis (the swelling of one or both kidneys causing urine buildup, occurring when urine flow is blocked or flows backward), with renal and ureteral calculous obstruction (kidney stone). The Care Plan documented interventions to be completed by staff to include; follow enchanced barrier precautions, monitor catheter tubing for drainage and kinks with all cares, position catheter tubing and bag below the level of the bladder and away from entrance to the door. A urinalysis with reflex microscopic and culture report (urine sample tested for bacteria identification and antibiotic treatment recommendations) collected on 3/30/26, reported on 4/1/26 revealed the resident's urine infected with more than 100,000 colony forming units per milliliter of urine of Proteus Mirabilis/Penneri, a harmful bacteria that caused a urinary tract infection and required treatment with antibiotic medication. A physician order dated 4/1/26 directed staff to administer Ceftriaxone (a very strong antibiotic medication) 1 Gram injected by intramuscular injection (a shot) 1 time daily for 6 days. The resident was hospitalized from [DATE] to 3/5/26 for treatment of a heart arrythmia, gross hematuria, urinary tract infection with sepsis, and treatment of renal calculi (stones). A computed tomography (CT) scan of the abdomen and pelvis completed on 2/25/26 revealed multiple coarse calcifications surrounding the urinary catheter, that indicated the catheter could not have been changed on 2/24/26 as documented. Observation on 4/6/26 at 2:29 p.m. revealed Staff L, Certified Nursing Assistant (CNA) in Resident #27's room, stated he had to transfer the resident from his wheelchair to his bed. When Staff L left the resident's room at 2:32 p.m. observation revealed the resident in bed and his urinary catheter bag laid directly on the floor near the resident's bed. 2. The MDS dated [DATE] identified Resident #25 as cognitively impaired and did not have a BIMS (Brief Interview for Mental Status) score. The MDS also identified Resident #25 had the following diagnoses: Hemiplegia (paralysis of one side of the body) after cerebral infarct (stroke), Gastrostomy and Slow Transit Constipation. The MDS also identified Resident #25 to be totally dependent on staff for assistance with all activities of daily living and being incontinent of both bladder and bowel. A review of the Hospital Discharge Instructions dated 4/6/26 did not include orders for the indwelling (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	urinary catheter. The Order Summary Report with run date of April 15, 2026 lack order for a indwelling urinary catheter. A review of the Care Plan on 4/8/26 did not have documentation of the indwelling urinary catheter. Observations on 4/7/26 revealed the following at: 12:09 PM lying in bed with the head of the bed elevated, air mattress in place and properly inflated. Tube Feeding bag dated 4/6/26 and running via Covidien pump at 60 ml/hr (milliliters per hour). Foley bag without a dignity flap or bag hanging below bladder level on side of the bed facing the door to his room which was wide open and visible from the doorway. The Foley tubing was observed on the floor. 12:20 PM assessment unchanged. Foley tubing remained on the floor. No staff noted in the hallway. 12:26 PM Staff G, CNA walked past this room pushing a food cart, picking up food trays and did not pick up the Foley tubing off the floor. 12:30 PM Staff II, RN/ADON walked past this room to talk to another resident yelling at the end of the hall. Did not stop to pick up Foley tubing off the floor after tending to the other resident. 12:31 PM Staff G, CNA and Staff II, RN,/ADON walked past this room and did not pick up Foley tubing off the floor. 12:32 PM Staff I, LPN stood in doorway to room next to this room with a medication cart. 12:35 PM Staff I, LPN walked into the resident's room, did not pick up Foley tubing off the floor. 12:44 PM Staff G, CNA walked past this resident's room with 2 full bags of trash and did not stop to pick up Foley tubing off the floor. 12:50 PM Staff I, LPN walked into the resident's room and did not pick up Foley tubing off the floor 1:03 PM Staff I, LPN walked into the resident's room and did not pick up Foley tubing off the floor. 1:18 PM Foley tubing remains on the floor, currently no staff in the hallway at this time. 1:25 PM assessment unchanged. 1:40 PM assessment unchanged. 1:55 PM assessment unchanged. 2:09 PM Staff H, CNA entered resident's room with isolation gown and gloves on, used correct technique to empty Foley bag and picked up tubing off the floor. In an interview on 4/8/26 at 7:36 AM, Staff G, CNA reported if a resident had an indwelling urinary catheter, the tubing should never be on the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/8/26 at 8:15 AM, Staff H, CNA reported when taking care of a resident with an indwelling urinary catheter, he would ensure the Foley tubing would never be on the floor. In an interview on 4/8/26 at 9:38 AM, Staff I, LPN reported when taking care of a resident that had an indwelling catheter, she would make sure the Foley tubing is never on the floor. When a resident comes back from the hospital with an indwelling catheter and does not have orders for it, the nurse should call to get an order within 24 to 48 hours. She reported Resident #25 did not have the catheter before he went to the hospital and she informed the Staff II, RN/ADON that he did not have orders for it. In an interview on 4/8/26 at 12:29 PM, the DON reported she would expect staff to ensure that Foley catheter tubing should never be on the floor. When a resident returns from the hospital with an indwelling catheter and has no physician orders for it, she would expect the nurse to call the physician for orders within 24 hours. She could not explain why this was not completed for Resident #25. In an interview on 4/8/26 at 12:55 PM, Staff C, LPN/ADON reported if she received a resident after being transferred from a hospital with an indwelling catheter and no order for it, she would call the physician for an order within the first 24 hours. A review of the Facility Policy titled: Catheter Care, Urinary dated as last revised August 2022 had documentation to be sure the catheter tubing and drainage bag are kept off the floor.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on direct observation, clinical record review, staff and resident interview, and facility policy review, the facility failed to protect residents from significant medication errors by allowing residents who were not assessed as competent to self administer medication to do so, and by preparing and issuing medications to multiple residents simultaneous. This impacted two residents. (Resident #1, #16). The facility reported a census of 83 residents. Findings include: Review of Resident #1's Minimum Data Set (MDS), revealed his Brief Interview for Mental Status (BIMS) score was 15, indicating intact cognition. Review of other clinical files for the resident revealed he did not have an order to self-administer medication. Review of Resident #16's MDS revealed her BIMS score was 15, indicating intact cognition. It revealed the following relevant diagnoses: Anemia, Hypertension (High blood pressure), heart failure, renal insufficiency (kidney disease), seizure disorder or epilepsy. Review of other clinical files for the resident showed she did not have an order to self-administer medication. A direct observation on 04/06/2026 at 02:40 PM of Resident #1's room revealed a medication cup with two small white pills on a bed-side table next to the resident's bed. The resident was in bed and informed the surveyor the medication was Tylenol. During the observation Resident #1 told the surveyor staff members let him take his medication on his own, setting the pills on his table for him to take it. He stated they usually do not watch him take his medication. Review of the nursing progress notes for Resident #16 documented the following: During the night shift on 04/08/2026 a staff member prepared both Resident #16 and her roommates medication at the same time, entered the room, and gave both residents their medication. It documented the staff member did not observe the residents taking their medication and left the medication with the residents to self-administer. Upon returning back to the room, the staff member was informed by Resident #16's roommates that the name on the medication cup she was handed was not hers. Upon review the staff member realized she had given the residents the wrong medication. Resident #16 had already consumed her roommates medication when she entered the room again. Nursing progress notes also document a change in the resident's mental status, increased thirst, and an increase in desire to sleep. The following medications were noted to have been given in error: Simvastatin Oral Tablet 40 MG Gabapentin Oral Tablet 600 MG oxyBUTYnin Chloride Oral Tablet 5 MG In an interview on 4/7/26 at 10:06 a.m., Staff V, LPN stated since the last Iowa DIAL visit nursing staff had been instructed they were to observe residents take their dispensed medications, and they were not to leave dispensed medications in resident rooms for them to take later. Staff V stated despite the instruction there were at least 2 times that night shift staff had left medications in resident rooms that she found when she worked on her assigned 6 a.m. to 6 p.m. shift. She reported the issue to the manager and the staff responsible were not happy about it. She went on to say when she spoke to the nurse responsible for it they expected her to dispense the medications for them (since they were already signed out), which she would not do and part of the reason she reported it to the manager. In an interview on 04/08/2026 at 03:07 PM with Staff Q, Licensed Practical Nurse (LPN), she identified herself as the staff member responsible for the medication error. She stated it is never appropriate to pass medication to two residents at the same time and noted that it is because medication errors like this are more likely to occur when you are passing medication to multiple people at the same time. She confirmed she is required to watch residents take the medication unless they have an order to self administer and confirmed the resident did not have an order to self administer medication. She also confirmed that preparing multiple residents medication had been a source of ongoing education within the facility. In an interview on 04/08/2026 at 03:26 PM with Staff JJ, Certified Medication Aide (CMA), she stated she is only allowed to pass medication to one resident at a time. Only when she is finished and the resident has either taken or refused the medication can she move on to the next resident. She stated it is to avoid confusion and prevent medication errors. Additionally, she stated it wasn't appropriate to leave a medication at a residents bedside unless they have an order to take it themselves. In an (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 04/08/2026 at 03:29 PM with Staff KK, CMA, She stated they are instructed to pass medication to only one resident at a time. She also stated she wasn't allowed to leave medications at a residents bedside. In an interview on 04/08/2026 at 01:03 PM with the Assistance Director of Nursing (ADON), she confirmed it was inappropriate to prepare multiple medications for multiple residents at the same time, and stated it was prohibited to leave medication at a residents bedside unless they had an order to self-administer medications. She stated it had to be assessed by the team and the resident had to be cleaned before that could happen. She confirmed the residents involved did not have orders to self-administer medications. In an interview on 04/08/2026 at 12:37 PM with the Director of Nursing (DON), she stated she was aware of the medication error that had occurred in the early morning hours of the day. She stated it is her expectation that staff members prepare one residents medication at a time, watch them take the medication or document a refusal, and then move on to the next resident. She confirmed the residents did not have an order to self administer their medications and agreed staff members cannot leave medications at a residents bedside without the order. Review of a facility provided document titled Administering Medications, with a last revised date of December 2012, documented the following: Staff members must confirm the identify of the resident they are administering medication to. Residents may self administer medication only if the medical team has assessed the resident as competent to do so and the physician has written and order for them to do so. Staff members must follow the seven rights of medication administration, which includes ensuring the medications are passed to the right person.

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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, record review and staff interviews, the facility failed follow proper isolation precautions for 4 of 4 residents reviewed and failed to put on (don) an isolation gown while providing catheter care and incontinence cares for Resident #11. The facility also failed to provide personal protective equipment (PPE) for two residents that required contact precautions for Parainfluenza Virus for Resident #17, and for Clostridium difficile for Resident #29. The facility additionally failed to don PPE prior to transferring Resident #27. The facility reported a census of 83 residents.1.The Minimum Data Set (MDS) Assessment tool with 1/07/26 reference date revealed Resident #27 had diagnoses that included obstructive uropathy, urinary tract infection, hemiplegia (paralysis on 1 side of the body), sepsis from unspecified organism, gross hematuria (blood in the urine) and bacteremia (infection in the blood). The assessment revealed a urinary catheter used for urination. A physician order dated 3/16/26 directed staff to change the urinary catheter size 16 French with 10 cubic centimeter (cc) sized balloon and drainage bag monthly and as needed. A physician order dated 3/16/26 directed staff to used Enhanced Barrier Precautions (EBP), with gown and gloves worn for high contact resident care that included transfers. A urinalysis with reflex microscopic and culture report (urine sample tested for bacteria identification and antibiotic treatment recommendations) collected on 3/30/26, reported on 4/1/26 revealed the resident's urine infected with more than 100,000 colony forming units per milliliter of urine of Proteus Mirabilis/Penneri, a harmful bacteria that caused a urinary tract infection and required treatment with antibiotic medication. A physician order dated 4/1/26 directed staff to administer Ceftriaxone (a very strong antibiotic medication) 1 Gram injected by intramuscular injection (a shot) 1 time daily for 6 days. Observation on 4/6/26 at 2:29 p.m. revealed Staff L, Certified Nursing Assistant (CNA) in Resident #27's room, without personal protective equipment (PPE) worn, stated he had to transfer the resident from his wheelchair to his bed, and provided 1 to 1 assistance with direct resident contact as the resident was transferred to bed. When Staff L left the resident's room, he was questioned about the PPE equipment located on the resident's room door, and the Enhanced Barrier Precautions sign affixed to the door with the PPE equipment. Staff L stated this was only his 2nd or 3rd day there, he saw the sign but saw other staff go into the resident's room without any PPE on and didn't think he was required to use PPE. Observation at that time revealed the resident in bed, and his urinary catheter bag laid directly on the floor near the resident's bed. During an interview on 4/6/26 at 3:20 p.m. the Administrator stated the facility did not utilize Skills Competency Checklists, new staff were assigned to work with another employee with the same position to orient to the facility, and continued to work with the assigned employee until the new-hire was comfortable and thought they didn't require additional guidance or instruction. 2. A direct observation on 04/06/2026 at 2:33 PM noted two doors, one marked Transmission Based Precautions and another marked Droplet Precautions to be opened without staff in them. The Room marked Droplet Precautions was identified as Resident #17's room. The room marked Transmission Based Precautions was identified as Resident #29's room. The surveyor approached Staff DD, CNA, at this time and asked him if the doors should be open. He stated he did not know. He was then asked if (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Resident #17 was on droplet precautions and if Resident #29 was on transmission based precautions, he stated he did not know. It was requested at this time that Staff DD close the doors for safety. Staff DD entered both rooms to inform the residents he was closing the doors, both times without Personal Protective Equipment (PPE). After closing the doors he was asked if he should have worn PPE when entering a resident's room who was noted to be on droplet precautions. He stated he did not know.Review of Resident #17's nursing progress notes revealed the resident had recently returned from the hospital with a diagnosis of Parainfluenza Virus, a contagious respiratory illness, and confirmed he was on droplet precautions as of 04/06/2026Review of Resident #29's nursing progress notes revealed the resident was on isolation precautions due to a diagnosis of Clostridium Difficile (C-Diff), a highly contagious fecal bacteria that causes cramping and diarrhea as of 04/08/2026In an interview on 04/06/2026 at 03:11 PM with the Director of Nursing (DON), she confirmed that Resident #17 was on droplet precautions and Resident #29 was on isolation. She confirmed the doors should have been closed and not let open to the hallway.

3.The Minimum Data Set (MDS) dated [DATE] identified Resident #11 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 12 and had the following diagnoses: Cancer, Neurogenic Bladder and Coronary Artery Disease. The MDS also identified Resident #11 as totally dependent on staff for assistance with toileting, showers, dressing, putting on and removing footwear and repositioning. The MDS also identified Resident #11 had an indwelling urinary catheter and was incontinent of bowel.

On 9/10/24, the Care Plan identified Resident #11 with the problem: she has a SP (Supra Pubic) urinary catheter due to a diagnosis of MS (Multiple Sclerosis) and Neurogenic Bladder, and is at increase risked for UTIs.

On 10/4/24, the Care Plan directed staff to follow enhanced barrier precautions.

Observations of catheter care and incontinence cares on 4/1/26 revealed the following:

6:30 AM Staff A, CMA/CNA in Resident #11's room providing incontinence care after she had a bowel movement. Staff A wore gloves, however, did not don an isolation gown.

6:42 AM Staff A, CMA/CNA changed gloves, however, did not don an isolation gown before he emptied the catheter bag.

A review of the Physician Orders revealed the following order:

3/16/26 Enhanced Barrier Precautions (EBP): Use gown and gloves for high contact resident care including dressing, bathing, showering, transfers, hygiene care, assisted toileting, peri care, wound care and care of any device (Catheter, wound care) every shift.

In an interview on 4/8/26 at 7:36 AM, Staff G, CNA reported before providing catheter care on a resident, he would inform the resident what he would be doing, put on the gown and gloves and complete cares.

In an interview on 4/8/26 at 8:15 AM, Staff H, CNA reported before providing catheter care on a resident, he would need to put on a gown, mask and put on gloves.

In an interview on 4/8/26 at 9:38 AM, Staff I, LPN reported before providing catheter care on a
(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026

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

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident, she would need to don an isolation gown and gloves. In an interview on 4/8/26 at 12:29 PM, the DON (Director of Nursing) reported before providing catheter cares, she would expect the staff to don a gown, wash hands and don gloves. A review of the undated Infection Control Precautions Summary had documentation that Enhanced Barrier Precautions will be utilized for residents that have active or colonized epidemiological important MDROs (Multi Drug Resistant Organisms). The PPE (Personal Protective Equipment) to be utilized include gown and gloves. This would include during dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs/toileting, device care including catheter, open wound care, central line, feeding tube, or trach/ventilator.