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	06/11/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility investigation summary report, resident and staff interview and policy review the facility staff failed to provide care for a resident in an environment that maintained or enhanced dignity for one of six residents sampled that required assistance (Residents #1). The facility reported a census of 81 residents. Findings include: The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 admitted to the facility on [DATE] and had diagnoses of a colostomy and an ileostomy. The MDS documented the resident had a Brief Interview for Mental Status score of 15, indicating intact cognition. The MDS indicated the resident had dependence on staff for toileting and had a surgical wound.The Care Plan initiated 4/9/26 and revised 4/16/26 revealed the resident had a colostomy and ileostomy related to an ileus (a temporary slowdown or stoppage of intestinal movement). The Care Plan directed staff to change the bag after each bowel episode or when the bag was full, and to alert the nurse to change the bag. Progress Notes dated 4/10/26 at 10:44 AM, revealed Resident #1 reported to the Social Services Director (SSD) that on the evening of 4/9/26, he activated the call light due to a concern that his colostomy bag was leaking. The resident stated the nurse responded and applied tape to further secure the colostomy appliance. The resident called the nurse back shortly thereafter, stating the bag continued to leak. The resident expressed concern that the removal caused or worsened a skin irritation around the stoma site, and he felt the irritation was done intentionally by the nurse. The nurse reported she responded to the resident's call light regarding a leaking colostomy appliance and initially attempted to secure the bag with tape. Upon being notified that the appliance continued to leak, the nurse removed the appliance, stating a concern that it may have been contributing to the skin irritation. The nurse reported she attempted to loosen the appliance using a warm washcloth during removal. The nurse noted that a skin irritation was present around the stoma site. The appliance was subsequently replaced by the facility nursing staff. The resident expressed dissatisfaction with the placement and independently adjusted the colostomy appliance himself. The facility's investigation summary revealed on 4/10/2026 at approximately 9:00 AM, the SSD was made aware of an allegation of abuse from Resident #1. Resident #1reported to the SSD that on 4/9/2026 at approximately 6:45 PM, Staff K, Registered Nurse (RN), removed his colostomy bag causing skin irritation. Resident #1felt that it was intentional. The SSD immediately reported the concern to the Director of Nursing (DON). The DON reported it to the Administrator. The Administrator reported the incident to DIAL (Department of Inspections, Appeals and Licensing). The facility's investigation revealed Staff K denied taking the colostomy bag off in a manner that caused skin irritation. The other staff member present that evening was Staff J, certified nursing assistant (CNA). Staff J stated that he was at the nurse's station when Staff K asked him to assist with cleaning up Resident #1. When Staff J entered Resident #1's room, he noted that there was BM (stool) present from the colostomy bag and noted that Resident #1seemed agitated and yelled to his family on the phone. Resident #1 kept telling Staff J that she [Staff K] should have never done that, and I'm going to report her. Resident #1 then requested pain pills. Staff K brought him Tylenol. Staff J stated that Resident #1cleaned his body and (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that Staff J cleaned down the chair and leg rest. Staff J was not in the room when the colostomy bag was removed by Staff K. Staff J went in the room after Staff K asked him to assist cleaning Resident #1 up. A head-to-toe assessment was completed on Resident #1 and irritation was noted around the stoma measuring 2.4 centimeters (cm) by 1.6 cm by 0.2 laterally. Irritation was also noted below the stoma measuring 4.8 cm by 0.8 cm by 0.3 cm and anteriorly 1.6 cm by 1.2 cm. Resident #1 reported feeling safe and that his needs were being met since the evening of 4/9/26. The Facility's Investigation Summary revealed Staff K was suspended. In an email dated 4/10/26 at 9:26 AM, Staff B, Assistant Director of Nursing (ADON) sent Staff K's Statement to the DON. Staff B wrote: Upon arrival to her shift, staff alerted Staff K that the resident's bag was leaking. Staff K took a wet washcloth to loosen the adhesive and pulled back slowly and then she put a new one on. Stool got on the resident's clothes so she asked Staff J to assist in changing the resident. Resident #1 said that she (nurse) ripped it off but Staff K stated that she did not. In an email dated 4/10/26 at 9:51 AM, Staff B wrote to the DON regarding Staff J's Statement. Staff B wrote the following: Staff J was at the nurses station and Staff K came in to ask him to clean the resident up. The resident had BM all over but not super bad when Staff J entered the room. Resident #1 was agitated and yelling but not cussing. The resident called his family and kept telling Staff J that she should have never done that. I'm gonna report her. Staff J notified Staff K that the resident was upset with her. The resident asked for management and the resident was told they (management) would be back in the AM. The resident wanted pain pills and asked who could get them for him. Staff J said Staff K was passing pills. The resident said he did not want to ask her (Staff K) for anything. Staff K did bring the resident Tylenol. The resident cleaned his body and Staff J cleaned the chair and the leg rest. Staff J states that he was not in the room when it happened he was just there after Staff K asked him to clean the resident up. In an interview on 5/26/26 at 4:05 PM, Resident #1 reported he had a colostomy and an ileostomy. Someone ordered the wrong bag/supplies initially and he had trouble with the ostomy bag leaking. Some of the staff did not know how to take care of the colostomy and do the bag changes. On the day of the incident, he sat in the brown recliner chair in his room. When he sat down in the chair, his bag was leaking under and around the bag. He pressed the call button. The nurse came in and said she did not know how to do it, left his room and then came back. When the nurse came in, the colostomy bag was leaking. The nurse was trying to find something and she was not paying attention to what he was trying to say and she just ripped the bag off. There was blood and stuff like that all over. The CNA then came in and cleaned it up. When the nurse ripped it off, she put another bag on and it also started leaking 5 minutes later. The resident stated the nurse seemed like she was in a hurry, she did not clean the area or apply anything before she put a new colostomy appliance or the bag on. In an interview on 5/26/26 at 3:35 PM, Staff J, CNA, reported the nurse came out and told him to go to Resident #1's room and clean him up. Staff J went into the room and told the resident he was going to get him cleaned up. Resident #1 was very angry and bent out of shape. Resident #1 said the nurse came in and just ripped his colostomy bag off. Staff J believed something had happened because there was feces everywhere. Feces was on the resident's back, all over the front of him and on his clothes. Staff J apologized to the resident. Resident #1 was cussing and said he did not want that bitch back in his room again. Staff J told the resident that she was the only nurse working and he would have to deal with her for the time being. Resident #1 was on the phone telling a family member what had happened. After Staff J cleaned the resident up, Staff J told the nurse do not be surprised if she got called in by management because the resident was upset and on the phone telling his family about it. The next day, Staff J got a call from the ADON asking about what happened. Staff J thought the colostomy bag was forcibly removed because of how it looked with feces all over the resident. Staff J stated he had worked for several years as a CNA and he had put colostomy bags on before but it never looked like that. Staff J stated he did not notice any skin irritation when he cleaned the resident up that day. Staff J reported the resident had thrown a towel on the floor and said there was blood on the towel. Staff Jj reported when he picked the towel up, the towel had a brownish- red (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	color. Staff J thought it was feces, not blood. Staff J reported he had never worked with Staff K before the night of the incident. Staff J reported he was in training at the time and another CNA was working on the opposite hall of where Staff J was assigned. In an interview on 5/26/26 at 4:00 PM, the SSD reported the Director of Therapy asked the SSD to talk to Resident #1. Resident #1 reported he had a concern that a nurse had ripped off the bag. He told her he had turned on the call light, the nurse came down and said the bag was fine. He turned the call light on again because the bag was leaking. The resident said the nurse got irritated and ripped it off. The SSD notified the DON and Administrator about the concern. The SSD stated she provided supportive visits afterward, and the resident voiced no other concerns after that day. In an interview on 5/27/26 at 9:45 AM, the Administrator reported Resident #1 had a colostomy and was very particular about the bag. The colostomy/bag was leaking and he wanted the nurse to take a look at it. The nurse went in, checked the bag and said it was fine. The resident put his call light on again because it was leaking. The nurse went in again and removed or ripped the bag off. The resident thought it was intentional. Staff B, ADON, talked to Staff K. Staff K denied doing it intentionally. In an interview on 5/27/26 at 9:55 AM, Staff B, ADON, stated Resident #1 reported a concern to the SSD. The DON asked Staff B to assist in getting the story from the resident. Staff B and the SSD talked with Resident #1. Resident#1 said the colostomy kept leaking. He reported it to the nurse. Resident#1 said the nurse came in and appeared frustrated and just ripped the bag off. Resident #1 appeared frustrated when he talked to Staff B about the incident. Staff B then called Staff K per the Administrator's request. Staff K told Staff B that she used a wet washcloth to remove the edges around the bag to make it easier and less painful to get the bag off. Staff K denied pulling or ripping the colostomy bag off. Staff J, CNA, went in to change the resident. Staff J reported to the nurse the resident was upset with her. In an interview on 5/27/26 at 1:04 PM, Staff K, RN, reported she had worked at the facility since 1/2026 and had been a nurse for 18 yrs. She received training /orientation on one evening shift with a nurse that worked PRN and one shift with a seasoned night nurse. She had a total of two shifts for orientation at the facility. Staff K reported Resident #1 had a colostomy. He also had a lot of generalized anxiety. Staff K reported she thinks she got in a little bit of a hurry while working with the resident. His colostomy was leaking and when she changed it, she did not go through all of the steps, such as to ensure the area got cleaned. On the day of the alleged incident, the CNA came to her and let her know the resident's colostomy was leaking. Staff K said oh, bummer. She went in and grabbed a new colostomy bag then said ok we need to get this emptied. That was the plan, but it was such a mess. The colostomy was leaking pretty bad and stool was coming down at the site where the stoma was. She wondered if she just pulled the bag off and just started fresh that it would work better. It did not work out the way she thought it would. She apologized and said oh I am so sorry. Staff K explained that she used a wet washcloth to wipe the area off when she removed the colostomy bag, and then she went around the edges to loosen and wiped things off. Staff K stated again that it did not work out the way she thought it would. She told the resident she would get him some pain medication, then left the room and told the CNA to go in. Staff K went back in the room after the CNA cleaned him up and gave the resident his pain medication. The surveyor asked Staff K if the CNA said anything to her about the resident being upset. The CNA told Staff K he cleaned the resident up, and that it was a mess. The CNA said the resident was frustrated and shook up about the whole thing. The CNA told her Resident#1 was pretty upset and that the resident would possibly be saying something to someone about it. Staff K said she notified the ADON on duty about it. Staff K stated she had not worked extensively with a colostomy or ostomy. She worked at another facility where another resident had a colostomy but that resident took care of the colostomy for the most part. Resident #1's colostomy was different than what Staff K had seen before. In an interview on 5/28/26 at 2:20 PM, the DON reported the SSD let her know that Resident #1 was not happy. The DON and SSD spoke with the resident. Resident #1 said his bag had been leaking. He called the nurse. The nurse attempted to tape the area where it was leaking. He pushed his call light when the colostomy leaked again. The nurse (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	came back and said the bag needed to be changed. Resident #1told the DON that the nurse ripped the bag off. He thought the incident was deliberate. The DON talked with Staff K. Staff K said she used a washcloth to loosen the adhesive. The DON requested the ADON to perform a skin assessment. The ADON performed the skin assessment. There was a skin tear around the underside of the stoma. The DON stated she thought maybe it was where the adhesive was but the colostomy had been leaking as well. A Quality of Life-Dignity policy revised 8/2009 revealed residents shall be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. Staff shall keep the resident informed. Procedures shall be explained before they are performed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, hospital record review, staff, medical provider and vendor interviews, and guidance from the 2025 Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to take steps necessary to avoid the development and worsening of a pressure ulcer for one of four (Resident #8) residents reviewed. This resulted in harm to Resident #8 when her wound continued to worsen and she was sent to the hospital for wound management on [DATE]. Upon admission to the hospital, Resident #8 was diagnosed with a sacral decubitus ulceration extending to the bone. She was additionally diagnosed with an MRSA infection (Methicillin-Resistant Staphylococcus aureus, an antibiotic-resistant infection. It causes dangerous infections when it enters the body and doesn't respond to standard medications) of the wound on [DATE]. The facility reported a census of 81 residents. Findings include: The RAI manual details the following definitions: STAGE 1 PRESSURE INJURYAn observable, pressure- related alteration of intact skin whose indicators, as compared to an adjacent or opposite area on the body, may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the injury may appear with persistent red, blue, or purple hues. STAGE 2 PRESSURE ULCERPartial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising.May also present as an intact or open/ ruptured blister. STAGE 3 PRESSURE ULCERFull thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling STAGE 4 PRESSURE ULCERFull thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. UNSTAGEABLE PRESSURE ULCER: An ulcer that is known but not stageable due to coverage of wound bed by slough and/or eschar OR is unstageable due to not being able to see the wound due to a non-removable dressing or device. Other staging considerations include: DEEP TISSUE INJURYPurple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. TUNNELINGA passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound. UNDERMININGThe destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface. SLOUGH TISSUENon-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed. ESCHAR TISSUEDead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound. The Minimum Data Set (MDS) of Resident #8 dated [DATE] identified a Brief Interview of Mental Status Score of 14, indicating cognition intact. The MDS documented diagnoses which included peripheral vascular disease (a circulation disorder that affects blood vessels most commonly in the legs and feet, when arteries become narrowed by plaque buildup reducing healthy blood flow), quadriplegia, Multiple Sclerosis, and malnutrition. The MDS recorded the presence of one Stage IV pressure ulcer which was not present upon admission or entry to the facility. The MDS documented that the resident was dependent on staff to roll left and right: the ability to roll from lying on back to left and right side, and return to lying on back on the bed, as well as transfers from surface to surface (example bed to chair). The Care Plan of Res. #8 identified a focus area of actual impaired skin integrity/pressure injury related to impaired mobility, assistance needed with Activities of Daily Living (ADL's) and episodes of incontinence. On [DATE] the Care Plan directed staff to monitor skin with cares, notify nurse and doctor with changes as (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	needed, and assist with incontinent care as needed. On [DATE], the focus area was updated to state Res. #8 prefers to direct her own care and occasionally refuses repositioning/incontinence care and had a note of a Stage 2 pressure to her right buttocks. The Focus area was updated again on [DATE] to read the pressure ulcer was now a Stage 4. The Care Plan directed the resident has been known to turn away care if overly tired. Encourage resident to allow repositioning and incontinence care, dated [DATE]. The Care Plan identified a focus area of ADL self care performance deficit, dated [DATE]. An intervention was added on [DATE] documenting the resident is alert and oriented and prefers to direct her care. Occasionally requests incontinence care at later times or refuses due to preference. The Weekly Pressure Injury Evaluation dated [DATE], locked at 3:43 pm, documented a pressure injury was noted on the resident's right buttock. The evaluation documented the onset was [DATE] and was acquired in the facility, as a Stage II. The measurements were recorded as 3.5 x 4.5 x 0 centimeters. The Medication Admin Audit Report of Res. #8 dated [DATE] documented that Staff M, Licensed Practical Nurse (LPN) applied Z-guard (protective zinc oxide cream) to the resident's peri-rectal area (the skin, muscles, and soft tissues located immediately around the anus and the lower part of the rectum) at 11:10 am and 2:53 pm on [DATE]. A Nursing Note dated [DATE] at 3:49 pm documented during an assessment, a new Stage 2 pressure ulcer to the right buttocks was noted. The note identified the physician was aware and new orders received for treatment. On [DATE] at 3:00 pm, the Director of Nursing (DON) stated the resident had been in bed at the time the pressure ulcer was discovered on [DATE]. She stated it had been found in the approximate time frame of the nursing note late afternoon. (One hour after the documentation of the Z-guard being administered). On [DATE] at 3:20 pm, Staff M, LPN stated she was not the nurse who discovered the pressure ulcer. She stated she recalled coming back in on her next shift and being made aware of the pressure ulcer and a new treatment for it. The Nursing Note dated [DATE] at 12:15 pm documented the resident reporting she felt something pop in her stomach and had some abdominal pain. The resident was transferred to a community hospital for assessment of her catheter. The Nursing Note dated [DATE] at 5:55 pm documented the resident returned from the emergency room with a new catheter and no new orders. Review of facility documentation failed to reveal a skin check being completed until [DATE] when the pressure ulcer was then documented as a Stage III with measurements of 5.0 x 5.0 x 0.2 centimeters. The Documentation Survey Report for Resident #8 for January of 2026 revealed a task assigned to the Certified Nursing Aides to turn and reposition Res. #8 every 2-3 hours. In 31 days of 3 shifts per day (total of 93 shifts) there were 35 shifts of no documentation being completed. Additionally, there were 25 shifts which the CNA on duty documented N for no, the task was not completed and 3 shifts documented Not Applicable. This totaled 63 shifts out of 93 (68%) which revealed no documentation of the resident being repositioned. The Documentation Survey Report for Resident #8 for February of 2026 was next reviewed. A total of 84 shifts were in February. 33 shifts had no documentation of the task being completed. An additional 20 shifts were documented as the task not being completed. This totaled 53 out of 84 shifts (63%) which revealed no documentation of the resident being repositioned. A review of the options for this task revealed the options for the documentation included YesNoResident Not AvailableResident RefusedNot Applicable No shifts were documented as resident refused. Wound assessments were performed weeklyXXX[DATE] measurements of 2.9 x 3.7 x 0.2 centimeters[DATE] measurements of 5.0 x 5.0 x 0.2 centimeters[DATE] measurements of 5.0 x 5.0 x 0.2 centimeters[DATE] measurements of 4.2 x 5.1 x 0.4 centimeters [DATE] measurements of 4.4 x 5.4 x 3.6 centimeters (now documented as a Stage IV)[DATE] measurements of 3.7 x 5.7 x 1.3 centimeters with undermining present from 11-1 o'clock at 1.2 depth[DATE] measurements of 3.6 x 4.3 x 0.9 centimeters with undermining present from 11-2 o'clock at 1.2 depth[DATE] measurements of 3.8 x 4.8 x 0.6 centimeters with undermining present from 11-2 o'clock at 0.8 depth[DATE] measurements of 3.8 x 4.9 x 0.9 centimeters with undermining present from 11-2 o'clock at 0.6 depth[DATE] measurements of 3.4 x 3.9 x 0.5 centimeters with undermining present from 11-2 o'clock at 0.6 depth[DATE] measurements of 4.0 x 4.2 x 0.7 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	centimeters with undermining present from 11-2 o'clock at 1.1 depth[DATE] measurements of 6.1 x 4.6 x 0.6 centimeters with undermining present from 11-2 o'clock at 0.6 depth[DATE] measurements of 6.8 x 7.9 x 0.4 centimeters with undermining present from 11-2 o'clock at 1.0 depth. The wound APRN, FNP-C (Advanced Practice Registered Nurse, Family Nurse Practitioner-Certified) visited the facility weekly, first seeing Res. #8 on [DATE]. There were times the resident refused to see the APRN on some visits. The original visit notes dated [DATE] documented the wound as a Stage 3 pressure ulcer with the wound being cleansed and debridement type being listed as autolytic (a wound cleaning process that uses the body's own moisture and enzymes to soften and dissolve dead tissue, achieved by applying moisture-retentive dressings to the wound). The visit notes detailed autolytic debridement each visit and wound treatments were monitored and changed periodically. The visit note dated [DATE] noted the wound appeared to have improved on this visit. The following visit on [DATE] was noted as wound not healed, with continued cleansing and autolytic debridement. Each note also documented the resident as having impaired judgement. The final visit dated [DATE] noted the wound status to be deteriorated. A portable 3-view x-ray of the sacrum due to pain, poor wound healing to rule out osteomyelitis (a serious, inflammatory bone infection) was ordered. The Nursing Note dated [DATE] documented the x-rays were reviewed by the APRN, FNP-C and an MRI was ordered. Prior authorization process was started. The next Nursing Note dated [DATE] documented the wound appearing larger and darker. On [DATE] a note documented a rapid decline of the wound and orders to send the resident to the emergency room for evaluation and treatment. A Dietary Note dated [DATE] documented the resident's x-ray showed osteomyelitis. Review of the Treatment Administration Record (TAR) of Resident #8 revealed eleven times the prescribed wound treatment was not documented as completed. One of those dates, [DATE], with the wound care being scheduled for AM, included a nursing note written at 5:57 pm that the resident was up in the wheelchair and refused to lay down, the treatment was passed down to the evening shift. Nine of the remaining ten times the treatment was not documented as being completed had no reasoning for it not being done. The final time was on [DATE] which coincided with the wound nurse seeing the resident and completing wound care that day. None of the other times coincided with the wound care nurse being present. The records from the resident's hospitalization revealed culture results showing MRSA of the wound. The MRI performed on [DATE] confirmed clinical confirmation of the worsening sacral pressure ulcer and specifically identified it as having progressed to involving the bone (osteomyelitis). The Assessment & Plan was noted as acute on chronic sacral osteomyelitis and infection with CR-Pseudomonas aeruginosa (a multi drug resistant bacteria) and MRSA. In the hospital, the surgical team performed bedside debridement on [DATE] and an excision wound debridement on [DATE] along with a bone biopsy. A hospital wound care note dated [DATE] documented the majority of the wound bed remained covered in necrotic tissue (dead, non-viable body tissue that has died prematurely due to injury, infection, or a lack of blood flow) despite two debridements that week. The wound nurse documented she notified the physician regarding a concern for the worsening sacral wound despite the debridements and treatments and requested the resident not discharge from the hospital due to those concerns. The resident remained in the hospital throughout the course of the on site survey. On [DATE] at 1:15 pm, the Occupational Therapy Assistant (OTA) who worked with the resident at the facility stated she worked with Res. #8 for sip and puff chair navigation (the resident was unable to move her electric wheelchair with a joystick due to disease process. She navigated the chair with a mouth piece). She stated she did not work with the resident for any repositioning. She stated as far as she was aware, the resident had a regular cushion in her wheelchair, no specialty cushion. She stated she worked with the resident three times a week. She described the resident as unable to move herself/reposition herself in the chair. She stated the resident only worked with OT and not physical therapy. She stated she was aware of the staff finding the wound on the resident. She said she appeared comfortable during therapy though she was not able to move her arms or reposition at all. She described the resident as fully dependent. She said the (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	resident usually got into her chair around 10:30 in the morning and stayed in the chair all day at least until the evening. On [DATE] at 1:22 pm, the Director of Rehab (DOR) stated the facility works with the wheelchair vendor as needed but stated the resident's wheelchair was less than five years old so therefore she was unable to obtain new equipment (due to Medicare regulations of 5 years for new equipment). She stated when the resident received the wheelchair four years prior, she would have been fit for her needs at that time through an assistive technology assessment. She stated no changes had been made to her chair since that time. On [DATE] at 1:42 pm the resident's wheelchair and cushion were observed. The chair had a gel cushion on the wheelchair seat which was pliable in the rear of the cushion and firmer to the touch towards the front of the chair. On [DATE] at 1:45 pm, Staff L, LPN/Assistant Director of Nursing stated the resident's normal routine was to get up between 9:00 and 10:00 am. Nursing staff would do the wound treatment so she could get up. She stated she usually stayed in the wheelchair until around 9:00 pm. She stated it was difficult to try to reposition her in the chair but they would try to put pillows under her legs, etc. She described it as not being the greatest. She said the resident would state it was her right to stay up in the chair. The ADON was asked if a dressing change would be needed if the resident was incontinent of bowel and she stated that generally would require a PRN (as needed) dressing change. She said the CNAs would tell the nurses when the resident had a bowel movement but that she rarely ever did a PRN dressing change. The TAR for March of 2026 reflected a PRN dressing change was not completed at all during the month. The Survey documentation report recorded 34 bowel movements during the month. The TAR for April of 2026 reflected a PRN dressing change was completed one time during the month. The TAR for May of 2026 reflected a PRN dressing change was completed one time during the month. On [DATE] at 2:50 pm, a representative from the wheelchair vendor stated the resident had a gel pack cushion in her wheelchair. He stated the facility had reached out to the vendor in February of 2026 and in May of 2026 for some configurations and adjustments needed, the arm pads were replaced and some hardware was replaced. He stated the facility had recently reached out reporting Res. #8's chair was not running. He stated he had no record of the facility reporting to them the resident had developed a pressure ulcer. He stated it would have been best practice for them to have been informed and they would have come out and assessed the resident's wheelchair cushion to see if there was a better type to meet the resident's current needs. On [DATE] at 8:27 am, the Director of Nursing (DON) stated the facility had done an internal investigation regarding the pressure ulcer of Res. #8. When she was asked if anyone had looked into an alternative or new wheelchair cushion, she stated if an order was received for a new cushion, they would send that to Occupational Therapy to take care of. She stated it is OT's job to order the equipment. She clarified this was if an order was received. (When the DON was asked if anyone had requested a new cushion or an assessment for a new cushion, she was unable to state if that had been done). The facility form of Unavoidable Pressure Ulcer dated [DATE] included the following information: -diagnosis of quadriplegia. (This was added to her Electronic Medical Record on [DATE], almost two months after the development of the pressure ulcer and over a week after the Unavoidable Pressure Ulcer documentation). -diagnosis of Severe-Protein Calorie Malnutrition -diagnosis of anemia -history of pressure injuries - resident was repositioned every 2 hours in bed - Refuses repositioning, refuses turning schedule Progress notes from January of 2026 through early June of 2026 failed to reveal any documentation of refusal of cares. One note on [DATE] documented the resident refusing a shower. A dietary note on [DATE] stated the resident often refused cares. The facility Advanced Registered Nurse Practitioner wrote a visit note dated [DATE] which mentioned the ER visit on [DATE]. No mention of the pressure ulcer was found in this note, and quadriplegia was not a noted diagnosis. On [DATE] at 10:55 am, the ARNP stated she did not recall when the facility notified her of the pressure ulcer. She said if it was not in her notes, then she was not informed of it. She said the resident's malnutrition was a prior diagnosis and she did not consider that to be a current diagnosis. She stated she has monitored the labs of Res #8 which were within normal range. She stated the routine of Res. #8 is for her to be in bed or in her (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	power chair and that she is often not receptive of cares. She stated she has refused to see the wound nurse on some occasions because she is already up in her chair when the wound nurse arrives. She stated at one time the resident believed the pressure ulcer was an end of life ulcer and she desired to go on hospice care. She stated she discussed this with her and told her it was not an end of life ulcer and she did not qualify for hospice care at that time. During a follow up interview with the Director of Rehab on [DATE] at 11:30 am, it was asked if therapy can change the plan of care for a resident currently receiving therapy. The DOR stated the provider or the nursing team would have needed to initiate that. She stated if a further evaluation of therapy had been initiated for Res #8, therapy could have established an up/down schedule or an off loading schedule. She stated Res. #8 is physically unable to use the tilt feature in her wheelchair. She only has passive range of motion in her fingers (cannot move them on her own). She stated to use the tilt feature for repositioning, staff needs to do this for her. She stated Res. #8 had straps around her feet an ankles to stop her from sliding in the wheelchair which often needed adjusted. She stated when these adjustments were made, she would advise the tilt function be used at the same time to assist in repositioning. She stated Res. #8 is able to verbalize when she wants to sit back up. She also stated the resident received her wheelchair in February of 2022 and could provide that documentation. On [DATE] at 2:00 pm, Staff A, Certified Medication Aide (CMA) stated Res. #8's normal routine is to get up in her chair around 10:00 in the morning. She went to therapy and different things but stayed in her chair. She stated they would tilt her chair back to pull her up in the chair, add a pillow, things like that to reposition. She stated generally Res. #8 would always allow it and would let staff know if she had any pain or wanted repositioned. On [DATE] at 2:25 pm, Staff W, CNA stated she was a newer employee to the facility. She stated she had assisted Res #8 during her orientation time. She stated the resident called whenever she wanted to be repositioned and would let staff know if she was uncomfortable. On [DATE] at 2:30 pm, Staff V, CNA stated for the night shift, normally Res. #8 would use her call light. Staff would check on her every two hours, but the resident liked to stay up in her chair till as late as midnight. She said around midnight they would get her ready for bed and the resident would ring her call light (using her chin) whenever she needed anything. She stated unless the resident rang, then they just let her sleep but would check on her. On [DATE] at 2:50 pm, Staff Y, CNA stated her shift begins at 6:00 am. She stated she would check on the resident until she was ready to get up. She stated usually around 10:00 or 10:30 am is when the resident would want to get in her chair. She said once she is up, she stays up. She said she will call if she needs something but otherwise she just checks in on her. She stated she will always to offer to reposition each round and sometimes the resident says yes and sometimes she says no. She stated she will inform the nurse if the resident had a bowel movement. On [DATE] at 3:01 pm, Staff X, CNA stated the resident spent most of her time in her chair during her 2pm-10pm shifts. She said sometimes she would be ready for bed towards the end of the shift but was often visiting with another resident who she is friends with. She stated Res. #8 tells staff when she wants repositioned. She stated if the resident told her this, then she would get help from another employee and would normally use the sling from the mechanical lift to reposition her. She stated she generally was always upright in the chair and normally did not tilt back in the chair. She said the resident is really good about telling them when she wants to move. An email from the DON dated [DATE] at 3:08 pm clarified some of the information from the Non Avoidable Pressure Ulcer form. The email included the following information: -Res #8 had a prior history of a Stage 3 Pressure Ulcer to the sacrum identified in August of 2022 which resolved. -She stated the documentation of Res #8 refusing care prior to the development of the pressure ulcer included: July of 2021: intermittent refusals of care with preference to remain in bed[DATE]: refusals of showers, incontinence cares and other direct care interventions[DATE]: episodes of care refusal with redirection and re-approach attempts documented[DATE]: refusals of care with preference for select staff members to provide assistance. -She stated the diagnoses of malnutrition and anemia were historical diagnoses in the resident's medical record and remain listed on the problem list. She added (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	that recent weight trends and laboratory data do not indicate current evidence of acute protein calorie malnutrition; however, the resident continues to present with nutritional risk factors due to overall clinical condition and comorbidities that may impact wound healing the skin integrity and her most recent labs revealed a low vitamin D level. Progress Notes were reviewed for the year 2022 and no mention of a pressure ulcer was revealed in these notes. One note from [DATE] noted MASD (moisture associated skin damage) to the sacrum was improved. The first MDS for the time frame of a pressure ulcer being found in August of 2022 was dated [DATE]. It failed to reveal any documentation of a pressure ulcer. The receipt for the resident's wheelchair in February of 2022 did note a history of pressure ulcers of the right and left heel. On [DATE] at 3:54 pm, the Registered Dietitian stated the resident is very particular about what supplements she will take and she will not take them more than once a day. She stated her labs are very good and she does not consider to be malnourished but meets the requirements of risk of malnutrition. She stated she has heard that the resident does not accept repositioning well and is very specific about what she will do. On [DATE] at 4:22 pm, the Administrator stated Res. #8 is alert and oriented and knows she should be repositioned and has been educated and has been non compliant and the team determined the pressure ulcer development was not avoidable. The Wound Care Nurse was out of state and unavailable for an interview. The resident remained in the hospital. In a second interview with the facility ARNP on [DATE] at 9:15 am, she stated she knows Res. #8 very well and she has a good relationship with her. She stated she had talked to her many times and more than once she would find her laying on her right side (the side the wound is on) and she reminded her and the resident stated she knew what she should be doing for the wound. She stated Res. #8 is very much her own person. The facility policy titled Skin and Wound Management System, Revision Date [DATE], documented the following policy statement: It is the policy of this center's Skin Management System to identify and assess residents with wounds and/or pressure ulcers, as well as those at risk for skin compromise. Such residents are then provided appropriate treatment to encourage healing and/or integrity. Ongoing monitoring and evaluation are then provided to ensure optimal resident outcomes. Point 4: Preventative intervention will be implemented for residents identified at risk as appropriate, for example beds, wheelchair cushions, nutrition, incontinence, therapy etc. These interventions are documented in the medical record based on overall score. Point 9: Ongoing monitoring and Quality Assurance and Performance Improvement (QAPI) will be achieved through a Multidisciplinary Team. The Team will meet regularly to review residents who are found to be at risk or with compromised skin integrity. The Team will evaluate resident skin changes, treatment modalities and interventions, and make recommendations, based upon the interdisciplinary evaluation.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, hospital record review, staff interviews, and facility policy review, the facility failed to provide adequate nursing supervision for two out of five (Resident #3 and Resident #15) residents reviewed for nursing supervision by failing to provide one person assistance to Resident #3, resulting in the resident eloping from the building. The facility additionally failed to provide staff accompaniment to an off site physician's office visit for a cognitively impaired resident (Resident #15). The facility reported a census of 81 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment of Resident #3 dated 5/14/26 documented a Brief Interview for Mental Status (BIMS) score of 9, which indicated moderate cognitive impairment. The MDS documented the resident exhibited wandering daily during the look-back period, placing the resident at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility). The MDS documented an admission date to the facility of 5/8/26. The Care Plan of Res #3 documented a Focus Area of limited physical mobility related to use of cane or walker, date initiated 5/8/26. The Care Plan included an intervention of Mobility: The resident requires 1 staff participation for mobility, dated 5/8/26. The Focus Area and interventions were resolved on 5/11/26. The Care Plan documented a Focus Area of the resident being an elopement risk/wanderer, as evidenced by resident wanders aimlessly, initiated 5/9/26. The Focus Area was updated on 5/10/26 to state the resident has had an actual elopement from the facility. On 6/2/26 at 8:40 am, the Regional Nurse verified Res #3 was Care Planned to be one staff assistance for mobility from 5/8/26 through 5/11/26. She added the resident's Baseline Care Plan was done on pen and paper and they would provide that. On 6/2/26 at 9:05 am, the Director of Nursing (DON) provided the Baseline Care Plan of Res #3, dated 5/8/26. The Baseline Care Plan documented Resident #3 required assistance of one staff member for transfers and mobility, but also noted the resident desired to be independent in the facility and would be evaluated. The DON stated that the therapy team evaluated the resident later that day and the resident was deemed to remain care planned as requiring one staff assist for transfers and mobility. The Physical Therapy Evaluation dated 5/8/26 documented the Clinical Impressions of the resident as: Patient demonstrates decreased balance, decreased strength, decreased activity tolerance limiting patient's ability to perform functional mobility. The Reason for Therapy was documented as: Patient requires physical therapy services to analyze gait pattern, facilitate independence with all functional mobility, improve dynamic balance, increase functional activity tolerance and promote safety awareness in order to enhance patient's quality of life by improving ability to decrease level of assistance from caregivers. The Elopement/Wander Risk Evaluation dated 5/9/26, completed by Staff B, Assistant Director of Nursing (ADON) documented the resident to be forgetful and have a short attention span. It further documented that the resident had a recent change in financial status, loss of self control, expressing the desire to go home and aimless, non goal directed wandering. The Evaluation documented the resident was independent with a cane/walker, although the care plan directed the resident was to have the assistance of one staff member. The Evaluation failed to document the resident having decreased cognition, although his BIMS score was a 9. The Evaluation documented the resident had no history of wandering, and no substance use disorder. The Evaluation scored the resident to have a risk factor of 8, moderate risk. The hospital referral paperwork, uploaded into Resident #3's chart on 5/7/26 prior to facility admission, documented the following:a. Diagnosis of alcohol use disorder, noting the resident was actively intoxicated on arrival to the hospital (this conflicts with the documentation on the Elopement Risk Evaluation) as well as being homeless. b. Hyponatremia (low sodium), noted to likely be chronic and exacerbated by excessive alcohol use.c. A Nursing Note dated 5/3/26 documented that the resident had removed his gown, IV and leads (heart monitor), put his pants on, and stated he wanted to leave. He was found after having fallen in the doorway of his room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility Reported Incident (FRI, also known as a self report) dated 5/11/26 documented that on 5/10/26 at approximately 1:00 pm, Res #3 was seen walking on the sidewalk outside of the facility. Staff immediately went to the resident and redirected him back to the facility. It was noted that Res #3 had removed his wanderguard (an electronic bracelet placed on a resident which sets off alarms when the resident is too close to an exit door). The FRI documented staff had last seen the resident inside the facility approximately ten minutes earlier at approximately 12:50 pm. The Medication Admin Audit Report of Resident #3 for 5/10/26 documented medications had last been administered to Resident #3 at 12:25 pm. This was the last documented time a staff member had visualized the resident. During an interview on 5/27/26 at 12:14 pm, Staff C, a Certified Nurse Aide (CNA), confirmed she was assigned to the hallway where Resident #3 resided on 5/10/26. She stated at the time he was observed being outside, she was in a different resident's room providing cares. She said she had last seen him around lunchtime but was unable to give any details as to whether she had seen him in his room, in the dining room or elsewhere in the facility. She could not recall where he had eaten lunch that day or give a specific time as to when she had seen him last. She said the only thing she could really recall was that he was kind of agitated and was constantly asking for coffee.On 5/27/26 at 1:06 pm, Staff L, Licensed Practical Nurse (LPN), reported working at Station 1 (the area of the facility where the resident's room was) on 5/10/26, though she was not assigned to Resident #3's specific hallway. She detailed that she and Staff M (LPN) were counting medications as Staff M prepared to cover the medication cart for the rest of the shift. She reported a nurse from Station 2 came running down and informed them that Resident #3 was seen outside. Staff L and Staff M immediately exited the front door of the building to search for him. She stated that Resident #12, who was sitting outside, pointed them in the direction that Resident #3 had gone. Staff L stated that as they rounded the south corner of the building, they saw another staff member who had already reached Resident #3 and was walking him back toward the facility. On 5/27/26 at 1:13 pm, the Dietary Manager stated she was not on duty on 5/10/26 but she stated Resident #3 always ate lunch in the dining room and not in his room. She stated lunch is served daily at 11:30 am. On 5/27/26 at 1:15 pm, Staff A, Certified Medication Aide (CMA), reported that she and other staff were alerted that Resident #3 was outside. She said two nurses exited the front door while she took the west door of the Station 1 area, as it had been reported Resident #3 was heading towards the bank (located directly west of the facility). Staff A found him on the sidewalk, aligned with the facility's south-facing door. She turned him around and walked him back inside the facility. Staff A added that she had last seen him approximately half an hour earlier that day. She believed he had a room tray for lunch and ate in his room, noting it was rare for him to eat in the dining room. She described Resident #3 as looking more like a visitor than a resident. She added that although staff kept a close eye on him if he wandered to the front of the building, he generally stayed in his room. Staff A voiced she had no concerns regarding him that shift prior to his leaving the building.On 5/27/26 at 1:38 pm, Staff B, one of the two facility Assistant Directors of Nursing (ADON) said she was in the building on Station 2 on the day shift of 5/10/26. The other nurse at Station 2 had received a phone call from Resident #12 that she had spotted Resident #3 outside independently. After the resident was assisted back inside the building, Staff M, LPN came and reported the incident to her. She then went to his room and performed a head to toe assessment, finding no injuries to the resident but noting he had removed his wanderguard. She stated she sat with him one to one (1:1) until 6:00 pm where he was cooperative although agitated that staff was sitting with him. (another staff member relieved her at 6:00 pm). She stated she oversees the other portion of the building and did not really know Resident #3 as he had only been admitted to the facility recently. On 5/27/26 at 1:50 pm, the Director of Rehabilitation (DOR), Occupational Therapist, stated Res #3 had admitted the Friday afternoon prior to his elopement and she performed her initial evaluation with him. She reported he walked with a walker and was able to ambulate approximately 50 feet.On 5/27/26 at 3:33 pm, Staff C, activities assistant, confirmed she was in the building on 5/10/26 and, at approximately 1:00 pm, she gathered several (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents to the locked front door. She described escorting residents one at a time to the courtyard area, which is in visual distance from the front door. She stated Resident #3 was not in the area, nor in the group of residents she took outdoors. She also confirmed Resident #12 was not part of the group that day. She said at no time during that time period had she seen Resident #3 and she felt he must have gotten outdoors prior to her taking other residents out. She added she had only been outside for a short amount of time when staff came outside looking for him and asked her if she had seen him. After telling them she had not seen him, staff went in another direction to look for him. On 5/27/26 at 4:25 pm, Resident #12 (BIMS score of 15, cognitively intact) stated that on 5/10/26, she was sitting near the end of the sidewalk towards the south end of the facility parking lot. She saw Resident #3 outside, recognized he was a new resident, and verbally tried to stop him. When he did not stop, she immediately called the staff using her cell phone to report that he was outside alone. Resident #12 stated she did not see anyone else outside with him or in the area immediately prior to the resident being seen outdoors.In a second interview on 5/28/26 at 1:00 pm, Resident #12 confirmed that she saw Resident #3 outdoors prior to the activities staff bringing other residents outside. She added that 5/10/26 was Mother's Day, which resulted in more visitors than usual. Although she did not witness Resident #3 exit the building, she guessed he had walked out as a visitor was entering, noting the front door was open more frequently that day than normal. She also stated there was no staff at the front desk that day.On 5/28/26 at 2:25 pm, the DON stated there is no code used to open the front door from inside. There is a button behind the reception desk which staff can push (behind a locked door) or the door can be opened with a staff badge/fob. Only staff can exit the building without assistance. She stated the building does not have security cameras. She also added the facility does keep a badge inside of the double entrance doors so visitors can use that badge to enter the building only, but it is not available for exiting the building. She stated it was likely that a visitor entered the building and Resident #3 exited at the same time. On 5/28/26 at 2:35 pm, Staff M, LPN stated the ADON had previously called her and stated she was concerned about Resident #3 being anxious and requested she place a wanderguard on him. She said after placing the wanderguard around his ankle, he was wandering and setting off multiple alarms that day. She also described that on Mother's Day, there were a lot of people in the building and also that the Activities department was taking residents to sit outside in the nice weather. She felt that Resident #3 likely got out either following activities or following a visitor. She said when the Station 2 nurse (who answered the phone when Res #12 called) came down telling her the resident was outside, she and Staff L went running out the front door and did not see him and then headed around the corner (south side of building). When they spotted him, Staff A, CMA had already gotten to him. She stated when he was back inside an assessment was completed and his wanderguard was found in the trash. She described the wanderguard had been ripped. She said it definitely had not been cut, it was ripped and he had pried it off somehow. She said he may have used a fork or some other object. On 5/28/26 at 3:20 pm, the ADON clarified she had asked Staff M to place a wanderguard on Resident #9 on 5/9/26 and the elopement was on 5/10/26. The facility policy titled Elopement, revision date 6/2023 documented the following policy statement: It is the policy of this facility to provide a safe and secure environment for our residents and to be proactive in preventing resident elopement. Residents at risk for elopement will be appropriately monitored to reduce the potential for injury. Elopement is defined as a resident leaving the premises of the facility without the knowledge and supervision of facility staff. Staff shall investigate and report all cases of missing residents. Policy Interpretation and Implementation: Point 1: Upon admission, readmission, quarterly, and with a significant change of condition, residents will be assessed for elopement risk.Point 3: Elopement risk will be care planned with individualized approaches to reduce the potential for elopement and/or to redirect the resident in the event that an elopement attempt is made. The facility policy titled Care Plans, Comprehensive Person-Centered, revision date 03/2022 documented the following: Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.Policy Interpretation and Implementation:Point 1: The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.Point 3: The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.Point 7e: The comprehensive, person-centered care plan reflects currently recognized standards of practice for problem areas and conditions.Point 9: Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making 2. The admission MDS of Resident #15, dated 4/23/26 identified a BIMS score of 5 which indicated severe cognitive impairment. The MDS documented diagnoses which included cancer, Non Alzheimer's Dementia, anxiety, depression and schizophrenia. The MDS documented the resident had experienced a fall since admission on [DATE]. The Significant Change MDS of Resident #15, dated 5/8/26, identified her BIMS had declined to a 4.The Physician Order Note dated 4/21/26, authored by the DON, documented a phone call had been received from the Mental Health clinic of a local hospital in regards to the medications which the hospital had ordered upon the resident's recent hospital discharge. Updated orders were received as well as orders to draw labs on 5/17/26 and to fax the results to the clinic. The note additionally documented the resident's next follow up appointment at the clinic was scheduled for 5/28/26 at 10:00 am. The note detailed the van transportation service had been contacted with a pickup time of 9:15 am. The History and Physical of Resident #3 dated 3/17/26 from her records of pre-admission status documented increasing confusion in addition to frequent falls over several weeks. Review of additional facility progress notes revealed that between 4/19/26 and 5/25/26, the resident experienced eleven (11) falls, one with injuries resulting in bruising and a laceration requiring stitches. The Nursing Note dated 4/27/26 documented due to physical decline, the resident's guardian requested a hospice referral. The resident was hospitalized for a short time and the admission summary dated [DATE] identified the resident had enrolled in hospice.The Interdisciplinary Note dated 4/30/26 identified the resident had a diagnosis of Stage 4 breast cancer with metastasis and was receiving hospice care. The Nursing Note dated 5/26/26, authored by Staff B, ADON documented she had spoken to the provider at the hospital clinic regarding the ordered monthly labs and stated due to the resident no longer taking psychotropic medications, labs were not needed to be drawn. On 5/28/26 at 10:30 am, Res #15 was observed sitting in a wheelchair behind the nursing station and attempted to stand up by the desk. Staff approached the resident and asked her to sit down. The resident then grabbed the phone and was pulling on the cords. Another staff member walked by the desk and requested she give the phone to him.On 6/1/26 at 7:42 am, Res #15 was observed sitting at the nursing station in her wheelchair. A bruise was noted to her left chest and stitches above her eyebrow extending to her forehead were seen. On 6/1/26 at 11:45 am, a representative of the van transportation service stated the service had no policy regarding cognitively impaired residents using the service without a facility staff member accompanying them but added that most facilities sent a staff member along in these situations. He looked up the records for Resident #15 and stated he showed a pick up time of 9:15 for a 10:30 appointment at the Behavioral Health Clinic on the second floor of the clinic. He stated if the resident did not have accompaniment, the van driver would take the resident to the second floor and assist to get her checked in before leaving the clinic. He added the driver would additionally leave a card with a contact phone number with the clinic. On 6/1/26 at 12:34 pm, a driver from the transportation service stated he did not pick Resident #15 up from the facility that day, but he was the driver who picked her back up from the clinic and returned her to the facility. He stated he picked the resident up from the clinic approximately 10:45 or 11:00 am but he did not have the exact time documented. He stated he picked up only the resident, no staff accompanied her. On 6/1/26 at 1:22 pm, Res #15 was observed sitting behind the nursing desk next to a hospice employee. The hospice employee was gathering her items (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to leave and wheeled Res #15 over to the lounge area where Staff B, ADON was sitting doing paperwork. The hospice employee asked Staff B if she could leave Res #15 with her.On 6/1/26 at 1:24 pm, Staff B, LPN, ADON stated Res #15 was being seen at the clinic for the psychotropic medications she had been taking. She stated during a phone call on 5/26/28, the clinic told her the resident no longer needed to have labs drawn due to no longer taking the medicaions as she had started hospice care and was only on comfort medications. She voiced that during that phone call, the clinic also stated the resident no longer needed to be seen at the clinic. She stated she was told Res# 15's next appt was June 28th, not May 28th which was when the appt was. She said she called the van transportation service to cancel the appointment but was told there was no appointment for June 28 and she added she was not aware of the May 28th appointment. The ADON stated normally if a cognitively impaired resident has an outside appointment, a CNA or another employee would ride with the resident. She stated most cognitively impaired residents do not leave the building as the vendors (medical providers) come into the building instead. She reported she was not in the building on 5/28/26 so she was unsure if anyone accompanied the resident to the appointment.During this interview, Resident #15 was observed to be sitting in her wheelchair a few feet from the ADON. She appeared semi anxious and fidgety but did not make any attempts to stand or transfer. On 6/1/26 at 1:30 pm, the DON stated she was not aware if any staff member accompanied Res #15 to the clinic appointment but stated she would find out.At 1:35 pm, the DON returned and verified no staff member was present with Resident #15 during the 5/28/26 clinical visit. She stated the van transportation service drove the resident and assisted her to the area of the building she needed to be in. She voiced the 5/28/26 appointment was set up prior to her admission to the facility when she was more independent and at a different level of function than she currently was. She stated had she been aware, she would have cancelled the appointment. She said if the facility was the one to set up the appointment, then it would have been arranged to have an employee attend with her. She detailed the facility has an appointment book at each station and normally the night shift nurse on the night prior to the appointment prepares the paperwork for the appointment. She stated the who had been on duty the day of the appointment was a new employee. (Review of the schedule detailed the nurse assigned to Resident #15 that day was an agency nurse, not a facility employee. The nurse the DON referred to as being new was assigned the same station but a different hallway).On 6/1/26 at 2:29 pm, the Administrator stated the facility does not have a policy regarding resident transportation.On 6/1/26 at 4:00 pm the Administrator stated it is a case by case basis if a staff member accompanies resident appointments. She said they would do that if it was needed. She acknowledged she would have advised someone to set up for a staff member to ride along with Resident #15 but that the facility did not have a designated person to set up appointments or transportation, it can be any nursing staff. She said it is just communicated when a resident needs accompaniment but was unable to voice any specific procedure that was followed. The Administrator acknowledged the Resident had a BIMS of 5 upon admission and had since declined to a current BIMS of 4. On 6/1/26 at 4:15 pm, the Administrator provided a list of residents who had been evaluated by therapy and deemed safe to be outdoors independently. Resident #15 was not included on the list. She stated both ADONs would be auditing the appointment books weekly to monitor if a resident had an appointment who would need staff accompaniment. She stated the Interdisciplinary Team (IDT) would review these audits monthly and as needed and education had been provided to the nursing team that day. On 6/2/26 at 1:05 pm, the Behavioral Health Nurse Practitioner (NP) for the clinic where the Resident had her appointment clarified the resident's appointment time on 5/28/26 had been scheduled for 10:00 am. She verified the van driver did accompany the resident to the second floor and leave a card with a phone number to call for pickup. She stated that the resident was not checked in at the front desk until 10:17 am for the 10:00 am appointment. She also stated that her nurse at the clinic had entered a note on 5/26/26 into the resident's chart at the clinic which documented he had spoken to a nurse at the facility instructing that due to the resident being on hospice and on comfort medications only, she no longer needed to have labs drawn or have further clinic appointments.

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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. Based on observation, staff interview, resident interview, and facility policy review, the facility failed to provide incontinence care within the time frames established in the comprehensive care plan and failed to maintain infection control standards during the provision of incontinence care for one of three (Res #18) residents reviewed. The facility reported a census of 81 residents.Findings include:The Minimum Data Set (MDS) Assessment of Res. #18 dated 4/29/26 identified a Brief Interview for Mental Status (BIMS) score of 15 which indicated cognition intact. The MDS documented the resident to be always incontinent of bowel and bladder. The Care Plan of Res. #18 documented a Focus Area of requiring assistance with Activities of Daily Living (ADL). The Care Plan directed staff that Res. #18 does not use a toilet, bed pan or bed side commode. It further directed staff to assist with checking and changing of incontinence brief and providing peri-care (cleansing of the genital area and buttocks) with each incontinent episode and as necessary as the resident allows, date initiated 11/29/23. An additional Focus Area of risk of impairment to skin integrity directed that Res #18 had vocalized she did not want disturbed on the overnight shift (10:00 pm - 6:00 am) or to be awoken during rounds. It further directed that Res #18 would use her call light to ask for assistance with changing her brief overnight, date initiated 11/29/23. Observation of incontinence cares of Res #18 began on 6/11/26 at 10:37 am. Staff T and Staff U, both Certified Nurse Aides (CNA) knocked on the door to assist Res #18. They brought supplies for incontinence care and bed linen change, as well as a full body mechanical lift into the room. Both staff washed their hands and donned gloves.Staff U assisted to remove Res. #18's nightgown and then began removing the soiled incontinence brief from Res #18 as Staff T was looking for wet wipes to use for peri care. Staff T removed her gloves and put new gloves on with no hand hygiene observed. She obtained a package of wet wipes that was sitting on the resident sink vanity. She then told Staff U they would need more supplies. She removed her gloves and left the room with no hand hygiene observed. Staff U then assisted Res. #18 to turn to her right side as he removed her soiled brief and placed it in the trash can near his feet. He used the sheets to clean up the mattress which was wet with urine. With no sanitizing of the mattress and no glove change, he then picked up clean sheets off the bedside table and began to tuck them under the resident. He obtained wipes from the package and cleansed the resident's buttocks front to back. Staff T then returned to the room with another package of wet wipes. She used hand sanitizer and placed new gloves on her hands. Staff T obtained a clean brief as Staff U completed cleansing the resident's buttocks. Staff U then reached for more clean bedding still wearing the same soiled gloves. He then handed Staff T a roll of plastic trash bags. Staff U obtained a clean cloth incontinence bed pad and tucked it underneath the resident. He then turned and obtained a second cloth incontinence bed pad and double padded underneath the resident. He then began to tuck a clean brief under the resident. He assisted the resident to turn towards him, on her left side. He passed Staff T another clean plastic bag and removed his gloves. Staff U went to the sink and washed his hands, leaving the resident lying on the bed with no clothing or bed sheets. After washing his hands, Staff U placed clean gloves on his hands. He returned to the resident and tucked the bed pads further underneath her. Staff T gathered the soiled linens from the foot of the bed and placed them in a plastic bag. She then removed her gloves, performed hand hygiene and obtained clean gloves. Staff U then began to do peri care on the front of the resident, cleansing her vaginal area back to front and then closed her incontinence brief with the tabs. Staff U then obtained the resident's clean clothing and with the same gloves on, assisted the resident to place a clean dress on. Both staff assisted the resident to roll left to right to get her dress in place and to put a sling underneath her for the full body mechanical lift. Staff U then removed his gloves. No hand hygiene was observed. He obtained the full body mechanical lift and put it in place to use for the resident. After placing the sling loops in place and verifying safety, the resident was raised above the bed and her weight obtained. The resident was then (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lowered back to the bed, and the sling was removed from behind her. Staff U removed his gloves and used hand sanitizer and placed new gloves. Staff T kept her gloves on, picked up the bed remote control and put the bed at the appropriate height while they removed the sling from under the resident and made her comfortable with position and coverings. Staff T then obtained cleaned wet wipes from the package that was used for performing peri care and wiped down the full body mechanical lift. On 6/11/26 at 11:00 am, Staff T was asked if the observed cares was the first time the resident had been checked and changed for incontinence since the day shift started. Staff T verified it was and verified the shift started five hours earlier at 6:00 am. Staff T was also asked what she had used to clean the full body mechanical lift and she verified she used regular wet wipes, the same type used to clean a resident. On 6/11/26 at 11:07 am, Res. #18 stated she had last been checked and changed for incontinence at approximately 6:00 pm the prior evening (16.5 hours earlier). She stated it is her desire to not be awoken overnight and said this was a part of her care plan. She said she normally goes to sleep sometime after dinner and wakes up anytime between 5:00 am and 7:00 am. She said that morning she had awoken at approximately 5:30 am. She said she normally won't ring her call light unless she needs to have a bowel movement and she will just wait for staff to come in. She confirmed that she was aware that on this day, she was very wet. She added that although she knew how wet she was, she knew staff would be coming. She confirmed that it did not bother her when she was left lying exposed with no clothing or coverings on. On 6/11/26 at 1:15 pm, the Director of Nursing stated her expectation for incontinence cares for Res. #8 is every two hours and as needed, outside of the night shift per Res. #8's requested routine. The facility policy titled Activities of Daily Living (ADL), Supporting, revision date April 2025, documented the following:Policy Statement: Residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Point 5:Appropriate care and services are provided for residents who are unable to carry out ADLs independently, with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with:a. hygiene (bathing, dressing, grooming, and oral care);b. mobility (transfer and ambulation, including walking);c. elimination (toileting); d. dining (eating, including meals and snacks); and e. communication (including speech, language, and other functional communication systems).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interview and policy review the facility failed to provide medication as ordered by the physician after the resident admitted to the facility for one of four residents reviewed for medications (Resident #2). The facility staff also failed to prepare and administer medications to one resident at a time for two of five residents observed for medication pass (Resident #13 and #14). The facility reported a census of 81 residents. Findings include: 1.The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 admitted to the facility on [DATE] and had diagnoses of atrial fibrillation (irregular heart rhythm), heart failure and anxiety disorder. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The Care Plan initiated 3/25/26 revealed the resident had altered cardiovascular status related to CHF (congestive heart failure), pulmonary hypertension (high blood pressure in the arteries of the lungs), and anxiety. The Care Plan also revealed the resident had a behavior problem and high anxiety. The Care Plan directed staff to provide medication as ordered. The After Visit Summary dated 3/24/26 revealed instruction to take the following medications in the evening or bedtime (HS): a. Metoprolol tartrate (Lopressor) (used to treat high blood pressure) 12.5 mg by mouth (PO) two times a day (BID) was last given on 3/24/26 at 8:24 AM. b. Rivaroxaban (Xarelto) (a blood thinner used to prevent blood clots) 15 mg PO daily with dinner was last given on 3/23/26 at 4:59 PM. c. Senna-docusate (a laxative and stool softener) 8.6-50 mg take 2 tablets PO at HS was last given on 3/21/26 at 8:55 PM. d. Simethicone 80 mg (used to relieve symptoms of bloating and gas) 2 chewable tablets four times a day (with meals and nightly) was last given on 3/24/26 at 8:23 AM. e. Spironolactone (a water pill) (used to treat heart failure and high blood pressure) 12.5 mg PO BID was last given on 3/24/26 at 8:25 AM.f. Sulfamethoxazole-trimethoprim (Bactrim DS) (an antibiotic) 800-160 mg one tablet PO BID was last given on 3/24/26 at 8:25 AM. g. Trazodone (used for treating major depression) 25 mg PO at HS was last given on 3/23/26 at 9:15 PM. h. Hydroxyzine HCL (used to treat anxiety) 50 mg tablet PO every six hours if needed for anxiety was last given on 3/22/26 at 3:39 AM. A Physician's Encounter Note dated 3/26/26 revealed the resident had a recent hospitalization for fluid overload secondary to an acute on chronic heart failure. She had two paracentesis (a procedure to remove excess fluid buildup in the abdomen) with five liters of fluid removed each time. She had a history of cardiomyopathy, HTN and CHF. She is on spironolactone, metoprolol and hydralazine. She has significant anxiety. She reports she was on a trazodone to help her sleep. A Progress Notes revealed the resident admitted to the facility on [DATE] at 4:00 PM. A Nursing Progress Note on 3/25/26 at 5:51 AM documented by Staff E, Licensed Practical Nurse (LPN), revealed the resident alert and oriented x 4 (to person, place, time and situation) and able to make her needs known. She was a new admit on the previous shift. Resident had intermittent episodes of anxiety and tearfulness. Resident called this nurse at 1:00 AM and asked for her HS meds. Upon checking, all meds were signed off. When the resident was informed of this she stated I'm sure I did not take my medication, the nurse said she's coming back and I'm still waiting. On further discussion resident said she wants her bumetanide (water pill) and ABX (antibiotic). The ABX was scheduled to start this AM. The E-kit list of medications revealed sulfamethoxazole-trimethoprim (Bactrim DS) 800-160 mg available in the E-kit. The Pharmacy Delivery Report revealed medications for Resident #2 delivered to the facility on 3/24/26 at 8:43 PM. The medications included tramadol, hydroxyzine, metoprolol, spironolactone, xarelto and sulfamethoxazole-TMP DS. The Medication Administration Record (MAR) dated 3/2026 revealed Resident #2 did not receive any medications on the evening or at HS on 3/24/26. In an interview on 5/27/26 at 9:15 AM, Resident #2 reported she did not get her medications the first night she was at the facility. She was told when the pharmacy delivered the medications the nurse would bring the medications to her. Later that evening, she asked (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about her medications again. The next nurse on duty told her that another nurse checked the medications in and locked the medications in the medication cart. Resident #2 reported she did not get her blood pressure medication, antianxiety medication, or hydroxyzine medication. Resident #2 reported she took antianxiety and hydroxyzine medication because her anxiety got bad at time. In an interview on 5/27/26 at 2:00 PM, Staff E, LPN, reported the nurse or unit manager entered the orders when a resident got admitted to the facility. Staff E reported the pharmacy does not deliver on Sunday but she knew the pharmacy made two runs (delivery) each day. She is not sure what time the pharmacy delivered medication but they have delivered medication after 10 PM. Staff E reported she checked the E-kit or called the pharmacy if she did not have the medication. Staff E reported the first night Resident #2 was at the facility, Resident #2 told Staff E she did not get her medication. Staff E notified the ADON about the concern. She also checked the resident's blood sugar and her blood sugar reading was fine so she did not need insulin. Resident #2 was anxious but not confused. In an interview on 5/27/26 at 3:20 PM, Staff F, LPN, reported she had not done an admission at the facility. She believed the nurse or nurse leader entered the orders. The Pharmacy delivered medication in the afternoon.In an interview on 5/27/26 at 3:25 PM, Staff G, LPN, reported management staff entered the orders and someone else from leadership checked the orders after they had been entered. Staff G reported the pharmacy made a delivery to the facility around 2:00 or 2:30 PM each day and again after 6:00 PM. The facility had an E-kit with controlled substances and an E-kit tackle box for other medications such as an antibiotic or an anticoagulant. A list of medications was posted on the inside of the plastic bin. Staff G reported they obtained medication from the E-kit and gave the medication to the resident if the medication was needed and not delivered from pharmacy yet. In an interview on 6/1/26 at 2:35 PM, the Administrator reported they do not have a policy about processing doctor's orders.In an interview on 6/1/26 at 2:45 PM, the Director of Nursing (DON) reported the Assistant Director of Nursing (ADON) and the DON entered physician orders into the computer. The orders were also faxed to the pharmacy, and then the pharmacy delivered the medications to the facility. The DON reported it depended on the time of day when a resident got admitted . If a resident admitted to the facility in the AM and orders had been entered, the pharmacy delivered medications around 3 PM. If a resident admitted to the facility and orders entered in the afternoon or evening (PM), the pharmacy delivered medication between 9:00 to 10:00 PM. The DON confirmed the staff could obtain medications from the E-kit or call for a STAT delivery when needed. The floor nurse checked and verified the orders when they did their assessment. Orders were checked and entered into the computer when a resident admitted to the facility from the hospital. If a medication was supposed to be given medication BID, for example, and a dose of the medication was given at the hospital that AM, then another dose of the medication should be given at HS or when scheduled. At the time, the surveyor requested the DON to look at the electronic health record for the orders that were entered for a resident that came from the hospital. The DON stated she had entered the orders for Resident #2. She guessed since the resident admitted at 4:00 PM, the orders got put in later in the day and the system had populated the start time for that medication pass. Since it was later in the day, the HS medication time started as early as 6 PM. The DON thought since it was later in the day and after the time the computer likely did not flag for the nurse to give the medication on that shift, but rather for the following day. A Processing New Doctor's Orders procedure updated 4/9/26 revealed the nurse is responsible for entering new orders into the computer. The procedural steps included: select orders, select new, select order type (such as pharmacy, other, etc.), enter the order, fill out the order schedule, and press save. It was important to remember new orders needed processed timely and to make sure the order is designated to flag to the MAR (VERY IMPORTANT). Antibiotics need to be pulled from the E-kit and started immediately. If the medication is not in the E-kit then the pharmacy needed to be notified so the order could be requested as a STAT delivery. 2. On 5/28/26 at 11:51 AM, as the surveyor spoke with Resident #13 and Resident #14 in their room, Staff O, certified medication aide (CMA), brought medication in a medication cup for Resident #13, then walked over and handed a (continued on next page)

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	165580	A. Building B. Wing	06/11/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication cup to Resident #14. Resident #14 asked Staff O what is this? Resident #14 told Staff O he normally got three pills at this time of the day. Staff O told the resident his Tylenol was in the cup. Resident #14 said he gets gabapentin and Lasix but he doesn't usually get Tylenol. Staff O told the resident the medication order showed up on the computer. Resident #14 then proceeded to take the medication. The MDS assessment dated [DATE] revealed Resident #13 had diagnosis of an essential tremor. The MDS recorded the resident had a BIMS of 15, indicating intact cognition The Medication Administration Record (MAR) dated 5/2026 revealed carbidopa-levodopa (given for tremors) documented as administered on 5/28/26 for the Mid AM dose. The MDS assessment dated [DATE] revealed Resident #14 had diagnoses of chronic atrial fibrillation (irregular heart rhythm), peripheral vascular disease and anxiety. The MDS documented the resident had a BIMS score of 14, indicating intact cognition.The MAR dated 5/2026 revealed furosemide, gabapentin and extra strength acetaminophen (Tylenol) documented as administered by Staff O, CMA, on 5/28/26 for the Mid-AM dose. In an interview on 5/28/26 at 12:05 PM, Resident #13 reported a lot of times staff brought medications in at the same time for her and Resident #14. Resident #13 said one time she got Resident #14's medication and she thought Resident #14 got her (Resident #13's) medication. In an interview on 5/28/26 at 12:10 PM, Staff O, CMA, reported she gave Resident #14 Tylenol, gabapentin and Lasix on 5/28/26 for the Mid-AM doses. In an interview on 6/1/26 at 3:05 PM, Staff N, CMA, reported they are only supposed to set up one resident at a time for medication pass. In an interview on 6/2/26 at 9:05 AM, the DON reported she expected staff to set up and administer medications for one resident at a time. An Administering Medications policy revised 12/2012) revealed medications shall be administered in a safe manner and timely manner, and as prescribed. Medications must be administered in accordance with the orders, including any required time frame. The individual administering the medication must check the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on review of the Centers for Medicare & Medicaid Services (CMS) 2567's, staff interview and policy review the facility failed to have an effective QAPI (Quality Assurance Performance Improvement) process to address previously identified quality deficiencies to assist in the provision of quality care for residents and attain substantial compliance with Federal regulations and State rules. The facility had repeat deficiencies identified on the facility's recertification revisit and complaints survey. The facility identified a census of 81 residents.Findings include: Review of the Department of Inspections, Appeals and Licensing (DIAL) website under the facility's visit history revealed repeated deficient practices identified during the facility's recertification survey completed 5/20/25, complaint investigations 5/20/25, 2/11/26, 4/9/26 and the current revisit survey and complaint investigations. The repeat deficiencies cited included: F760 cited 5/20/25 and 4/9/26F880 cited 5/20/25, 2/11/26, 4/9/26 and during the current surveyIn an interview on 6/2/26 at 1:10 PM, the Administrator reported Quality Assurance (QA) meetings held daily with the leadership team, and the QA committee met monthly. The QAPI Committee had identified performance improvement areas they needed to work on including infection control. The facility had provided staff education on appropriate use of PPE (personal protective equipment) as well as staff competency and audits on donning and doffing PPE and handwashing. When the surveyor asked the Administrator how they were addressing repeat deficiencies cited since the past recertification survey and complaints survey, and how they were going to ensure future compliance related to the prior and current surveys, the Administrator responded the facility had planned to ramp up staff education, observe staff for PPE use at the appropriate times, conduct audits, as well as implement peer to peer training, and interview the residents about the staff's use of PPE. They also planned to have a more experienced certified nursing assistant (CNA) take on a leadership role and assist with ensuring things got completed properly when on duty. The facility's Quality Assurance and Performance Improvement Policy revised 9/2022 revealed the facility is committed to developing, implementing, and maintaining an effective QAPI program that focused on outcomes of care and quality of life. The leadership team looked for trends or faulty systems in order to prevent undesirable outcomes. Data is collected, analyzed, and the QAPI process applied for focus areas such as infection control compliance. The Root Cause Analysis are used to identify improvement opportunities and to understand how to improve them. Staff will be taught to focus on system and process correction and improvement, not placing blame or treating symptoms, and to support a culture of QAPI. The goal of QAPI is to achieve improvement and prevent recurrence of the problem.

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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 the record review, observations, staff interviews and policy review the facility failed to ensure staff utilize Enhanced Barrier Precautions (EBP) and infection control practices to prevent the potential spread of infection for 1 of 3 nursing units reviewed (100 Hall). Staff reached into their uniform pocket to obtain hand sanitizer and then placed the hand sanitizer back into their uniform pocket during the course of a treatment and dressing change for 1 of 3 residents observed for treatments (Resident # 8). The facility additionally failed to properly sanitize a full body mechanical lift after resident usage and properly sanitize a mattress which was pooled with urine. The facility reported a census of 81 residents. Findings include: 1.The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 had diagnoses of Stage 4 pressure ulcer, quadriplegia and multiple sclerosis. The Care Plan revised 4/6/26 revealed Resident #8 had a Stage 4 pressure injury to her right buttock related to impaired mobility and incontinence. The resident also had a ESBL (bacteria that is resistant to many common antibiotics). The Care Plan directed staff to administer treatments as ordered and utilize enhanced barrier precautions as ordered to prevent transmission to others. The Physician's Orders and Treatment Administration Record (TAR) revealed to use a gown and gloves for high contact resident care including dressing and transfers. The orders also included to administer Bactrim DS (an antibiotic) by mouth two times a day for seven days for osteomyelitis (a bacterial or fungi infection spread to the bone from an open wound or infected tissue) had a start date of 5/28/26. During observation on 5/26/26 10:55 AM Staff H, Licensed Practical Nurse (LPN), gathered supplies and placed the supplies on a paper towel on an overbed table. Staff H and Staff I, Registered Nurse (RN) donned a gown, washed their hands and donned a pair of gloves. Resident #8 was positioned onto her right side. The resident's right upper buttock had a baseball sized open wound with a blackened area around the wound. Staff H cleansed the open wound with wound cleanser and gauze. Staff H removed her gloves, moved the gown and reached into her uniform pocket. Staff H sprayed hand sanitizer on her hands, then donned a pair of gloves and cleansed the wound area again. Staff H placed a gauze with vashe (wound cleanser) solution inside and over the wound for 5 minutes. Staff H then removed the gauze from the wound area, removed her gloves and reached into her uniform pocket, took a hand sanitizer container out of her pocket, applied hand sanitizer to her hands, put the hand sanitizer back into her pocket then donned a pair of gloves. Staff H proceeded to pat the wound area with a dry gauze, removed her gloves, reached into her uniform pocket to obtain hand sanitizer, applied hand sanitizer to her hands and put the hand sanitizer back into her uniform pocket. Staff H donned gloves, placed calcium alginate into the wound bed then removed her gloves and washed her hands. Staff H donned a pair of gloves, applied a gauze dressing and a bordered dressing over the coccyx and right buttock area and removed her gloves. Staff H again reached into her uniform pocket to get hand sanitizer, sanitized hands and put the hand sanitizer back into her uniform pocket. After the resident's soiled brief was removed Staff I, RN, took disposable wipes and cleansed the buttocks area. Staff I removed her gloves, reached into her uniform pocket to get hand sanitizer, sanitized her hands, placed the hand sanitizer back into her uniform pocket and donned a pair of gloves, then placed a clean brief on the resident. In an interview on 6/1/26 at 4:35 PM Staff B, Infection Preventionist (IP), confirmed supplies (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including hand sanitizer should be prepared and available when staff performed a treatment or dressing change. Staff should not reach into their pocket for hand sanitizer as they performed a treatment. A Long-Term Care Isolation Precautions policy dated 5/15/20 revealed Standard precautions are the minimum infection prevention practices that apply to care in any health care setting. Hand hygiene performed when moving hands from a contaminated body site to a clean body site during resident care. An updated Wound Care Competency revealed wound care shall be provided in accordance with CDC infection-prevention practices including proper preparation such as gathering all supplies needed for the treatment. 2. The MDS assessment dated [DATE] revealed Resident #4 had diagnoses of dementia, Stage 3 pressure ulcer to the left buttock and two other sites, and an open lesion to her foot. The MDS indicated the resident had dependence on staff for bed mobility and transfers. The Care Plan revised 4/21/26 revealed the resident required assistance with ADL's (activities of daily living) and transfers related to her dementia. The resident also had a Stage 3 pressure ulcer to her right outer foot, a pressure area to the left buttock and right gluteal cleft related to immobility. The Care Plan directed staff to follow EBP's. The TAR revealed EBP's: Use a gown and gloves for high contact resident care including dressing, transfers, hygiene care, peri care and wound care. During observation on 5/27/26 at 7:45 AM, Staff Q, certified nursing assistant (CNA), and Staff R, CNA, provided care for Resident #4. An EBP's sign indicating use of a gown and gloves needed for high contact care activities. Staff Q and Staff R did not have a gown on. At 7:50 AM, Staff Q and Staff R used a mechanical lift and transferred Resident #4 from the bed to a large portable recliner chair. Staff Q and Staff R wore gloves but no gown worn. At the time, Resident #4 had a dressing visible on her right foot and dark brown drainage on the dressing around the right heel. Staff Q pushed the mechanical lift into the hall but did not sanitize the lift after use. A continuous observation on 5/27/26 from 7:50 AM to 8:11 AM revealed the mechanical lift used on Resident #4 remained parked in the 100 hallway. At 8:11 AM, Staff S, LPN, took the mechanical lift into another resident's room and used the mechanical lift to transfer that resident. In an interview on 6/1/26 at 3:05 PM, Staff N, certified medication aide (CMA), reported EBP's required for residents that had a bacterial infection or had a catheter. A gown and gloves worn for EBP's. Staff N reported an EBP's sign was on the door to the resident's room if a resident needed EBP's. In an interview on 6/1/26 3:10 PM Staff L, CNA, reported EBP's needed if a resident had a catheter or some kind of infection. A gown and gloves worn when a resident on EBP's. In an interview on 6/1/26 at 4:35 PM Staff B, IP, reported EBP's implemented for residents that had a wound or catheter. Staff should wear a gown and gloves for residents requiring EBP's. An Enhanced Barrier Precautions policy revised 12/2024 revealed EBP's are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents during high contact care activities (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	such as transferring the resident and the provision of care. Gloves and gown are applied prior to performing the high contact resident care activity. 3. On 6/11/26 at 10:37 am, observation of morning cares of Resident #18 performed by Staff T and Staff U, both CNAs, began. Staff assisted Res #18 to remove her night clothes, and perform incontinence care. Resident #18's mattress was drenched in urine. During the provided care, Staff U, CNA absorbed the urine on the mattress with the dirty sheets and placed them in a plastic bag. He then placed new sheets under Resident #18 during care. No sanitization of the mattress was observed. After the resident's incontinence care, clothing and sheet change was completed, staff brought a full body mechanical lift over to the bed in order to obtain the resident's weight. Staff had placed the sling to the lift under the resident. After properly securing Res #18 to the sling and lifting her in the air over her bed, staff obtained her weight. They then lowered her back down and removed the sling from beneath her. After completing all cares for Res #18, Staff T then obtained a standard wet wipe (the type used for incontinence cares, not a sanitizing type of wipe) and cleansed the full body lift with the wet wipe. She told Staff U that the lift had been sanitized. On 6/11/26 at 11:00 am, Staff T, CNA verified Res #18 had not priorly received incontinence care on this shift which started five hours earlier. She also verified the full body mechanical lift was sanitized using regular wet wipes from the same package as what had been used for incontinence care. On 6/11/26 at 1:05 pm, the Infection Preventionist Nurse stated equipment such as the full body mechanical lift are to be cleaned with sani wipes (a germicidal wipe used to clean microorganisms on hard, non porous surfaces).