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	05/20/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 observations, record review, resident and staff interview, and policy review, the facility failed to provide incontinence care at the resident's request for 1 of 23 residents (Res #81). The facility reported a census of 84 residents. Findings include: On 5/12/25 at 8:27 AM, Resident #81 propelled her wheelchair in the hall up to Staff Y, Licensed Practical Nurse (LPN) and notified her that she needed help because she wet her pants. Staff Y informed Resident #81 that Staff Z, Certified Nursing Assistant (CNA) would be in to change her. Staff Y continued to administer medications to other residents. She did not call for any staff to assist the resident. The resident remained in the hall in her wheelchair. At 8:28 AM, Resident #81 told Staff Y that she still needed help because she wet her pants. Staff Y told the resident someone would be in to help her. Staff Y did not call for assistance for the resident and continued to administer medications to other residents. At 8:29 AM, Staff Y pointed to the resident's room, asked the resident if she wanted to go to her room, and told the resident the aide would come help her. She entered the resident's room and activated the resident's call light. Staff Y returned to the medication cart and continued to pass meds to other residents. The resident propelled herself in her wheelchair to her room. At 8:34 AM, Staff Y asked Staff Z, CNA to assist Resident #81 change her underwear when she had time because the resident was wet. Staff Z said ok and entered another resident's room. At 8:38 AM, Staff Z responded to another resident's call light, exited the room, and went to get that resident some orange juice. At 8:39 AM, Staff Z returned to the other resident's room with the resident's requested orange juice. At 8:40 AM, Staff Z entered Resident #81's room to provide incontinence assistance. At 8:52 AM, Resident #81 stated she felt bad because she felt like the nurse didn't want to help her. (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	The Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #81's Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of anemia, hip fracture, need for assistance with personal care, muscle weakness, and age-related cognitive decline. It indicated the resident required supervision with eating, moderate assistance with oral and personal hygiene and upper body dressing, maximal assistance with footwear and bathing, and was dependent with toileting and lower body dressing. It also indicated the resident used a walker or wheelchair and required moderate assistance with mobility. It further indicated she required supervision with transfers. The Care Plan dated 1/02/25 indicated the resident was incontinent of urine and directed staff to provide incontinence care as needed. On 5/19/25 at 11:06 AM, the Director of Nursing (DON) stated the nurse could have stopped after the current task of medication pass and either helped the resident or found a CNA to make sure that the task was completed in a timely manner. A policy titled Resident Rights revised January 2019 indicated employees shall treat all residents with kindness, respect, and dignity. It also indicated the resident rights included the resident had the right to a dignified existence.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews, and policy review, the facility failed to develop a baseline care plan within 48 hours after admission for 1 of 23 residents reviewed (#60). The facility reported a census of 84 residents. Findings include: On 5/12/25 at 4:07 PM, Resident #60 stated the she took medication for chronic pain and anxiety. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated completely intact cognition. The MDS documented the resident had diagnoses including Anxiety, depression, contracture of both feet, pain in joints of right hand, unspecified osteoarthritis. It also indicted she received antianxiety, antidepressant, antipsychotic, and opioid medication within the 7-day lookback period. It further indicated the resident was admitted to the facility on [DATE]. Social Service Note dated 8/28/24 at 9:45 AM documented the following; resident transferred from another nursing facility admit orders included Cymbalta 60 milligrams (mg) for Major Depression Disorder (MDD), Buspar 15 mg for three times a day (TID) for diagnoses of Anxiety, plus Clonazepam TID for diagnoses of Anxiety. Electronic Medication Administration Note on 8/23/24 at 12:38 PM documented the following; Oxycodone HCL (opioid pain medication) 10 mg every four hours as needed for pain, Resident complained of pain in joints especially in shoulder, she normally received pain pill with lunch and in evening. The Care Plan was initiated on 9/05/24. The Baseline Care Plan did not include chronic pain nor psychotropic medication use and lacked a date and time of completion. On 5/14/25 at 8:29 AM, Staff BB, MDS Registered Nurse (MDS RN), stated the Baseline Care Plan did not have a signature nor a date. She added they usually obtain verbal confirmation from the resident or family if the resident is not able to sign. The Progress Notes lacked documentation of Baseline Care Plan confirmation from the resident or her family members. On 5/19/25 at 11:06 AM, the Director of Nursing (DON) stated the expectation is that all baseline care plans are dated and signed within the regulation timeline. A policy tilted Care Plans- Baseline revised March 2022 indicated a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, staff interviews, and clinical record review, the facility failed to follow the physician's orders for 1 of 23 residents (#66). The facility reported a census of 32 residents. Findings include: The Minimum Data Set (MDS) for Resident #66 dated 2/24/25 revealed a Brief Interview for Mental Status (BIMS) score of 02 out of 15 which indicated severely impaired cognition. The MDS documented the resident had the diagnoses including congestive heart failure, kidney disease, Non-Alzheimer's Dementia, and a right heel pressure ulcer. The MDS indicated the resident required maximal assistance with eating oral hygiene, bathing, and upper body dressing. It also indicated she was dependent with all other aspects of Activities of Daily Living (ADLs), mobility, and transfers. The Electronic Health Record (EHR) included a Physician's Order dated 3/14/25 for Prevalon boots on at all times as tolerated except when weight bearing every shift for promote wound healing. The Care Plan with initiated date of 4/14/25 included the resident's right heel ulcer and directed staff to apply Prevalon boots (a device used to prevent/treat heel pressure ulcers) to feet at all times as resident allows. On 5/13/25 at 9:30 AM, Resident #66 was observed in her wheelchair in front of the nurses' station not wearing the Prevalon boots. On 5/14/25 at 11:02 AM, Resident #66's Prevalon boots could not be located in her room. At 11:10 AM, Resident #66 was observed sitting in her wheelchair in front of another nurses' station not wearing Prevalon boots. At 1:31 PM, Resident #66 was observed lying in bed not wearing Prevalon boots. At 1:36 PM, Staff CC, Certified Medication Aide (CMA) stated weight-bearing means that the resident can stand. She added Resident #66 was non-weight bearing and required a mechanical lift for mobility and transfers. She also added if an order indicated to have an item off except for weight-bearing, the item should be applied after the resident is in a wheel-chair. At 1:49 PM, Staff E, Licensed Practical Nurse (LPN) stated a resident sitting in a wheelchair is not considered a weight-bearing activity. At 1:56 PM, Staff DD, Certified Nurse Aide (CNA) stated if the boots were to be on except when weight-bearing, the boots should be on while the resident is in bed, in a mechanical lift sling, or a wheelchair. At 2:13 PM, Staff EE, CNA transferred Resident #66 from her wheelchair to her bed. She stated the resident never refused care from her, and not was she aware the resident ever refused care by any other staff member. She added if the resident refused care, the nurse would be notified. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 2:25 PM, Staff O, CNA stated the resident had not refused care during her shift and was not informed about the Prevalon boots during shift change. She checked the resident's feet and confirmed the boots were not on the resident and was not able to locate the boots in the resident's room. At 2:32 PM, Staff E, LPN, stated she was not notified the resident refused any care during the shift. She added she was not aware the resident was not wearing the boots. On 5/19/25 at 11:06 AM, the Director of Nursing (DON) stated the expectation is that this would be included on the Care Plan as an intervention and not a physician's order. A policy titled Physician Services with effective date 3/2015 indicated the attending physician shall be responsible for the medical evaluation of the resident and shall prescribe a planned regimen of total resident care which incorporates all of the components of the resident's care and shall designate the resident's appropriate level of care.

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F 0689 Level of Harm - 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 clinical record review, hospital record review, resident and staff interviews, facility education review and facility policy review, the facility failed to ensure safety during transfers for 1 of 3 residents reviewed (Resident #61). This failure caused harm when Resident #61 was improperly transferred in the shower room, resulting in a fall with two fractures. These fractures caused the resident to have an increase in pain, a need for increased pain management and a decrease in her ability to transfer. During observations of other residents, the facility additionally failed to properly use a full body mechanical lift in a safe manner and per manufacturer's instructions for Residents #4, #17 and #39. The facility reported a census of 84 residents. Findings Include: 1. The Quarterly Minimum Data Set (MDS) of Resident #61 dated 3/13/25 identified a Brief Interview for Mental Status Score of 15 which indicated cognition intact. The MDS coded the resident required partial/moderate assistance to move from sitting to standing and for shower transfers. The MDS documented diagnoses which included seizure disorder or epilepsy. The MDS recorded the resident experienced pain during the 5-day look back period and rated her pain as moderate and over the last 5 days had rarely or not at all limited her day to day activities because of pain. The Care Plan of Resident #61 identified a Focus Area of ADL (Activities of Daily Living) Performance Deficit, initiated on 12/13/24, revised on 4/22/24. The interventions included a transfer status of one staff participation with transfers, dated 12/13/24. The Care Plan reflected this status was changed to assistance of two staff members with a full body mechanical lift, revised on 5/1/25. The Care Plan additionally identified a focus area of a left fibula fracture after a fall dated 4/25/25 and an additional care area of leg numbness and weakness due to fibula fracture as well as prior laminectomy surgery (a surgical procedure of the spine to relieve pressure on the spinal cord or nerves), initiated on 5/8/25. The Care Plan identified an additional focus area of acute pain due to fracture of the left fibula initialed 5/8/25. Facility Incident Report #2833, dated 4/20/25 at 10:00 am identified a fall incident with the following information: Nursing Description: Staff stated that she was transferring resident to a shower chair and the resident fell. Resident Description: Resident stated she fell and jammed her knee against the wall. Then she fell on left hip. Fall Intervention: Resident to have proper footwear on feet and utilize staff assistance when transferring. Predisposing Situation Factors: Bare feet or inappropriate footwear. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The impression findings of radiology reports from a local hospital dated 4/20/25 documented an acute-appearing minimally impacted proximal left fibular diaphyseal fracture, localizing proximal to a chronic-appearing fibular deformity (a fracture near the top part of the left fibula, the smaller bone in the lower leg. Appears recent but is near an area of an older deformity or previously healed injury) On 5/12/25 at 9:42 am, Resident #61 stated a staff member (Staff A, Certified Nurse Aide [CNA]) had taken her from her room to the shower room in her wheelchair. She stated once in the shower room, she was standing up, trying to reach for the grab bars. She said she lost her grip and fell to the floor. She stated Staff A was aware she was attempting to stand but did not offer assistance but that she was behind her. She stated Staff A apologized to her, telling her she was so sorry after the fall. Resident #61 stated when she fell she started screaming in pain. On 5/13/25 at 1:14 pm, Staff B, Registered Nurse (RN) stated she was working at the time Resident #61 suffered her fall, although she was not assigned to the resident. She said Staff A, CNA came out of the shower room for assistance explaining the fall. When Staff B entered the shower room, she noted Resident #61 was barefoot, and there was no gait belt (a safety device used to assist patients with limited mobility during transfers and walking. It provides a secure grip around the patient's waist, allowing caregivers to help with balance, prevent falls and guide them safely between surfaces) observed on the resident or anywhere in the room. She stated the shower floor was wet. She noted the position of the resident's chair and the position the resident was lying in and asked Staff A what had happened. Staff B stated Staff A had turned away from the resident with no gait belt on and wearing no footwear. She stated Resident #61 during the post fall assessment asked Staff B to pray with her and that she was in a lot of pain. Staff B described the shower room as when a person enters the room, and goes towards the back left, there is a corner where the shower chair is kept then a half wall separating the storage stall from the shower stall. She stated Staff A had pushed Resident #61 into the shower stall, near the grab bars in her wheelchair. She believed Staff A had left Resident #61 to grab the shower chair. She said that Staff A had told her that she had stood the resident up at the grab bars and then stepped away to get the shower chair which was out of reach, and that is when the resident fell. On 5/13/25 at 2:44 pm, Staff A, CNA stated she assisted Resident #61 from her room to the shower room via wheelchair. She stated she was getting ready to switch her into the shower chair. She said the resident had partially stood up and she (Staff A) reached for the shower chair to place it under her. She stated the resident had a reaction or something. She felt the resident's mind had just blanked for a moment, her hand fell off of the grab bar and she fell. Staff A stated she thought the resident was barefoot but may have been wearing socks. She said the resident was clothed from the waist down. She said she had turned her head away from the resident for only about two seconds and the resident slipped. She verified she had not used a gait belt during the transfer. She then went for help and found Staff B first and asked her to come help. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/13/25 at 4:04 pm, the Administrator stated the resident was barefoot at the time of the fall She stated any resident who is a one staff member assist would require the use of a gait belt. She confirmed a gait belt was not used during the transfer. The Administrator stated the resident now required a two person assist using a full body mechanical lift due to her fracture and her weight bearing status. She stated the resident's pain had increased, especially when she returned from the hospital and began working with physical therapy. She stated due to the facility not being able to get the resident's pain under control, they sent her back to the hospital for a second evaluation. The Administrator stated that during the second hospital visit, a Computed Tomography (CT scan) was performed and a second fracture was found on the CT scan. The Administrator stated she felt that having not known about the second fracture (a tibial fracture, the larger and stronger of the two bones of the lower leg), her leg was not stabilized and working with therapy increased her pain in the leg. She stated following the fall, transfer audits and education to staff were started immediately. The CT scan dated 5/7/25 identified a subacute (delayed related) fracture of the proximal tibial metaphysis with a slightly greater displacement compared to prior study (a fracture near the top of the shinbone, which has shifted slightly more since the prior imaging. The fracture was at the wider part of the bone shaft, near the knee joint.) The hospital notes dated 5/7/25 documented the resident presented to the emergency department for evaluation of left lower extremity pain. It stated the resident had sustained a left fibular fracture on 4/20/25 after a fall and was discharged back to the facility for rehabilitation. The note documented that despite taking Oxycodone (a narcotic pain medication) the resident had continued to experience left lower extremity pain radiating from her knee to her ankle, worse with movement as well as swelling of the lower extremity and chronic numbness. The Assessment/Plan notes stated she would be kept NPO (no food or drink) for potential surgical intervention and be admitted inpatient to the hospital. The orthopedic physician who saw her during this hospitalization documented that another physician would plan for a surgical revision of knee arthroplasty (knee replacement) within the following week. The Medication Administration Report (MAR) of Resident #61 for April of 2025 documented the resident had an order for Tramadol (a less potent opioid pain medication) scheduled twice a day which was discontinued on 4/25/25. A new order for Oxycodone, 5 mg every four hours as needed began on 4/25/25 and was discontinued on 4/28/25. At that time, the order was changed to be scheduled four times a day. The Pain Scale portion of the resident's Electronic Health Record documented that in the month prior to the fall, the resident rated her pain as zero on most days, with other days rating her pain as high as a 6 out of 10. On the day of the fall, 4/20/25, she rated her pain a 10/10. The following dates leading up to her second hospitalization, she rated her pain anywhere from 0 up to a 10 with greater than 10 instances of rating her pain at an 8 or above. The Consult report from a local hospital dated 5/13/25 documented the resident was hospitalized following left total knee arthroplasty revision performed on that date. Per this note, the resident's pain was poorly controlled, rated 8/10 and was requiring 2 liters of oxygen. The Medication Discharge Report dated 5/19/25 documented the resident's order for pain management to be Oxycodone, 5 mg, every 8 hours as needed for pain (severe 7-10) and acetaminophen, 1000 mg every six hours. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Progress Note dated 5/20/25 at 12:05 am documented the resident had returned from the hospital on 5/19/25 at 6:00 pm following her knee surgery six days prior. The Progress Note dated 5/20/25 at 2:06 am documented the resident requested pain medication at 1:10 am. The staff provided 500 mg of acetaminophen first, followed by Oxycodone half an hour later. The resident voiced these interventions were ineffective and stated she wanted to go to the hospital and would call 911. The staff contacted the physician on call and received orders for Morphine (an opioid pain medication) which was administered. The Progress Note dated 5/20/25 at 10:34 am documented the Advanced Registered Nurse Practitioner (ARNP) was notified of the resident's pain being uncontrolled during the overnight shift. The ARNP wrote orders to resume prior pain medication orders of 7.5 mg of Oxycodone scheduled every 8 hours and an additional 5 mg as needed every 8 hours. The facility provided undated records of Educational Inservice with topics of Proper Footwear and Gait Belt Education. The subject lines noted the following: A. Proper Footwear: All residents must have proper foot wear on when being transferred. Examples are gripper socks or tennis shoes. Do not transfer barefoot. B. Gait Belt Education: Gait belts are to be worn with all transfers. Must be around the resident's waist with about a finger wiggle room between belt and waist so belt does not slide up when transferring. On 5/14/25 at 1:49 pm, Staff M, Licensed Practical Nurse, Assistant Director of Nursing (LPN, ADON) stated education for staff began the day of the fall, on 4/20/25. She stated the education continued over several days until all staff had been educated. 3. The Significant Change MDS for Resident #17, performed on 12/16/2024, documented the following relevant diagnoses: Heart Failure, Hypertension, Peripheral Vascular Disease, Arthritis, and Hemiplegia or Hemiparesis (partial paralysis). It documented the resident was fully dependent on staff for all transfers and most cares. The Care plan for Resident #17, last revised on 4/23/2025, documented the resident required a mechanical lift transfer and assistance of two staff members with initiated date of 12/15/2015. A direct observation on 5/12/2025 at 4:07 pm revealed Staff Q, CNA, and Staff O, CNA, performing a two-person full body transfer with a mechanical lift for Resident #17. During the transfer the adjustable base of the mechanical lift was in the closed position while transferring across the room. During the transfer the resident was observed to tilt and the mechanical lift wobbled. 4. The Significant Change MDS for Resident #4, dated 2/7/2025, documented the following relevant diagnoses: Cerebrovascular event (stroke), Paraplegia, and seizure disorder. It further documented the resident was fully dependent on staff for all transfers. The Care Plan of Resident #4, last revised on 5/12/2025, documented the resident required two-person assistance for transfers in a full body mechanical transfer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation on 5/12/2025 at 4:17 pm, Staff Q, CNA, and Staff O, CNA, performed a full body mechanical transfer using a mechanical lift for Resident #4. During the observation, the adjustable base of the mechanical lift was in the closed position, and Resident #4 was observed to tilt and wobble, at one time appearing to lift slightly off the floor as she was transferred across the room. The adjustable base of the mechanical lift was not opened until it needed to be opened to fit around the resident's wheel chair and closed during the transfer across the room. In an interview on 5/15/2025 at 10:41 am, Staff O, CNA, was unable to describe safe transfer technique with a full body mechanical lift. She was unaware what position the adjustable base should be in during transfers. She stated the legs of a mechanical lift must be in the closed position at all times. This finding is discrepant from appropriate transfer techniques for the machine that was used. In an interview on 5/15/2025 at 12:05 pm, Staff K, CNA, stated the mechanical lifts only move if the legs of the adjustable base are in the closed position due to age of the machines. She stated she has noticed side to side movement and residents swinging back and forth on the lift when transferring them with the legs closed. In an interview on 5/15/2025 at 10:43 am, the Director of Nursing (DON), she stated staff are instructed to follow the manufacturer's recommendations for the positioning of adjustable bases, and acknowledged that failure to follow those recommendations could result in injury. Review of the user manual for the mechanical lift used during the observations, with a copyright of 2022, documented the following on page 12: It warns users that failure to follow these instructions creates a potentially hazardous situation which could result in injury or death. The Manual instructs as the user that the adjustable base of the lift must be in the maximum/open position before lifting and while transferring residents short distances. It again warns the user that failure to follow these instructions could cause the model to tip, potentially causing injury. The facility provided document titled Transfer with a mechanical lift, long-term care, revision date November 15th, 2019, documented the following: Set the mechanical lift's adjustable base to its widest position to help ensure optimal stability. The facility policy Gait Belt Use, revision date 5/27/2021 documented the following: Policy statement: Nursing staff may utilize gait belts on residents who need one- person assistance or more for transferring and ambulation unless the use is contraindicated. Gait belts can be used to promote ambulation by providing increased security for resident and staff and to provide a firm, grasping surface for staff to help protect the resident from accidental trauma to the skin. Gait belt use should be included in the resident's medical record when indicated. Guideline: Using a gait belt while transferring or walking with a resident can provide you and the resident with increased safety and security. You can help control a resident's balance and keep the resident from falling by using a gait belt. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Point 9: Instruct the resident to be ready to stand at a predetermined signal. Simple instructions are to tell the resident to be prepared to stand on the count of three. Point 13: If the resident loses their balance, use the belt to help them regain it. Point 14: If the resident begins to fall, and you cannot prevent it, slowly lower them to the floor, using the gait belt to help control the descent. It is also helpful to let the resident slide down your leg if possible for a safe, controlled assist to the floor. 2. Review of Resident #39's Significant Change MDS dated [DATE] revealed diagnoses of Stage 3 pressure ulcer of left heel, non-traumatic brain dysfunction, non-Alzheimer 's dementia, senile degeneration of the brain not elsewhere classified and chronic peripheral venous insufficiency. The MDS further revealed total dependence or assistance of 2 or more helpers for toilet hygiene, personal hygiene, rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair to bed transfer, toilet transfer and tub/shower transfer. In addition, the MDS indicated the resident is unable to ambulate. Review of Resident #39's Care Plan revealed interventions for transfers initiated 3/10/20 and revised 4/11/25 as assist of 2 with a full body mechanical lift. Observation of Staff F, Licensed Practical Nurse (LPN) and Staff I, CNA, began on 5/13/25 at 9:25 am. The two staff transferred Resident #39 from her wheelchair to the bed using a full body mechanical lift. When raising Resident #39 from the wheelchair in the mechanical lift sling, the legs of the lift were observed to be extended. Staff retracted the legs of the lift when moving Resident #39 to the bed. On 5/13/25 at 9:25 am, Staff I CNA stated the legs of the lift were opened only to get around the wheelchair and then they are to be retracted. Staff F did not make a comment. On 5/14/25 at 8:45 am, Staff F stated that the legs are extended to get around the wheelchair as well and then retracted. Staff F then demonstrated the use of the full body mechanical lift the way Staff F had described.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, resident interviews, staff interviews, and policy review the facility failed to provide respiratory care and services in accordance with professional standards of practice for 2 of 4 residents reviewed (Residents #48, and #83) requiring the use of oxygen. The facility reported a census of 84 residents. Findings include: 1. Review of Resident #48 Minimum Data Set (MDS) dated [DATE] revealed an admission date to the facility of 3/25/25 from a short-term general hospital stay. The MDS further revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. Observation 5/12/25 at 3:36 PM revealed no label or date on Resident #48's oxygen tubing as to when the tubing was changed. Interview 5/12/25 at 3:36 PM with Resident #48 revealed that the oxygen tubing had not been changed since being at the facility. Review of the Electronic Healthcare Record (EHR) page titled, Physician's Orders revealed orders for oxygen tubing to be changed weekly on Thursday PM shift with date on the tubing, as well as an order for 3 liters of oxygen via nasal cannula continuously related to chronic obstructive pulmonary disease. Interview 5/13/25 at 11:27 AM with Staff E Licensed Practical Nurse (LPN) revealed oxygen tubing is changed weekly, but is done on the PM shift. Staff E then revealed that when the tubing is changed it is to be labeled and dated with initials and date that it is changed. Interview 5/13/25 at 11:30 AM with Staff F LPN revealed oxygen tubing is changed on Sundays on the night shift. Staff F then revealed that tubing should be labeled with the date and initials of the person changing the oxygen tubing. Interview 5/13/25 at 12:08 PM with the Director of Nursing (DON) revealed her expectation would be for oxygen tubing to be changed weekly, and that tubing should be labeled and dated. 2. The discharge MDS for Resident #83, performed on 04/29/2025, documented the following relevant diagnoses: Heart Failure, Respiratory Failure, and Obstructive Sleep Apnea. It also documented Resident #83 used a non-invasive medical ventilator (Bi-Pap). The Care Plan for Resident #83, last revised on 05/07/2025, lacked documentation of a Bi-pap machine, but did document the resident is on continuous oxygen. A direct observation on 05/12/2025 at 09:58 AM revealed Resident #83 on oxygen, but an inspection of his portable oxygen concentrator showed the oxygen machine was unlabeled and undated. At the time of this observation the Bi-Pap machine was not in Resident #83's room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up visit and inspection of the portable oxygen concentrator on 05/13/2025 at 03:06 PM revealed a tag was found with a labeled date of 05/13/2025. Review of the nursing progress notes from 04/01/2025 until 05/15/2025 revealed the following: On 04/22/2025 the order was noted by the facility for a Bi-pap machine. On 04/23/2025 the Bi-pap machine was delivered to the facility. On 04/24/2025 the Bi-pap machine was marked as unavailable. On 04/26/2025 a progress note indicated the resident did not use the bi-pap machine. On 04/28/2025 a progress note indicated the resident did not use the bi-pap machine. On 04/29/2025 a progress note indicated the resident did not use the bi-pap machine. From 04/29/2025 until 05/05/2025 there is no documentation regarding the bi-pap. On 05/05/2025 a progress note indicated the resident did not use the bi-pap machine. On 05/06/2025 the resident did not use the bi-pap machine. On 05/07/2025 the resident did not use the bi-pap machine. On 05/07/2025 it is reported in the progress notes the bi-pap machine is missing. On 05/08/2025 the machine is still marked as missing. On 05/09/2025 it is reported staff are unable to locate the machine. On 05/12/2025 it is again reported the machine is not in the resident's room. On 05/12/2025 a progress note documented a new Bi-pap machine was ordered, but the facility was informed they would need to pay for both the missing and ordered bi-pap machine. On 05/12/2025 a progress note states they would ask the physician to discontinue the Bi-pap machine due to non-use. On 05/12/2025 An order is received to discontinue the Bi-Pap machine due to non-use. Review of the treatment administration record (TAR) from 04/01/2025 through 05/15/2025 documented the following: On 04/22/2025 the Bi-pap order was received. It was documented to be unavailable. On 04/23/2025 There is no documentation in the TAR indicating if the resident was provided with the Bi-pap. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/26/2025 the bi-pap is listed as unavailable. On 05/05/2025 the bi-pap is listed as unavailable during the day shift, but marked as provided on the evening shift. - this is discrepant from the nursing progress notes. On 05/06/2025 The bi-pap is listed as unavailable during the day shift, but marked as provided on the evening shift. - This is discrepant from the nursing progress notes. On 05/07/2025 The bi-pap is marked as unavailable. On 05/08/2025 The machine is marked as unavailable during the day, but marked as provided during the night. This is discrepant from the nursing progress notes. On 05/09/2025 The machine is marked as unavailable during the day, but marked as provided during the night. This is discrepant from the nursing progress notes. On 05/10/2025 Both the day and evening shifts marked this as having been provided. This is discrepant from the nursing progress notes. On 05/11/2025 Both the day and evening shifts marked this as having been provided. This is discrepant from the nursing progress notes. On 05/12/2025 the machine is marked as unavailable and then discontinued. An interview on 05/12/2025 at 09:58 AM with Resident #83 in which he stated his Bi-pap machine had been taken away by the facility, and they could not find it. He stated he is supposed to have it on at night, but it has not been available for him to wear. He stated he doesn't always wear it all night, but he was to be discharged home soon and wanted to make sure he had what he needed to prevent readmission to a facility. He stated it had been missing since April 2025. A follow-up interview on 05/13/2025 at 03:00 PM with Resident #83 in which he again stated the Bi-pap machine had been missing since the end of April. He stated he never told the facility he would not use it, and did not refuse to put it on. He stated he would sometimes take it off in the night, but agreed to wear it. He reiterated one day he had it and the next night they could not find it. He stated several Certified Nurses Aides (CNAs) as well as the Assistant Director of Nursing had looked for it, but had been unable to locate it, and they told him they would address it. He stated he was never told they were discontinuing the bi-pap, and informed the survey team he wanted the bi-pap machine. An interview on 05/14/2025 at 09:20 AM with Staff B, Registered Nurse (RN), in which she stated she was aware Resident #83 had an order for a Bi-pap machine. She stated she did not work nights and did not know if Resident #83 refused to put the machine on, but that he was never wearing it when she came in during the morning shift. She stated the Bi-pap machine was delivered on 04/24/2025, but she had never used it. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 05/14/2025 at 09:24 AM with Staff F, Licensed Practical Nurse (LPN), in which she stated she was aware the Bi-pap machine had been reported missing and that Resident #83 was going without it. She believes it was reported missing around 05/10/2025. She stated Resident #83 did wear the bi-pap at night when he was sleeping. She stated people were documenting they were placing the Bi-pap on him at night on the treatment administration record (TAR) after the bi-pap machine had been reported missing. She stated she had helped look for the machine when it was reported to her the machine had been missing, but could not find it. She stated they are supposed to label and date the oxygen tubing on Thursday of every week, and that she had been informed the oxygen label fell off and was instructed to relabel it. An interview on 05/14/2025 at 09:40 AM with Staff T, RN, in which she stated Resident #83 had reported the Bi-pap machine missing to her around 05/07/2025. She looked for it, but was not able to locate it and entered a Nursing Progress Note at this time. She informed the ADON it was missing. She stated she would never mark the task of placing the Bi-pap on the resident as completed when the bi-pap machine was unavailable or missing. She stated you would mark it as unavailable. She stated there have been issues with documentation, and stated if someone marked the task as completed after it was reported missing it was a lie. She acknowledged oxygen tubing should be labeled and dated. An interview on 05/14/2025 at 10:24 AM with the Director of Nursing (DON), it was stated her expectation is that staff members do not document a task is completed in the treatment administration record if it wasn't actually done. She acknowledged they could not have been providing the bi-pap machine to the resident at the same time it was missing. She stated she did not recall when the bi-pap machine was reported missing. She stated it was not fair to the resident to discontinue an order for non-use when the resident had not been offered opportunities to use the item and only two documented refusals were present. Review of a facility provided document titled Equipment management with a last revised date of 02/27/2019, it instructed staff to change the tubing to oxygen concentrators weekly and attach a dated label. Attempts were made to reach staff who were shown to have documented they provided the bi-pap machine to Resident #83 after it was reported missing, but they did not make themselves available for interview.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review, the facility failed to include psychotropic medication target behaviors and non-pharmacologic interventions in the Care Plan for staff for 1 of 23 residents (#60). The facility reported a census of 84 residents. Findings include On 5/12/25 at 4:07 PM, Resident #60 was stated she took medication for anxiety. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated completely intact cognition. It included diagnoses of anxiety, depression, and unspecified osteoarthritis. It also indicted she received antianxiety, antidepressant, and antipsychotic medication within the 7-day lookback period. It further indicated the resident was admitted to the facility on [DATE]. The Progress Notes included multiple documentation the resident seemed less anxious or no anxiety noted but did not include associated target behaviors. It also did not include details or depression or associated target behaviors. The Electronic Health Record (EHR) included a Physician's Order dated 10/29/24 which indicated the resident needed follow-up in two weeks on the effectiveness of the antidepressant. It did not include the associated target behaviors for staff to monitor. The EHR behavior observation history included the following behaviors: a) Physical behaviors directed at others b) Grabbing others c) Hitting others d) Kicking others e) Pushing others f) Physically aggressive towards others g) Scratching others h) Verbal behavior directed at others i) Accusing of others j) Cursing at others (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	k) Express frustration/anger at others l) Screaming at others m Threatening others n) Socially inappropriate behaviors o) Disruptive sounds p) Disrobing in public q) Entering other resident's room/personal space r) Public sexual acts s) Repetitive motions t) Rummaging u) Spitting v) Throwing/smearing food w) Throwing/smearing body waste x) Other behaviors not directed at others y) Agitated z) Anxious, restless A Psychiatric Services provider note dated 1/15/25 revealed on 10/14/24, the resident's target behavior was documented as tearful when depressed. It also revealed on 12/10/24, the resident's target behavior was documented as increased call light use without identified needs when anxious. The Care Plan was initiated on 9/16/24 included psychotropic medication use but did not include associated target behaviors for staff to monitor. It also failed to include non-pharmacological interventions for staff to implement. On 5/19/25 at 11:06 AM, the Director of Nursing (DON) stated the expectation is that target behaviors and non-pharmacologic interventions are included in the Care Plan. A policy titled Care Plans, Comprehensive Person-Centered revised March 2022 indicated The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (2) any specialized services to be provided as a result of PASARR recommendations; and (3) which professional services are responsible for each element of care; j. includes the resident's stated goals upon admission and desired outcomes; k. builds on the resident's strengths; and l. reflects currently recognized standards of practice for problem areas and conditions.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on family and staff interviews, resident record review, and policy review, the facility failed to verify resident identity to ensure accurate resident antipsychotic medications were ordered upon admission for 1 of 3 residents reviewed (#56). The facility failed to identify the discrepancy which prevented Resident #56 from receiving antipsychotic medications for two (2) weeks. This resulted in psychosocial harm to Resident #56 due to exacerbation of psychosis, agitation, antipsychotic medication withdrawal symptoms, and subsequent hospitalization with a worsening sacral pressure ulcer. The facility reported a census of 84 residents. Finding include: On 5/13/25, Resident #56 indicated she believed she had been hospitalized but wasn't sure. On 5/13/25 at 12:00 PM, Resident #56's family member verified Resident #56 transferred from another Long-Term Care (LTC) facility on 4/17/25. She stated a facility staff member contacted her on 5/01/25 and reported Resident #56 looked out of it. She also stated when she arrived to the facility, Resident #56 looked like she had a stroke with left-side affect and was sent to the hospital because she appeared to have had a stroke. She added Resident #56 did not meet admission criteria to the first hospital due to her declined physical abilities. She further stated when she questioned the Director of Nursing (DON) if Resident #56 received her psychotropic medications, the DON confirmed the orders the facility received and entered into the Electronic Health Record (EHR) were not for Resident #56. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #56 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition. It included diagnoses of hypertension, Gastroesophageal Reflux Disease (GERD - acid reflux), hypothyroidism, schizoaffective disorder, and Fibromyalgia (chronic condition that causes musculoskeletal pain, fatigue, and memory, mood, and sleep disturbances). It revealed the resident was independent with repositioning in bed; required setup assistance with eating; supervision with oral hygiene, personal hygiene, sit-to-lying, and lying-to-sitting; moderate assistance with toileting, dressing, and all transfers and mobility; and maximal assistance with bathing, and footwear. It also indicated the resident did not exhibit physical or behavioral symptoms directed at others or herself nor had she rejected care. It also indicated she was occasionally incontinent of bowels and frequently incontinent of urine. It further indicated she was at risk of developing pressure ulcers but did not have any. It revealed she received antidepressants but not antianxiety or antipsychotic medications within the 7-day look-back period. The resident's initial Order Summary Report (list of current orders) was scanned into Resident #56's EHR on 4/15/25 by the Director of Admissions and Marketing. It contained the resident's name, date of birth , allergies, and transferring facility. The Order Summary Report included the following medication orders: a) Benztropine Mesylate Oral Tablet 0.5 MG Give 0.5 mg by mouth every morning and at bedtime for involuntary movements related to other long term (current) drug therapy (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	b) Levothyroxine Sodium Oral Tablet 175 MCG Give 1 tablet by mouth one time a day for hypothyroidism c) Olanzapine Oral Tablet 10 MG (Olanzapine) Give 10 mg by mouth at bedtime for mood related to Schozoaffective disorder, unspecified with 20 mg tab at bedtime d) Olanzapine Oral Tablet 20 MG (Olanzapine) Give 20 mg by mouth at bedtime for mood related to Schozoaffective disorder, unspecified give with 10 mg Olanzapine e) Seroquel Oral Tablet (Quetiapine Fumarate) Give 50 mg by mouth in the morning related to Schozoaffective disorder, unspecified f) Seroquel Oral Tablet (Quetiapine Fumarate) Give 75 mg by mouth at bedtime related to Schozoaffective disorder, unspecified The Medication Administration Record (MAR) dated April 2025 revealed Resident #56 did not receive any of the aforementioned medications between 4/18/25 and 4/30/25. The Physician Orders revealed the aforementioned medications were ordered on 5/01/25. A Progress Note dated 4/24/25 revealed Resident #56 expressed a strong desire to return home and appeared somewhat emotional. Subsequent progress notes dated 4/30/25 by Staff GG, Licensed Practical Nurse (LPN) revealed Resident #56 refused all her morning medications because the meds are poisoned and she would not take them. A secondary progress note indicated Resident #56 had been refusing all meds and did not enjoy any of the food. It also revealed the resident complained of generalized all over discomfort/pain, did not want staff to get her out of bed, and stated she wanted to see Jesus, she was dying and wanted to drop dead. A Progress Note dated 5/01/25 revealed Staff M, LPN documented the resident's orders the facility received upon admission were incorrect and Resident #56 had not been receiving her psych meds since admission on [DATE]. It further revealed she was slurring her words that afternoon, was calling staff names, and her eyes were observed to be glossed over and jumping when neurological system was checked. A Progress Note dated 5/05/25 revealed Staff H, LPN documented the resident refused all meds over the weekend and refused all meds and cares that morning. This nurse and two other nurses attempted to give her meds but the resident cursed and yelled at every attempt. New orders were obtained to send the resident to the hospital for a psych evaluation. A Progress Note on 5/08/25 indicated the resident returned from the hospital with a stage 3 sacral pressure ulcer. The Care Plan dated 4/18/25 included information accurately applicable to Resident #56. It also included her date of birth . The resident's hospital notes for 5/06/25 date of service revealed the resident received the following medications: a) 5/05/25 at 9:54 PM - Quetiapine Fumarate 300 mg (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	b) 5/06/25 at 2:29 AM - Haloperidol Lactate 2.5 mg c) 5/06/25 at 3:30 AM - Haloperidol Lactate 5 mg On 5/13/25 at 4:02 PM, the DON stated she received Resident #56's admission paperwork and gave it to Staff AA, former Assistant Director of Nursing (fADON) to complete the admission process which included entering admission orders into Resident #56's EHR. The DON also stated the original admission paperwork could not be located. She provided the Cover Letter and Order Summary Report the Director of Admissions and Marketing electronically sent her on 4/17/25 at 10:08 AM. She stated Staff AA, fADON would've entered the admission data and orders in the EHR because the resident was admitted to her unit. She clarified that another ADON could have entered the orders. The Cover Letter and Order Summary Report revealed the information was for a resident at a different Long-Term Care (LTC) facility with the same name and psychiatric provider but different date of birth . It also contained a statement OK. For transfer to <facility name> continue same medications and treatments Follow-up with Primary Care Physician (PCP) there - <receiving ARNP name> goes there from <provider's group> if desired. It was signed by the transferring Advanced Registered Nurse Practitioner (ARNP). The EHR for Resident #56 revealed five documents with an accurate resident date of birth identifier were scanned and available prior to her admission on [DATE]. On 5/13/25 at 4:33 PM, Staff P, Director of Admissions and Marketing stated he receives a face sheet (demographic sheet), History & Physical (H&P), medication list, and Preadmission Screening and Resident Review (PASRR - screening tool used for appropriate Long-Term Care (LTC) facility placement for people with mental health illness or disabilities) prior to a resident's admission. He provided a document of resident information that is required (name, date of birth , SSN, demographics sheet, rehabilitation notes, History & Physical, medication list, PASRR, sex offender check) prior to the resident admission and stated he loads the documents into the EHR. He indicated Staff D, LPN ADON was responsible for reconciliating the resident's information. On 5/14/25 at 8:02 AM, a staff member at the different LTC facility confirmed the resident with the same name still resided there and still received care by the same psychiatric provider. On 5/14/25 at 9:00 AM, Staff D, LPN ADON stated previously, ADON's usually did their own admission but would enter other admission's orders if needed. She also stated she usually enters orders for others, if needed, but completes all of her own admissions. She further stated after she enters the orders, she usually gives the ADON of the admitting unit the orders back so they can check the orders. She indicated the admissions department gets orders, scans them into the EHR, and brings the paper copies to the ADONs. The ADONs enter the orders in the EHR, faxes them to pharmacy, and returns the paper to the admitting unit ADON. She stated the 6 rights of medication administration (patient, medication, dose, route, time, documentation) should be verified while entering the orders but admitted she did not confirm the 6 rights when she entered them into the EHR. She stated she took the paperwork to Staff AA, fADON who should have verified the reconciled orders. (continued on next page)

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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 0760 Level of Harm - Actual harm Residents Affected - Few	On 5/14/25 at 4:50 PM, the fDON stated the medication order error was identified by the resident's sister on 5/01/25 and corrected. The resident was sent to the hospital, returned, and resent on 5/05/25. On 5/15/25 at 8:29 AM, the medical provider's office director stated the transferring ARNP wrote the order but would not have been the one to have sent it. 5/15/25 at 8:48 AM, the transferring ARNP stated she was not directly involved in the transfer process. Her understanding was she believed the facility sending the resident is who sends the paperwork to the accepting facility. On 5/15/25 at 10:03 AM, the medical provider's office director stated his office received an email from the transferring facility which indicated Resident #56 was being admitted to another facility. The provider's office staff pulled a similarly named resident's file and sent it to the transferring facility which was signed by the practitioner. He also stated his staff nor the practitioner verified the date of birth to ensure the correct resident orders were sent to the facility. On 5/15/25 at 10:29 AM, the Director of Admissions and Marketing provided an email that he received the admission orders from the transferring facility staff on 4/17/25 at 9:54 AM. On 5/19/25 at 2:59 PM the contracted Pharmacist stated the potential risks of abruptly stopping Resident #56's Seroquel could lead to rebound psychosis (return of psychotic symptoms and potential physical symptoms such as agitation, difficulty sleeping, and not feeling well. He also stated abruptly stopping her Olanzapine could result in Parkinson-type symptoms such as tremors, rigidity, or return of extrapyramidal symptoms that may or may not resolve over time. On 5/19/25 at 3:25 PM, the facility provided a provider encounter note that revealed Resident #56 had a re-admit and post-hospitalization for psychotic episodes and a urinary tract infection (UTI). It also revealed some of her medications were not started at admission and she was showing signs of psychiatric distress and altered mental status on 5/1/2025. It further revealed she was sent to the ED where she was given a dose of Olanzipine. She returned to the facility with no new orders. Discussed restarting Olanzipine and Seroquel. Tapering them up to previous doses. The note continued that the resident was re-sent to the ED and admitted to hospital on [DATE], returning to the facility on 5/8/25. She got a pressure area to her coccyx during hospitalization, following by wound Nurse Practitioner. The Psychiatric Consultation from the hospital dated 5/5/25 documented the following entries; Patient is seen at bedside in the Emergency Department (ED) today, she is resting with her eyes closed. When approached she states You gave me Prolixin, I can't have that. I'm a Medical Doctor (MD), what are they? I know they are all below me. Advised patient we did not give her any Prolixin and attempted to ask about her medications, she states she is taking Only Latuda, my heart medication, and Levothyroxine for my high thyroid. Patient is adamant she has hyperthyroidism instead of hypothyroidism. She states her mood is shit because I'm in Hell. She is unable to elaborate on this statement. She does deny SI, HI but tells this resident she is done speaking and declines further interview. Psychosis: Endorses being an MD and that everyone else is beneath her and states she is talking to God. She also states we gave her Prolixin in the ED which was not done. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Psychiatric treatment: - START Quetiapine XR 300 mg oral at bedtime for mania, psychosis, mood stabilization - Start Quetiapine 25 mg oral every 6 hours as needed for agitation OR Haloperidol 2.5 mg IM every 6 hours as needed for severe agitation ED MD Note dated 5/5/2025 documented as follows: Resident#66 presented to the ED via EMS for altered mental status, behavioral issues and medication noncompliance. History obtained from patient and nursing staff at the Royal Oaks nursing and rehabilitation center; external records reviewed. Vitals on arrival were largely within normal limits and nonconcerning. Pertinent workup was obtained to assess the patients' current medical condition. All data - including labs, imaging and EKG's - were independently interpreted and integrated into the clinical decision-making process. Royal Oaks nursing staff was contacted upon patient's arrival. Patient was without her psychiatric medications for the past 2 weeks. Due to this and her altered mental status, an expanded diagnostic workup was obtained. CT head was negative for any acute intracranial process. Complete Blood Count (CBC) and Comprehensive Metabolic Panel (CMP) were largely unremarkable. Liver enzymes were mildly elevated, but this was similar to prior. Polly ingestion labs were negative but the patient's TSH was elevated at 27.700 with a free T4 low at 0.5. Per chart review, this was worse than 11 years ago. Troponin was mildly elevated but EKG was reassuring against cardiac ischemia and her urinalysis was questionable for an underlying infection. On reevaluation, patient continued to become more altered. She was saying that she was a medical doctor and that everybody around her was below her. Due to her underlying psychiatric history with recent medication noncompliance, IP psychiatry was consulted. They recommended admission to the hospital under geriatric psychiatry with internal medicine as a consult due to her hypothyroidism and concern for polypharmacy. The case was further discussed with Dr. <name redacted> (IM) who agreed to consult on the patient and she was ultimately admitted under Dr. <name redacted> (Psychiatry). While in the ED, patient was restarted on her Quetiapine and as needed Haldol was ordered. Her presentation is most consistent with an acute psychiatric illness. Her labs are concerning for hypothyroidism, but her presentation is not consistent with myxedema coma as she is without hemodynamic instability, bradycardia or hypothermia. Patient was made aware of admission. Admitting team(s) to reassess and adjust care as needed. On 5/19/25 at 11:06 AM, the DON stated staff are expected to enter the correct orders. On 5/20/25 at 3:00 PM, Staff AA, ADON stated she was not working the week Resident #56 was admitted and did not receive the admission packet that accompanied the resident. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A policy titled Reconciliation of Medications on Admission dated 2001 indicated when a resident is transferred to another facility, or within the organization, the reconciled medication list will be sent to the receiving care provider and the communication will be documented. It also directed staff to; 1. Gather the information needed to reconcile the medication list: a. Approved medication reconciliation form; b. Discharge summary from referring facility; c. admission order sheet; d. All prescription and supplement information obtained from the resident/family during the medication history; and e. Most recent Medication Administration Record (MAR), if this is a readmission. 2. Find a quiet place that is free from distractions.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, clinical record review and staff interview, the facility failed to have a process in place for a consistent accurate count of controlled medications. This failure resulted in narcotic medications prescribed to Resident #3 becoming unaccounted for. The facility reported a census of 84 residents. Findings include: The Quarterly Minimum Data Set (MDS) of Resident #3, dated 4/17/25, documented diagnoses that included cerebral palsy, stroke, and polyneuropathy (a condition affecting multiple nerves throughout the body which can cause numbness, weakness, burning, sharp pain and muscle cramping). The MDS coded the resident received scheduled and as needed pain medications during the 5-day look back period. The MDS documented the resident was receiving opioid medications. The Care Plan of Resident #3 identified a focus area of chronic pain, revised on 4/22/22. The Care Plan identified sources of pain as cerebral palsy, neuropathy, low back pain and muscle spasms, and directed staff to administer analgesic (pain relieving) medications as per physician orders. A self report from the facility to the Department of Inspections, Appeals and Licensing (DIAL) submitted on 4/18/25 at 6:57 pm revealed the facility staff were unable to account for a card of Oxycodone/acetaminophen, also known as Percocet, prescribed to Resident #3, which was believed to have had 12 administrations remaining. The controlled drug record sheet related to this card of medication was also missing, as well as the total count sheet (each medication cart in the facility had a count sheet for how many individual items of controlled medications were stored in the cart) for the medication cart. On 5/12/25 at 3:09 pm, the Director of Nursing (DON) stated that the contracted pharmacy had delivered a card of the Percocet on 2/4/25 for Resident #3 and another card was received on 2/14/25. When the card of 30 tablets was delivered on 2/14/25, the total count at that time was 50 tablets. It was counted daily with no discrepancies. The two count sheets were combined into one showing a total of 50 tabs. On 3/30/25, that sheet was down to 45 tabs, then the next sheet after that was the one that was missing. The DON stated that on 4/17/25, Staff U, Registered Nurse (RN) started a new count sheet, which showed being cosigned by Staff B, RN. That sheet stated there were 30 tabs. The DON said that Staff B, RN denied signing this count sheet and that it was not her signature. The DON said they compared the signature to other places she had signed and they were similar but differences could be seen. The DON stated she had checked how many other doses of the medication had been documented as administered and believed that 12 tablets of the Percocet were missing from the card that was delivered on 2/4/25. The full card of 30 tablets delivered on 2/14/25 was present. The DON stated the expected procedure when a card is empty is for the empty card and the narcotic count sheet that goes with it to be placed in a drop box outside of the Assistant Director of Nursing (ADON) office. She stated staff should not have combined the two cards onto a single count sheet and the expectation is for each card to have its own record. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON continued, stating that Staff B was working on 4/17/25 at Station 1 and Staff U was working at Station 2 (separate hallways of the facility). She said that Staff U had walked down to Station 1 and asked Staff B to cosign for a Fentanyl patch which she agreed to but that she did not sign the Percocet sheet. The DON stated when she asked Staff U about why he had started a new count sheet for the Percocet he was hmmmming a lot and then told her that there had been no room left on the prior sheet and that is why he started a new one. The DON reported the facility staff had gone through every shred bin in the facility more than once, checked all of the medication rooms and everywhere else they could think of looking for the missing narcotic sheet or the narcotic card and nothing was found. On 5/13/25 at 1:24 pm, Staff B, RN stated she got called into work on 4/17/25. She stated when a Fentanyl patch is removed from a resident, two nurses are to sign that it is being correctly disposed of. She stated Staff U asked her to cosign for the Fentanyl patch which she did. She said the signature on the Percocet sheet was not her signature. She stated she only uses gel pens which she always carries with her. She stated she could tell by the ink on the sheet it was not gel pen ink and she always uses her own pen to sign. On 5/15/25 at 11:23 am, Staff J, Licensed Practical Nurse (LPN) stated she worked the day shift on 4/17/25. She administered one tablet of the as needed Percocet to Resident #3 and she had completed a narcotic count with Staff U at the end of her shift on the 17th. She recalled on the total count sheet, they had counted 24 items in the cart, which was 23 cards of medications and a box of a controlled nasal spray which had two administrations inside the box. The following morning, 4/18/25, she overheard Staff H, LPN and Staff S, LPN doing their morning count. She said the total count sheet for the cart was missing. Staff H and Staff S at that time started a new one, and Staff J heard them counting a total of 23 items. She said that Staff S had told them that the night before, Staff U had told her the box of nasal spray counted as two items, not one, so she signed the count sheet listing 24 items. Staff J stated the box of nasal spray only counts as one but that Staff S was a newer employee and she recognized why Staff S could have misunderstood the total count. She said at that time, they stopped everything and started investigating to see if they could find what was missing. Staff J stated they called the DON and started at that time looking through shred bins for the missing total count sheet. She stated she went to Station 1 and asked Staff U to come down and told him the sheet was missing. She stated that around 7:00 am, Staff H asked her to complete the full cart count with her so that she could start passing medications. As they went through the book, when they got to Res #3, they realized a card of his Percocet was missing. Both Staff H and Staff J knew that there had previously been two cards of the as needed Percocet and there was now only one full card but the partial card was missing. She stated she knew when she had counted with Staff U the evening before, there had been two cards but when she asked Staff U about it, he stated no, there had only been one. The narcotic sheet for the Percocet was missing, the total count sheet for the cart was missing and the partial card of Percocet was missing. Staff J stated that when she had administered an as needed dose of the Percocet on the prior day, she knew there were several tablets still on the card. She did not recall exactly how many but thought it was at least 7 or 8 tablets. She stated the count sheet for the Percocet the prior evening was approximately half full. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/25 at 9:18 am, during a second interview, Staff B stated on 4/17/25 she worked approximately from 6:00 pm to 10:00 pm at Station 1. She said she came in just to help out with medication pass, but she never actually had keys to a cart. She stated that Staff AA, who was an ADON at the time (no longer employed at the facility) was doing a medication cart audit and organizing the cart and she had the cart keys. She said because she never had any keys that night, she never signed any count sheets. She again stated the only thing she signed that night was for the Fentanyl patch. She stated Staff U was working at Station 2 and was still in training. She said they had been hired on the same day and she thought it was odd he was still in training when she was working independently. She stated it was strange that he came and asked her to cosign the Fentanyl patch when there was another nurse on the hall he was working, but she also stated he had asked her out on dates multiple times and sent her personal text messages. She felt he had come and asked her to sign for the Fentanyl patch just so he could flirt with her. On 5/19/25 at 9:48 am, Staff S, LPN stated she had counted with Staff U at approximately 11:00 pm on 4/17/25. She stated there was an issue about what nurse was assigned to which cart but once they straightened that out, they counted. She said the total count sheet for the cart was 24 but she only counted 23 items. She stated she accepted the keys because he told her there were two sprays in the box and that made the 24 items. She believed him and she signed the count sheet. She stated after they were done counting, she was headed back to the skilled hall but she had noticed Staff U had not signed to the total count sheet. She said as she was walking away, she told him he needed to sign the sheet. She said she did not look at the log book again until morning. Staff S stated she and Staff H, LPN counted in the morning. When they realized things were missing and they asked Staff U about it, she stated Staff U got defensive and immediately said that they were accusing him of taking medications. She stated that Staff H and Staff J went through the medications and realized it was Res #3's Percocet that was missing because Staff J remembered it from the day before. She stated Staff U left before the DON arrived. She was not sure when he left but he was not there when she arrived. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/25 at 9:58 am, Staff H, LPN stated she came to work the morning of 4/17/25 and was assigned the cart which included Res #3. She stated she began to count with Staff S, LPN. She stated before starting the count, Staff S told her how she had completed the total count with Staff U the night before, counting the nasal spray as two items rather than one. Staff H said she then went to the book and looked for the total count sheet as Staff S told her about Staff U not signing it the night before. She stated she told Staff S that they would just complete the count but then realized the total count sheet was missing. She said that Staff S told her the count sheet at 10:00 pm had said 24 but that the count was only 24 if the nasal spray was counted as two. She said that they then completed a total count and there were 23 items, not 24. The DON was called and was coming in. Staff H stated she said they needed to have Staff U come to the station and they could all figure it out together. She stated Staff U instantly got very defensive. She said he made comments about still being in training and that the other staff were picking on him. She stated she told everyone that they all needed to remain in the building until the DON arrived but within 10 minutes he had left. She stated it took the DON 30-40 minutes to arrive after she was called. She said during that time, she and Staff J did a full count. She said Staff J had the narcotic book and she was going through the medications. She stated she had worked on 4/16/25 on that cart and Staff J had worked on 4/17/25 on the cart and they both remembered there had been two cards of as needed Percocet for Resident #3. She thought there had been at least 8 or 9 tablets left. She stated as they counted, they both realized that card was missing. When the DON arrived, we told her that card was missing. Res #3 also had scheduled Percocet three times a day and generally, that was enough to hold him over. He did not use the as needed medication very often. It could not have been all used up in that short of a period of time. She stated Staff S had not worked that hall very often so when she counted the night before, she would not have known there had been two cards previously. Staff U had started a count sheet for 30 tablets and that was what was there so she agreed with the count. But Staff J and she both knew that there had never been a sheet for just those 30 tablets. Both cards had been on the same sheet and had been for quite some time. She stated they could not locate that sheet which had been there when she had worked two days earlier. She stated the staff searched shred bins, through the nursing stations, the medication carts, other narcotic books, and multiple other places throughout the facility and neither the total count sheet nor the Percocet sheet were found. On 5/19/25 at 10:25 am, Staff AA, former ADON stated she was on Hall 1 the entire time on 4/17/25. She stated she was doing medication cart audits on Hall 1 and cleaning the carts. She stated part of her duties were to check stock medications being dated, checking signatures in the books, etc but she was only doing this at Station 1 and not the cart with the missing medications. She stated she was not on call and was not told about the missing medications until the next morning. After the phone interview with Staff AA, she then sent a text message at 10:31 am on 5/19/25. She stated she had brought multiple concerns regarding Staff U to management about his behaviors and his general lack of nursing knowledge. She said Staff U had been working at the facility for over a week and being alone on the medication carts before his references were even checked from his employment application. She stated when in house management did not respond to her concerns, the concerns were also shared with the corporate management. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/25 at 10:36 am, Staff V, LPN stated she worked with Staff U on 4/17/25 from 6:00 pm to 10:00 pm. She stated he took Cart A and she took Cart C on the 200 hall. She stated when she clocked on, Staff U had already counted Cart A so she took Cart C. When she was ready to leave at 10:00 pm, she counted her cart with him and he had keys to both carts at that time. She stated she was there when Staff S arrived, but Staff S went straight to the skilled hall. She stated when she arrived to work, Staff U had gotten straight to work and had taken the medication cart down the hall. When she was done with her medication pass, he was at the nurses station and had completed his work. She stated there was really no communication between the two of them during the shift and she did not have any interactions with him. On 5/19/25 at 10:58 am, Staff X, RN stated she worked with Staff U on 4/17/25 from 10:00 pm until 6:00 am. She stated he had trained with Staff V from 6:00 pm - 10:00 pm. She stated when Staff S arrived, she and Staff U had a disagreement about who needed to work the Hall 2 carts that shift. She stated she told Staff S that Staff U was still in training and if she needed any help, she would help her. So Staff S had keys to both carts on Hall 2 and the cart on the skilled hallway. Staff X was working on Hall 1. Staff S wanted Staff U to keep one of the Hall 2 carts for the shift. Staff X stated she told Staff S that when someone was still in training, they should not have a cart and then she returned to Hall 1 and Staff U also went to Hall 1. She stated around 2:00 am, she went to check and see how Staff S was doing and if she needed any assistance. She stated that Staff S still verbalized that Staff U should have kept one of the carts. She stated she offered assistance to Staff S and she asked for help printing the midnight census. She stated she knew that Staff S was relatively new so she wanted to assist her. She stated she stayed with her for a while and then returned to Hall 1. She stated she did not know anything about missing medications as that was not discovered until the morning. She stated she knew that Staff S and Staff U had counted before Staff S took the keys but she was not there when they counted. She only knew about the disagreement about her having three carts for the night. Then in the morning when Staff S was counting a cart with morning staff, she was told a paper was missing. She stated she asked Staff U what he knew about it and she stated he was upset about how he was being treated. On 5/19/25 at 12:15 pm, an attempt was made to reach Staff U for an interview. Staff U did not answer the phone and did not respond to a voicemail left for him. On 5/19/25 at 12:55 pm, Staff B, RN verified that if there were two cards of the same medication, even if they share a count sheet, they would be counted separately on the total count sheet. She stated the box of controlled nasal spray, Naylizam (for seizures) was for Resident #10. She stated it had caused confusion in the total count before as some nurses counted it as one and others counted it as two. She stated the box of medication was still in the cart and was still being counted daily. When she looked at the electronic health record (EHR) of Resident #10, she was unable to find an active order for the Naylizam. On 5/19/25 at 1:00 pm, it was observed during an inspection of the medication cart that the Naylizam box was opened and contained two administrations. The box was in the double locked portion of the medication cart. The count sheet showed it had last been counted that morning at 6:00 am. The Nursing note dated 4/25/25 at 5:25 pm, authored by Staff D, ADON, documented that the Nayzilam had been discontinued that day due to non use. The note detailed that the resident's Medication Administration Record had been updated, pharmacy had been notified and the resident/resident family had been made aware of the order. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/25 at 1:26 pm, Staff D stated the normal process when she notes orders for a discontinuation of a medication is to discontinue it in the EHR, and to make sure the pharmacy and the family were aware. She stated she would make the nurses aware to pull the medication from the cart and if it was a controlled medication, to waste the medication with two nurses. She stated she does not chart in her notes who she instructs to pull the medication from the cart. She stated without looking at the schedule, she would not know who had worked that day. When staff D was informed that the medication was still in the cart, several weeks after being discontinued, she stated That would be on the nurses. On 5/19/25 at 1:31 pm, Staff W, CNA stated she was at Station 2 for the night shift of 4/17/25. She stated she was there when Staff S and Staff U were counting the carts but she was sitting and charting and not really paying attention to what they were doing. She stated she did overhear them disagreeing about who needed to have the cart for the overnight shift but she did not really consider it an argument. She stated Staff U said that he was training with Staff X and that Staff S responded that he was still a nurse and should be able to pass medications. In Staff W's written statement, she had named an incorrect name as the female nurse on duty at this time. She verified in her phone interview that it was Staff S that she was referring to. She stated she only heard them discussing who needed to take the carts for the shift and she did not hear any issues regarding the medications until the morning. She stated she was not involved in it and when she completed her charting in the morning, she went home. On 5/19/25 at 4:20 pm, the Administrator stated if a medication had been discontinued, she would expect it to be removed from the cart. The Administrator also stated following the missing Percocet incident, staff education had been provided and a system put in place so everyone was aware of how the total count system was to be completed.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, resident interview, staff interview, and policy review the facility failed to provide food at an appetizing temperature to 2 of 2 residents (Residents #64, and #79) reviewed. The facility reported a census of 84 residents. Findings include: 1. Review of Resident #64's Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. Interview 5/12/25 at 1:34 PM with Resident #64 revealed that the food is constantly cold, and tastes bland. 2. Review of Resident #79's admission MDS dated [DATE] revealed a BIMS score of 13 indicating intact cognition. Interview 5/12/25 at 2:08 PM with Resident #79 revealed that the food is often bland in taste, and that the food is often cold when served on a room tray. Observation 5/13/25 at 12:38 PM a sample tray was obtained from the South Hallway. Temperatures were obtained with the ham temping at 120.3 degrees Fahrenheit, and the green beans temping at 119 degrees Fahrenheit. It was also observed that the ice cream was soft to the touch and not frozen. 05/13/25 12:45 PM Interview with Staff C Dietary Supervisor revealed that the food should be served at the appropriate temps. Review of a facility provided policy titled, Serving of Food with a revision date of 7/2023 revealed: a. All food items shall be served to the resident at a palatable temperature.

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	165580	A. Building B. Wing	05/20/2025

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and policy review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. In addition, the facility failed to maintain the kitchen in a safe and hygienic manner that promotes food safety. The facility reported a census of 84. Findings include: During the initial kitchen observation on 05/12/2025 at 07:44 AM, it was noted approximately 1-2 inches of standing water covering half of the kitchen floor, with the deepest part of the water located near the walk-in cooler and freezer. One staff member was preparing breakfast while the Dietary Manager attempted to push water down the drain to help it clear faster. The ceiling above the food prep table was hanging several inches. The tiles of the floor were uneven, cracked, and in places missing. The ceiling above the oven was also hanging, with black spots covering the area. The sink was broken and spraying water, contributing to the water pooling inside of the kitchen. The walk-in freezer had a large buildup of ice on the floor and walls, making the interior of the freezer difficult to navigate, there was also a buildup of ice on several food items and boxes. The walk-in cooler had standing water that was draining only when the door to the cooler was opened, again contributing to the standing water in the kitchen. Pictures were taken during the observation. In subsequent visits to the kitchen on the mornings of 05/13/2025 and 05/14/2025, the kitchen and walk-in cooler had standing water on both occasions. The sink remained broken and continued to leak, though the leak was no longer spilling onto the kitchen floor. Ice buildup remained on the floor and walls of the walk-in freezer. An interview on 05/12/2025 at 07:58 AM with Staff N, Cook, she stated the water in the kitchen is an every-day occurrence that has gotten worse in the last year. She stated the ceiling, floor, sink, and water have all been reported previously to management. An interview on 05/15/2025 at 10:36 AM with Staff L, Cook, she stated she has been here for approximately 7 months and the flooding issue and kitchen conditions existed when she started. She noted this has been reported to management a number of times. An interview on 05/12/2025 at 08:23 AM with the Dietary Manager, she stated the water is building up in the cooler, then spills into the kitchen when they open the cooler first thing in the morning. She stated this has been occurring since she was first hired nearly three years ago. The state of the kitchen, including the collapsing ceiling, broken tiles, water pooling, and build up of black spots has been repeatedly reported to management since she first started working here. She noted the kitchen sink has been leaking/broken for over a month, and while they had already ordered a replacement sink the replacement had arrived damaged and they were back to waiting for the sink to arrive. She stated helping the water drain, cleaning the walk-in cooler, and then attempting to clean and dry the floors when they first arrive in the morning has taken a considerable amount of time and she feels it takes valuable time away from food preparation. She stated they did not have maintenance or service logs for the walk-in cooler or freezer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 05/14/2025 at 11:55 AM with the Administrator, she acknowledged the kitchen was in bad shape, needing numerous repairs. She stated the kitchen is next on her list of renovations, she offered to send scheduling emails to show evidence of good faith attempts to address the situation but these were not provided. She acknowledged the sink had been broken for some time and a new one had been purchased, and acknowledged the flooding issues were an ongoing issue since she took over as administrator in January of 2025. She stated they had contacted a plumber at an earlier date, but that had not remedied the situation. In a follow-up interview on 05/15/2025 at 09:54 AM with the Administrator, she stated they had remedied the kitchen flooding issue. She stated the walk-in cooler had been improperly installed, causing water to build up and flood the area. Review of facility provided document titled Kitchen Sink Invoice documented the facility had purchased a replacement kitchen sink on 04/22/2025. 2. During a continuous meal observation on 05/12/2025 starting at 11:11 AM and ending at 12:30 PM revealed the following. At 11:25 AM - Staff EE, Certified Nurses Aide (CNA), serving food to a resident while directly touching the vegetable with an ungloved hand. At 11:28 AM - Staff EE, CNA, again serving food to a resident while directly touching it with an ungloved hand. At 11:29 AM - Staff R, Cook, touching a resident's dessert with ungloved hands while serving it to him. At 11:39 AM - A resident who had been served food by Staff R flagged down another staff member and reported that someone had a finger in his dessert and he would not eat it. He sent the food item away. At 11:54 AM - Staff P, Marketing Director, confirmed the resident had stated a finger was in his food and refused to eat it. Staff P reported he brought the resident a new item for replacement but stated he was unsure if someone had actually had a finger in his food. During a continuous meal observation on 05/13/2025 starting at 11:40 AM and ending at 12:31 PM revealed the following. At 11:45 AM Staff R was observed touching what appeared to be green beans on a resident's plate as he served them their food. At 12:10 PM Room trays were taken to a resident hallway. They were observed to have ill-fitting coverings that came off of the food for several trays as they were taken down the hallway. At 12:26 PM The Room trays remained sitting untouched, with several of them being partially or fully uncovered. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 12:29 PM The first room tray was served by Staff EE. - The last room tray served in this hallway had temperatures taken which revealed Ham and green beans were below acceptable temperatures and the ice cream was melted. An interview on 05/15/2025 at 10:41 AM with Staff O, CNA, stated that when she serves residents she is to avoid touching a resident's food with bare hands, and that room trays are to be served as they go out. They should not be waiting. An interview on 05/15/2025 at 12:05 PM with Staff K, CNA, she stated the staff or told to get the food out while it is nice and hot, and she feels she does a good job of that. She feels some CNAs take their time and let food sit and when it gets to the resident it is barely warm. She stated they are also instructed to avoid touching a resident's food, if they do make contact they are supposed to offer a replacement. An interview on 05/15/2025 at 11:42 AM with The Dietary Manager, she stated staff are never supposed to touch a resident's food with their bare hands. If they do accidentally make contact, they are supposed to replace the item they touched. She stated she had been aware the lids used to cover food as it was transported to rooms did not fit properly. She stated she had made the administrator aware they did not fit correctly shortly after they were purchased, she believed that was in February of 2025. She also acknowledged food should not be sitting undelivered to rooms in the hall way. She stated food is supposed to be served as it arrives in the hallway. An interview on 05/15/2025 at 10:43 AM with the Director of Nursing (DON), she acknowledged staff members could not touch food with bare hands. She stated if staff members do touch a resident's food they are supposed to discard the food item and offer the resident another. She also acknowledged food should be served as it arrives in the hallway, not sit and wait. She acknowledged 20 minutes was too long for food to sit unserved. An interview on 05/14/2025 at 11:55 AM with the Administrator, she acknowledged she had been previously informed the covers did not fit and had been told by the dietary manager she needed to replace them. Review of a facility provided document titled Culinary Services Policy and Procedures, last revised in July 2023, documented the following: On Page 5 it stated food must be served at a safe and appetizing temperature. On Page 22 it stated staff are to never touch a residents food with bare hands directly, and that food must be covered for transportation. On Page 63 it stated equipment repairs that require outside help will be reported to the maintenance department and approved on an as-needed basis. On Page 73 it stated freezers will be defrosted as needed (when frost is ½ inch thick, the freezer should be defrosted), or per the manufacturer's recommendation.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observations, staff interviews, and policy review, the facility failed to properly protect resident information from unauthorized access. The facility reported a census of 84 residents. Findings include: On 5/12/25 at 8:21 AM, an unsecured document was observed, face-up, on a medication cart containing resident specific health information. There were no residents or visitors in the hall however, several residents on that hall were independently mobile. On 5/12/25 at 8:23 AM, Staff Y, Licensed Practical Nurse (LPN) stated the information is normally supposed to be face down but a resident called her to take his blood pressure. She turned the paper over at that time. On 5/13/25 at 8:06 AM, an unattended, open laptop was observed with multiple residents' Electronic Health Information (EHR) visible. There were several mobile residents within eyesight of the laptop. Staff FF, Registered Nurse (RN) stated he made a mistake and left the laptop open. On 5/19/25 at 11:06 AM, the Director of Nursing (DON) stated protected health information should be secured at all times. A policy titled Confidentiality of Information and Personal Privacy revised October 2017 indicated the facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. It also indicated access to resident personal and medical records will be limited to authorized staff and business associates.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4. On 5/15/25 at 7:11 AM, Staff B, Registered Nurse (RN) dropped a resident's medication on a report sheet on the medication cart. She picked up the medication with ungloved hands, put it back in the resident's medication cup, took it to the resident's room, and administered it to the resident. At 7:36 AM, Staff B stated she should've had gloves on or used a spoon to prepare medications. She also stated she should've never touched the medication with her hands. On 5/19/25 at 11:06 AM, the Director of Nursing (DON) stated the staff should have discarded the pill and gotten a new pill. An undated document titled Infection Control prevention directed staff to use strict aseptic technique when changing connections, accessing catheters, given IV push medications, changing bags, handling supplies, changing dressings, flushing and starting an IV. Based on clinical record review, observation, staff interview, and policy review the facility failed to utilize Enhanced Barrier Precautions (EBP) during wound care and while completing catheter care for 2 of 3 residents (Resident #39, and #52) reviewed. The facility further failed to properly disinfect a full body mechanical lift after use on a resident with EBP in place, and then taking the lift to another room to utilize the lift with another resident. The facility further failed to complete appropriate hand hygiene while completing medication pass. The facility reported a census of 84 residents. Findings include: 1. Review of Resident #52's Quarterly Minimum Data Set (MDS) dated [DATE] revealed diagnoses of obstructive uropathy, hemiplegia, and need for assistance with personal care. The MDS further revealed the utilization of an indwelling catheter. Review of the Electronic Healthcare Record (EHR) page titled, Physician's Orders revealed an order for a 22Fr. Foley catheter with 30ml cath bulb. Ensure the catheter is intact and patent every shift. This page further revealed an order for Enhance Barrier Precautions for catheter use. Observation 5/14/25 at 2:33 PM Staff G Certified Nursing Assistant (CNA) completed hand hygiene and donned gloves. Staff G then placed a barrier onto the floor with a urine graduate and drained Resident #52's catheter drainage bag. Staff G was observed not wearing a gown for EBP. Interview 5/14/25 at 2:41 PM with Staff G CNA revealed that he should have worn a gown for EBP while draining Resident # 52's catheter. Interview 5/14/25 at 2:51 PM with the Director of Nursing (DON) revealed that she would expect gowns to be worn when catheter care and drainage are being completed. The DON further revealed she would expect full body mechanical lifts to be cleaned between being used for residents. The DON then revealed that her expectation would be for EBP to be utilized for any wound. (continued on next page)

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