

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165586	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/17/2025
NAME OF PROVIDER OR SUPPLIER  Timely Mission Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  109 Mission Drive Buffalo Center, IA 50424	

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)
<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p>(continued on next page)</p>

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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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, clinical record review, staff and resident interview, the facility failed to ensure the provision of occupation and physical services for 1 of 3 resident reviewed for therapy services upon admit. (Resident #1). The facility identified a census of 33 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition with decision making abilities, was able to understand and was understood by others. The resident required staff dependence with mobility and transfers and the use of a walker or wheelchair. The MDS included diagnoses of Parkinson Disease, (a progressive brain disorder that affects movement, primarily caused by the death of brain cells), fracture of left ankle, weakness and low back pain. The Care Plan initiate dated 10/13/25, indicated Resident #1 had a limited physical mobility related to weakness, and Parkinson Disease. Interventions included weight bearing (supporting body weight), assistance of 2 staff to walk, uses a front wheeled walker for ambulation, and dependent on 1 staff for locomotion in the wheelchair. The Inpatient Patient Summary Final Report dated 10/13/25 at 12:57 PM, documented consults for occupational therapy evaluation and treatment and physical therapy evaluation and treatment, activity as tolerated, Cam boot (an immobilizer to protect foot and ankle injuries) to lower left extremity with weight bearing as tolerated. Uses a front wheeled walker and wheelchair for mobility and a gait belt. Resident #1's clinical record lacked documentation the resident received physical and occupational therapy evaluation and treatment on 10/13/25. The Clinical Referral Note dated 11/10/25 signed by the physician, documented left ankle fracture that is healing, ordered physical and occupational therapy. The Physical Therapy Evaluation and Plan of Treatment dated 11/14/25, documented, patient was referred to physical therapy for evaluation and treatment. Following a fall with the left ankle fracture, patient presents with decreased strength and impaired functional mobility. Patient would like to be able to walk by herself with her walker. Patient reports pain in her left ankle at night and when moves it wrong or stand on it. The Occupational Therapy Evaluation and Plan of Treatment dated 11/14/25, documented, patient was referred to occupational therapy upon admission to this nursing facility following a fall resulting in an ankle fracture. Patient main concern is remaining safe. Patient presents with impairments in balance, mobility, strength, planning, problem solving and interpersonal interactions resulting in limitations and/or participation restrictions in the areas of cooking, self care, mobility and light housekeeping. Observation on 11/13/25 at 10:30 AM, Resident #1 sitting in recliner with feet elevated on a pillow and left foot in a cam boot. Interview on 11/13/25 at 10:30 AM, Resident #1, confirmed they did not receive physical or occupational therapies on admission to the facility. On 11/13/25 at 3:00 PM, Resident #1 family confirmed that no physical or occupational therapies were received when Resident #1 was admitted to the facility on [DATE]. On 11/17/25 at 11:00 AM, the facility Director of Nursing (DON), confirmed Resident #1's clinical record lacked any documentation of physical and occupational therapies being completed on day of admit and that the expectation is for orders to be followed and residents to receive physical and occupational therapies as ordered. On 11/17/25 at 1:10 PM, the facility Administrator stated that the expectation of the staff are to follow the physician orders for physical and occupational therapies, and that it is the responsibility of the facility to make sure that residents receive the ordered therapies.</p>		