STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165587	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northbrook Healthcare and Rehabilitation Center	6420 Council Street NE Cedar Rapids, IA 52402

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interviews, staff interviews, and policy review the facility failed to answer call lights within 15 minutes to meet resident needs for 7 of 9 residents reviewed (Residents #13, #28, #53, #55, #58, #60, #81). The facility reported a census of 85 residents.Findings include: 1.The Minimum Data Set (MDS) for Resident #53 dated 7/28/25 listed diagnoses of hemiplegia and hemiparesis (weakness/loss of movement on one side of the body), urinary tract infection in the past 30 days, and cerebral infarction (stroke). The Brief Interview for Mental Status (BIMS) indicated intact cognition with a score of 13/15. Section GG indicated the resident required assistance with self care due to functional limitations that interfered with daily function on one side of his upper body and both sides of his lower body. The Care Plan (CP) for Resident #53 with an admission date of 7/22/25 documented activities of daily living self care deficits and directed staff to encourage the resident to use the bell to call for assistance. A section that documented a risk for falls directed staff to ensure the call light was in reach and to encourage the resident to use it. The resident needed prompt response to all requests for assistance. During an interview on 8/11/2025 at 8:54 AM the resident reported the some days call lights were longer than they should be. He thought they should be answered in 10-15 minutes and stated he knew others needed help too. During an observation on 8/11/25 the surveyor noticed the call light on at 12:46 PM for the resident's room. At 12:50 a staff member walked by without answering the light. At 12:53 PM the surveyor stood by the resident's room. Resident #53's roommate (Resident #55, MDS dated [DATE] BIMS 5/15 which indicated severe cognitive impairment) was sitting in bed with a tray in front of him on the bedside table. He waved the surveyor in. He stated his call light was on because he needed his table higher so he could eat better. At 12:59 PM 2 staff walked by headed toward the dining room and offices at the end of the hall. Neither staff member addressed the light. At 1:02 PM the surveyor observed staff at the medication cart in view of the call light. She did not respond. At 1:03 PM the Director of Nursing (DON) came out of her office directly across the hall and did not address the light. At 1:03 PM the same 2 staff who walked by at 12:59 returned to the hallway. Neither addressed the light. At 1:04 PM a nurse walked by and did not address the light. At 1:04 PM a dietary staff member walked by and did not address the light. At 1:05 PM a CNA answered the light and assisted the resident with adjusting the table. She left without asking if the resident needed his food warmed. During a follow up interview with Resident #53 and his roommate Resident #55, Resident #55 was unable to answer call light questions. When asked if there were other days or specific times call lights (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were over 15 minutes, Resident #53 stated his roommate couldn't remember but he could. He stated call lights were often as long as 30 minutes. He knew because he watched a lot of television shows that were 30 and 60 minutes long. On 8/14/2025 at 9:23 AM Staff I, Certified Nurses Aide (CNA) stated all staff are responsible for answering call lights. On 8/14/2025 at 9:33 AM Staff H, Registered Nurse (RN) stated answering call lights was a collaborative effort. On 8/14/2025 at 9:54 AM the Assistant Director of Nursing stated all staff were expected to answer call lights. The facility policy Call Lights: Accessibility and Timely Response, dated 3/27/25, directed staff to respond to call lights and if they could not meet the resident's request, to remain with them until help arrived. 2. The MDS assessment tool, dated 7/7/25, listed diagnoses for Resident #13 which included diabetes, depression, and respiratory failure. The MDS stated the resident required substantial/maximal assistance for toilet transfers and listed his BIMS score as 15 out of 15, indicating intact cognition. On 8/11/25 at 11:00 a.m., Resident #13 stated he did not get care in a timely manner. He stated he needed to use the bathroom and sat helpless three feet from the toilet waiting for staff for 20 to 30 minutes. He stated he had an incontinence accident that was preventable if staff had been there in time. 3. The MDS assessment tool, dated 8/4/25, listed diagnoses for Resident #28 which included muscle weakness, lack of coordination , and abnormal posture. The MDS stated the resident was dependent on staff for toilet transfers and listed the resident's BIMS score as 13 out of 15, indicating intact cognition. On 8/11/25 at approximately 2:00 p.m., Resident #28's spouse stated the resident had to go to the bathroom and staff said they would be right back but never returned. He stated they had to wait until shift change three hours later and by that time the resident had an incontinence accident. Resident #28 stated this made her feel terrible. 4. The MDS assessment tool, listed diagnoses for Resident #60 which included weakness, lack of coordination, and diabetes, and listed his BIMS score as 11 out of 15, indicating moderately impaired cognition. On 8/11/25 at 4:16 p.m., via phone, Resident #60's spouse stated on 8/1/25, the resident reported to her that staff took too long to assist him to the bathroom so he had an incontinence accident. The resident stated staff kept coming in and stating they would be back but not return for an hour. An 8/1/25 Care Plan entry stated the resident required the assistance of two staff for toileting. On 8/13/25 at 11:22 a.m., via phone, Staff O Certified Nursing Assistant(CNA) stated she took care of Resident #60 on 8/1/25. She stated that day was very chaotic and there were many residents which (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	required the assistance of two staff. She stated there were not enough staff to answer call lights in a timely manner and there was never enough staff for them to take care of everyone. 5. The MDS assessment tool, dated 7/17/25, listed diagnoses for Resident #81 which included anxiety, depression, and weakness and stated the resident required substantial/maximal assistance for toileting hygiene. The MDS listed the resident's BIMS score is 14 out of 15, indicating intact cognition. On 8/12/25 at 9:25 a.m., Resident #81 stated that she was supposed to have help to go to the bathroom but because she had to wait an hour, she just went by herself. On 8/13/25 at 4:38 p.m., the Director of Nursing (DON) stated she expected staff to answer call lights within 10 minutes or at least enter the room to touch base with the resident and tell them they would be back. She stated they had a lot of residents which required the assistance of two staff so it could take a minute. On 8/13/25 at 5:05 p.m., the Administrator stated staff should answer call lights in a timely manner and they added more staff. 6. The MDS assessment for Resident #58, dated 7/11/25, identified the resident had diagnoses of heart failure, repeated falls and difficulty in walking. The MDS assessment revealed a BIMS score of 5 (indicative of severe cognitive impairment) and assessed the resident was dependent on staff for toileting, lower body dressing, mobility and transfers. The Care Plan, last revised 8/12/25, revealed Resident #58 required assistance by staff with a walker for toileting, ambulation, and transfers. The resident required assistance of staff for dressing and personal hygiene. On 8/12/2025 at 8:05 AM, during an interview, Resident #58 reported he had to wait to get up for up to hour in the mornings, because he was waiting on help from staff. Resident #58 reported it (waiting to get up in the morning) happened frequently; he explained waiting to get up happened a couple times a week. Resident #58 reported going to the bathroom was the main issue. The resident reported he had a couple falls back to back last week, one at night and one in the morning. Resident #58 reported he had to go to the bathroom and used his call light prior to each of the falls. Resident #58 explained staff did not respond for about one hour, he got tired of waiting, got up and fell. Review of Progress Notes, titled Nurses Note Narrative, dated 8/5/25 at 5:58 AM and 8/5/25 at 4:05 PM, Resident #58 had falls in relation to trying to use the bathroom in his room. A Nurses Note Narrative, dated 8/9/25, included documentation the resident was found sitting on the floor in front of the toilet in his room. Resident #58 was noted to be continent and reported he lost his footing while entering the bathroom. On 8/13/25 at 11:05 AM, Staff B, CNA, explained the morning time was the busiest time at the nursing home. Staff B reported she had one other CNA working the hall she was on. Staff B reported there were a few times residents had to wait longer than 30 minutes for their call light to be answered. On 8/13/2025 at 11:13 AM, Staff N, CNA, reported Resident #58 did not like to wait when he needed to use the bathroom. Staff N reported the residents usually did not have to wait longer than minutes. Staff N reported the morning time was busiest with trying to get resident's up for the day.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, Food and Drug Administration (FDA) Food Code, and policy review dietary staff failed to properly wear hair restraints while preparing and serving food during 3 of 3 observations. The facility reported a census of 85 residents.Findings include: During lunch observations on 8/11/2025 at 12:44 PM dietary staff were serving food from the steam table parked outside of the kitchen door. Staff E, [NAME] was wearing a hair net that did not cover the sides of her hair or approximately 2-3 inches of her bangs. She plated and served food. Staff C, Food Service Manager (FSM) was wearing a ball cap. Her hair was in a bun under the back of the cap. The bun and approximately 1-2 inches of hair below the bun were not in a hair net. On 8/12/2025 at 7:18 AM the Dietary Manager was wearing a ball cap with her hair in a bun. She was not wearing a hair net. At 7:31 AM observed Staff F, [NAME] left the kitchen pushing the steam table down the hall to another dining room. Her hairnet did not cover the back 2 inches of her hair. Between 7:38 AM and 7:55 AM Staff F leaned over open steam table compartments 6 times and the FSM leaned over them 4 times. Staff F also took food to 3 tables and assisted 2 residents to cut food while leaning over their plates. On 8/12/2025 at 8:16 AM Staff F and the FSM moved to the main dining room with their hair still exposed. On 8/12/2025 during the food puree process Staff D, [NAME] was observed wearing a hairnet that covered her bangs. In the back approximately 4-5 inches of hair was exposed along with about 3 inches on the side. Staff E was observed in the kitchen with her bangs exposed. On 8/12/25 at 12:01 PM the FSM was asked who needed to wear hairnets. She stated all dietary staff had to wear them and that she was told that if she wore a ball cap she did not need a hair net. She acknowledged the other staff were not fully covering their hair and stated she would tell them right away. At 12:05 PM the surveyor observed her tell Staff D to correct hers, and at 12:09 PM tell Staff E to correct hers. During dining room observations at 12:25 PM Staff D had 3 inches of exposed hair in the back and Staff E had hair hanging out of the left side of her hair net. The FSM was wearing the ball cap without a hairnet.On 8/14/2025 at 10:21 AM when asked who completed training with the FSM, the Administrator stated she, the Dietician, and other staff and participated in her training and it was still a work in progress. The Administrator stated she was the one who told the FSM she didn't have to wear a hairnet if she wore a ball cap because in prior facilities that was acceptable. She expected the team to wear hairnets any time they were in the kitchen and when providing meal service.The FDA Food Code 2022, Section 2-402 documented food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair that are designed to effectively keep hair from contacting exposed food, clean equipment, utensils, linens, and single-service and single-use articles.A policy titled Dietary Department dated 10/1/24 documented the department would comply with all state, federal, and local infection control standards and regulations concerning personnel requirements, food storage, and preparation and handling.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and policy review the facility failed to maintain a safe, functional, sanitary, and comfortable environment for residents. The facility failed to adequately clean toilets and keep them in good repair, ensure beds were made in a timely manner, and to repair damaged or missing window screens. The facility reported a census of 85 residents.Findings include: 1. The Minimum Data Set (MDS) for Resident #85 dated 7/10/25 listed diagnoses of cancer, non-Alzheimer's dementia, hip fracture, and dependence on a wheelchair. His Brief Interview for Mental Status (BIMS) assessment score of 5/15 indicated severe cognitive impairment. The Care Plan (CP) for Resident #85 revised 10/23/24 indicated the resident had self care deficits and required the assistance of 1 staff with toileting before and after meals. The care plan documented a risk for falls, with interventions that included therapy evaluation 7/11/25, a toileting program at 7:00 am as of 7/23/25, non-slip footwear, and staying with the resident when using the toilet. During an interview at 11:42 AM on 8/11/25 a resident representative expressed concerns about wheelchair, bathroom, and room cleanliness. They reported the resident's wheelchair was not cleaned regularly and the cushion in the chair smelled of urine. The representative mentioned being embarrassed at a recent appointment because the smell was so bad and stated other members of the resident's family reported similar concerns. They further stated the toilet had been broken and overflowing 'forever' and it was always dirty in there. On 8/11/2025 at 2:49 PM the resident's toilet was running and the floor was damp. On 8/12/2025 at 1:42 PM the resident's bathroom floor remained wet and the toilet was running. Urine odor in bathroom and into room. On 8/13/2025 at 9:57 AM the resident's toilet was running, there was a strong odor of urine. The floor was wet to the corners, about a foot from the base, and about 9 - 12 inches in front of the toilet. On 8/13/2025 at 10:08 AM Staff Q, Housekeeping stated sometimes the residents using that bathroom had a lot of accidents and could use a cleaning twice a day. She indicated in a binder on the cart that the bathroom was scheduled for cleaning on Tuesday, Thursday, and Saturday. She stated the aides were supposed to help monitor and she had not been told there was an odor. During an interview on 8/14/2025 at 9:41 AM Staff J, Maintenance Director stated no one reported an issue with the toilet in the resident's room and should have told him or filled out a form in the maintenance book at the nurses stations. Maintenance documentation from May through August 2025 provided by the facility confirmed there was not a report for this room. An interview with the Administrator on 8/14/2025 at 10:21 AM determined she expected staff to use the maintenance book, verbal communication, or department group chats to get repairs made for safety. The running toilet had not been reported to her. She expected staff to make sure wheelchairs and bathrooms were clean, and equipment in working order. 2. On 8/11/25 at 2:49 p.m. the bed in room [ROOM NUMBER] was not made and had a bare mattress. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/12/25 at 8:28 a.m., the bed in room [ROOM NUMBER] was only made with sheets but no blanket or bedspread. On 8/12/25 at 1:09 p.m., the bed in room [ROOM NUMBER] remained not fully made. 3. On 8/13/25 at 9:05 a.m., the bathroom toilet in room [ROOM NUMBER] had black splatters inside the toilet and on the inside of the toilet riser. A graduate sat atop the toilet tank and contained a yellow liquid and the top of the tank had yellow splatters. On 8/13/25 at 2:23 p.m., the bathroom in room [ROOM NUMBER] remained unchanged. 4. The MDS assessment for Resident #17, dated 5/22/25, identified the resident had a BIMS score of 14 out of 15 (indicative of a mild cognitive impairment). On 8/11/25 at 10:43 AM, Resident #17 reported concerns with a broken window screen in her room. She explained the screen had been broken all summer and the other 2 screens were missing. Resident #17 reported housekeeping had broken the window screen when they were cleaning it in either June or July 2025. 5. The MDS assessment for Resident #7, dated 6/5/25, identified the resident had a BIMS score of 13 out of 15 (indicative of a mild cognitive impairment). On 8/11/2025 at 1:48 PM, Resident #7 reported the following concerns: a. Two different wall outlets were loose and her plug for her phone and Continuous Positive Airway Pressure (CPAP- a medical device used to treat sleep apnea or absence of breath when sleeping) machine were half-hanging out of the wall. Resident #7 reported she told the Maintenance Director about the concern in May of 2025, but nothing was done. She reported the Maintenance Director quit working at the facility a couple weeks ago. Observation of the two wall outlets revealed a plug-in for the phone and CPAP both hanging loosely from the outlet. Attempts to re-plug the phone and CPAP machine resulted in both plugs still hanging half-way out of the outlet. b. Resident #7 complained to staff that for 3 days in a row, there was BM (feces) on inside edge and top end of the toilet seat where the resident's upper thigh and leg would touch the seat. Resident #7 reported that the BM was still present on the seat as of today (8/11/25). Resident #7 reported the BM was from an episode of diarrhea her roommate had. Observation of the toilet seat revealed a dark brown, dried substance located on the inner left side of the seat and top end of the seat where the resident's back of their leg would touch. On 8/12/2025 at 12:13 PM, Staff Q, Housekeeping, reported she cleaned residents room daily and some rooms 2 times per day if requested. Staff Q reported when she cleaned the residents rooms she cleaned off counters, tray tables, dressers, toilet, handrails, sink and swept and mopped the floor. On 8/14/2025 at 8:06 AM, during an interview with Staff Q, Housekeeping, when asked if she had received any complaints from residents about their bathrooms not getting cleaned, she responded, It's on my weekend. I have the whole nursing home. Staff Q explained the she was the only housekeeper for the facility every other weekend. Staff Q reported the residents used to having their bathrooms cleaned by a certain time in the morning, but it might be afternoon before she got to them. Staff Q reported she had heard residents complain of not getting their bathrooms cleaned. Staff Q reported (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	being off this last weekend and had not received a complaint about the bathroom from Resident #7. Staff Q reported facility staff had been in the process of cleaning and replacing screens for months. Staff Q was aware there were missing and bent window screens. Staff Q reported Resident #17 was correct that housekeeping staff were cleaning the screens and her window screen got bent by housekeeping. On 8/14/2025 at 8:12 AM, Staff R, housekeeping, reported she had heard complaints from residents about their toilets not getting cleaned. Staff R reported she cleaned Resident #7's toilet on Monday and the resident did not complain to her about staff not cleaning it for three days. On 8/14/25 at approximately 9:00 AM, the Housekeeping Manager provided an audit of window screens and window cleaning and replacement. Housekeeping staff documented they last cleaned Resident #17's windows and screens on 6/23/25. On 8/14/25 at 11:00 AM, during an interview, the Administrator reported they had been working on a facility wide project to replace window screens for the last several months. The Administrator reported being unaware of outlet issue in Resident #7's room. The Administrator contacted maintenance to repair the outlets immediately. Review of the undated facility policy, titled Housekeeping Daily Tasks, revealed directions to housekeeping staff to clean residents toilets daily.

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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. Based on observation, clinical record review, resident interviews, staff interviews, and policy review the facility failed to treat residents with dignity and respect, and to provide care in a dignified manner for 3 of 4 residents reviewed for dignity (Residents #58, #85, #93). Facility staff failed to maintain a resident's wheelchair in a clean and sanitary manner, staff used an expletive when describing a resident's behavior in front of others, and the facility posted signs in a resident's room regarding toileting without consulting them. The facility reported a census of 85 residents.Findings include: 1. The Minimum Data Set (MDS) for Resident #85 dated 7/10/25 listed diagnoses of cancer, non-Alzheimer's dementia, hip fracture, and dependence on a wheelchair. His Brief Interview for Mental Status (BIMS) assessment score of 5/15 indicated severe cognitive impairment. The Care Plan (CP) for Resident #85 revised 10/23/24 indicated the resident had limited physical mobility and ambulated with a wheelchair in the hallway. The CP listed a goal to prevent complications related to immobility that included skin breakdown. An intervention initiated 11/7/23 revised on 5/22/25 directed staff to clean the wheelchair weekly. During an interview at 11:42 AM on 8/11/25 a resident representative expressed concerns about cleanliness. They reported the resident did receive a shower twice a week but their wheelchair was not cleaned regularly, and the cushion in the chair smelled of urine. The representative mentioned being embarrassed at a recent appointment because the smell was so bad and stated other members of the resident's family reported similar concerns. The representative stated they asked for the chair to be cleaned more than once. During on observation on 08/11/2025 at 2:49 PM the resident's wheelchair was next to his bed. There was a noticeable odor coming from the chair. When the cushion was lifted it exposed crumbs in all of the fasteners lining the sides of the chair below the arm rests. A follow up observation on 08/12/2025 at 1:42 PM revealed the wheelchair had not been cleaned On 08/13/2025 at 9:52 AM Resident #85 wheeled himself into his room from the hallway. An odor of urine was noticeable from his wheelchair as he pushed himself around the corner and adjusted himself in his seat. At 1:13 PM the resident reported they cleaned his wheelchair when they had time. Upon raising the cushion crumbs remained pressed against the fasteners and smears of an unknown substance were on the arm rests. There was a stain on the back of the cushion and a strong urine odor coming from it. On 08/14/2025 at 9:23 AM Staff I, Certified Nursing Assistant (CNA) confirmed she worked with Resident #85. She stated third shift had a checklist for wheelchair cleaning but any CNA could get crumbs off and bleach wipe a chair, at least that is what she would do. She stated she would inform the restorative staff or maintenance and try to figure out how to get the cushion clean. An interview with the Assistant Director of Nursing (ADON) on 8/14/2025 at 9:54 AM revealed she was aware wheelchairs were not being cleaned according to a schedule she set up 4 months ago. She stated third shift CNAs were supposed to follow a cleaning schedule she provided. They had not been doing it in spite of training, and the facility was planning to roll it out again in September. She stated if staff saw a dirty wheelchair or smelled an odor on one she expected them to clean it up regardless (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the schedule. A blank document titled Nightly CNA duty list was provided by the ADON which verified the resident's wheelchair had not been cleaned that week. 2. The MDS assessment tool, dated 6/5/25, listed diagnoses for Resident #93 which included non-Alzheimer's dementia, depression, and anxiety. The MDS stated the resident had physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) 1-3 days out of the 7 day review period. The MDS listed his Brief Interview for Mental Status(BIMS) score as 2 out of 15, indicating severely impaired cognition. The facility policy Promoting/Maintaining Resident Dignity, dated 3/27/25, stated the facility protected and promoted resident rights, treated each resident with respect and dignity, and cared for each resident in a manner that maintained or enhanced quality of life by recognizing each resident's individuality. Care Plan entries, dated 5/2/25, directed staff to give the resident reassurance as needed and visit with him about feelings/events that bothered him. On 8/11/25 at 11:35 a.m., Staff B Certified Nursing Assistant(CNA) walked by the nurses station and stated she attempted to assist Resident #93 but he slapped the s***(expletive) out of me. Staff B stated this while near the nurses station with residents in close proximity at the dining tables and other staff at the nurses station. On 8/13/25 at 4:38 p.m., the Director of Nursing(DON) stated it was not acceptable for staff to state something in public about a resident in front of others. On 8/13/25 at 5:05 p.m., the Administrator stated staff should treat residents with dignity and respect and not speak negatively about them in front of other residents. 3. The MDS assessment for Resident #58, dated 7/11/25, identified the resident had diagnoses of heart failure, repeated falls and difficulty in walking. The MDS assessment revealed a BIMS score of 5 (indicative of severe cognitive impairment) and assessed the resident was dependent on staff for toileting and transfers. The Care Plan, last revised 8/12/25, revealed the resident required assistance by staff with a walker for toileting and transfers. The Care Plan identified the resident was a fall risk and included the following interventions: Sign placed in room to encourage call light use for help getting up (dated 8/5/25); and, sign placed on walker to ask for assistance before getting up (dated 8/9/25). On 8/12/2025 at 8:05 AM, during an interview, Resident #58 reported he did not like the signs posted in his room and walker to use the call light and ask for help. Resident #58 reported the signs were irritating and insulting to his intelligence. Resident #58 explained he had a couple falls back to back last week, one at night and one in the morning. After the falls, Resident #58 described staff as giving him heck and then putting the signs in his room without asking if it was okay. Resident #58 reported he had to go to the bathroom and used his call light prior to each of the falls. Resident #58 explained staff did not respond for about one hour, he got tired of waiting, got up and fell. Review of Progress Notes, titled Nurses Note Narrative, dated 8/5/25 at 5:58 AM and 8/5/25 at 4:05 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM, Resident #58 had falls in relation to trying to use the bathroom in his room. A Nurses Note Narrative, dated 8/9/25, included documentation the resident was found sitting on the floor in front of the toilet in his room. Resident #58 was noted to be continent and reported he lost his footing while entering the bathroom. The Progress Notes lacked documentation facility staff discussed changes to the care plan with either the resident or resident's representative to include the interventions of signs. On 8/13/2025 at 11:13 AM, Staff N, Certified Nurses Aide (CNA), reported Resident #58 did not like to wait when he needed to use the bathroom. When asked by the surveyor if Resident #58 had complained about the signs in his room, Staff N reported Resident #58 did say something the other day after falling about the signs. Staff N reported Resident #58 said that if he had to go, he was going to get up and go no matter what the signs told him. Facility staff failed to consider the dignity and response of the resident when posting signs in the resident room.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, the Long Term Care Facility Resident Assessment Instrument 3.0 Version 1.18.11 last updated October 2023 (RAI), and staff interview the facility failed to submit the Minimum Data Set (MDS) within the required time frame for 1 of 1 resident's reviewed for timely submission. The facility reported a census of 85 residents. Findings include: Clinical record review for Resident #92 showed a quarterly MDS dated [DATE]. The resident had an annual MDS dated [DATE]. Both assessments had a status of complete, not accepted. During an interview on 08/13/2025 at 10:31 AM, the MDS coordinator explained the quarterly dated 6/20/25 was flagged as do not submit. She further explained it should have been submitted. She continued, it was discovered the quarterly should have been an annual and the annual assessment was completed. That assessment too was flagged as do not submit and it should have been submitted. During an interview on 8/13/25 at 4:45 PM the MDS coordinator explained they do not have an MDS policy, they follow the RAI.

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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 clinical record review, facility policy review, resident interview, and staff interview, the facility failed to ensure staff obtained and/or administered medications per physician order and professional standards of practice for 1 of 1 residents sampled (Resident #7) with a resident reported medication error by staff. The facility reported a census of 85 residents.Findings include: The Minimum Data Set (MDS) assessment for Resident #7, dated 6/5/25, revealed diagnoses of end stage renal disease and systemic Lupus (an autoimmune disease). The MDS identified the resident had a Brief Interview for Mental Status (BIMS) of 13 out of 15 (indicative of a mild cognitive impairment). The MDS identified the resident received renal dialysis. The Care Plan for Resident #7, last revised 8/1/25, revealed the resident took a sedative/hypnotic for insomnia. On 8/13/2025 at 8:09 AM, Resident #7 reported concerns with nursing staff medication administration for two different medications. Resident #7 explained that she had been taking Zolpidem (Ambien) to treat insomnia for the last 15 years. Resident #7 reported she typically received the medication at 8:00 PM every evening. The resident explained that without the Ambien, she could not sleep at night. Resident #7 report that she was scheduled for an arteriovenous (AV) fistula (surgically created connection between an artery and vein and used as a dialysis access point) on 5/8/25. The cardiovascular surgeon had provided pre-operation orders that included instructions that Resident #7 could receive their nightly dose of Ambien on 5/7/25. Resident #7 explained that the nurse working the evening of 5/7/25 refused to give her the Ambien medication and informed her they were holding the medication due to her upcoming surgery. Resident #7 reported she showed the pre-operative orders to the nurse and tried to explain she was supposed to get the medication, but the nurse refused to do anything further. Resident #7 reported not being able to sleep the night of 5/7/25, and she was angry. Resident #7 reported the surgery ended up being cancelled and rescheduled for 6/16/25. Resident #7 reported the same thing happened again. Nursing staff withheld her Ambien medication even though the pre-operative orders stated that she could have the Ambien. Resident #7 reported arguing with the nurse again, but the nurse told her that the medication was locked up and could not be accessed. Resident #7 reported she did not sleep that night and was very upset. She reported that she complained to nursing staff and specifically identified Staff L, Registered Nurse (RN). Resident #7 reported she did have the AV fistula surgery on 6/19/25. Resident #7 reported concerns with not receiving a second medication, Benlysta (Belimumab) weekly injections to treat her Lupus. Resident #7 showed a medication print out from the facility's electronic record which identified an order for Belimumab 20 milligrams (mg)/ ml, 200 mg subcutaneous every 7 days and a start date of 7/25/25. Resident #7 reported she had not received the medication. She reported her nephrologist ordered the medication and the medication was a specialty medication that could only be obtained from a pharmacy in Omaha. Resident #7 reported she had complained to several staff about not getting her injection, including Staff L, RN. Review of the clinical record for Resident #7 revealed the following: a. Review of the Medication Administration Record (MAR), dated May 2025, revealed nursing staff held Resident #7's scheduled Ambien 10 milligram (mg) by mouth at bedtime dose (scheduled between 7:00 PM to 10:00 PM) on 5/7/25. Review of pre-operative orders from the cardiothoracic and vascular center provider performing the AV fistula surgery scheduled for 5/8/25 revealed an order for the resident to receive her scheduled dose of Ambien 10 mg on 5/7/25. The provider did not write a hold order for the Ambien. A Progress Note, titled Nursing Note, dated 5/7/25 at 9:52 AM, included documentation that Resident #7 was upset because she did not get her medications. The nurse informed the resident that her medications were on hold due to a procedure. The resident informed the nurse that the procedure was cancelled. The nurse informed the resident that she could not give the resident her medications due to the hold order. On 8/14/2025 9:10 AM Staff Q, ARNP, confirmed that the resident should have received her 5/7/25 dose of Ambien based on the pre-operative surgery orders. Review of the MAR, dated June 2025, revealed nursing staff held Resident #7's scheduled (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ambien 10 mg by mouth at bedtime dose (scheduled between 7:00 PM to 10:00 PM) on 6/17/25. Review of pre-operative orders from the cardiothoracic and vascular center provider performing the AV fistula surgery scheduled for 6/17/25 revealed an order for the resident to receive her scheduled dose of Ambien 10 mg on 6/16/25. The provider did not write a hold order for the Ambien. On 8/13/2025 at 9:59 AM, the Director of Nursing (DON) reported being unaware that Resident #7 had an issue with not receiving her Ambien. On 8/13/2025 at 10:08 AM, Staff L reported Resident #7 did complain about not getting her Ambien. Staff L was not sure at what point the resident told her about not getting the Ambien and was unaware that the resident did not receive her Ambien on two separate occasions. Staff L told the resident her plan to call and clarify the order with the physician. Staff L reported she followed through with contacting the physician, and the resident received her Ambien before her surgery on 6/19/25. On 8/13/2025 at 12:48 PM Staff M, RN, confirmed she put the 6/17/25 hold order for Ambien in the electronic medical record (EMR) system. Staff M confirmed she did not get an order from Staff Q, Advanced Registered Nurse Practitioner (ARNP), who was also Resident #7's primary care practitioner (PCP) even though the order in the system identified it came from Staff Q, ARNP. Staff M reported she put in the order to hold the Ambien based on pre-operative surgery orders. Staff M explained the EMR had a limited number of providers to chose from, so she chose to place the order to hold under Staff Q, ARNP. Staff M confirmed she put an incorrect hold order for the Ambien in the EMR. b. A document titled Mobile App Encounter, dated 7/21/25, included documentation of Resident #7's appointment with a nephrologist. The nephrologist ordered Belimumab 20 milligrams (mg)/ ml, 200 mg subcutaneous every 7 days starting 7/21/25. On 8/13/25, review of the MAR for Resident #7, dated July 2025 and August 2025, revealed Belimumab had been added to the medications with a start date of 7/25/25, but the resident had not received an injection. On 8/13/25 at 8:45 AM, review of Resident #7's Progress Notes revealed a lack of documentation regarding why the resident was not receiving Belimumab weekly injections. On 8/13/2025 at 9:59 AM, the DON reported she was aware the resident was supposed to get a weekly Belimumab injection. The DON explained that they tried to get this filled through the facility pharmacy, but the pharmacy did not have access to the medication. The DON reported they planned to reach out to the previous pharmacy that the resident was getting the medication from. The DON explained that if they could not get the medication, they would reach out to the provider. The DON agreed to provide contact information for Resident #7's nephrologist.On 8/13/2025 at 10:08 AM, Staff L reported not being aware that the resident was supposed to be getting Belimumab weekly injections and denied the resident said anything to her regarding this medication. On 8/13/2025 at 10:35 AM, during an interview with the DON and the Assistant Director of Nursing (ADON), the ADON reported she had been checking into the Belimumab injections and found that the medication came from a special pharmacy. The ADON denied Resident #7 had said anything to her about not getting the injections. The DON and ADON denied Resident #7's Nephrologist had contacted them. A Progress Note, tiled Nurses Note, dated 8/13/25 at 11:31 AM, included the following documentation: Call placed to (Nephrologist) office on 8/8/25 and 8/11/25 left message to return call. Call placed again today. Was advised that they need to talk to (Nephrologist) and will call back with additional information. A Progress Note, tiled Nurses Note, dated 8/13/25 at 11:36 AM, included the following documentation: rec'd (received) verbal order from (Nephrologist)'s office to hold the injection until they get additional information. A Progress Note, tiled Nurses Note, dated 8/13/25 at 11:54 AM, included the following documentation: Call rec'd from (Nephrologist)'s office, was advised that (Resident #7) only sees the provider when she is at dialysis so the office staff is not always immediately aware of new orders or changes. Provider was in office today so they were able to discuss questions face to face. Was advised that the original order was d/c on 3/19 due to resident self reporting not taking the med for the last year. Provider saw resident on dialysis treatment day 7/21(25). Belimumab was discussed and it was decided to restart the medication. The medication was originally sent to (facility contracted) pharmacy but they are unable to fill. Provider then sent prescription to another specialty pharmacy. Office staff has not seen a PA (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or a request for additional information as of 8/13(25). Prescription was resent. Provider and staff are aware that resident has not rec'd an injection since the reorder on 7/21/25. Provider did not have any concerns advised they will reach out with any updates from the specialty pharmacy and the pharmacy will reach out to our facility to schedule a delivery once the PA and everything has been completed. On 8/13/2025 at 12:30 PM, Staff V, Pharmacy Technician (facility contracted pharmacy), reported the pharmacy did not have access to Belimumab and could not obtain the medication. Staff V reported they received the order for the medication on 7/21/25. Staff V reported they faxed the facility with a note on 7/21/25, and told them only the medication was only obtainable with a specialty pharmacy and that they needed to reach out to the provider who ordered the medication. On 8/14/2025 at 10:39 AM, the nurse for Resident #7's Nephrologist, reported the facility had not contacted their office from when the Nephrologist ordered Belimumab on 7/21/25 until yesterday, 8/13/25. The nurse explained that they track and document all telephone encounters, and they had not received any calls from facility staff. The Nephrologist was unaware of the need to send the medication order to a specialty pharmacy until nursing home staff contacted their office on 8/13/25 (23 days after the physician order date). Review of the facility policy, titled Medication Administration, dated 3/27/25, identified staff were to administer medications per physician orders and professional standards of practice.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on clinical record review, policy review, and resident and staff interviews, the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities for 1 of 1 residents reviewed for activities(Resident #81). The facility reported a census of 85 residents. The admission Minimum Data Set (MDS) assessment tool, dated 4/23/25, listed diagnoses for Resident #81 which included anxiety, depression, and weakness. The MDS stated it was very important for the resident to go outside when the weather was good. The MDS listed the Brief Interview for Mental Status (BIMS) score as 14 out of 15, indicating intact cognition. The facility policy Activities, dated 3/27/25, stated the facility would provide an ongoing program to support the resident in their choice of activities based on their comprehensive assessment, care plan, and preferences. A 4/23/25 Resident Preferences Evaluation stated it was very important to the resident to go outside to get fresh air when the weather was good. On 8/12/25 at 10:08 a.m., Resident #81 stated she was not able to go outside and she wished to do so. On 8/13/25 at 11:30 a.m., the Administrator provided activity participation calendars and stated the notes covered activities participated in from May 2025 through July 2025. The calendars revealed the following:May 2025: The resident participated in music one time, ladies tea one time, pet therapy two times, bingo two times, pretty nails four times, happy hour four times, Mother's Day party one time, card games two times, exercises two times. The calendar lacked documentation staff offered the resident an outdoor activity. June 2025: The resident did not have a June 2025 activity calendar in the notes provided by the Administrator.July 2025: The resident participated in bingo two times, and pretty nails one time. An additional untitled activity sheet for July 2025 stated the resident participated in an ice cream activity.The facility lacked additional documentation the resident was offered outdoor activities during the period of 5/1/25 to 7/31/25. On 8/13/25 at 12:08 p.m., the Activities Director (AD) stated she just began at the facility last week. She stated her plan for the future was to take residents outside twice per week. She stated activities should be centered on what the residents want to do. On 8/13/25 at 4:38 p.m., the Director of Nursing (DON) stated it the facility had at least 1 activity per day and sometimes 2-3. She stated there was a shift in activities staff and the new AD tried to schedule more events. She stated the residents were able to go outside in the mornings.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, clinical record review, and staff interviews, the facility failed to utilize foot pedals during wheelchair transport in order to ensure safety and failed to ensure good working order of a walker to prevent falls for 3 of 5 residents reviewed for accidents (Residents #12, #49, and #101). The facility reported a census of 85 residents.Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 6/18/25, listed diagnoses for Resident #12 which included non-Alzheimer's dementia, anxiety disorder, and cancer. The MDS stated the resident was dependent on staff to propel her wheelchair and listed her Brief Interview for Mental Status (BIMS) score as 12 out of 15, indicating moderately impaired cognition. On 8/11/25 at approximately 11:00 a.m., Staff A Hospice Tech pushed Resident #12 in her wheelchair from the nursing station to her room, a distance of approximately 50 feet. The resident's feet were not placed on foot pedals and the bottoms of her feet lightly touched the ground while Staff A pushed her. On 8/13/25 at 4:38 p.m., the Director of Nursing(DON) stated foot pedals should be used if staff pushed residents in their wheelchairs. On 8/14/25 at 11:15 a.m., the Administrator stated she did not have a policy related to foot pedals. 2. The MDS for Resident #49 dated 8/7/25 revealed diagnoses of fracture, muscle weakness, and abnormal posture. The BIMS documented a score of 14/15 which indicated intact cognition. Section GG indicated the resident experienced functional limitation in range of motion in both lower extremities. The Care Plan (CP) for the resident dated 5/6/25 indicated they had an activities of daily living (ADL) self care performance deficits and were at risk for falls. Resident #49 needed assistance with maintaining a safe environment. During a dining room observation on 8/13/2025 at 8:54 AM Staff G, Certified Nurses Aide (CNA) pushed Resident #49 in his wheelchair from the dining room down the A hallway to his room without the use of foot pedals for safety. The resident was able to hold his feet up past the nurses station and 3 doors, then his feet started to drop towards the floor as they passed 3 more doors to get to his room. On 8/13/2025 at 9:04 AM the Administrator stopped in the hall while the surveyor was waiting to speak with Staff G. She stated she saw Staff G push the resident in the hallway without pedals and had already provided education to the CNA that residents should not be transported in wheelchairs without foot pedals. On 8/13/2025 at 9:09 AM an interview with the resident revealed that the pedals got in the way at the table in the dining room so staff often just left his pedals in his room. An observation during the interview determined his pedals were on his floor under his sink and there was not a bag for pedals on the back of his wheelchair. During an interview with the Assistant Director of Nursing (ADON) on 8/14/2025 at 9:54 AM she stated the facility did a wheelchair audit recently because it was a common thing for them to catch missing foot pedals and she thought residents needed bags for them on the back of their chairs. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The MDS for Resident #101 dated 5/27/25 (3 days after his fall) revealed diagnoses of cancer, hip fracture and other fracture (rib), and malnutrition. The BIMS documented a score of 15/15 which indicated intact cognition. Section GG indicated the resident experienced functional limitation in range of motion in one lower extremity and used a walker with supervision or touch assistance. The baseline Care Plan (CP) for the resident dated 5/20/25 indicated the resident needed physical, occupational, and speech therapies. It documented a history of falls and fall related injuries of right femur fracture and rib fractures. It listed the resident used a walker and wheelchair. A document titled Physical Therapy Treatment Encounter Notes, date of service 5/26/25, documented Resident #101 was weight bearing as tolerated and contact guard staff assist with a four wheel walker for toilet transfers during the session. A Progress Note titled admission Follow-up Note dated 5/25/25 at 12:14 AM documented the resident was found on the floor next to his bed with his back against the bed and his legs out in front of him. He stated he was going from the chair to the bed when his walker collapsed and he fell. The resident told staff he had permission from therapy to transfer in his room. The note further documented staff obtained a different walker for the resident as he was correct in stating the walker collapsed. The writer noted the walker was in poor condition and had screws missing that would keep the walker working properly. The Assistant Director of Nursing (ADON) was notified. On 8/14/2025 at 8:36 AM the Director of Nursing (DON) reported the Assistant Director of Nursing (ADON) was responsible for monitoring cleaning of equipment and ensuring staff monitored it for safety. During an interview with the ADON on 8/14/2025 at 9:54 AM she reported when she thought about the walker, she recalled one of the sides didn't have something right about it and it was discussed in a morning meeting. She stated the restorative aide would have been responsible for checking the walker and it should have been repaired or out of service if not safe. She said she would need to continue to work with the new restorative aide to monitor things like that. On 8/14/2025 at 10:21 AM the Administrator stated she thought the documentation had been over-exaggerated. She recalled the walker was disposed of and discussed that morning in a quality assurance meeting. The restorative aide participated and staff were told to double and triple check equipment for safety after the incident. She also asked maintenance and therapy to look into it.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on clinical record review, review of facility policy/protocol, resident and staff interview, the facility failed to ensure that a resident with symptoms of a potential urinary tract infection (UTI) received prompt testing and ongoing assessment to prevent worsening of symptoms for 1 of 1 resident (Resident #17) with a complaint of a possible UTI. The facility reported a census of 85.Findings include:The Minimum Data Set (MDS) assessment for Resident #17, dated 5/22/25, identified diagnoses of atrial fibrillation, heart failure, and chronic kidney disease. The MDS identified a Brief Interview for Mental Status (BIMS) score of 14 out of 15 (indicative of mild cognitive impairment).The Care Plan for Resident #17, last revised 7/30/25, included a focus area of bladder incontinence and the following intervention: Monitor/document for s/sx (signs/symptoms) UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns.On 8/11/25 at 10:43 AM, Resident #17 reported that she thought she had a kidney infection. She explained that she told the nurse today and thought the nurse was going to take care of it today (8/11/25). Resident #17 reported symptoms of pain and burning with urination, lower abdominal pressure and frequency of urination. Resident #17 reported she had a history of getting UTIs frequently. On 8/12/2025 at 3:27 PM, review of Resident #17's Progress Notes revealed the following three Nurses Note narratives:a. Nurses Note narrative by Staff K, Licensed Practical Nurse (LPN) , dated 8/11/25 at 9:25 AM, Messaged (Staff P), ARNP (Advanced Registered Nurse Practitioner) on resident stating dysuria (pain, burning with urination) and abdominal distention. T. (temperature) 97.7 (degrees Fahrenheit).b. Nurses Note narrative, dated 8/11/25 at 8:47 PM, Acetaminophen Oral Tablet 500 MG (milligrams)Give 2 tablet by mouth every 6 hours as needed for Elevated Temp/General Discomfort Not to exceed 3gms (grams) in 24hrs from all sources no new orders.c. Nurses Note narrative, dated 8/11/25 at 10:14 PM, indicated the Acetaminophen was effective. The clinical record lacked any further assessment, documentation or orders related to the resident's complaint of a possible UTI.On 8/13/2025 at 8:39 AM, Resident #17 reported she was still having symptoms of burning with urination, pressure in the lower abdomen, lower back ache, urine frequency, and felt unbalanced. Resident #17 reported nursing staff had not followed up with her or reassessed her condition since she notified nursing staff of the possible UTI on Monday (8/11/25). On 8/13/2025 8:42 AM, Staff L, Registered Nurse (RN), explained that if a resident reported symptoms related to a possible UTI, she would get a set of vitals, ask the provider for a urinary analysis (UA) with culture and sensitivity (C and S, a test used to help determine the type of infectious organism) to rule out UTI or kidney infection. Staff L reported the nursing staff used a secure messaging system to contact the providers. All nursing staff had access to the secure messaging system and could see the messages put in by other nurses and the providers. Staff L reported that the facility did not have a standing protocol for assessment with a change in condition. Staff L reported the resident did not say anything to her yesterday (8/12/25) or today (8/13/25). Staff reported none of the other nurses reported a concern to her regarding Resident #17. On 8/13/2025 at 8:44 AM, Staff M, RN, reported she just processed an order for UA with C and S around 8:00 AM today (8/13/25) for Resident #17 and put the order in the electronic medical record (EMR). Staff M reported that according to the secure messaging system, Staff Q, ARNP sent the order to the facility on 8/11/25 around 2:00 PM. Staff M was unsure why it took so long for the order to be processed.Review of the clinical record revealed a Physician Order, created by Staff M, RN, dated 8/13/25 at 8:15 AM, for a one time UA with C and S to rule out a UTI. The order included an end date of 8/15/25. The clinical record failed to identify Staff Q, ARNP, sent the order request on 8/11/25. On 8/13/2025 at 10:35 AM, during an interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), the DON reported nursing staff used a secure messaging system for physician/provider contact, and the messages were available for (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	all nursing staff. The ADON reported that all nurses were required to review the secure messaging system before they left at the end of their shift. The ADON reported the nurses should also give information on any resident condition changes at shift change. Nursing staff should follow up within 24 hours, or sooner if the concern was more urgent, if they had not heard from a provider. The ADON reported they experienced good response time from the providers. The ADON reported the DON and ADON reviewed all faxes and secure messages from the previous day, and if they have not received a response, they resend the fax or reach out to the provider. The ADON reported they expected physician orders to be followed up on right away and denied that they had a problem with this. The ADON and DON did not know why the order for a UA and C and S did not get put in the electronic system right away. The ADON reported she did not look at secure messages as much yesterday.On 8/13/2025 at 3:08 PM, the ADON reported nursing staff put the time they processed orders in the EMR, not the time the provider submitted the order via secure message. The ADON reported an inability to print secure documentation messages. The ADON and surveyor reviewed the following messages sent via the secure message system for Resident #17:a. Staff Q, ARNP, sent an order, dated 8/11/25 at 2:11 PM, for a UA with C and S.b. The DON put a message in the secure messaging documentation system, dated 8/12/25 at 11:20 AM, to process the order.c. Order processed by Staff M, RN, dated 8/13/25 at 8:06 AM.On 8/14/2025 at 9:05 AM, Staff Q, ARNP, and primary care provider for Resident #17 reported the expectation that nursing staff would carry out the order the same day Staff Q issued the order. Staff Q explained if nursing staff had not followed through with the order within 24 hours, then she would expect nursing staff to notify her of the reason why they did not carry the order out. Staff Q, ARNP explained the concern with not following through checking and treating a possible UTI in a timely manner was that the condition could worsen and there was a potential for sepsis (a systemic blood infection).Review of an undated facility protocol, titled Change of Condition Protocol Add/Remove from Hot Chart List, revealed the purpose of the protocol was ensure care of residents through nursing assessments, interventions and appropriate follow up. The protocol identified a change in condition included an alteration in a person's physical, mental and/or psychosocial status from normal status and included direction to staff to complete Hot Charting for residents not limited to, but including the following reasons: 2 or more signs and symptoms of acute infection, new or increased pain, and change in urinary status. Hot charting included the documentation of vital signs and a focused assessment every shift. The protocol included instructions to staff to carry out new orders per facility protocol. Review of the facility policy, titled Consulting Physician/Practitioner Orders, dated 5/27/25, revealed nursing staff were to verify orders received in a timely manner.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on clinical record review, observation, facility policy review and staff interview, the facility failed to ensure nursing staff followed facility policy and physician orders regarding checking for enteral feeding tube placement, checking for residual gastric volume, and flushing with the correct amount of fluid prior to administering an enteral feeding to 1 of 1 sampled residents (Resident #4) with an gastric feeding tube. The facility reported a census of 85.Findings include: The Minimum Data Set (MDS) assessment, dated 7/14/25, identified Resident #4 had diagnoses of cerebral infarction (stroke) and dysphagia (difficulty swallowing). The MDS identified the resident received nutrition enterally (through a feeding tube) and had a severe cognitive impairment. The Care Plan for Resident #4, last revised 5/22/25, identified the resident had an order for nothing by mouth (NPO) and required feeding, medication, and hydration through a gastric feeding tube (G-Tube). The Care Plan included an intervention for staff to check for tube placement and gastric contents/residual volume. A Physician Order, dated 10/29/24, included an order for enteral feed three times per day with Osmolite 1.5 to 2 cartons via gravity, flush G-Tube with 90 milliliters (ml) before and after feeding. Before each feeding check for residual, if residual of 250 ml, delay feeding at least one hour. On 8/11/25 at 1:37 PM, observation revealed Staff K, Licensed Practical Nurse (LPN), entered Resident #4's room. Staff K gloved, poured two cartons of Osmolite eight fluid ounces into an intravenous (IV) bag, and primed the tubing line with the Osmolite. Staff K removed her gloves, donned another pair of gloves, opened the G-Tube port located on the resident's abdomen, and utilized a syringe with 30 ml of tap water to flush the G-Tube site. Staff K connected the tubing line with Osmolite to the G-Tube port and started the tube feeding. Staff K rinsed out the syringe in the sink, removed her gloves, and washed her hands. Staff K failed to check for placement of the G-Tube per the resident's Care Plan and failed to check for residual gastric content prior to the enteral feeding per physician orders. In an interview during the same observation, Staff K, LPN, confirmed the use of 30 ml of tap water to flush the G-Tube prior to feeding. Staff K reported she checked placement of the G-Tube once a day with a stethoscope. Staff K failed to flush the G-Tube with 90 ml of tap water prior to starting the enteral feed. On 8/12/2025 at 10:50 AM, Staff L, Registered Nurse (RN), used a syringe to inject air into Resident #4's G-Tube port and listened with a stethoscope to check the placement of the G-Tube prior to administering medication. Staff L reported she checked for placement of the G-Tube every time she planned to access the G-Tube. Review of the facility policy, titled Medication Administration Via Enteral Tube, dated 3/27/25, revealed staff were required to verify enteral tube placement prior to administering any fluids or medications.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on electronic health record (EHR) review, clinical record review, facility records, resident, physician and staff interviews, the facility failed to ensure a resident understood the Alternative Dispute Resolution before signing the agreement for 1 of 3 residents (Resident #104) reviewed. The facility reported a census of 89 residents. Findings include:During the Entrance Conference on 8/11/25, The Administrator revealed the facility offered Alternative Dispute Resolution agreements to residents. Staff X, Licensed Practical Nurse (LPN)/Admissions & Marketing Coordinator was responsible for explaining and reviewing the paperwork with the resident and/or the resident's legal representative. The History & Physical (H&P) dated 7/26/25 provided by the facility documented Resident #104 had dementia with major neurocognitive disorder.The Preadmission Screening and Resident Review (PASRR) screening dated 7/29/25 provided by the facility documented the Level I screen showed Resident #104 to have evidence of a primary neurocognitive disorder/dementia. Further PASRR evaluation had not been required because Resident #104 neurocognitive disorder/dementia is so progressed that it was considered to be the primary condition requiring treatment at the time of the review. The PASRR documented the following for Resident #104: A diagnosis of dementia/neurocognitive disorder. Difficulty recognizing familiar people or familiar objects. Significant short-term memory impairment. Significant long-term memory impairments.The admission Agreement lacked an effective date. The admission Agreement had been signed by Resident #104 and lacked signatures of a legal representative and the facility's authorized agent. The admission packet included the following attachments:Attachment 1: Consent to admission and TreatmentAttachment 2: Physician Contacts and Room RatesAttachment 3: Authorization and AssignmentsAttachment 4: Consent to Photograph/Publish & Mail ProcessingAttachment 5: Advance Directive Guidance & DocumentationAttachment 6: Notice of Bed Hold Policy and ReturnAttachment 7: Notice of Privacy PracticesAttachment 8: HIPAA Contact IdentificationHealth Information Portability and Accountability ActAttachment 9: Alternative Dispute ResolutionAttachment 10: Electronic Monitoring Devices Policy and ProhibitionsAttachment 11: Transfers and DischargesAttachment 12: Rules Regarding Selected PayorsAttachment 13: Residents Rights Federal Code of RegulationAttachment 14: Iowa Resident Rights & DignityAttachment 15: State Agencies and Advocacy GroupsReview of Attachment #9 Alternative Dispute Resolution documented Resident #104 had accepted the terms and conditions of the Alternative Dispute Resolution agreement. The Alternative Dispute Resolution agreement revealed Resident #104's signature and lacked the date of Resident #104's signature. The agreement lacked signatures of a legal representative, the facility's authorized agent. Resident #104's EHR Census documented an admission date of 8/6/25. The EHR Profile (Face Sheet) listed the son of Resident #104 as the Responsible Party and Emergency Contact. A Brief Interview for Mental Status (BIMS) assessment dated [DATE] identified a score of 7, indicating severe cognitive impairment. In an interview on 8/13/25 at 8:21 AM, Resident #104 verbalized she was unsure of the day of the week and didn't know where she was at. Resident #104 reported she didn't remember signing any paperwork when she arrived in the facility. Resident #104 verbalized she didn't understand she had given up the right to litigation in a court proceeding. In an interview on 8/13/25 at 8:31 AM, Staff L, Registered Nurse (RN) reported Resident #14 has dementia, is forgetful and not a good historian. Staff L verbalized she doubted Resident #104 could sign her own legal documents. In an interview on 8/13/24 at 10:41 AM, Resident #104's Primary Medical Provider reported Resident #104 needed shared decision making with her son and wouldn't have known what she had been signing. In an interview on 8/13/25 at 10:53 AM, Staff S, Social Services acknowledged Resident #104 had a BIMS of 7 upon admission to the facility. Staff S reported Resident #104 signs her own paperwork and the Durable Power of Attorney for Healthcare Decisions (DPOA) had not been enacted. Staff S verbalized (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a statement from the Primary Medical Provider is needed to enact the DPOA. In an interview on 8/13/25 at 10:59 AM, Staff T, Licensed Practical Nurse (LPN)/Admissions & Marketing Coordinator reported she is responsible for explaining the admission Agreement and attachments including the Alternative Dispute Resolution to the resident or resident legal representative. Staff T verbalized she reviews the paper work from the hospital and asks the resident questions to determine if a resident is able to sign admission documents. Staff T reported she didn't see anything in Resident #104's hospital records that stated she couldn't make her own decisions. Staff T acknowledged Resident 104's son or daughter hadn't been present when the admission Agreement and attachments had been signed. Staff T acknowledged she witnessed Resident #104 sign the admission Agreement and the Alternative Dispute Resolution agreement. Staff T acknowledged she forgot to sign the agreements as the facility's authorized agent.In an interview on 8/13/25 at 11:48 AM, the Administrator expects the facility representative to sign the admission Agreement and attachments including the Alternative Dispute Resolution as the Facilities Authorized Agent. The Administrator acknowledged the facility lacked policies for the following: To determine if a resident is capable of understanding and signing agreements. To determine if/when a Power of Attorney or Durable Power of Attorney needs enacted.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on clinical record review, observation, facility policy review and staff interview, the facility failed to ensure staff followed infection prevention policies including enhanced barrier precautions for 3 of 3 sampled residents (Resident #4, #6, and #58) who required the use of enhanced barrier precautions and for the staffs' lack of knowledge in the handling of soiled linens. The facility reported a census of 85. 1. The Minimum Data Set (MDS) assessment, dated 7/14/25, identified Resident #4 had diagnoses of cerebral infarction (stroke) and dysphagia (difficulty swallowing). The MDS identified the resident received nutrition enterally (through a feeding tube) and had a severe cognitive impairment. The Care Plan for Resident #4, last revised 5/22/25, identified the resident had an order for nothing by mouth (NPO) and required feeding, medication and hydration through a gastric feeding tube (G-Tube). The Care Plan included a focus on enhanced barrier precautions (EBP) which included interventions of wearing a gown and gloves for all high contact activities. The Care Plan described high contact activities to include care/use of the G-Tube. On 8/11/25 at 11:39 AM, observation of Resident #4's room revealed an EBP sign posted outside the door with instructions to staff regarding the use of gown and gloves with cares. a. A Physician Order, dated 10/29/24, included an order for enteral feed three times per day with Osmolite 1.5 to 2 cartons via gravity, flush G-Tube with 90 milliliters (ml) before and after feeding. On 8/11/25 at 1:37 PM, observation revealed Staff K, Licensed Practical Nurse (LPN), entered Resident #4's room with a mask on. Staff K gloved, poured two cartons of Osmolite eight fluid ounces into an intravenous (IV) bag, and primed the tubing line with the Osmolite. Staff K removed her gloves, donned another pair of gloves without performing hand hygiene (washing hands or using a alcohol based hand rub), opened the G-Tube port located on the resident's abdomen, and utilized a syringe with 30 ml of tap water to flush the G-Tube site. Staff K connected the tubing line with Osmolite to the G-Tube port and started the tube feeding. Staff K rinsed out the syringe in the sink, removed her gloves, and washed her hands. Staff K failed to wear a gown per the resident's care plan and facility EPB policy. b. A Physician Order, dated 10/29/24, included an order for Baclofen oral tablet 20 milligrams (mg), give one tablet via G-Tube three times per day. On 8/12/2025 at 10:50 AM, Staff L, Registered Nurse (RN), crushed the resident's Baclofen into a powder prior to entering Resident #4's room. Staff L mixed the Baclofen with 30 ml of tap water, performed hand hygiene and gloved. Staff L checked for placement of the G-Tube by opening the port of the G-tube, inserting a syringe with air into the G-Tube and listening to the air insertion with a stethoscope to the G-Tube site. Staff L put the Baclofen and water mix into the syringe. Staff K inserted the syringe into the G-Tube port and administered the medication. After administering the medication, Staff L closed the G-Tube port, covered the resident up, removed her gloves and washed her hands. Staff L failed to wear a gown while performing the task of accessing the resident's G-Tube per the resident's Care Plan and facility EPB policy. 2. The MDS assessment for Resident #58, dated 7/11/25, identified a diagnosis of heart failure, and revealed the resident had two Stage 2 (partial loss of skin which presented as a shallow open ulcer or intact blister) pressure ulcers, and one Stage 3 (full thickness tissue loss with possible visualization (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of subcutaneous fat) pressure ulcer. The resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 (indicative of a severe cognitive impairment). The Care Plan for Resident #58, last revised 8/12/25, revealed the resident had a Stage 3 ulcer to the right sacrum and two Stage 2 ulcers to the left sacrum. The Care Plan included an intervention for Advanced Barrier Precautions due to the wound requiring a dressing. A Physician Order, dated 7/24/25, included orders to cleanse wound areas on the sacrum and left buttock, use one package of Collagen Powder in 15 ml of Triad (cream), apply wound paste topically to open wounds, cover with sacral heart silicone bordered foam every other day and every 12 hours as needed for soiling. On 8/11/25 at 11:18 AM, observation of Resident #58's room revealed a lack of sign to indicate the resident was on EBP. On 8/12/2025 at 1:04 PM, Staff L, RN, brought a cart with wound care supplies into Resident #58's room. Staff L put Triad cream into a medication cup. Staff L cut open a package of Collagen wound filler and poured the contents of the package into the Triad cream. Staff L mixed the the medications together, gloved, used 4 by 4 gauze and wound cleanser to clean the affected wound care areas on the resident's left buttocks and right sacrum. The wound beds appeared pink in color and shallow. Staff L removed her gloves, used hand sanitizer and donned gloves. Staff L applied the Triad wound paste mixture with a gloved finger to the affected areas. Staff L removed her gloves, used a hand sanitizer, donned gloves, applied a foam border dressing, pulled the resident's pants up, removed wound supplies and her gloves and sanitized her hands. Staff L failed to wear a gown per the facilities EBP policy and resident's care plan. On 8/12/2025 at 2:02 PM, Staff L, RN, reported that residents with an IV, Foley catheter, or open area should be placed on EBP. Staff L reported EBP included the use of gown, gloves and a splash or face shield if needed. When asked about whether a resident with G-Tube should be on EPB, Staff L did not have response. When asked about Resident #58 and whether not he should be on EBP, Staff L explained that she did not consider the wounds open any more. Staff L reported that the facility usually had a supply of gowns, but not in a location near the resident. Staff L explained it was not convenient to have to track down a gown when a resident with EBP needed care. 3. During an observation of emptying a catheter bag on 08/13/2025 at 2:12 PM for Resident #6, Staff I, CNA, applied gloves and began the procedure. As she was emptying the drainage bag into the graduate, she explained she should have put on a gown and mask to be in compliance with enhanced barrier precautions. 4. During a tour of the laundry area on 8/13/25 at 1:24 PM, Staff U, Housekeeping and Laundry Supervisor reported gowns aren't worn when handling soiled linens. Staff U verbalized the only personal protective equipment worn are gloves. Review of Staff U personnel file revealed a Housekeeping/Laundry Supervisor job description revised on 6/3/02. The job description lists the following responsibilities: Develop, maintain, and implement infection control and standard precautions policies and procedures to assure that a sanitary environment is maintained at all times and that housekeeping/laundry aspect and isolation techniques are followed by all housekeeping/laundry personnel. Make sure that appropriate protective clothing and devices are on hand for handling infectious waste and/or blood/body fluids. Staff U signed the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	job description on 7/14/24. In an interview on 8/13/25 at 1:31 PM, the Administrator verbalized the facility has no policy for handling soiled linens and stated gowns are not needed if the linens don't come into contact with their clothing. On 8/13/2025 at 2:27 PM, the Assistant Director of Nursing (ADON) reported that residents placed on EBP had a sign on their door and personal protective equipment (PPE) located outside the door. On 8/14/25 at 10:37 AM, the ADON identified that she was also the Infection Preventionist for the facility. The ADON reported that if staff were doing care for a resident with EBP, staff were expected to wear a gown, gloves and mask. Review of the facility policy, titled Enhanced Barrier Precautions, dated 4/16/24, revealed EBP was an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employed targeted gown and gloves use during high contact resident care activities. Staff obtained orders for enhanced barrier precautions for residents with any of the following: wounds such as pressure ulcers, and indwelling medical devices such as catheters and feeding tubes.