STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165591	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spurgeon Manor	1204 Linden Street Dallas Center, IA 50063

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review the facility failed to develop a care plan to address suicidal ideations and interventions for suicidal precautions for 1 of 3 residents (Residents #1) reviewed for comprehensive care plans. The facility reported a census of 50 residents.Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS identified Resident #1 required partial/moderate assistance with bed mobility and transfers. The MDS included diagnoses of vascular dementia with anxiety disorder and depression. A Hospital Psychiatry Consult Note dated 1/6/26 documented Resident #1 presented from the assisted living care facility for suicidal gestures. Resident #1's daughter was present and reported there had been discussion with the assisted living care facility to transition Resident #1 to a higher level of care given the number of falls she has had despite optimizing her environment. Resident #1 was informed of this which precipitated her using a pen to cut her wrist and using the lens of her glasses to attempt to cut her wrist. The note documented there had been history of one other suicidal gesture using a plastic cup to express her frustration per family report while transitioning care. The note documented clinical impression was non-suicidal self-harm and recommended discharging back to the care facility. A Progress Note titled admission Note dated 1/7/26 at 2:50 PM, documented Resident #1 admitted from the emergency room for suicidal ideation. Review of the Interim Plan of Care dated 1/7/26 and the Comphrensive Care plan initiated on 1/8/26 did not address suicidal ideation or gestures. The plan of care lacked direction or interventions on suicide precautions, what to do if Resident #1 expressed suicidal ideation or attempted self harm.A Progress Note dated 1/24/26 at 5:40 PM documented Resident #1 was in the recliner rubbing a drink coaster across her wrist. Staff A, Licensed Practical Nurse (LPN) asked what she was doing and she stated she was trying to kill herself. Staff A took the coaster away and provided one on one. A Progress Note dated 1/24/26 at 5:48 PM documented Resident #1 was sitting in her recliner, she took off her glasses, twisted them and broke them. Resident #1 made statements about wanting to die. Resident #1 assisted to bed to lie down. Resident #1's daughter notified and one on one provided. A Progress Note dated 1/24/26 at 6:54 PM documented Resident #1 had been in bed with Staff A providing one on one. Resident #1 took off her rings and tried to put them in her mouth to swallow them. Staff A took the rings. Resident #1 then took off her earrings and tried to put them in her mouth and Staff A intercepted the earrings. Resident #1 then reached for the telephone cord on the floor and Staff A took the cord away. Resident #1 kept saying that she wanted to kill herself and just die. The note documented one on one was not working with the nurse sitting with Resident #1.A Progress Note dated 1/24/26 at 7:18 PM revealed Staff A notified the Provider, daughter and called for an ambulance. A Progress Note dated 1/24/26 at 7:32 PM revealed Resident #1 left the facility via ambulance.The Clinical Census revealed Resident #1 was admitted to the hospital on [DATE] and returned to the facility on 2/10/26. Review of the Comprehensive Care Plan revealed the care plan was not updated when Resident #1 return from the hospital on 2/10/26. The care plan was updated on 2/18/26 to include interventions related to self (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165591	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spurgeon Manor	1204 Linden Street Dallas Center, IA 50063

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	harm. On 4/21/26 at 11:40 AM, the Director of Nursing (DON) acknowledged she had updated Resident #1's care plan to include interventions related to self harm on 2/18/26. The DON said she would have expected self harm and interventions to be addressed prior to 2/18/26 on the baseline care plan and comprehensive care plan. On 4/21/26 at 2:25 PM, the MDS Coordinator acknowledged the comprehensive care plan was not updated when Resident #1 returned from the hospital. She said she had 19 assessments due that week and no help to update the care plans.The facility policy titled Comprehensive Care Plans revised 2025 documented it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. f