| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165602 | A. Building<br>B. Wing | 07/01/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Prestige Care Center of Fairfield | 400 Highland Street<br>Fairfield, IA 52556 |

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

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, resident representative and staff interviews, the facility failed to notify the family and the physician that 1 of 1 resident (Resident #21) reviewed for notification missed six doses of an anti-anxiety medication scheduled for administration two times daily. The facility reported a census of 54 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The list of diagnoses included anxiety disorder, and the resident prescribed an anti-anxiety medication. Review of the Clinical Physician Orders section in the electronic health record (EHR) revealed an order for Alprazolam tablet 0.5 milligram (mg): take 1 tablet by mouth twice daily for anxiety. Start Date: 5/18/26.Review of the June 2026 Medication Administration Record (MAR) revealed a Resident #21 did not receive the alprazolam on the following dates and times due to the medication being on order: 6/1/26 AM and PM doses, 6/2/26 AM dose, 6/3/26 AM and PM doses, and 6/4/26 AM dose.During an interview on 6/30/26 at 12:54 PM, the Resident #21's resident representative stated Resident #21 had been out of antianxiety medication for 3 days and in the past when the medication stopped in the hospital did not react well and at one point reported seeing bugs crawling on the ceiling. The resident representative stated they were not notified about Resident #21 being out of the medication prior to the resident representative asking.During an interview on 6/30/26 at 5:15 PM, Staff B, Registered Nurse (RN) stated family and the provider need to be notified when a resident did not receive the prescribed medication.During an interview on 7/1/26 at 10:32 AM, Staff O, Nurse Practitioner stated she should of been notified Resident #21 being out of the alprazolam prior to June 4th. During an interview on 7/1/26 at 12:28 PM, the Director of Nursing confirmed the family should have been notified of the missed doses. The DON stated the provider should have also been notified of the medication not coming in to see if a new script needed sent in. Review of the facility policy titled Notification of Changes revised on 3/2025 revealed the a Policy statement which declared: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification.The Compliance Guidelines section directed: The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification.2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on clinical record review, policy review, and staff interview, the facility failed to ensure the provision of a routine medication for 1 of 7 residents reviewed for medications (Resident #9). The facility reported a census of 54 residents.Findings included:The Minimum Data Set(MDS) assessment tool, dated 4/23/26, listed diagnoses for Resident #9 which included heart failure, obesity, and high blood pressure. The MDS listed a Brief Interview for Mental Status(BIMS) score as 15 out of15, indicating intact cognition. A 7/11/25 Nursing Note listed a new order for fluticasone (a nasal spray used to reduce inflammation) 50 micrograms (mcg) 2 sprays daily in the morning.A 7/12/25 Nursing Note stated the medication was unavailable. A 9/20/25 eMar (electronic Medication Administration Record) note stated the medication was not in the facility.Progress Notes on the following dates stated the medication was on order: 2/7/26, 2/8/26, 2/9/26, 2/10/26, 4/14/26, 5/16/26.A 6/26/26 eMar note stated the medication could not be located. On 7/1/26 at 12:13 p.m., the Director of Nursing (DON) stated fluticasone was located in the carts and there were 2 extra bottles in the building.The facility policy Medication Reordering, dated 4/19, stated the facility would accurately and safely provide pharmaceutical services including the provision of routine medications. The policy directed staff to reorder medications if less than 6 doses remained. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>Based on observation, clinical record review, policy review, and staff interview, the facility failed to ensure a medication error rate less than 5 percent when a medication administration observation resulted in a 7 percent error rate. The facility reported a census of 54 residents.Findings included:<br><br>1. The Minimum Data Set (MDS) assessment tool, dated 4/4/26, list of diagnoses for Resident #42 included anxiety, depression, and muscle weakness. The Brief Interview for Mental Status (BIMS) score of 8 out of 15, indicates a moderate cognitive impairment.<br><br>The June 2026 Medication Administration Record (MAR) for Resident #42 listed a 2/2/26 order for sucralfate (an oral medication used to coat the stomach in order to prevent ulcers) 1 gram, 1 tablet by mouth twice daily. The order directed staff to make this into a slurry (a semi-liquid mixture of solids suspended in a liquid, usually water) and administer 1 hour prior to meals.<br><br>During an observation on 6/29/26 at 3:02 p.m., Staff J Licensed Practical Nurse (LPN), administered Resident #42, 1 gram of sucralfate in a tablet form with water without making a slurry. The facility Meal Serving Times schedule listed a dinner time of 5:45 p.m. for Resident #42's unit.<br><br>On 7/1/26 at 12:13 p.m., the Director of Nursing (DON) stated staff should follow orders and give sucralfate within an hour of eating. She stated Resident #42's unit did not eat until 6:00 p.m.<br><br>2. Review of the Clinical Physician Orders listing for Resident #21 revealed, in part, the following orders:<br><br>a. Senna Plus 8.6-50 mg tablet, take two tablets by mouth twice daily for constipation with a start date of 5/18/26.<br><br>b. Lidocaine Patch Pad 4 percent, apply one patch topically and change daily (apply at 8:00 AM and remove at 8:00 PM).<br><br>During an observation on 6/29/26 starting at 10:40 a.m., Staff M, Registered Nurse (RN), set up medications to administer to Resident #21. Medications placed into a pill cup included Senna Plus 8.6-50 mg, one tablet. Staff M reported she was looking for the Lidocaine patches for Resident #21, and was unable to find them. Staff M reported she had to order more Lidocaine patches from the pharmacy, and the pharmacy would not deliver the patches until later that evening.<br><br>At 10:51 a.m., Staff M administered medications to Resident #21 which failed to include two Senna Plus tablets.<br><br>Review of the June 2026 MAR revealed Staff M, RN, documented a 9 for the 6/29/26 Lidocaine patch. The MAR Chart Code indicated a 9 = Other/See Nurses Notes.<br><br>Review of progress notes revealed a noted entered on 6/29/26 titled E-MAR Medication Administration which documented Lidocaine 4 percent patch was on order.<br><br>Review of the facility policy, titled Medication Reordering, dated 6/2026, revealed, in part, the facility will utilize a systematic approach to provide or obtain routine and emergency medications and biologicals in order to meet the needs of each resident .Acquisition of medications should be<br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | completed in a timely manner to ensure medications are administered in a timely manner .Each time a nurse is administering medications and observes (6) or less doses left of one kind, that nurse will reorder the medication, time permitting. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, provider and staff interviews, the facility failed to reorder a medication and utilize the emergency pharmacy stock in an effort to prevent a resident from missing six doses of an anti-anxiety medication for 1 of 11 residents (Resident #21) reviewed for medication administration. The facility reported a census of 54 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The list of diagnoses included anxiety disorder, and the resident prescribed an anti-anxiety medication. Review of Resident #21's Care Plan dated 3/18/26, revealed a Focus area to address [name redacted, Resident #21] uses anti-anxiety medications r/t (related to) anxiety disorder. 3/17/26 GDR (Gradual dose reductions) declined for Alprazolam- [name redacted, Resident #21] refuses to try because she has taken this medication for so long. Interventions include, in part: Administer anti-anxiety medications as ordered by physician. Monitor for side effects and effectiveness every shift. Revised: 9/10/25. Review of the Clinical Physician Orders section in the electronic health record (EHR) revealed an order for Alprazolam tablet 0.5 milligram (mg): take 1 tablet by mouth twice daily for anxiety. Start Date: 5/18/26Review of the June 2026 Medication Administration Record (MAR) revealed a Chart Code which indicated a 9 = Other/See Nurses Notes. A 9 documented on the June 2026 MAR on the following days:a. On 6/1/26 during the 1000-1200 (10 AM to 12 PM) and 1500-1700 (3 PM to 5 PM) scheduled times. 1. A Nursing Note entered on 6/1/26 at 1:26 PM documented: on order.b. On 6/2/26 during the 1000-1200 scheduled time.1. A Nursing Note entered on 6/2/26 at 1:07 PM documented: on order.c. On 6/3/26 during the [PHONE NUMBER] and 1500-1700 scheduled times. 1. A Nursing Note entered on 6/3/26 at 11:19 AM documented: out of medication;2. And a Nursing Note entered at 6:57 PM documented: on order. d. On 6/4/26 during the 1000-1200 scheduled time. 1. A Nursing Note entered on 6/4/26 at 10:41 AM documented: on order. During an interview on 6/30/26 at 1:06 PM, Resident #21 stated there had been an issue with her medications running out and she had to wait 3 or 4 days before receiving it. During an interview on 6/30/26 at 5:15 PM, Staff B, Registered Nurse (RN) queried on Resident #21 being out of her alprazolam and Staff B stated she tells the Certified Medication Aides to let Staff B know when there are 5-7 days left on the cards so Staff B can order it. Staff B stated the nurse needed to notify the provider if the medication didn't come in. During an interview on 7/1/26 at 10:32 AM, Staff O, Nurse Practitioner queried on Resident #21 alprazolam and Staff O stated she placed an order on 4/28/26 for 5 refills and then put in another order on 6/4/26 for 60 tablets. Staff O stated the facility asked for refills from the pharmacy and typically contacted her if they didn't receive it in 2-3 days. Staff O stated staff would request a refill 4 to 5 days prior to running out of the medication.During an interview on 7/1/26 10:47 AM, Staff P, CMA queried on Resident #21 alprazolam and Staff P stated Resident #21 was out of the alprazolam for a couple of days. Staff P stated if she was not able to order on the computer, Staff P would take the reorder sticker off the card and fax it to the pharmacy. During an interview on 7/1/26 at 11:08 AM, Staff Q, Pharmacy Technician queried on when the last refill request received for an alprazolam refill for Resident #21 and Staff Q stated he didn't see any requested for refills between 4/28/26 and 6/4/26. Staff Q stated the pharmacy might not have received the request if a fax or email did not go through. Staff Q queried if the 4/28 order was current prior to the new order on 6/4 for Resident #21 medications and Staff Q stated yes, the order was current until September 2026. During an interview on 7/1/26 at 12:01 PM, Staff C, Licensed Practical Nurse (LPN) queried on Resident #21 alprazolam order and Staff C wasn't sure why it didn't come in. Staff C confirmed Resident #21 not receiving the medication for multiple doses was little excessive. During an interview on 7/1/26 at 12:28 PM, the Director of Nursing (DON) queried on Resident #21 not receiving the alprazolam for multiple doses and the DON stated she remembered the pharmacy not sending it and needing a new order. The DON<br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | stated she thought the medication was in their emergency stock medication. The DON stated she would have checked the emergency stock and pulled from there and called the pharmacy to see why the pharmacy didn't send it. The facility policy titled Reordering Medication Policy revised 6/2026, revealed a Policy statement which declared: It is the policy of this facility to accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals in a timely manner to meet the needs of each resident. The Policy Explanation and Compliance Guidelines section directed, in part:1. The facility will utilize a systematic approach to provide or obtain routine and emergency medications and biologicals in order to meet the needs of each resident.2. Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner.3. Each time a nurse is administering medications and observes (6) or less doses left of one kind, that nurse will reorder the medication, time permitting. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, facility policy review, resident and staff interviews, the facility failed to ensure that dietary staff served meals that met the therapeutic needs (Resident #18) and preferences (Resident #49) for 2 of 5 residents reviewed for diet orders. The facility reported a census of 54 residents.Findings include: 1.Review of the Minimum Data Set (MDS) Assessment for Resident #18, dated 5/1/2026, revealed a Brief Interview for Mental Status (BIMS) score of 0 out of 15, indicating a severe cognitive impairment. The list of diagnoses included diabetes, aphasia (difficulty swallowing) and morbid obesity. The MDS identified Resident #18 as dependent on staff for eating, and the received a mechanically altered, and therapeutic diet. Review of Resident 18's Care Plan dated 5/1/2026, revealed a Focus area to address [name redacted, Resident #18] has a potential nutritional problem of weight fluctuations r/t advanced age, current cognitive status, and need for mechanically altered diet w/full feeding assistance. Interventions included, in part: Provide, serve diet as ordered. Res (resident) to receive small portions and double protein to promote weight loss per provider.Review of the Clinical Physician Orders revealed an order for Regular diet, *Pureed texture, thin consistency, small portions, double protein. Start Date: 5/15/2024.During an observation on 6/29/2026 that started at 11:29 AM, Staff R, Cook, prepared two servings of pureed food items for one resident with a puree diet order (Resident #18). Review of the Week 2 menu revealed the noon meal to consist of: country fried steak, mashed potatoes, cream gravy, honey buttered carrots, bread/[NAME](erine), banana berry cup and milk. Staff R placed three (three servings) country fried steak patties into a blender with beef broth and pureed the mixture. The Dietary Manager then split the 3 servings of protein between two resident plates, placing 1.5 servings on each resident's plate. The Dietary Manager reported Resident #18 had a puree diet order with double serving of protein. Staff R, [NAME] also prepared three servings each of pureed carrots, mashed potatoes, and bread and divided the servings between the two residents. Resident #18 received 1.5 servings of each food item. At 12:04 PM, Staff R, Cook, started the lunch meal service. Staff R sent out a divided plate with pureed food for Resident #18. At 12:32 PM, Resident #18 noted to have eaten 100 percent of the lunch meal. 2. Review of the MDS Assessment for Resident #49, dated 4/3/2026, revealed a BIMS score of 0 out of 15, indicating a severe cognitive impairment. The list of diagnoses included stroke, chronic respiratory failure and malnutrition. The MDS identified Resident #39 dependent on staff for eating and required a mechanically altered diet. Review of Resident #49 Care Plan dated 4/3/2026, revealed, a Focus area to address [name redacted, Resident #49] is at nutritional risk as diet is mechanically altered/therapeutic diet and thickened liquids as ordered.Interventions included, in part: Provide diet as ordered and record intake. Staff to provide feeding assistance. Review of the Clinical Physician Orders revealed an order for General diet, mechanical soft texture, nectar consistency for pleasure diet per resident's request. Start Date: 4/4/25.Review of a Nurse Practitioner Progress Note dated 10/14/25 revealed in part: Plan: Dysphagia following cerebral infarction: Continues on mechanical soft diet despite speech therapy recommendations of pureed food. Is now taking pills orally with applesauce per speech therapy recommendations, no episodes of choking, difficulties taking meds noted. Review of a physician's progress note, dated 10/14/2025, revealed, in part, a plan for dysphagia treatment following cerebral infarction .continues on mechanical soft diet despite speech therapy recommendations of pureed food. Review of a progress note, titled RD (Registered Dietician) Q (quarterly) review, dated 6/29/2026, revealed, in part, .Weight shows no sig changes over past 30 (days)/180D (days). Reg ([NAME]) Mechanical soft, nectar thick diet continues with good po (oral) intakes noted .Continue current POC (plan of care).During an observation on 6/28/2026 at 12:28 PM, Resident #49 served her lunch with consisted in part of whole barbeque pork rib patty. Staff V, Certified Nursing Assistant (CNA) cut up the rib patty and started to feed Resident #49. The resident<br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | ate 3 to 4 bites of meat, and then refused to eat any more meat. During an observation on 6/29/2026 at 12:04 PM, Staff R, [NAME] during the lunch meal served Resident #49 a whole chicken fried steak patty. At 12:32 PM, Resident #49 noted to not have eaten the patty. During an interview on 6/29/2026 at 12:35 PM, Resident #49 communicated she did not ask for meat to be serviced whole, and wanted it to be ground into small pieces. During an interview on 6/30/2026 at 1:33 PM, the Dietary Manager (CM) stated Resident #18 received 1.5 servings of protein instead of two servings, and confirmed the resident received an extra half serving instead of small portion for carrots, potatoes and bread. The DM explained he had sent out mechanical soft food to Resident #49 in the past, and the resident had sent it back and requested regular instead of ground meat. Review of the facility's policy, titled Therapeutic Diet Orders, 11/2025, revealed, in part, the facility provides all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, facility policy review and staff interview, the facility failed to ensure dietary staff prepared and served food in accordance with safe hygienic practices to prevent cross-contamination of foods for 1 of 1 observation of a meal service. The facility reported a census of 54 residents.Findings include:During an observation on 6/29/2026 at 11:29 AM, Staff R, [NAME] and the Dietary Manager prepared meals. Both staff members wore gloves. Staff R opened a drawer to retrieve a pair of tongs, removed a lid from a steam table container with her gloved hand, and used the tongs to place three chicken-fried steak patties into a blender. Using a 2-ounce spoon, Staff R carried a spoonful of broth from a pan on the stove across the kitchen and added it to the blender. Staff R then reached into a drawer to retrieve a spatula. After pushing the patties further down into the blender, Staff R carried three more spoonfuls of broth across the kitchen, one at a time, to add to the blender. Staff R held her gloved hand under the spoon. Broth spilled into Staff R's gloved hand, and she then poured the spilled broth into the blender. Next, Staff R pureed carrots and mashed potatoes separately. After completing the purees, Staff R removed the lids from the blenders and opened drawers to retrieve spatulas and serving spoons. Staff R then opened a loaf of bread and pulled out three slices of bread using her gloved hand. She placed the bread into a blender with milk and pureed it. Staff R wore the same pair of gloves throughout the entire observation.During an observation on 6/29/26 at 12:04 PM, Staff R, Cook, started lunch meal service. Staff R used her gloved hands to take lids on and off food throughout the meal service. Staff R used tongs and spoons to serve the food. After dishing up food for the sixth resident, Staff R reached into a refrigerator, located behind the steam table, to get out barbeque sauce. Staff R squirted sauce onto a resident's plate and then returned the sauce to the refrigerator. Staff R observed touching a plastic-coated menu located on the top of the steam table with each resident meal plated. During preparing the eighth resident plate, Staff R reached her gloved hand into a loaf of bread, pulled out a slice, and placed it on the plate. Staff R then reached into the refrigerator to get butter patties. Staff R reached into the loaf of bread with her gloved hand to grab a slice of bread for each of the last three residents with a room tray. Staff R wore the same pair of gloves throughout the entire observation.During an interview on 6/30/2026 at 1:33 PM, the Dietary Manager (DM) stated dietary staff needed to wash their hands when going from the dining room to the kitchen, before putting on and after taking off gloves. The DM stated dietary staff needed to change their gloves after touching food, touching their face or any part of their body, after touching surfaces such as opening the refrigerator or opening drawers. Review of the facility's policy, titled Food Safety Requirements for Outside of Vendor Food Source Policy, dated 1/2026, revealed, in part, when preparing food, staff shall take precautions in critical control points in the food preparation process to prevent, reduce, or eliminate potential hazards .Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects .Staff shall wash hands according to facility procedures .Staff shall not touch food with bare hands, exhibiting appropriate use of gloves, tongs, deli paper, and spatulas. |