

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165602	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2026
NAME OF PROVIDER OR SUPPLIER Prestige Care Center of Fairfield		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Highland Street 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on a facility list of residents who utilized a mechanical lift, policy review, and staff interviews, the facility failed to launder mechanical lift slings according to manufacturer instructions for 11 of 11 residents who utilized mechanical lift slings. The facility reported a census of 54 residents. Findings included: The undated facility List of Hoyer (a type of mechanical lift) Slings, provided to the survey team on 7/1/26, documented 11 residents who utilized a mechanical lift. During a tour of the laundry on 7/1/26 at 10:15 a.m., Staff H Director of Housekeeping stated the facility dried mechanical lift slings in the dryer at a normal heat setting. She stated the facility did not dry them on a lower heat setting and stated this had been the practice since she began at the facility in 2024. Following the interview, Staff H provided a mesh mechanical lift sling and a solid material mechanical lift sling. Both slings had labels affixed to them which directed staff to air dry or tumble dry the slings at a lower temperature. The facility policy Safe Resident Handling/Transfers revised 6/2026, directed staff to launder mechanical slings according to manufacturer's instructions.		

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 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, 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.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff interview, the facility failed to ensure the provision of pneumococcal and/or influenza vaccines and/or obtain informed consents or declinations for the vaccines for 5 of 5 residents reviewed for immunizations(Residents #2, #8, #10, #21, and #23). The facility reported a census of 54 residents.Findings included:1. The Minimum Data Set (MDS) assessment tool dated 5/21/26 lists diagnoses of chronic pain, morbid obesity, and diabetes for Resident #2. The Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicates intact cognition.Review of the electronic health record (EHR) Clinical - Immunizations section revealed Resident #2 refused the pneumococcal vaccine. The EHR lacked documentation that the staff educated the resident or her representative on the risks and benefits of the vaccine, and of the resident's declination. 2. The MDS assessment tool dated 5/15/26 lists diagnoses of heart failure Alzheimer's disease, and non-Alzheimer's dementia for Resident #8. The BIMS score of 6 out of 15, indicates severely impaired cognition. Review of the EHR Clinical - Immunizations section revealed Resident #8 received the Prevnar 20 (a type of pneumococcal vaccine) on 10/28/25. The EHR lacked documentation that the staff educated the resident or her representative of the risks and benefits of the vaccine, and of the resident's consent for the vaccine.3. The MDS assessment tool dated 4/1/26 lists diagnoses of heart failure, abnormal posture, and muscle weakness for Resident #10. The BIMS score of 4 out of 15, indicates intact cognition. Review of Resident #10's EHR Clinical - Immunizations section revealed a lack of documentation to indicate if the resident received or refused the influenza or pneumococcal vaccine. The EHR lacked documentation that the staff educated the resident or his representative on the risks and benefits of the vaccine, and the resident's consent for or declination of the vaccine.4. The MDS assessment tool dated 6/6/26 lists diagnoses of anxiety, depression, and muscle spasms of the back for Resident #21. The BIMS score of 15 out of 15, indicates intact cognition. Review of the EHR Clinical - Immunizations section revealed Resident #21 received the Prevnar 20 vaccine on 10/21/25. The EHR lacked documentation that the staff educated the resident or her representative of the risks and benefits of the vaccine, and the resident's consent for the vaccine.5. The MDS assessment tool dated 3/28/26 lists diagnoses of non-Alzheimer's dementia, depression, and insomnia for Resident #23. The BIMS score of 12 out of 15, indicates moderately impaired cognition.Review of the EHR Clinical - Immunizations section revealed Resident #23's received a PPSV23 (a type of pneumococcal vaccine) on 12/4/19 and PCV13 (a type of pneumococcal vaccine) on 11/28/18. The EHR lacked documentation to indicate if the resident received or declined the most current pneumococcal vaccine (Prevnar 20), and lacked documentation that the staff educated the resident or her representative on the risks and benefits of the vaccine, and the resident's consent for or declination of the vaccine.On 7/1/26 at 12:13 p.m., the Director of Nursing (DON) stated residents should be up to date on their immunizations. The Center for Disease Control and Prevention's (CDC's) Pneumococcal Vaccine Recommendations, dated 2/25/26, retrieved from https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html on 7/7/26, stated adults over the age of 65 years or older had the option to receive PCV 20 or 21(types of pneumococcal vaccinations) if they received both PCR13 and PPSV23 over the age of [AGE] years old.The facility policy Influenza Vaccination, revised 10/2025, stated the facility offered residents annual immunization against influenza. Prior to administration, the facility would provide the resident with information regarding the benefits and potential side effects of the vaccine.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on clinical record review, policy review, and staff interview, the facility failed to ensure the provision of COVID-19 vaccine for 1 of 5 (Resident #10) residents, and failed to obtain an informed consent or declination for the vaccine for 5 of 5 (Resident #2, Resident #8, Resident #10, Resident #21, and Resident #23) residents reviewed for immunizations. The facility reported a census of 54 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool dated 5/21/26 lists diagnoses of chronic pain, morbid obesity, and diabetes for Resident #2. The Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicates intact cognition. Review of the electronic health record (EHR) Clinical - Immunizations section revealed Resident #2 refused a COVID -19 vaccine. The EHR lacked documentation that staff educated the resident or her representative on the risks and benefits of the vaccine, and of the resident's declination. 2. The MDS assessment tool dated 5/15/26 lists diagnoses of heart failure Alzheimer's disease, and non-Alzheimer's dementia for Resident #8. The BIMS score of 6 out of 15, indicates severely impaired cognition. Review of the EHR Clinical Immunization section revealed Resident #8 received a COVID -19 booster on 1/8/26. The EHR lacked documentation that staff educated the resident or her representative on the risks and benefits of the vaccine, and of the resident's consent. 3. The MDS assessment tool dated 4/1/26 lists diagnoses of heart failure, abnormal posture, and muscle weakness for Resident #10. The BIMS score of 4 out of 15, indicates intact cognition. Review of Resident #10 EHR Clinical Immunization section revealed a lack of documentation to indicate if the resident received or refused a COVID-19 vaccine. The EHR lacked documentation that staff educated the resident or his representative on the risks and benefits of the vaccine, and resident's consent for or declination of the vaccine. 4. The MDS assessment tool dated 6/6/26 lists diagnoses of anxiety, depression, and muscle spasms of the back for Resident #21. The BIMS score of 15 out of 15, indicates intact cognition. Review of Resident #21's EHR Clinical Immunization section revealed she received a COVID -19 booster on 1/8/26. The EHR lacked documentation that the staff educated the resident or her representative on the risks and benefits of the vaccine, and the resident's consent. 5. The MDS assessment tool dated 3/28/26 lists diagnoses of non-Alzheimer's dementia, depression, and insomnia for Resident #23. The BIMS score of 12 out of 15, indicates moderately impaired cognition. Review of Resident #23's EHR Clinical Immunization section revealed she received a COVID-19 booster on 1/8/26. The EHR lacked documentation that the staff educated the resident or her representative of the risks and benefits of the vaccine, and the resident's consent. On 7/1/26 at 12:13 p.m., the Director of Nursing (DON) stated residents should be up to date on their immunizations. The facility policy COVID-19 Vaccination, revised 12/2025, stated the facility would minimize the risk of acquiring, transmitting or experiencing complications from COVID-19 by educating and offering residents the COVID-19 vaccine. The facility would provide education regarding the risks, benefits, and potential side effects of the COVID-19 vaccine. The Centers for Disease Control and Prevention's (CDC's) guidance Staying Up to Date with COVID-19 Vaccines retrieved from https://www.cdc.gov/covid/vaccines/stay-up-to-date.html on 7/7/26 stated the CDC recommended a 2025-2026 COVID-19 vaccine for people ages 6 months and older based on individual-based decision-making. The guidance stated protection from the COVID-19 vaccine decreased with time.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, facility policy review, resident and staff interview, the facility failed to ensure staff treated residents with dignity and respect for 2 of 18 sampled residents (Residents #13 and Resident #40). The facility reported a census of 54 residents. Findings include: 1. Review of Resident #13's Minimum Data Set (MDS) assessment dated [DATE], revealed intact cognition based on a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Diagnoses included irritable bowel syndrome, and morbid obesity. The MDS indicated an upper body impairment on one side and lower body impairments on both sides. The resident dependent on staff for toileting, hygiene, and transfers, needs partial assistance to roll in bed, and always incontinent of urine and frequently incontinent of bowel. During an observation on 6/29/26 at 2:22 PM, Staff K, Certified Nurse's Aide (CNA), answered the call light for Resident #13. Staff K knocked on the closed room door, entered and shut the door behind herself. At 2: 33 PM, Staff K, CNA, knocked and entered Resident #20's room to assist Staff L, CNA, with a mechanical lift transfer. Both Staff K and Staff L completed the transfer and exited Resident #20's room at 2:48 PM. At 2:48 PM, Staff D, CNA, exited Resident #13's room, shut the door behind him and grabbed a pair of gloves located outside of the room door. During an interview with Staff D, he stated Resident #13 did not have a brief on and that was a problem. Staff D then knocked on Resident #13's door, and after the resident acknowledged him, he entered the room. Upon entering, Resident #13 found to be facing away from the door with her buttocks uncovered and exposed to the open doorway. A strong bowel movement smell present in the room. Staff L, CNA, knocked and entered the room. Staff D came out of Resident #13's room and stated when he initially entered the room he found the resident to have a bare bottom. Staff D got supplies, including wet wipes, a cloth bed chux (type of reusable incontinent pad placed under residents) and bed linens, and then returned to Resident #13's room. Staff D and Staff L exited the resident's room at 2:58 PM. During an interview on 6/29/2026 3:01 PM, Resident #13 identified Staff K, CNA, as the staff who responded to her call light. The resident was unsure if Staff K had assisted her on or off the bed pan. The resident thought she had already had a BM, and had put her call light on to request assistance with getting cleaned up. The resident reported an inability to roll herself in bed without assistance, and stated the first staff had left on her right side facing away from the room door with her bottom bare. The resident reported Staff K couldn't find the supplies she needed and left the room. Resident #13 reported Staff K returned at some point and dropped off a bed chux on her sink counter. Observation revealed a folded cloth bed chux on the resident's counter by her sink. The resident denied being upset, and stated she had been unclear as to why the aide left and did not return promptly. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/29/2026 at 3:06 PM, Staff K, CNA, reported she responded to Resident #13's call light. The resident asked to get off the bedpan. Staff K reported she took the resident off the bedpan, and the resident had not gone to the bathroom yet. Staff K reported the resident did not have the supplies she needed in the room except for briefs. Staff K left to find a bed chux and wet wipes. During the interview, Staff K reported she had still not been able to find the supplies she needed. Staff K reported being unsure if she had left the resident covered or not when she left the room. During an interview on 6/29/2026 at 3:18 PM, Staff D, CNA, stated he walked into Resident #13's room to check on her. He found the resident on her right side, facing away from door with her bottom bare and large amount of BM on the resident and on her bed. Staff D reported the resident told him that she had been waiting for someone to come in and help her. The resident had him where the aide was and then stated the aide told the resident they would come back. During an interview on 6/29/2026 at 3:42 PM, Staff L, CNA, stated when he went to get help to transfer Resident #20, he found Staff K, CNA, by the linen closet. Staff K told him that she was getting a chux for Resident #13's bed, and she would be there to help Staff L after she put the chux in Resident #13's room. Staff L reported Staff K did not say anything about Resident #13 waiting on Staff K for assistance. During an interview on 7/01/2026 at 12:14 PM, the Director of Nursing reported it was acceptable to leave a resident's room to get supplies, but it was not acceptable for staff to leave to help another resident once the CNA had started cares on a resident. 2. The MDS assessment dated [DATE] revealed Resident #40 scored a 15 out of 15 on the BIMS exam, which indicated cognition intact. During an interview on 7/1/26 at 9:31 AM, Staff D, Certified Nurse Aide (CNA) queried on staff interactions with residents and he stated he had heard Staff E, Dietary Aide call Resident #40 a ***ch. Staff D stated Staff E had been upset he needed to remake a plate for the resident. Staff D stated Staff E also told the resident You should know what you wanted. Staff D stated the incident occurred in early June 2026 During an interview on 7/1/26 at 1:21 PM, Staff E, Dietary Aide queried about the incident with Resident #40 and Staff E stated he cussed around Resident #40 but not at her. Staff E asked why he cussed and Staff E stated because he tended to cuss when talking. Staff E queried on what he said and Staff E stated he didn't remember. During an interview 7/1/26 at 2:15 PM, the Administrator queried on the incident dietary staff in the dining room and the Administrator stated she knew something about Staff E getting loud in the dining room and the Administrator had a meeting with the dietary team about appropriate conversations and language. Review of the facility policy titled Resident Rights Policy dated 2/2026 revealed a Policy Explanation and Compliance Guidelines section which directed, in part: All residents will be treated equally regardless of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, resident and staff interview, the facility failed to ensure staff informed the residents and families of the risks, benefits and side effects of psychotropic medications prior to the administration of those medications for 3 of 3 residents sampled (Residents #54, #7 and #11). The facility reported a census of 54 residents. Findings include: 1. Review of the Minimum Data Set (MDS) Assessment for Resident #54 dated 4/20/26, revealed a Brief Interview for Mental Status (BIMS) score of 2 out of 15, which indicated the resident had a severe cognitive impairment. The MDS listed a primary diagnosis of senile degeneration of the brain. The MDS indicated the resident prescribed antipsychotic and antidepressant medications. Review of Resident #54's Care Plan, last revised 4/20/26, revealed, in part, the following Focus areas and Interventions: a.uses antidepressant medication. 4/9/25 increase in Lexapro. Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of anti-depressant drugs being given. b. The resident uses psychotropic medications r/t hallucinations. 1/14/26 new order for Quetiapine bid added to Risperidone started on the 10th (1/10/26). Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of psychotropic medication drugs being given. Review of the Clinical Physician Orders listing, revealed the following psychotropic medication orders: a. quetiapine (generic Seroquel, an antipsychotic) 50 milligrams (mg) tablet, take one-half tablet (25 mg) by mouth twice daily with a 6/5/26 start date. b. lorazepam (an antianxiety) 0.5 mg tablet, take one tablet by mouth twice daily with a 5/14/26 start date. c. risperdone (an antipsychotic) 0.5 mg tablet, take one table by mouth every evening with a 1/9/26 start date. d. bupropion (antidepressant) 300 mg extended length tablet, take one tablet by mouth daily with a 12/31/25 start date. A review of the clinical record lacked signed informed consents for the prescribed psychotropic medications prescribed. Review of a separate folder revealed unsigned and undated consent forms for Resident #54, which included bupropion, risperidone, and Seroquel (quetiapine). During an interview on 7/1/26 at 11:14 AM, the MDS Coordinator stated she is responsible for completing psychotropic medication consent forms with the residents and their representatives. She (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she assumed this responsibility after the last Director of Nursing left. She stated she is behind on getting psychotropic consent forms done. The MDS Coordinator added the previous DON had not been gotten consents signed. The MDS Coordinator explained she had not had time to work on the consents due to covering night shifts for the last couple months. The MDS Coordinator reported she had difficulty getting a hold of the responsible person for Resident #54, and just tried again yesterday (6/30/26). During an interview on 7/1/26 at 11:25 AM, the Administrator reported the previous DON left her position in January 2026. During an interview on 7/01/2026 at 12:27 PM, the DON explained nursing staff should complete psychotropic medication consent forms with the residents and families upon admission if the resident already takes the medication. She added nursing staff must also obtain a consent when initiating psychotropic or if there is a change in dosage. The DON explained the purpose of the psychotropic medication consents forms were to inform the residents and families of the risks, benefits and side effects of the medication so they could make an informed decision. 2. Review of Resident #11's MDS assessment tool dated 6/20/26, revealed a BIMS score of 1 out of 15, indicating a severe cognitive impairment. The list of diagnoses included Alzheimer's disease, anxiety, and depression. The MDS indicated the resident prescribed antipsychotic, antianxiety, and antidepressant medications. Review of the June 2026 Medication Administration Record (MAR) revealed Resident #11 prescribed: a. bupropion 150 mg daily. Start Date: 2/12/26. D/C (discontinue) Date: 6/22/26. b. fluoxetine (an anti-depressant) 20 mg daily. Start Date: 6/14/26. D/C Date: 6/22/26. c. haloperidol (an antipsychotic) 1 mg twice daily. Start Date: 10/30/25. D/C Date: 6/22/26. d. lorazepam 2 mg every 2 hours. Start Date: 6/28/26. D/C Date: 6/29/26. e. olanzapine (an antipsychotic) 5 mg twice daily. Start Date: 5/30/26. D/C Date: 6/22/26. f. quetiapine 100 mg twice daily. Start Date: 5/27/26. D/C Date: 6/22/26. g. risperidone 0.5 mg twice daily. Start Date: 6/16/26. D/C Date: 6/20/26. Review of Resident #11's clinical record lacked signed informed consent forms for the prescribed psychotropic medications. 3. Review of Resident #7's MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, which indicated intact cognition. The list of diagnoses included anxiety disorder, depression, schizophrenia, and Post Traumatic Stress Disorder (PTSD). The MDS indicated resident took antipsychotic, antidepressant, and antianxiety medications. (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan revealed the following Focus areas and Interventions: a. Dated 11/25/25, Resident uses antidepressant medications. Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of antidepressant drugs being given. b. Dated 6/18/25, Resident uses psychotropic medications. Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of psychotropic medication drugs being given. c. Dated 11/19/24, Resident uses anti-anxiety medications. Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of anti-anxiety medication drugs being given. Review of the Clinical Physician Orders revealed Resident #7 prescribed: a. trazodone (anti-depressant) 50 mg - take 1/2 tablet by mouth. Start Date: 10/15/25. b. duloxetine HCL (an anti-depressant) 60 mg- give one cap by mouth twice a day. c. clozapine (an antipsychotic) 200 mg- take one tablet by mouth twice daily. Start Date: 5/27/21. d. bupropion tablet 150 mg XL (extended release)- take 1 table by mouth daily. Start Date: 11/25/25. Review of Resident #7's clinical record lacked signed informed consent forms for the prescribed psychotropic medications. During an interview on 6/30/26 at 11:47 AM, Resident #7 stated he never signed consents for his psychotropic medications and the facility really hadn't spoken to him about his psychotropic medications. Review of the facility policy titled Use of Psychotropic Medication revised 5/2026, revealed a Policy statement which declared: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). The Policy Explanation and Compliance Guidelines section directed, in part: 5. Residents and/or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm 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. **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.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review and staff interviews, the facility failed to report an allegation of abuse to the State Agency for 1 of 1 resident reviewed for abuse (Resident #40). The facility reported a census of 54 residents. Findings include: Review of Resident #40's Minimum Data Set assessment dated [DATE], revealed a Brief Scale for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition. During an interview on 7/1/26 at 9:31 AM, Staff D, Certified Nurse Aide (CNA) queried on staff interactions with residents and he stated he had heard Staff E, Dietary Aide call Resident #40 a ***ch. Staff D stated Staff E had been upset he needed to remake a plate for the resident. Staff D stated Staff E also told the resident You should know what you wanted. Staff D stated the incident occurred in early June 2026. When queried on reporting the incident, Staff D stated he did not report the incident and thought Staff G, Certified Medication Assistant (CMA).Review of facility reported incidents on the State Agency database revealed no reports regarding Staff E, Dietary Aide and Resident #40. During an interview on 7/1/26 at 9:58 AM, Resident #40 queried if she had any dietary staff speak to her in an undignified way and Resident #40 stated no, she loved dietary and thought the facility had a great dietary team. During an interview on 7/1/26 at 1:02 PM, Staff F, Registered Nurse (RN), queried on the incident with Resident #40 and Staff F stated she went to the dining room and an aide told Staff F that Staff E was rude to Resident #40. Staff F stated she talked to Staff E and Staff E told her that Resident #40 was rude to him, and Staff E explained he got upset and cussed in front of the resident. Staff F stated she did not remember what was said, but recalled it not appropriate. Staff F asked if the incident had been reported and Staff F stated she did not report it, but thought another staff did.At 1:12 Staff F, RN contacted the State Agency to clarify that she had talked to Resident #40 also. She added she didn't contact the Administrator because as charge nurse she handled the situation. Staff F stated she did not know if the incident was reportable or not, and added it did not happen again so her approach worked. During an interview on 7/1/26 at 1:27 PM, Staff G, Certified Medication Aide (CMA) queried on the incident with Resident #40 and Staff E, Dietary Aide. Staff G stated Staff E told Resident #40 she didn't have to be such a dick. Staff G stated she asked the nurses on duty to come to the unit and while waiting for them to arrive, Staff E continued to be belligerent and used the f word. Staff G said she told Staff E to leave and he went into the kitchen. Staff G stated she did not report the situation to the Administrator because she thought the nurses would report it. Staff G stated a few days later she thought about the incident and thought she should have reported it to the Administrator or the Director of Nursing.During an interview 7/1/26 at 2:15 PM, the Administrator queried on the incident with a Staff E, Dietary Staff and Resident #40 and she stated she knew something about him getting loud in the dining room and she held a meeting with the dietary team about appropriate conversations and language. The Administrator stated at that time she did not know what specifically Staff E had said to Resident #40, and if she had known she would have suspended him and reported the incident.Review of the facility policy titled Abuse, Neglect, and Exploitation revised 1/2025 revealed a Policy statement which declared: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The Definitions sections defined Alleged Violation as a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. The Policy Explanation and Compliance Guidelines section directed, in part: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review and staff interviews, the facility failed to conduct a thorough investigation of an allegation of abuse for 1 of 1 resident (Resident #40) reviewed for abuse. The facility reported a census of 54 residents. Findings include: Review of Resident #40's Minimum Data Set assessment dated [DATE], revealed a Brief Scale for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition. During an interview on 7/1/26 at 9:31 AM, Staff D, Certified Nurse Aide (CNA) queried on staff interactions with residents stated he had overheard Staff E, Dietary Aide call Resident #40 a ***ch. Staff D stated Staff E had been upset he needed to remake a plate for the resident. Staff D stated Staff E also told the resident You should know what you wanted. Staff D stated the incident occurred in early June 2026. When queried on reporting the incident, Staff D stated he did not report the incident and thought another staff reported the incident to the Administrator. During an interview on 7/1/26 at 2:15 PM, the Administrator stated she did know about Staff E, Dietary Aide being loud in the dining room with Resident #40. She stated she talked to the Dietary Staff about interactions with residents. She stated if she had known at the time what specifically was said by Staff E she would have reported the incident to the State Agency, and started an investigation. Review of the facility policy titled Abuse, Neglect, and Exploitation revised 1/2025 revealed a Policy statement which declared: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The Policy Explanation and Compliance Guidelines section directed, in part: V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review, policy review, and staff interview, the facility failed to provide bed hold notices for 2 of 3 residents (Resident #10 and Resident #60) reviewed for hospitalizations. The facility reported a census of 54 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 4/1/26, listed diagnoses for Resident #10 which included insomnia, muscle weakness, and heart failure. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 14 out of 15, indicating intact cognition. A 6/13/26 Activities Note stated the resident had a fall and transferred to the hospital. A 6/15/26 Health Status Note stated the resident returned to the facility. The resident's clinical record lacked documentation of bed hold information relayed to the resident or the resident's representative upon transfer to the hospital. 2. The MDS assessment tool, dated 3/4/26, listed diagnoses for Resident #60 which included heart failure, anxiety disorder, and depression. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition. The resident's clinical record lacked documentation of bed hold information relayed to the resident or the resident's representative upon transfer to the hospital. On 7/1/26 at 12:13 p.m., the Director of Nursing (DON) stated she could not locate bed hold notifications provided to the above residents. She stated the nurse usually verbally explained the bed hold information to the resident upon discharge and the social worker obtained a signature the next day. The facility policy Bed Hold Notice revised 2/2025, directed the facility would provide written information to the resident and/or the resident's representative regarding bed hold practices at the time of a hospital transfer.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interviews, and the facility policy, the facility failed to identify and assess a non pressure skin wound for 1 of 2 residents (Resident #1) reviewed for wounds. The facility reported a census of 54 residents. Findings include: Review of Resident #1's Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of a 13 out of 15 on the exam, indicating intact cognition. The list of diagnoses included hemiplegia/hemiparesis. The MDS indicated Resident #1 required substantial/maximal assistance to change position from sit to lying, sit to stand, and chair/bed-to-chair transfer, and at risk for pressure ulcers. The MDS indicated Resident #1 admitted with no pre-existing pressure ulcers, venous/arterial ulcers, surgical, or diabetic wounds. admission date listed as 6/1/26 from a short-term hospital stay. Review of Resident #1 Care Plan dated 6/16/26 revealed a Focus area to address the resident has potential for actual impairment to skin integrity. During an interview on 6/29/26 at 10:01 AM, Resident #1 stated she had a wound on her right hip. Resident #1 stated she didn't know how it happened and staff noticed it and said they would get cream for it, but didn't. Resident #1 described the area to be about the size of a quarter. Review of Weekly Skin Reviews in the electronic health record (EHR) revealed: a. On 6/5/26 at 10:32 PM: Skin Condition: No boxes checked. (Choices - Skin intact, Dry, Rash, Skin tears, Blisters, Bruise, Open area. The Other section documented: No changes. b. On 6/12/26 at 3:22 PM: Skin Condition: Skin intact checked. c. On 6/19/26 at 9:57 AM: Skin Condition: Skin intact checked. d. On 6/26/26 at 11:12 PM: Skin Condition: Skin intact checked. During an interview on 6/30/26 at 1:27 PM, Resident #1 stated she didn't remember nursing doing skin checks or who noticed the wound on her hip. Resident #1 stated she didn't realize she had the wound until staff pointed it out to her. During an interview on 6/30/26 at 1:47 PM, Staff U, Certified Nurse Aide (CNA) stated she remembered Resident #1 having a patch on her hip when she came in. During an observation on 7/1/26 at 10:07 AM, Resident #1 lowered her incontinence brief to reveal her right upper hip. There was a slightly reddened area with a flat dark brown/black center with peeling skin along the edges. During an interview on 7/1/26 at 10:07 AM, Staff S, Licensed Practical Nurse (LPN) observed Resident #1 wound and stated it appeared like eschar tissue and something that had been there awhile. During an interview on 7/1/26 at 10:25 AM, Staff O, Nurse Practitioner queried on Resident #1 wound and Staff O stated she measured it and it was 1.5 centimeters (cm) x 2.1 cm. Staff O stated Resident #1 noticed it a couple of days ago and Staff O thought the wound was a shear injury. Staff O confirmed staff should have noticed it and notified Staff O of the wound. During an interview on 7/1/26 at 12:42 PM, the Director of Nursing (DON) queried on Resident #1 skin condition and the DON stated it was a communication issue and the DON didn't know who found it first, but the facility would be discussing it at the all training. The DON confirmed the wound should have been reported to the nurse and a risk management needed to be completed. Review of the facility policy titled Skin Assessment revised on 6/2026 revealed a Policy statement which declared: It is our policy to perform a full body skin assessment as part of our systematic approach to pressure injury prevention and management. This policy includes the following procedural guidelines in performing the full body skin assessment. The Policy Explanation and Compliance Guidelines directed, in part: 1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. The assessment should also be performed upon any change in condition or identification of new wound(s) (i.e., pressure injury, no pressure injuries, diabetic ulcers, skin tears, etc.).		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and the facility policy, the facility failed to complete pre and post dialysis assessments 1 of 1 resident (Resident #5) review for dialysis. The facility reported a census of 54 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The list of diagnoses included end stage renal disease (ESRD). The MDS indicated resident received hemodialysis while a resident. Review of Resident #5 Care Plan dated 5/1/26 revealed a Focus area to address [name of redacted, Resident #5] is at risk for complication related to receiving dialysis for diagnosis of ESRD. Interventions initiated on 5/1/26 included, in part: a. Observe for clinical signs of infection at shunt site-redness, hardness, swelling, pain, or pus-like drainage. b. Notify MD and dialysis for s/s of infection; c. Observe for hypotension: Dizzy or light headed with a feeling of passing out. Instruct me to lie down with my head lower than my arms and legs, if possible. Notify my MD if symptoms persist. d. Observe/document edema. Review of the electronic health record (EHR) revealed a. Pre Dialysis Assessments not found for 5/8/26; 5/13/26; 5/18/26; 5/22/26; 5/29/26; 6/1/26; 6/3/26; 6/10/26; and 6/22/26. b. Post Dialysis Assessments not found on 5/22/26 and 6/10/26. During an interview on 6/30/26 at 4:31 PM, Staff A, Licensed Practical Nurse (LPN) queried on the pre and post dialysis assessments and Staff A stated the assessments needed to be completed each time Resident #5 went to dialysis. During an interview on 7/1/26 at 12:05 PM, Staff C, LPN queried on the pre and post dialysis assessments and Staff C stated yes, they complete them and were supposed to check the bruit, thrill, vitals, and weight. Staff C stated the expectation was to complete the assessments every time a resident went to dialysis. During an interview on 7/1/26 at 12:34 PM, the Director of Nursing (DON) queried on the pre and post assessments for Resident #5 and the DON stated the facility just hired a lot of nurses for second shift. The DON asked what should happen and the DON stated when the resident came back from dialysis the vitals, weights, and fistula needed checked and before the resident went to dialysis the fistula needed checked. The DON confirmed the pre and post assessments needed to be completed when residents received dialysis services. Review of the facility policy titled Hemodialysis updated on 4/2024 revealed a Policy statement which declared: The facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the residents goals and preferences, to meet the special medical, nursing, mental and psychosocial needs of resident receiving hemodialysis. The Compliance Guidelines directed, in part: 3. The facility will monitor for and identify changes in the resident's behavior that may impact the safe administration of dialysis before and after treatment and will inform the attending practitioner and dialysis facility of the changes. The nurse will ensure that the dialysis access site (e.g. AV shunt or graft) is checked before and after dialysis treatments and every shift for patency by auscultating for a bruit and palpating for a thrill.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on record review and staff interviews, and the facility policy, the facility failed to perform annual evaluations for 2 of 3 certified nursing assistants reviewed for performance reviews. The facility reported a census of 54 residents. Findings include: 1. Per an email from the Administrator on 6/30/26 at 11:18 AM, Staff D, Certified Nursing Assistant (CNA) had a date of hire of 4/24/25. A review of Staff D's employee file found no annual evaluation. 2. Per an email from the Administrator on 6/30/26 at 11:18 AM, Staff I, CNA had a date of hire of 4/17/25. A review of Staff I's employee file found no annual evaluation. During an interview on 6/30/26 at 4:53 PM, the Administrator stated the facility confirmed annual evaluations had not been completed for Staff D or Staff I. The Administrator stated the evaluations were missed during a transition of Director of Nursing (DON) personnel. During an interview on 7/1/26 at 12:44 PM, the DON explained the Human Resource department gives the DON a list of staff annual evaluations that are due, and it is the DON who is responsible for completing the reviews. Review of the facility policy titled Competency Evaluation dated 5/2024 revealed a Policy statement which declared: It is the policy of this facility to evaluate each employee to assure appropriate competencies and skills for performing his or her job and to meet the needs of facility residents. The Policy Explanation and Compliance Guidelines section directed, in part: Subsequent and/or annual competency is evaluated at a frequency determined by the facility assessment, evaluation of the training program, and/or job performance evaluations.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 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 of 15, 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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 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: 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. 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. 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. 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. 2. Review of the Clinical Physician Orders listing for Resident #21 revealed, in part, the following orders: 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. b. Lidocaine Patch Pad 4 percent, apply one patch topically and change daily (apply at 8:00 AM and remove at 8:00 PM). 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. At 10:51 a.m., Staff M administered medications to Resident #21 which failed to include two Senna Plus tablets. 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. 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. (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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: 5/18/26 Review 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 (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 Level of Harm - Minimal harm or potential for actual harm 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. **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 (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(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 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 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 observation, clinical record review, facility policy review, and staff interview, the facility failed to ensure staff performed hand hygiene during glove changes to prevent the potential spread of infection for 1 of 3 residents observed for wound care treatment (Resident #20). The facility reported a census of 54 residents. Findings include: Review of Resident #20's Minimum Data Set (MDS) assessment tool dated 4/24/26 lists diagnoses of multiple sclerosis, heart failure and peripheral vascular disease. Review of the electronic health record (EHR) an IDT (interdisciplinary team) Note dated 6/25/26 at 11:56 AM revealed, in part: IDT met to review resident's non-pressure skin issue. Resident currently has non-pressure skin issue to right great toe. Review of the EHR revealed a Physician Order for Triple Antibiotic Ointment and Optifoam Gentle 3 dressing applied once daily to the right great toe. During an observation on 6/30/26 at 9:39 AM, Staff O, Advanced Registered Nurse Practitioner (ARNP), and Staff N, Infection Preventionist (IP)/Licensed Practical Nurse (LPN), sanitized their hands and set up supplies to perform wound care on Resident #20's right great toe. Staff O, ARNP, and Staff N, IP/LPN, donned gloves. Staff O, ARNP, uncovered the resident's legs and removed the soft bilateral boots, socks, and tubigrips (a type of soft skin covering) from the resident's lower legs and feet. Staff O then removed the wound dressing covering the resident's right great toe. The dressing contained deep red bloody drainage, and red blood covered the wound site. Staff O, ARNP, removed her gloves, failed to perform hand hygiene, and donned a new pair of gloves. Staff O cleaned the wound using 4x4 gauze and Vashe Wound Wash. Staff O applied antibiotic ointment to the wound bed. Staff O removed her gloves, skipped hand hygiene, and donned a new pair of gloves. Staff O measured the wound, covered it with a small foam dressing, and applied Aquaphor cream to the right lower leg. Staff O removed her gloves, skipped hand hygiene, and donned a new pair of gloves. Staff O applied Aquaphor cream to Resident #20's left lower leg. Staff O removed her gloves and failed to perform hand hygiene before donning a glove on her left hand only. She then pushed hair out of her face with her right hand and opened and closed a drawer of the resident's nightstand to obtain a clean pair of tubigrips. Staff O asked Staff N, IP/LPN, to get her another glove. Staff O donned a glove on her right hand. Staff O failed to perform hand hygiene after removing gloves and prior to donning gloves. Staff O applied a tubigrip cover to the resident's left lower leg. Staff N, IP/LPN, applied a tubigrip on the resident's right lower leg, applied soft bilateral boots, removed her gloves, and washed her hands. Staff O, ARNP, picked up the resident's dirty breakfast dishes with her gloved hands, exited the room, took the dishes to the unit kitchenette, removed her gloves, and washed her hands. During an interview on 6/30/26 at 3:46 PM, Staff N, IP/LPN, stated hand hygiene should be done before starting wound care and with every glove change. Staff N reported gloved hands should be changed after the removal of a wound dressing, after cleaning the wound and after applying the wound treatment/dressing. During an interview on 7/1/26 at 9:31 AM, Staff O, ARNP, stated she knew that she forgot to perform hand hygiene with glove changes while performing wound care on Resident #20 during the observation on 6/30/26. On 7/01/2026 at 12:24 PM, during an interview, the Director of Nursing, (DON), stated staff should be performing hand hygiene with every glove change. Review of the facility policy, titled Hand Hygiene, dated 12/2025, revealed, in part, Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.		