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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2026
NAME OF PROVIDER OR SUPPLIER Rehabilitation Center of Lisbon		STREET ADDRESS, CITY, STATE, ZIP CODE 905 West Main Street Lisbon, IA 52253	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, staff interview, clinical record review, and facility policy review, the facility failed to ensure that interventions to prevent falls were implemented for 1 of 6 residents reviewed for falls (Resident #52). The facility reported a census of 62 residents. Findings include: Review of the MDS assessment, dated 12/03/25, revealed that Resident #52 had a BIMS score of 15/15, which indicated intact cognition. The list of diagnoses included fracture and other multiple trauma, Cerebral Vascular Accident (CVA or stroke), muscle wasting and atrophy. Resident #52 required supervision or touching assistance with transfers and walking. Review of the Care Plan, revised on 12/19/25, revealed a Focus area for Resident #52's need for assistance with ADLs (activities of daily living) due to Type 2 Diabetes Mellitus, Chronic Kidney Disease (CKD), history of Transient Ischemic Attack (TIA or sudden stroke-like symptoms), and limitations due to history of fall with fracture and repair to left hip. Interventions dated 9/5/25 identified that Resident #52 required assistance of one staff member to transfer and one staff member assistance to walk to and from the bathroom using a wheeled walker and gait belt. Review of the Care Plan, revised on 9/08/25, revealed that Resident #52 was at risk for falls. The fall interventions included the following, in part: a. Do not leave unattended in wheelchair when in room. Date initiated: 10/09/25. b. Assist resident with ambulation and transfers as needed. Date initiated: 8/29/25. c. Sign in room to utilize call light. Date initiated: 10/22/25.Review of nursing progress Note, dated 12/05/25 at 3:24 PM, revealed that Resident #52 had an unwitnessed fall in room, when resident reported she self ambulated for a blanket and did not activate call light as Resident #52 thought she could do it by herself. An intervention identified reinforcing education to Resident #52 on utilizing the call light. During an observation on 1/11/26 at 1:16 PM, Resident #52 propelled self in wheelchair, through the hallway from the dining room into her room and took self into the bathroom, located inside resident's room. A sign noted to be hung on the wardrobe in Resident #52's room that instructed staff to not leave resident unattended in wheelchair in room. During an observation on 1/13/26 at 9:07 AM, Resident #52 propelled self in wheelchair from the dining room to her room. At 9:20 AM, Resident #52 noted to be in her bathroom. At 9:22 AM, Resident #52 observed ambulating independently from the bathroom, pushing wheelchair backwards, with hands on the seat and a stooped (bent forward) posture to her recliner where she then turned and sat self down. During an observation on 1/14/26 at 8:51 AM, Resident #52 sat in wheelchair unattended in her room and at 8:54 AM, transferred self from wheelchair into her recliner. During an interview on 1/14/26 at 2:13 PM, Staff D, CNA, reported that Resident #52 required assistance of 1 staff to transfer using a walker and gait belt. Staff D identified interventions to prevent Resident #52 from falling included have her call light in reach, and don't leave unattended in wheelchair in her room. During an interview on 1/21/26 at 3:39 PM, the Director of Nursing (DON) reported that fall interventions determined at the time of fall would be discussed in nursing meetings every week to ensure all interventions were care planned, implemented, and appropriate for each (continued on next page)

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident. The DON revealed an expectation that all fall interventions be implemented to prevent falls and injury. Review of the facility policy, titled Fall Occurrence, dated February 2024, revealed a Purpose Statement stating that it is the policy of the facility to ensure that residents are evaluated for fall risks and implement interventions to minimize risk for falls and/or risk for injury from falls. The policy listed the following procedures to follow, which included, Based on assessment, interventions are implemented and placed on the Care Plan.

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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, staff interviews and facility policy review the facility failed to administer medication as ordered to 3 out of 11 resident reviewed (Resident#4, Resident #9,& Resident #47).The facility reported a census of 62 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #4 dated 7/2/25, listed diagnoses of gastrointestinal hemorrhage (bleeding), Alzheimer's disease, anemia (lack of healthy red blood cells), heart failure, and orthostatic hypotension (low BP). The Brief Interview for Mental Status Score (BIMS) reflected 5 out of 15, which indicated severe cognitive impairment. Review of the resident's Care Plan for antidepressant medication use with goal target date 10/09/25 revealed the following intervention: Administer medications as ordered. The Progress Note for Resident #4 dated 9/17/25 at 8:40 AM revealed [Provider] notified of medication error. The Provider ordered give Midodrine (medication to treat low blood pressure)10 milligrams (mg) now and to check vitals every hour for 1 hour. The Progress Note for Resident #4 dated 9/17/25 at 8:52 AM reflected the facility contacted the daughter of Resident #4 regarding the medication error that happened that morning, resident was stable with plan to monitor and double dose of midodrine. The Incident Report Note for Resident #4 dated 9/17/25 at 3:06 PM explained Resident #4 received another resident's medications in error. The medication administered to Resident#4 included apixaban 5 milligrams (prescription blood thinning medication), pantoprazole 20 mg (medication to decrease stomach acid), amiodarone 200 mg (medication to treat irregular heartbeats), Zofran 4mg (medication to prevent nausea and vomiting), levothyroxine 50mcg (medication to treat underactive thyroid), senna-plus (stimulant laxative & stool softener medication), Wellbutrin XL 150 mg (antidepressant), clopidogrel 75mg (antiplatelet medication), escitalopram 20 mg, (antidepressant medication), ferrous sulfate 325mg (iron supplement), furosemide 40mg (diuretic medication), and losartan 50mg (used to treat high blood pressure). The Incident Report note revealed the following treatment provided: manual blood pressure (BP) every 1 hour for 8 hours, then every 4 hours for 5 hours. Midodrine increased to 10 mg 3 times a day for 9/17/25 only, then resume 5mg three times a day. The Medication Administration Record (MAR) dated 9/17/25, revealed Staff A, Licensed Practical Nurse (LPN) provided the morning medications to Resident #4. 2. The MDS for Resident#9 dated 10/22/25 listed diagnoses of osteoarthritis (OA) (degenerative joint condition causing bones to rub, leading to pain) anemia, Hypertension (high BP), and heart failure. The BIMS reflected a score of 14 out of 15, which indicated intact cognition. The Care Plan for Resident #9 initiated 8/20/25 directed staff to administer pain medication per physician orders. Review of Resident #9's December 2025 MAR revealed, Oxycodone tablet 10mg (opioid analgesic for moderate to severe pain) with directions to give one tablet by mouth every 6 hours as needed (PRN) for (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	left shoulder pain (start date 2/12/25). Resident #9's December 2025 MAR further revealed, Morphine Sulfate (MS) Contin tablet 15 mg Extended Release (opioid pain medication) with directions to give one tablet by mouth two times a day for chronic left shoulder pain (start date 3/4/25). Resident #9's MS Contin was scheduled to be administered at 10:00 AM and 10:00 PM per the MAR. Continued review of the MAR revealed on 12/4/25, Staff A administered PRN Oxycodone 10mg to the resident at 7:44 AM, as well as at 10:27 AM. A dose of the medication had been administered by a different nurse on 12/4/25 at 5:41 AM. Review of Resident #9's Order Administration Notes revealed the following: a.12/4/25 at 5:41 AM: oxycodone 10 mg give 1 tablet by mouth every 6 hours PRN for left shoulder pain. b.12/4/25 at 7:43 AM oxycodone 10 mg give 1 tablet by mouth every 6 hours PRN for left shoulder pain. Ineffective with follow-up pain scale 7. c.12/4/25 at 7:44 AM: oxycodone 10 mg give 1 tablet by mouth every 6 hours PRN for left shoulder pain. The Incident Report-Medication Event Note dated 12/4/25 at 8:10 AM revealed the resident was ordered oxycodone 10mg administered, and medication was scheduled every 6 hours PRN. Description of medication incident revealed, PRN medication administered after only 2.5 hours from last dose. The note reflected Resident #9 did not display signs or symptoms of distress. The Provider ordered the nurse to give routine MS Contin at 10am and continue to give PRN oxycontin as prescribed. The MAR revealed on 12/4/25, Staff A, LPN, documented HO (hold see Progress Note) for the resident's 10:00 AM dose of MS Contin 15 mg. The Order Administration Note dated 12/4/25 at 10:27 AM revealed PRN oxycodone given instead of scheduled MS Contin. 10 AM MS Contin dose held per physician orders. The Incident Report-Medication Event note dated 12/4/25 at 11:28 AM revealed Oxycodone 10mg given instead of MS Contin 15mg. The employee file for Staff A, LPN included an Employee Warning Notice dated 9/8/25, which reflected violation pills were found at the table with the resident, nurse not in the area. The form reported the facility completed education before about not leaving meds in resident room or at the table. The form also stated it was the expectation that we watch all meds be taken to assure that the right resident takes the medication. The document signed by Staff A and the facility on 9/9/25. The Employee file failed to include an education/warning for Resident #4's medication error on 9/17/25. The Employee Warning Notice for Staff A dated 12/5/25 revealed: On 12/4/25 Staff A gave an as needed oxycodone to a resident without checking previous administration which ended up giving the resident the medication prior to the ordered time it was available. The warning identified the facility addressed there was no way [the nurse] looked at her MAR before she administered the medication or [Staff A] would have seen it was not time for the dose. During the same shift [Staff A] gave the same (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident oxycodone in place of her mid-morning morphine sulfate ER. Demonstrating how she failed to follow the 5 rights of medication administration. The document revealed the nurse will be provided additional training. Signed by Staff A and the facility on Signed 12/17/25. On 1/21/26 at 11:52 PM, Staff B, Certified Medication Aide (CMA) reported she knew who a resident was by the picture on the MAR. She said if she ever questioned who a resident was, she would ask a coworker. Staff B reported the MAR told when the medications were due by the color of the medication on the screen. Staff B stated the color white meant the medication was not due yet, yellow meant it was time to give, green indicated the medication given, and pink color meant the medication was late. Staff B said the PRN medication would tell (staff) if was too soon to give. On 1/21/26 at 12:20 PM the Nurse Practitioner reported the staff follow up as needed with any medication errors. On 1/21/26 at 12:32 PM Staff C, LPN reported there were several ways to identify a resident. Staff used the photo in the MAR, the name, asked the resident, asked other staff, asked the resident their date of birth . Staff C, described the colors of the MAR and what each color meant. Yellow meant medications were due, green meant medication were given, red meant medications were past due. Staff C stated the PRN medication directed the staff if they were able to be given, or if it was too soon to give the medication. On 1/21/26 at 3:39 PM, the Director of Nursing (DON) reported she expected the nurses to check MAR and follow the 5 rights for all medication administration. The DON reported she provided education to Staff A before the incident with Resident #4 in September, when she observed Staff A left medications unattended on the table. The DON reported Staff A knew the expectations of the facility. On 1/21/26 at 4:23 PM the Administrator reported she expected the nurses to follow the physician's orders and give the right person the correct medication as the physician ordered. The facility provided a policy titled Medication Administration Medication Pass dated 5/2023 revealed, Read transcribed physician order on EMAR (electronic medication administration record): patient name, medication name, dosage, route and interval ordered. 3. Review of the MDS assessment dated [DATE] revealed that Resident #47 had a BIMS score of 10 out of 15, which indicated moderate cognitive impairment. The list of diagnoses included heart failure, End Stage Renal Disease (ESRD), Type 2 Diabetes Mellitus, and non-Alzheimer's dementia. Review of Resident #47's Census Report, revealed the resident was sent to the hospital on 1/3/26 with return on 1/5/26, was sent back to the hospital on 1/5/26 for less than 24 hours with return to facility on 1/6/26, and was sent to the hospital again on 1/6/26 until return to facility on 1/10/26. Review of the Hospital After Visit Summary, dated 1/04/26-1/05/26, revealed new orders to stop taking Jardiance (empagliflozin) (medication used to improve glucose control in Type 2 Diabetes Mellitus). Review of the MAR dated January 2026 lacked orders for Jardiance prior to hospitalization, and revealed the resident was ordered Farxiga (Dapagliflozin Propanediol) (medication used to improve glucose control in Type 2 Diabetes Mellitus) 5 milligrams (mg) with instructions to give 1 tablet by mouth in the morning, which was started on 7/10/25. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing Progress Notes, between the dates of 1/05/26 and 1/15/26 lacked documentation of attempt to clarify the order from the hospital to discontinue Jardiance. Review of the Hospital Discharge summary, dated admission on [DATE] and dated discharge on [DATE], revealed orders to stop taking Farxiga (Dapagliflozin Propanediol) 5mg tablet. The MAR revealed that Farxiga (Dapagliflozin Propanediol) 5mg tablet was given 1/11/26 through 1/15/26, then discontinued on 1/15/26. Review of a nursing Progress Note, dated 1/15/26 at 3:11 PM, revealed an order to discontinue Resident #47's Farxiga. b. Review of the Hospital After Visit Summary, dated 1/05/26, following visit to Emergency Department, revealed an order to start taking amoxicillin-clavulanate (Augmentin) (antibiotic), with diagnoses urinary retention and acute cystitis (bladder infection) with hematuria (blood in the urine). Review of the Hospital Discharge summary, dated admission on [DATE] and dated discharge on [DATE], revealed orders to stop taking Amoxicillin-Clavulanate (Augmentin) 875-125mg and change order to Amoxicillin 875mg tablet (Amoxil) with instructions to take 1 tablet by mouth every 12 hours. Review of the MAR, dated January 2026, revealed an order for Amoxicillin-Clavulanate (Augmentin) 875-125mg, with instructions to give one tablet by mouth two times a day for seven days for UTI was started on 1/06/26, held while in the hospital 1/07/26-1/09/26, resumed on 1/10/26 and discontinued on 1/12/26. The MAR revealed an order for Amoxicillin 875mg, with instructions to give 1 tablet every 12 hours for UTI for 4 administrations was started on 1/14/26 and completed on 1/16/26. Review of a nursing Progress Note, entered on 1/14/26 at 10:34 AM, revealed that Resident #47's Provider was in the facility for post-hospital visit and reviewed orders for Amoxicillin-Clavulanate (Augmentin) 875-125mg. The Provider gave new order to give additional doses of Amoxicillin 875mg every 12 hours for 4 administrations. c. Review of the Hospital Discharge summary, dated admission on [DATE] and dated discharge on [DATE], revealed orders to hold Resident #47's order for Furosemide (Lasix) (used to remove excess fluid and treat high blood pressure) 60 mg, until Provider restarts, due to low blood pressure. Review of the MAR, dated January 2026, revealed an order for Furosemide 60 mg, with instructions to give 60 mg by mouth in the morning related to Chronic Systolic Heart Failure. The order for Furosemide 60 mg started on 1/06/26. Furosemide continued to be given on and after 1/11/26. d. Review of the Hospital After Visit Summary, dated 1/04/26-1/05/26, revealed new orders to start the medication, Midodrine (proamatine) (used to treat low blood pressure upon standing) 5 mg, with instructions to take 1 tablet by mouth three times a day for 30 days for a diagnosis of syncope (fainting). Review of a nursing Progress Note, entered on 1/14/26 at 10:34 AM, revealed that Resident #47's Provider was in the facility for post-hospital visit and added parameters to the Midodrine, instructing to hold the medication if systolic blood pressure is greater than 140. Review of the MAR dated January 2026 revealed an order for Midodrine 5 mg, with instructions to (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	give 1 tablet by mouth three times a day for syncope for 30 days, started on 1/05/26. The MAR lacked parameters to hold medication if systolic blood pressure is greater than 140. The Midodrine was given three times a day between 1/14/26 and 1/20/26 without ensuring Resident #47's blood pressure was within parameters. Review of Resident #47's Medical Records lacked documentation of blood pressures checked three times a day to ensure blood pressure was within parameters and Midodrine was safe to administer. During an interview on 1/21/26 at 12:21 PM, a Provider for Resident #47 reported that there had been some medication errors involving Resident #47 upon his return from the hospital. The Provider stated that there was error with the Farxiga and that Augmentin had not been switched to Amoxicillin as indicated in the hospital discharge summary. The Provider stated that in response, ordered additional doses of Amoxicillin to ensure resolution of UTI and discontinued the Farxiga and Tramadol. The Provider reported that orders were given on 1/14/26 to add parameters to the medication, Midodrine, to hold if systolic blood pressure is greater than 140. The Provider was unable to find that blood pressures were being checked prior to medication administration and stated they would follow up with the facility to ensure this was implemented. The Provider stated that no negative outcomes had been observed as a result of medication errors. During an interview on 1/21/26 at 1:17 PM, Staff C, Licensed Practical Nurse (LPN), reported that Resident #47's Midodrine was supposed to have parameters to hold if systolic blood pressure is greater than 140 and informed that she was unable to find that parameters had been added to the medication order. During an interview on 1/21/26 at 1:52 PM, Staff B, Certified Medication Assistant (CMA), reported that Resident #47's Midodrine order did not have parameters to hold or require check of blood pressure prior to administration. Staff B stated she wondered about the medication hold parameters, due to other residents on this medication requiring blood pressure checks, but thought that the doctor didn't need that for Resident #47. During an interview on 1/21/26 at 3:39 PM, the DON stated that medication errors related to Resident #47's Farxiga, Tramadol, and Amoxicillin were identified during Provider visit (1/124/26) and that the error to implement Midodrine parameters was identified on 1/21/26. The DON revealed an expectation of nursing staff to transcribe and follow Provider orders and expected that nursing staff use an audit/double noting system to ensure implementation of orders. Review of the facility provided Incident Report Medication Event Note dated 1/14/26 at 9:30 AM, revealed a medication event which identified that Resident #47 had orders to hold Lasix until seen by Provider and to stop Augmentin 875-125mg BID x7days and start Amoxil 875mg one tablet by mouth every 12 hours and that the incident was related to communication with pharmacy. The Report documented that Resident #47's family and Provider were notified of incident on 1/14/26. The facility provided a policy titled Medication Administration Medication Pass dated 5/2023. Listed the purpose: To safely and accurately prepare and administer medication according to physician order and patient needs. The procedure directed: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Open MAR to patient record and review physician medication order against medication label Administer medication in accordance with frequency prescribed by physician - identify patient. Administer medication according to specific procedure such as oral, topical, injection, etc.