STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165619	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fieldstone of Dewitt	1301 Maynard Way DE Witt, IA 52742

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility policy reviews, facility record reviews, resident and staff interviews, the facility failed to ensure call lights answered in a timely manner for 4 of 4 residents (Resident #14, Resident #15, Resident #23, Resident #30) reviewed for call lights. Facility reported a census of 63.Findings include: 1.Review of Resident #14 Minimum Data Set assessment dated [DATE] revealed intact cognition based on a Brief Interview for Mental Status (BIMS) score of 15 out of 15. The diagnoses listed included a abnormalities of gait and mobility, fracture, and hypertension. The MDS indicated Resident #14 dependent for chair/bed-to-chair transfer and toilet transfer; dependent for toilet hygiene and required partial/moderate assistance for personal hygiene. During an interview on 5/19/2026 at 8:31 AM, Resident #14 stated that she had had to wait over an hour for staff to respond to her call light, and frequently has to wait more than 15 minutes. Resident #14 stated she used a hoyer lift (a mechanical lift, hoyer is a brand name and not identified as the brand used by the facility, rather it is generic trademark often used for a mechanical lift) which took 2 staff, when she needed to use the bedpan. Resident #2 noted the delays could cause her discomfort and the result in her being incontinent. She explained that she is normally able to use a bedpan and avoid being incontinent. Resident 14 described staff members coming into her room to turn off the call light and then leave, and then waiting for another half hour before they returned. A review of the facility provided call light log for Resident #14 revealed: a. On 4/21/2026 at 7:29 AM light activated for 26 minutes(m) 38 seconds(s). b. On 4/25/2026 at 8:28 AM light activated for 18m 24s. c. On 4/25/2026 at 10:56 AM light activated for 29m 55s. d. On 4/29/2026 at 4:30 PM light activated for 16m 15s. e. On 5/1/2026 at 1:41 PM light activated for 16m 20s. f. On 5/2/2026 at 6:54 AM light activated for 16m 40s. g. On 5/4/2026 at 6:10 AM light activated for 18m 3s. h. On 5/5/2026 at 7:07 AM light activated for 16m 34s. (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. On 5/9/2026 at 7:48 AM light activated for 19m 4s. j. On 5/19/2026 at 7:02 AM light activated for 36m 43s. During an interview on 05/ 20/2026 at 12:10 PM, Staff B, Certified Nursing Assistant (CNA) stated that some call lights still took longer than 15 minutes to answer due to more intense resident needs. She explained that when the facility is at full capacity, there are typically two CNAs assigned to each Home, plus two float CNAs who move between the homes to help where needed. If a staff member calls in sick, a CNA is usually pulled from another area to cover multiple homes. Because the Homes are far apart, these floating staff members have to walk long distances, making it harder to provide timely care. She added that when residents turned their call lights back on shortly after receiving care, she had to inform them that it would take a while for staff to return because they had to care for other residents first. During an interview on 05/20/2026 at 2:55 PM, Staff C, Registered Nurse (RN) stated that the facility had been experiencing ongoing staffing shortages for some time, including during the current week despite a low number of residents. She stated that she was unable to take a break because she had to manage two separate resident Homes by herself. Staff C explained that because the units were located too far apart, it was difficult for staff to provide resident care in a timely manner. She stated that the workload was particularly heavy on Thursdays when two medical practitioners visited the building, as nursing staff had to spend extra time processing and updating new medical orders during patient rounds. Staff C explained that staff were trained to turn off the call light upon entering a room. If they could not assist the resident immediately, they would inform the resident that they had to help someone else first. Staff were then supposed to turn the call light back on before leaving the room to serve as a visual reminder to return later, but this often doesn't happen leaving the resident to wait for longer periods of time. She stated that during high workload times she would often request help from Nurse Managers, but they would rarely step in to assist. During an interview on 5/21/2026 at 10:36 AM, the Administrator stated that the facility sometimes does not meet their staffing targets. The Administrator explained that on Thursday's when providers are rounding, floor nurses can request assistance if they are feeling overwhelmed, and the Nurse Managers are required to help during those times. The Administrator stated management reviewed call light reports daily during huddles to identify unusual delays. 2. Review of the MDS for Resident #23 dated 3/1/26 revealed diagnoses of non-Alzheimer's dementia, Parkinson's disease, and restlessness and agitation. The MDS identified Resident #23 dependent for transfers and bathing, and required substantial/maximal assistance with hygiene and dressing. During an interview on 05/19/2026 at 4:23 PM, Resident #23 and their spouse reported concerns about the number of aides available for bathing, meals, and cares. The spouse stated a CNA recently told them she couldn't give the resident a shower when they wanted one because she was the only one there and they just had to wait for someone else to show up. The spouse reported staff were very kind, there were just not enough of them for residents with that much need. During an interview on 05/21/2026 at 10:15 AM Staff D, CNA reported residents and family had complained to her about not having enough staff. She stated it was hard to get everything done when it was just her and one other person for 16 residents and thought over half needed two people to help them transfer. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions included, in part: TOILET USE: The resident needs assist x 2 with Sara Steady (a type of mechanical lift) to transfer to and from the toilet. Assist with clothing and hygiene management. I prefer for staff to remain with me while using the Restroom. A review of the facility provided call light log for Resident #30 revealed: a. 05/09/26 at 11:15 AM light activated 18m 42s. b. 05/11/26 at 6:17 AM light activated 39m 3s. c. 05/13/26 at 9:22 PM light activated 25m 25s. d. 05/15/26 at 5:19 AM light activated 16m 26s. e. 05/17/26 at 7:04 AM light activated 17m 59s. f. 05/17/26 at 7:41 AM light activated 18m 44s. g. 05/18/26 at 6:46 AM light activated 20m 44s. h. 05/19/26 at 10:42 AM light activated 18m 5s. i. 05/19/26 at 12:45 PM light activated 17m 31s. During an interview on 5/20/26 at 10: 52 AM, Resident#30 reported staff came into her room in the morning to get her call light when she wanted to get up. The staff told her they needed to get two other residents up and then they would be back to help her. During an interview on 05/20/2026 at 2:42 PM, Staff J, Licensed Practical (LPN) said all the residents say not enough staff. Staff J reported they complain the staff float from one unit to the other and it is a big place, it takes time. Staff J said nurses float 2 wings. Staff J said the call lights alarm to the system and pop up on the phone and keeps going until they get the light, more than 15 minutes sometimes. During an interview on 05/20/2026 at 3:21 PM, Staff I, Assistant Director of Nursing (ADON) reported the call lights can go long. Staff I reported she expected the staff to get the all light in 10 minutes. Staff I stated they get a report and are to review call light logs daily. During an interview on 5/21/26 at 10:35 AM, the Resident Council President, Resident #13 reported residents in the meeting have reported at times they are put in the restroom and have to wait for 30 minutes before the staff comes back and helps them. During an interview on 05/20/2026 3:29 PM, Staff A, LPN stated they keep the phone in their pockets and can see the call lights. Staff A confirmed residents reported long call light times at least weekly. Review of Resident Council notes dated March 2026 revealed Administration concern: Would like more CNAs on each shift. The notes included a March 2026 Department Response page. The Administration section response to the concern read: Response: In response to the request for more CNA's: We understand how important consistent staffing is to your comfort and well-being. We staff each shift (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	based on the number or residents we are serving, and the care needs of our community. We schedule to meet or exceed state-required expectations, and we build our schedules with enough team members to support quality care. However, when we experience unexpected team call-offs or no-call/no-shows at the start of a shift, it can create gaps that are difficult to fill on short notice. We consistently reach out to available team members or agency support as needed, but those options are not always immediately available – in which we will reorganize the staffing structure to best meet the needs of our community., In addition, we balance staffing within our budget to ensure that we are good stewards of our financial resources while prioritizing resident needs. We are actively working on improving attendance and reducing call-offs so that we can maintain consistent coverage across all shifts. Please continue to share suggestions at any time. Review of the facility policy titled Call System Use dated 2026 included Purpose section which included: To respond promptly to resident's call for assistance and To assure call system is in proper working order. The Procedure section directed, in part: a. Answer ALL call system calls promptly, whether or not you are assigned to the resident. b. Never make the resident feel you are too busy to give assistance; offer further assistance before you leave the room.

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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, record review and staff interview the facility failed to maintain the cleanliness of kitchen equipment and the areas used for resident food prep in an effort to prevent food borne illness. The facility identified a census of 63 residents. Findings include: During an initial kitchen observation on 5/18/2026 at 9:50 AM:a. The vents over the stove noted to have a grease buildup, and oil stains noted at the base. b. Several small dried white splash-like areas noted on the floor near the stove.c. Black debris noted over the top of the stove and a grease build up observed at the back of the fryer. During an observation of the bistro kitchen on 05/20/2026 at 11:10 AM:a. Main kitchen area under hood of grill and fryers are splatters of dried substance.b. A buildup of debris noted on the bent above the grill on the front of stove.c. Runs of a dried substance on the front of the fryer.d. The freezer next to the fryer had a dried brown substance on the door, and on the back of the top prep area.e. A buildup of spills and dried runs of a substance on the lower half and side of the oven.f. Garbage can next to oven uncovered. g. Dried splashes of a substance noted on the refrigerator doors, and spills of a white substance on the inside and outside of the glass doors. h. Smeared, dried white and brownish red substance noted on the handles of the refrigerator. During an interview on 05/21/2026 at 10:56 AM, Staff K, [NAME] stated staff have a cleaning schedule. She explained The Bistro is cleaned every Sunday. Staff K stated staff sweep and mop and wipe down everything, every night. Staff K added on a weekly basis staff pull equipment, like the fryer and grill out and wipe down behind it. She stated Maintenance cleans the hood above the fryer and grill once every 3 months. Staff K explained the stove has to be disconnected from the gas to clean on the side of it and there is a large amount of food crumbs and debris on the floor. Staff K acknowledged there are spills going down the wall and on the side of the stove of dried food. During an interview on 05/21/2026 at 11:10 AM, the Dietary Manager stated he would expect the areas around the stove and grill/fryers to be clean. He stated there is a cleaning schedule posted on the wall in the Bistro. The side of the stove and the hood above are done by contracted staff. Review of the facility document titled Food and Safety Sanitation Checklist dated 10/20/24, directed staff to make sure food contact surfaces smooth, easily cleaned, and free of breaks, seams, cracks, chips, and pits. The checklist directed staff to check the refrigerator, range/oven, and fryer clean. It also directed for the hood to be cleaned professionally routinely. The checklist indicated garbage cans should be covered unless in use.

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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. Based on observation, clinical record review, facility policy review, resident and staff interviews, the facility failed to assess and intervene with a high blood sugar result for 1 of 1 resident (Resident #76) reviewed. The facility reported a census of 63 residents.Findings include:The Minimum Data Set (MDS) assessment for Resident#76 dated 5/15/26, listed diagnoses of diabetes mellitus and osteoporosis. The Brief Interview for Mental States (BIMS) reflected a score of 15 out of 15, indicating intact cognition. The MDS did not identify any high-risk medications used by Resident #76. The MDS identified an admission date of 5/11/26. Review of Resident #76's Care Plan dated 5/20/26, revealed a Focus area to address The resident has Diabetes Mellitus. Interventions initiated on 5/20/26 included:a. Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. b. Monitor/document/report PRN (as needed) any s/sx (signs or symptoms) of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing, acetone breath (fruity smell), stupor, coma. c. Monitor/document/report PRN any s/sx of hypoglycemia: Sweating, Tremor, Increased heart rate (Tachycardia), Pallor, Nervousness, Confusion, slurred speech, lack of coordination, Staggering gait. d. Fasting serum blood sugar as ordered by doctor. Review of the May 2026 Medication Administration Record (MAR) revealed the following orders:a. Blood Sugar checks 4 times per day. ACHS (before meals and at bedtime) and PRN for diabetes mellituis. b. Insulin Lisp injection 100 units/milliliter (ML) subcutaneous (SQ, meaning injection into fatty layer under the skin) sliding scale (amount of insulin to be administered based on blood sugar reading) three times a day with meals: Blood sugar of 150-200=1 UNIT; 201-250=2 UNITS; 251-300=3 UNITS; 301-350=4 UNITS; and 351-400=5 UNITS.The Insulin Lisp order did not provide parameters of when to call the provider in the event of low blood sugar (typically below 70 mg/dl) or a high blood sugar (above 400 mg/dl)Review of the May 2026 MAR revealed a blood sugar reading of 500 mg/dl at 8:00 AM on 5/17/16. Review of the electronic health record (EHR) revealed a X-Orders Administration Note Progress Note entered on 5/17/26 at 8:57 AM which stated the MAR order for Insulin Lisp, and Registered HI - rechecked after insulin 323. During an interview on 5/19/2026 at 8:50 AM, Resident #76 stated she had not gotten her insulin yet.During an interview on 05/20/2026 at 2:40 PM, Staff J, Licensed Practical Nurse (LPN) stated if a resident had a blood sugar of 500 mg/dl she would assess the resident, call the Provider for what to do next. Staff J added this would need to be documented in the Progress Notes. During an interview on 05/20/2026 at 3:03 PM. Staff I, Assistant Director of Nursing (ADON) stated residents on sliding scale insulin needed parameters for when to notify the Provider of a high or low blood sugar. Staff I explained she and the other ADON check to make sure the parameters are in place on admission. Staff I stated they missed that for Resident #76. Staff I reported she expected the nurses to complete an assessment with a high blood sugar, notify the Provider for orders, inform the family and document in the progress notes. Staff I confirmed she failed to see an assessment, provider notification or orders in the progress note for Resident#76 on 5/17/26. Review of an undated facility tool titled Admit Audit Leadership included Diabetic - YES/NO and the options to indicate Insulin/MAR and BG (blood glucose) checks w/ (with) parameters. Review of the facility policy titled Hyperglycemia Guidance dated 11/2025, it directed staff to obtain accucheck (blood sugar). See accucheck order for parameters for physician notification. If no parameters outlined-notify Provider if results greater than 300.

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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 observation, clinical record review, manufacturer instructions, facility record review, facility policy review and staff interviews, the facility failed to prime an insulin pen as directed by the manufacturer for 1 of 1 resident (Resident #77) reviewed for insulin administration; and failed to ensure a resident only received medications prescribed to them for 2 of 2 residents (Resident #73 and Resident #35) reviewed for medication errors. The facility reported a census of 63 residents.Findings include: 1. Review of Resident #77's entry Minimum Data Set (MDS) assessment dated [DATE] revealed the resident admitted to the facility on the same date. Review of the electronic health record (EHR) Diagnosis List revealed, in part: Type 2 diabetes mellitus.and long term (current) use of insulin.Review of May 2026 Medication Administration Report (MAR) revealed an order for: Fiasp (type of fast acting insulin) flex inj[ection] touch inject ?SQ (subcutaneous, an injection made into the fatty tissue under the skin) per sliding scale (amount of insulin delivered based on blood sugar) before meals: Blood Glucose: 80-130=5 UNITS; 131-160=6 UNITS; 161-190=7 UNITS; 191-220=8 UNITS; 221-250=9 UNITS; 251-280=10 UNITS; 281-310=11 UNITS; 311-340=12 UNITS; 341-370=13 UNITS; 371-410=14 UNITS. Greater than 410 = 15 units. During an observation on 05/20/2026 at 7:11 AM, Staff H, Registered Nurse (RN) prepared the resident for her insulin by checking her blood sugar. The RN entered the blood sugar result of 118 mg/dl (milligrams/deciliter), into the EHR and determined Resident #77 required 5 units of insulin. Staff H sanitized her hands, donned clean gloves, checked the pen against the MAR, and turned the dial to 5. She asked the resident where she wanted her insulin and administered it to her stomach as requested. Staff H held the pen in place for a count of 4-5 seconds and removed it.During an interview with Staff H, RN at 7:19 AM on 05/20/2026, when asked if insulin pens needed to be primed (turning the dial to 2 and depressing the injector to 0 to remove air bubbles and ensure the resident received a full dose of insulin), she stated that particular insulin pen did not need to be primed like the resident's long-acting insulin pen did.A document provided by the facility titled Instructions on how to use Fiasp Flextouch directed, in part:2 Check the insulin flow (page 49 of 50) directeda. Always check the insulin flow before you start. This helps you to ensure that you get your full insulin dose.b. Turn the dose selector to select 2 units. Make sure the dose counter shows 2.c. Hold the pen with the needle pointing up. Tap the top of the pen gently a few times to let any air bubbles rise to the top.d. Press and hold in the dose button until the dose counter returns to 0. The 0 must line up with the dose pointer. A drop of insulin should appear at the needle tip. A small air bubble may remain at the needle tip, but it will not be injected. If no drop appears, repeat steps 2A to 2C up to 6 times. If there is still no drop, change the needle and repeat steps 2A to 2C once more. 4 Inject your dose (page 51 of 52) directed, in part:a. Keep the needle in your skin after the dose counter has returned to 0 and count slowly to b. If the needle is removed earlier, you may see a stream of insulin coming from the needle tip. If so, the full dose will not be delivered. During an interview on 5/21/26 at 10:20 AM, Staff E, Licensed Practical Nurse (LPN) stated insulin pens should be primed before every administration. She stated there was a cheat sheet in the medication room and that to her knowledge all insulin pens should be primed before administration to ensure the resident got the full dose of insulin.During an interview on 05/21/2026 at 10:34 AM, the Director of Nursing (DON) stated she expected the nurses to prime insulin pens before every administration, and facility policy was to hold the needle in the resident's skin for 5-10 seconds to insure an accurate dose. She reported that staff were educated on insulin pen use.2. Review of Resident #73's MDS assessment dated [DATE], revealed diagnoses of hypertension, Parkinson's disease, and chronic obstructive pulmonary disease. The BIMS score of 5 out of 15 indicated a severe cognitive impairment. Review of the October 2025 MAR revealed the following medications prescribed for Resident #73: carbidopa-levodopa 10-100mg, risperidone 0.25mg, furosemide 40mg, ticagrelor 90mg, and metoprolol succinate ER (extended release) 25mg. Review of a facility Medication Error report (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 10/1/2025 at 11:00 AM revealed Went into resident's [Resident #73] room to give morning medications, realized resident was on bedpan; placed medications on med cart with plan to return to room when resident available. Went into (name redacted, Resident #73) room to give morning medications. Had to leave room to get insulin pen needles, placed cup of pills in locked drawer. Returned to room and grabbed the medications off med cart and gave to (name redacted, Resident #73). Insulin was given and when returning pens to drawer realized cup of pills was still in drawer. Immediately called (name of medical provider redacted) and spoke with (name of nurse practitioner name redacted) received back from (NP name redacted) after reviewing medications. Order received to hold Metoprolol x 1 dose, hold Lasix x 1 dose, hold Brilinta x 1 dose. Check BP (blood pressure) and Pulse Q (every) 2 hours x 12 hours. Hospice was notified, no orders received. TC placed to daughter, message left, no answer. BP 110/62, Pulse 79. Resident awake and resting in bed3. Review of Resident #35's MDS dated [DATE], revealed a diagnoses list which included Parkinson's disease, non-Alzheimer's dementia, and anxiety. The Brief Interview for Mental Status (BIMS) score of 8 out of 15 indicated a moderate cognitive impairment. Review of the March 2026 MAR revealed Resident #35 prescribed the following medications to be taken during the morning medication pass: furosemide 20 mg, lisinopril 20 mg, potassium chloride 10 mEq (milliequivalents), amlodipine 10 mg, and carbidopa-levodopa 25-100 mg.Review of the EHR Progress Note dated 3/26/26 at 7:29 AM revealed, in part: This nurse gave resident [Resident #35] the wrong medication, call to Dr on call.Review of the EHR Encounter note dated 03/26/2026 revealed, in part: .Chief Complaint: Medication error.I received a phone call this morning noting that nurse made a medication error. Patient [Resident #35] given another patient's medications. He was given aspirin, Plavix, diltiazem 120, Lasix 80, potassium 10 mEq, probiotic, Tylenol. He has had no side effects.documented the chief complaint for the provider's visit was a medication error. During an interview on 05/21/2026 at 10:20 AM, Staff E, LPN stated she knew staff had training about medication errors. Part of the education was related to medication cards in the wrong drawer and how to prevent those errors. She thought that training was last year. Another education, maybe in February or March, included not leaving medications with residents and not leaving medication cups with medication in it on the carts in the hallway.During an interview on 05/21/2026 at 10:34 AM, the DON stated that only the nurses involved in the medication errors (r/t to Resident #35) received training. She said the incident with Resident #35 was a one-off situation and that nurse received counseling. When asked about the error with Resident #73 she stated there was a different DON at that time this error was made. She reported there was a skills fair later that year so all of the nurses would have been educated then.During an interview on 05/21/2026 at 11:11 AM, Staff F, Advanced Registered Nurse Practitioner (ARNP) stated she was able to follow up with both residents in person within a day or two. Both Resident #35 and Resident #73 required blood pressure monitoring and had to have their regular medications held. She did not think Resident #35 had any long-term impact. Resident #73 had initial fatigue and blood pressure monitoring had to be extended an extra 12 hours.In response to a request for documentation of Medication Administration education the facility provided an undated document for annually required training plans provided, which included: Quality Assurance and Performance Improvement, Dementia Care, Protecting Resident Rights, Alzheimer's Disease and Related Disorders: Communication, and Behavioral Health for Older Adults. Review of the facility policy titled Accident/Incident Investigation and Reporting Policy and Procedure documented the intent was to ensure the facility provided an environment that was free from accident hazards over which the facility has control. Medication errors were included as a type of accident/incident that required investigation.