STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E263	A. Building B. Wing	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanford Senior Care Sheldon	118 North Seventh Avenue Sheldon, IA 51201

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, staff interviews and policy review the facility failed to prepare and serve food in a form designed to meet individual needs and according to their assessments and care plans for 5 of 9 residents (Resident #4, #9, #30, #117 and #217) reviewed. The facility failed to prepare and serve 5 meals according to the residents' prescribed diet orders. The facility reported a census of 46 residents.Findings include: 1. Resident #4's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 9/15 indicating moderate cognitive impairment. The document revealed the resident received a mechanically altered diet during the last 7 days of the assessment period. The resident's Care Plan contained a problem area dated 10/15/25 of receiving a mechanically altered diet related to dysphagia. The approach dated 10/15/25 revealed a Level 6 Soft and Bite Sized Diet with moist meat or gravy/mildly thick liquid and no straws. The resident's diet order dated 8/26/25 revealed regular bite sized food, dry meat to be cut in small bites with thin liquids - no straws. 2. Resident #9's MDS dated [DATE] revealed a BIMS of 15/15 score indicating normal cognition. The document revealed the resident received a mechanically altered diet during the last 7 days of the assessment period. The resident's Care Plan contained a problem area of a mechanically altered diet related to poor dentition with a last reviewed date of 10/15/25. The approach for the intervention included a Level 6 Diet (Soft and Bite Sized) with ground meats per resident choice with a start date of 2/6/22. The resident's diet order dated 3/15/22 revealed Level 6 (Soft and Bite Sized) with ground meats. 3. Resident #30's MDS dated [DATE] revealed a BIMS of 6/15 indicating severe cognitive impairment. The document revealed the resident did not receive any alterations to her diet during the reporting period. The resident's Care Plan contained a problem area dated 10/15/25 of mechanically altered diet due to swallowing difficulty with an approach of Level 6 Soft and Bite Sized Diet with meals. The resident's diet order dated 10/16/25 revealed a Soft and Bite Sized Diet. 4. Resident #117's MDS dated [DATE] revealed a BIMS score of 3/15 indicating severe cognitive impairment. The document revealed the resident received a mechanically altered diet during the last 7 days of the reporting period. The resident's Care Plan contained a problem area dated 10/16/25 with a requirement of mechanically altered diet related to esophageal constriction with an approach of Level 6 Soft and Bite Sized Diet. The resident's diet order dated 10/22/25 disclosed a mechanical soft diet. 5. Resident #217's MDS dated [DATE] revealed a score of 0/15 indicating severe cognitive impairment. The document revealed the resident did not receive any alterations to her diet during the reporting period. The resident's Care Plan contained a problem area dated 10/15/25 of requiring a mechanically altered diet with an intervention of Soft and Bite Sized. The resident's diet order dated 10/2/25 disclosed National Dysphagia Diet (NDD)6 - Soft and Bite Sized with meals. During an observation on 10/4/25 at 10:10 AM the Dietary Manager (DM) prepared diet modifications for the #4 Pureed Diet and #5 Minced and Moist Diet. The DM stated she was preparing a total of 4 #4 Pureed Diet servings (3 for residents and 1 extra) and 3 #5 Minced and Moist Diet (2 for residents and 1 extra). The staff prepared noodles, beef and broccoli and egg rolls for both consistencies. The Diet Spreadsheet for the noon meal on 11/4/25 disclosed the following was to be (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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	served to the residents on modified diets:#6 Soft and Bite Sized Diet: bite sized beef and broccoli stir fry with thick gravy, soft and bite sized buttered fettuccine noodles, pureed egg roll, Smooth and Thick Sweet and Sour Sauce and pureed brownie.#5 Minced and Moist Diet: minced beef and broccoli stir fry with thick gravy, minced fettuccine noodles with thickened broth, pureed egg roll, Smooth and Thick Sweet and Sour Sauce and pureed brownie.#4 Pureed Diet: pureed beef and broccoli stir fry, pureed soft fried noodles, pureed egg roll, Smooth and Thick Sweet and Sour Sauce and pureed brownie. During a continuous observation on 10/4/25 beginning at 11:42 AM Staff A, Dietary Aide, and Staff B, Dietary Aide, began the meal service. Staff A prepared Resident #30's plate with Minced and Moist noodles, beef and broccoli and a regular egg roll. The resident's plate was transferred to an unidentified staff who served the resident. The resident picked up a utensil and was prepared to initiate eating when the serving was stopped. Staff A when questioned about the Resident #30's diet order and what was served, admitted the resident should have been served a pureed egg roll versus a regular egg roll. Staff A prepared a corrected egg roll serving for the resident and provided it to the staff for Resident #30. The DM entered the kitchenette and reviewed Resident #30's dietary order and confirmed the resident should have received a pureed egg roll with her meal not the regular egg roll that had been provided. Staff B continued serving the meal. During the meal service observation Staff A and Staff B prepared and served #6 Soft and Bite Sized diets for Resident's #4, #9, #117 and #217 brownies cut into bite sized pieces. On 11/4/25 at 12:20 PM the Registered Dietitian acknowledged awareness of a resident who was ordered a #5 Minced and Moist Diet being provided a regular egg roll. The staff stated if a resident was on a #6 Soft and Bite Sized Diet their egg roll should have been cut up. On 11/4/25 at 12:22 PM the DM stated Resident #30 was recently discussed during the Morning Meeting and the decision was made to downgrade to a #5 Minced and Moist Diet due to spitting foods out and exhibiting some coughing during meals. The staff stated they were waiting for the official order to come down for the change of diet consistencies. When asked what the consistency should be for the egg roll for the Soft and Bite Sized Diet, the Kitchen Supervisor initially stated it would be chopped, then stated would like to refer to the menu. When referring to the Diet Spreadsheet for 11/4/25, the staff acknowledged the document stated the residents were to receive a pureed egg roll. When counting the number of residents with #4 Pureed, #5 Minced and Moist and #6 Soft and Bite Size diets there were 9 residents who should have received pureed egg rolls. The Dietary Manager conceded that she did not prepare pureed egg rolls for 9 residents; she only prepared pureed egg rolls for the 5 residents on the #4 Pureed and #5 Minced and Moist diet consistencies, not the 4 residents on the #6 Soft and Bite Sized Diets. On 11/5/25 at 10:05 AM the DM reviewed the Diet Spreadsheet for 11/4/25 noon meal and acknowledged the residents receiving a #6 Soft and Bite Sized Diet should have received a pureed brownie, not a brownie that had been cut into bite sized pieces. The staff stated she was not aware neither Staff A nor Staff B provided a Smooth and Thick Sweet and Sour Sauce for residents receiving a #4 Pureed Diet, #5 Minced and Moist Diet and #6 Soft and Bite Sized Diet. The DM stated a Diet Spreadsheet was available in the kitchen and kitchenette and expected staff to utilize it when preparing and serving meals. The facility's Texture-Modified Diets-Food and Nutrition Services Policy, reviewed 5/12/25, revealed its purpose is to ensure the safe consumption of food/fluids for residents who have difficulty chewing or swallowing. The document disclosed that the food and nutrition services department alter the texture and consistency of foods that are prescribed by the resident's attending physician and all diet orders, including texture modifications, must have a physician's order.

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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, staff interview, and policy review the facility failed to prepare, serve and distribute food in accordance with professional standards by not practicing accepted hygiene practices. The facility reported a census of 46 residents. Findings include: During a continuous observation on 10/4/25 beginning at 11:42 AM Staff A, Dietary Aide, and Staff B, Dietary Aide, began the meal service. Staff A left the kitchenette area and moved into the main dining room. Staff B requested Staff A's assistance in the kitchenette preparing 3 special request meals. Staff A entered the kitchenette, went to the stove top and initiated making scrambled eggs. The staff did not complete hand hygiene upon entry into the kitchenette. The staff cracked the eggs and proceeded to don a single glove on the left (L) hand. With the gloved L hand Staff A opened the bread wrapper, removed the bread and placed it in the toaster. The staff continued to monitor scrambled eggs until complete, transferred the eggs to the plate, carried the plate with the L gloved hand, placed a cover over the food, placed it on the steam table, and returned to the toaster. Staff A continued with the single gloved L hand to hold bread while buttering with the right. The toast was transferred to the plate and provided to the serving staff. Staff B worked at the steam table, washed her hands and moved to the food prep area, donned a single glove, placed a pre-assembled grilled cheese sandwich on a skillet, obtained bread from the wrapper and placed 2 slices of bread in the toaster. The gloved hand touched the wrapper as well as the bread. Staff B returned to the steam table with one gloved hand when Staff A indicated the sandwich had burned on the skillet and a new one would need to be started. Staff A cracked an egg into the skillet for making a fried egg sandwich using the gloved and ungloved hands. Staff A obtained new bread from the package using the same gloved hand, obtained cheese from the refrigerator, and used the gloved hand to place the cheese on the sandwich. The grilled cheese was removed from the skillet and placed on a plate for serving. Staff A obtained the bread from the toaster using the same gloved hand and placed it on a plate, stabilized the toast with the L gloved hand while the right buttered, and then added the egg for serving. On 11/6/25 at 12:15 PM the Dietary Manager stated it was the expectation that hands should be washed when entering the kitchenette area prior to touching any food items, as well as prior to donning gloves and glove removal. The Dietary Manager stated serving/preparatory staff should not be touching non ready to serve food items with a gloved hand and returning to ready to eat food items without changing gloves and hand hygiene. The facility's Glove Use in NFS Department, reviewed 3/4/25, revealed staff would utilize single use gloves as needed to avoid direct contact with ready to eat foods. The document further revealed fresh gloves were to be used if staff change tasks, hands must be washed and replaced with clean gloves and when possible use utensils rather than the gloved hand to handle food. The facility's Wash Hands document revealed hands should be washed before starting work, after touching raw poultry, meats or fish and during food preparation as necessary.

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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 record review and staff interview, the facility failed to notify the physician and the resident's representative of a significant weight loss for 1 of 3 residents reviewed (Resident #11). The facility reported a census of 46 residents. Findings include:According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #11 had long and short term memory problem, and severely impaired cognitive skills for daily decision making. The resident required supervision or touching assist with eating. The resident's diagnoses included non-Alzheimer's dementia. The resident weighed 125# and did not have a weight loss of 5% or more in a month, or 10% or more in 6 months. The Care Plan dated 10/15/25 identified the resident at nutritional risk related to dementia. The weight record documented the resident weighed: a. 129 on 9/2/25, b. 125.4 on 9/16/25, c. 120.7 on 10/7/25, a 6.4% loss, (5% in 1 month is significant). d. 117.5 on 10/14/25, e. 116.9 at 10/21/25, a 9.4% loss in 50 days, (7.5% in 90 days, and 10% in 180 days is significant). The clinical record lacked any documentation the facility notified the physician or Resident #11's representative of the significant weight change. On 11/6/25 at 8:40 a.m. the Director of Nursing (DON) stated she found no notification of the physician or family of the significant weight loss. The facility Weight and Height policy reviewed/revised 9/30/25 identified the purpose to ensure residents maintained acceptable parameters of nutritional status regarding weight and to report changes in a resident's clinical condition (significant weight change) to the physician and family and/or resident. The location would immediately inform the resident, consult with the resident's physician and, notify the resident's legal representative when there was a significant change in the resident's weight. Significant weight change was defined as five percent in 30 days, 7.5 percent in 90 days and 10 percent in 180 days.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and staff interview, the facility failed to update a resident's care plan with an intervention to prevent further falls for 1 of 2 residents reviewed with falls (Resident #4). The facility reported a census of 46 residents.Findings include:According to the Minimum Data Set (MDS) assessment dated 7/325, Resident #4 scored 11 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident demonstrated independence in ambulation. The resident required set up assist with transfers. The resident's diagnoses included cerebral infarction or stroke. The Care Plan with a start date of 4/17/25 identified the resident at risk for falling related to weakness and use of medications. Interventions included encouraging the resident to assume a standing position slowly, ensuring the resident wore eyeglasses, giving the resident verbal reminders not to ambulate/transfer without assistance, keeping in lowest position with brakes locked, keeping the call light in reach at all times, keeping personal items and frequently used items within reach, providing, well maintained footwear, and providing an environment free of clutter (all dated 4/17/25). The Progress Notes dated 7/29/25 at 2:05 a.m. documented the nurse was called to the residents room at 11:30 p.m. and observed the resident laying on the floor, on her back with her legs straight down and arms straight down to her sides, with a large amount of bright red blood under and around her her head. Range of Motion (ROM) done with her upper and lower extremities without difficulty or discomfort. No shortening of a leg or leg turned outward. No other injuries noted. The resident stated her head hurt. She said she was going to peek out into hallway to see if anything was going on. The next thing she was laying on the floor. They were under a thunderstorm watch and warning, most of the evening shift. Used a total mechanical lift and 3 staff members to get the resident up off floor and seated into her wheelchair. They pushed the resident to the emergency room (ER). In the fall packet dated 7/28/25 at 11:30 p.m. the nurse documented she believed the resident sat in a locked wheelchair and could not get the brakes unlocked, so she climbed over the foot pedals and lost her balance and fell. There were no witnesses to the fall. The form indicated documentation would include updating the care plan. There must be an immediate intervention, and notification of leadership if unable to find a long term intervention. These 2 items were not checked they were done. The Care Plan failed to identify any new interventions. On 11/6/25 at 8:20 a.m. the DON stated after a fall, Care Plans should be updated to include new interventions to try to prevent any further falls.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to ensure a resident received services to maintain or improve Range of Motion (ROM) for 1 of 3 residents reviewed (Resident #4). The facility reported a census of 46 residents.Findings include:According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #4 scored 11 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident had no limitation in functional Range of Motion (ROM) of the upper or lower extremities. The resident's diagnoses included cerebral infarction or stroke. According to the MDS assessment dated [DATE], Resident #4 scored 9 on the BIMS indicating moderate cognitive impairment. The resident had limitation in functional ROM of both upper extremities. The clinical record lacked documentation the facility consulted the physician about the noted declines for a therapy evaluation. The Care Plan dated 4/17/25 identified Resident #4's limited ability to transfer herself related to weakness from cerebral infarction. Interventions included Physical Therapy (PT)/Occupational Therapy (OT) for strengthening per the physician's order, and following PT/OT recommendations. On 11/5/25 at 1:20 p.m. Staff C Licensed Practical Nurse (LPN) took the resident to the bathroom. She asked the resident to put her left arm up to the grab bar. The resident could not do it. Staff C tried to help her put the arm up and the resident cried out to go slower. Staff C tried again and able to get her arm up to the bar and she grabbed on. Using the gait belt Staff C lifted the resident to a standing position. After toileting, Staff C again got the resident to a standing position. When back in the wheelchair the resident said when she had the stroke she laid on the affected side awhile, the right side. She said she thought the left side was a problem from that side having to do everything. Staff C said it had been getting worse. On 11/4/25 at 4:44 p.m. the MDS coordinator stated she started in July and she coded the (9/25/25) MDS for ROM as impairment both sides upper because the resident had difficulty raising her arms and they had to maneuver her arms into clothing. She did not feel that was a change for the resident (she did not do the previous assessment). The resident attended exercise class when she wanted to. The CNA's did some ROM when they assisted with care. The MDS Coordinator reported the resident only attended exercise class 5 times in October. She said there were no staff at exercises to assist with the exercises. Residents did what they were able to do. She said they had some residents on restorative, but mostly walking programs. On 11/5/25 at 8:30 a.m. (when asked about restorative), the Director of Nursing (DON) stated they did not have a restorative aide. The facility Restorative Walk and Dine Program revised 7/30/25 identified the purpose to assist a resident to maintain ability to ambulate independently or with limited assistance. Responsible employees included Certified Nursing Assistant's (CNA's) and Restorative Nursing Assistant's (RNA's). A resident capable of ambulating to and from the dining room would be placed on the Walk and Dine Program. The facility's restorative program did not address a resident's ROM.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure a resident received dietary supplements as planned to maintain or increase weight for 1 of 3 residents reviewed (Resident #11). The facility reported a census of 46 residents.Findings include:According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #11 had long and short term memory problem, and severely impaired cognitive skills for daily decision making. The resident required supervision or touching assist with eating. The resident's diagnoses included non-Alzheimer's dementia. The resident weighed 125# and did not have a weight loss of 5% or more in a month, or 10% or more in 6 months. The Care Plan dated 10/15/25 identified the resident at nutritional risk related to dementia. The interventions included a regular diet with boost supplementation 3 times a day (TID). The weight record documented the resident weighed: a. 129 on 9/2/25, b. 125.4 on 9/16/25, c. 120.7 on 10/7/25, a 6.4% loss, (5% in 1 month is significant). d. 117.5 on 10/14/25, e. 116.9 at 10/21/25, a 9.4% loss in 50 days, (10% in 180 days is significant).The record lacked a weight the last week in October.The resident's weight obtained per request on 11/5/25 of 119.8#. The clinical record lacked any documentation the facility notified the physician or Resident #11's representative of the significant weight change. The diet sheet utilized by dietary showed Resident #11 on a regular diet with Boost TID. The Dietary flowsheet for October 2025 showed documentation the resident received supplement with breakfast and dinner. It lacked documentation the resident received a supplement 3 times a day. On 11/5/25 at 8:22 a.m. Staff D Dietary Aide (DA) stated the supplement was Boost and how much she took. On 11/5/25 at 8:45 a.m. the Director of Nursing (DON) looked at the weights and the last weight recorded on 10/21/25. She thought they had the supplement taken care of. She would see about a weight, and the supplement. On 11/5/25 at 5:20 p.m. the DON and Dietary Supervisor (DS) stated they were to give the resident Boost 3 times a day. The DS said she couldn't say why it was not documented on the evening shift. The DON stated they talked about the resident in the weight meeting, so they knew about the loss. In an email on 11/6/25 at 9:23 a.m. the DON wrote she didn't have specific notes, but they talked about Resident #11's weights at the 10/21 and 10/28/25 weight meetings. The facility Weight and Height policy reviewed/revised 9/30/25 identified the purpose to ensure residents maintained acceptable parameters of nutritional status regarding weight and to report changes in a resident's clinical condition (significant weight change) to the physician and family and/or resident, to accurately measure weight and height, and to monitor weight loss or gain in a resident. Residents at nutritional risk would be weighed weekly. The location would immediately inform the resident, consult with the resident's physician, and notify the resident's legal representative when there was a significant change in the resident's weight. Based on a resident's comprehensive assessment, the location ensured that a resident maintained acceptable parameters of nutritional status, such as body weight, unless his/her clinical condition demonstrated it was not possible. If weight varied by more than three percent, reweigh the resident and document. Significant weight change was defined as five percent in 30 days, 7.5 percent in 90 days and 10 percent in 180 days.