STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165397	A. BUILDING B. WING	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartland Care Center	**604 East Fenton PO Box 608 PO BOX 608, Marcus, Iowa, 51035**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 X DC	INITIAL COMMENTS Correction date 6/3/2026 The following deficiencies resulted from the facility's annual recertification survey conducted on May 4th, 2026 to May 7th, 2026. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000		
F0801 SS = E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.	F0801	F801 Qualified Dietary Staff 1. Resident # 4, #14, and #26 were reviewed for weight loss, skin/pressure areas/change in conditions and admissions by the dietician. Resdt # 17 and #20 no longer reside at Heartland Care Center. 2. Like residents were reviewed and assured assessments are completed timely. 3. Nursing and dietary staff were educated on the need to have the assessments completed by the dietician. 4. An audit will be completed for Dietitian Assessments on admissions and change of conditions weekly for four weeks and then once a month for 2 months. The results will be reviewed through the QAPI committee as needed. The DON is responsible for monitoring and follow-up as needed	6/3/2026

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 reverse for further 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
[signature]	Administrator	5/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165397	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/07/2026

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F0801 SS = E	Continued from page 1 (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.	F0801		

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F0801 SS = E	Continued from page 2 This REQUIREMENT is NOT MET as evidenced by: Based on facility record review, staff interviews, and facility policy, the facility failed to provide nutritional assessments for Resident's #4, #14, #17, #20, #26, #32. The facility reported a census of 27 residents. Findings include: 1. Resident #4's Minimum Data Set (MDS) dated 4/28/26 assessment identified a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. Resident #4's diagnoses include gastro-esophageal reflux disease (GERD), type 2 diabetes mellitus (DM), and congestive heart failure (CHF). The MDS identified Resident #4 was on a regular diet and needed supervision or touching with eating. The MDS also identified Resident #4 admitted to the facility on 2/6/26 with a Stage 2 and Stage 3 pressure ulcer. Review of the clinical assessments revealed the facility failed to do an nutritional admission assessment on Resident #4. 2. Resident #14's MDS dated for 3/2/26 assessment identified a BIMS score of 10 indicating moderately impaired cognition. The MDS documented diagnosis of stroke, anxiety disorder, diabetes mellitus and hypertension. The MDS identified Resident #14 was on a regular diet and needed supervision or touching assistance with eating. The MDS indicated Resident #14 admitted to the facility on 2/23/26. Review of the clinical assessment revealed the facility failed to do an nutritional admission assessment on Resident #14. 3. Resident #17's MDS dated for 4/30/26 assessment identified a BIMS score of 6 indicating severe impaired cognition. The MDS documented a diagnosis of cerebrovascular accident (CVA), anxiety disorder, hypertension (high blood pressure). The MDS identified Resident #17 was on a general diet and is independent with eating. Review of the Progress Notes on 4/30/26 indicated Resident #17 had a choking episode.	F0801		

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F0801 SS = E	Continued from page 3 Review of the clinical assessment revealed Resident #17 had a nutritional assessment completed on 12/30/25 and 12/13/24. The clinical assessment lacked nutritional assessments between these two assessments and after her choking incident on 4/30/26. 4. Resident #20 MDS dated for 4/27/26 assessment identified a BIMS score of 15 indicating intact cognition. The MDS documented a diagnosis of dysphagia(difficulty swallowing), coronary artery disease (CAD), hypertension(high blood pressure), and Diabetes Mellitus (DM). The MDS identified Resident #20 was on a regular diet and independent of eating. The MDS indicated Resident #20 admitted to the facility on 4/20/26. Review of the clinical assessments revealed the facility failed to do an nutritional admission assessment on Resident #20. 5. Resident #32 MDS dated for 4/9/26 assessment identified a BIMS score of 15 indicating intact cognition. The MDS documented a diagnosis of stroke, hemiplegia, hemiparesis, anxiety and depression. The MDS identified Resident #32 was on a mechanically altered diet and needed supervision or touching assistance with eating. Review of Progress Notes revealed Resident #32 had a choking episode on 4/11/26, the progress notes also showed Resident #32 has a hx of choking with an episode on 4/16/25, which also stated has had choking episodes in the past. Review of the clinical assessments revealed the facility completed a nutritional assessment on 1/29/25 and 10/29/25. Interview on 5/6/2026 at 5:06 pm with Staff G, Registered Dietician, stated that she comes to the facility once a month and tries to participate in the care conferences and stated sometimes they have been cancelled. Staff G stated there is not a good process when it comes to communication between her and the facility. Staff G stated that she pulls reports from the electronic health record to see who has been admitted/discharged or if there had been a change with a resident. Staff G stated that she	F0801		

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F0801 SS = E	Continued from page 4 reviews section K on the MDS, but does not always sign it off. Staff G stated that the MDS coordinator completes section K and signs it off. Staff G stated that she was not notified of the weight loss with Resident #26, or the pressure area with Resident #4. Staff G stated Resident #26 slipped through the cracks. Staff G stated she was not notified of the choking episodes for Resident #17 or Resident #32. Staff G stated that she is playing catch up on her assessments due to other responsibilities. Staff G stated the expectation would be to have all new admissions or residents with a change have an assessment and also quarterly assessment completed or more as needed. Review of the facility policy named Nutritional Management dated 1/1/26 revealed the facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. The dietary manager or designee shall obtain the resident's food and beverage preferences upon admission, significant change in condition, and periodically throughout his or her stay. A comprehensive nutritional assessment will be completed by a dietitian within 72 hours of admission, annually, and upon significant change in condition. Follow-up assessments will be completed as needed. 6. Resident #26's Minimum Data Set (MDS) dated 2/27/26 assessment identified a Staff Assessment for Mental Status indicating severely impaired cognition. The MDS identified Resident #26 was dependent on staff for eating . Resident #26's MDS included diagnoses of Alzheimer's disease, non-Alzheimer's disease, seizure disorder, anxiety and depression. The MDS identified Resident #26 was on a mechanically altered diet. A Progress Note titled Weight Change Note dated 4/7/26 revealed Resident #26 had a weight loss of 5% in the last 30 days. On 03/09/2026, the resident weighed 179.6 lbs (pounds). On 04/02/2026, the resident weighed 169.5 lbs which was a -5.62% loss. The Clinical record lacked documentation the Registered Dietician was notified regarding the significant weight loss and lacked a nutritional assessment.	F0801		

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F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interviews and policy review, the facility failed to prepare, distribute and serve food in accordance with professional standards for food service safety. The facility identified a census of 27 residents. Findings include: 1- During the initial tour of the kitchen on 5/4/26 at 10:30 AM observed the oven hood was dirty with build up of debris, dust and grease. A sticker on the hood indicated the last time the hood was cleaned by an outside company was in January 2026. On 5/5/26 at 12:05 PM, observation revealed the Dietary Manager placed one of the oven hood inserts/filters into the sink to soak and to clean. She reported the cold water outside did not help clean the insert. The Dietary Manager acknowledged the hood vent was dirty with a lot of build up. She reported with a lot of Dawn dish soap and scrubbing she might be able to get some of the buildup off. On 5/5/26 at 12:45 PM, the Dietary Manager reported the facility did not have a schedule to clean	F0812	F812 Food Storage and Procurement 1. Current resdts were reviewed for food safety and sanitation 2. Like residents were reviewed to assure food safety and sanitation is completed with meals 3. Dietary staff were educated 5.8.2026 on food procurement/temperatures and sanitation/cleaning. 4. An audit will be completed on the three residents for food sanitation/ cleaning and procurement/temperatures by the dietary manager/dietitian weekly for four weeks and then once a month for two months. The results will be reviewed through the QAPI committee as needed.	6/03/2026

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F0812 SS = E	Continued from page 6 the hood vent in-between the professional cleaning. She said she did not think the professional cleaning company did a very good job the last time the hood vent was cleaned in January 2026. She reported she thought the facility might purchase new vent inserts/filters and then start a regular cleaning schedule. She said it might not hurt to clean the hood vent monthly. 2- On 5/5/26 at 11:30 PM, observation revealed three cans of tomato soup on the steam table. Staff C, Cook took a temperature of one can of tomato soup and the temperature was 152 degrees Fahrenheit. Staff C said she heated the tomato soup in the can as she had better luck with the temperatures then putting the soup in a coffee mug on the steam table. On 5/5/26 from 11:30 PM to 12:30 PM, observation revealed Staff C, Cook wore gloves during the meal service. Staff C touched multiple services with the gloves that included but not limited to the resident's paper menus, plates, utensils, aluminum foil, serving cart, ketchup bottle, and scissors. Staff C did not use a utensil to serve the buttered bread or when getting the hamburger buns and bread out of the plastic bag. Staff C used her gloved hands that had touched multiple surfaces. In addition, Staff C while wearing contaminated gloves took a hamburger bun out of the plastic bag, reached into the steam table and grabbed a plastic bag that had a hamburger patty in it. Staff C took the hamburger patty out of the plastic bag with her gloved hand and placed the patty on the hamburger bun then served it. On 5/5/26 at 12:30 PM observation revealed one puree pouch of carrots, one puree pouch of green beans and two puree pouches of chicken on the steam table. Staff C, Cook reported the puree pouches were reheated on the steam table. Additional observations during meal service included the following: a. Staff D, housekeeper came into the kitchen, walked up next to the steam table during meal service with no hair net in place. b. Three room trays were assembled and taken to the resident's rooms with a piece of cake on each tray not covered. On 5/5/26 at 12:45 PM, the Dietary Manager reported the cook wore gloves during the meal service because she had long finger nails. The Dietary Manager said the expectation was for the	F0812		

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F0812 SS = E	Continued from page 7 staff to use a utensil like tongs when serving the bread/buns and food items should be covered when delivering room trays. On 5/5/26 at 3:20PM, the Dietary Manager reported the steam stable was to be used to hold temperatures and not reheat food. She said she would expect the food to be heated in the microwave to a temperature of 165 degrees Fahrenheit and then held on the steam table at 135 degrees Fahrenheit. The facility policy titled Food Safety Requirements dated 2/1/26 documented the following: a. Reheating food that was cooked and cooled must be reheated so that all parts of the food reach an internal temperature of 165 degree Fahrenheit. b. Cover all food when traveling a distance (down the hallway) c. Dietary staff must wear hair restraints to prevent hair from contacting food. d. Staff should maintain nails that are clean and neat, and wear disposable gloves in good condition that are changed appropriately to reduce the spread of infection. The 2022 Food Code included: 46. The observation of food preparation activities and glove use by food employees was necessary. Gloves may serve as a source of cross contamination if misused. 3-304.15 Single-use gloves shall be used only for one task such as working with ready to eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruption occurs in the operation. 4-202.18 Filters or other grease extracting equipment should be designed to be readily removable for cleaning and replacement if not designed to be cleaned in place.	F0812	F580 Family and Provider notification of changes in condition 1. Resdt #26, and #32 families and providers were notified of the change in condition. Resdt #17 no longer resides at Heartland Care Center. 2. Like residents were reviewed to assure family and provider notifications are in place for change in conditions. 3. Nursing staff were educated 5.8.2026 on the need to notify family and providers with changes in conditions to include concerns that are being followed up on. 4. An audit will be completed on the three residents that has a change of condition by the DON or Designee weekly for four weeks and then once a month for two months. The results will be reviewed through the QAPI committee as needed.	06/03/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F0580		

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F0580 SS = D	Continued from page 8 representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by:	F0580		

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F0580 SS = D	Continued from page 9 Based on clinical record review, staff interviews and policy review, the facility failed to notify the Physician and/or family when a resident had a significant change of condition for 3 of 3 residents reviewed (Resident #26, #17, #32). The facility reported a census of 27 residents. Findings include: 1. Resident #26's Minimum Data Set (MDS) dated 2/27/26 assessment identified a Staff Assessment for Mental Status indicating severely impaired cognition. The MDS identified Resident #26 was dependent on staff for eating . Resident #26's MDS included diagnoses of Alzheimer's disease, non-Alzheimer's disease, seizure disorder, anxiety and depression. The MDS identified Resident #26 was on a mechanically altered diet. A Progress Note titled Weight Change Note dated 4/7/26 revealed Resident #26 had a weight loss of 5% in the last 30 days. On 03/09/2026, the resident weighed 179.6 lbs (pounds). On 04/02/2026, the resident weighed 169.5 lbs which was a -5.62% loss. The Clinical Record lacked documentation Resident #26's family was notified regarding the significant weight loss. On 5/5/26 at 5:00 PM, the Director of Nursing (DON) reported she could not locate any documentation that Resident #26's family was notified of the weight loss. The DON reported it was an expectation for the family to be notified. The facility policy titled Weight Monitoring dated 1/1/26 documented a significant change in weight was defined as: 5% change in weight in 1 month 7.5% changed in 3 months 10% change in weight in 6 months The undated facility policy titled Family Notification and Update Policy and Procedure documented in the event a resident experiences a significant change in level of care or major incident, the facility was to notify the responsible party. The policy documented a list of reasons a family would be notified included	F0580		

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F0580 SS = D	Continued from page 10 significant change in condition and a choking incident. In addition, the policy directed anytime a physician was required to be contacted; the facility policy was to contact the responsible party as well. The facility policy titled Notification of Changes dated 1/1/26 documented the purpose of the policy was 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 was a change requiring notification. 2. The Minimum Data Set (MDS) assessment dated 4/30/26 for Resident #17 showed the Brief Interview for Mental Status (BIMS) score of 6, indicating severely impaired cognition. The MDS documented diagnosis of cerebrovascular accident (CVA), anxiety disorder and gastro esophageal reflux disease (GERD). The facility progress notes dated 4/30/26 at 12:14 pm revealed Staff E, MDS Coordinator was informed Resident #17 was choking on a piece of meat, by her tablemate. Staff E took Resident #17 out of the dining room to clear her throat. Resident #17 was talking and coughing. Will assess Resident #17's lung sounds and temperature every shift x 3 days. The facility progress notes dated 4/30/2026 at 12:51 pm revealed Resident #17's temperature was 98.2 and lungs sounds had slight expiratory wheezes. Staff F, Registered Nurse (RN) helped clean food out of teeth and rinse mouth. Resident #17 reported she just chewed her meat wrong. The clinical record lacked documentation Resident #17's physician was notified of the incident. 3. The Minimum Data Set (MDS) assessment dated 4/9/26 for Resident #32 showed the Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented diagnosis of Cerebrovascular Accident (CVA), hemiplegia (a form of paralysis affecting one side of the body, either the right or left side, including the arm, leg, and sometimes face) and hemiparesis (a neurological condition characterized by weakness, numbness, or reduced movement capability on one side of the body, often following a stroke, brain injury, or tumor), depression and anxiety disorder. The MDS identified Resident #32 was on a mechanically altered diet. The facility progress notes dated 4/11/2026 at 9:00	F0580		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartland Care Center	**604 East Fenton PO Box 608 PO BOX 608, Marcus, Iowa, 51035**

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F0580 SS = D	Continued from page 11 am revealed Resident #32 had a choking episode at breakfast while eating scrambled eggs. Resident #32 had a small emesis but reports feeling fine. Lung sounds clear and oxygen saturation at 97%. Resident #32 reported feeling better and went back and finished eating her breakfast. Review of the physician orders dated 7/22/25 reveled Resident #32's diet as regular diet, moistened ground meat texture, thin consistency. The clinical record lacked documentation Resident #32's physician was notified of the incident. On 5/6/26 at 2:00 pm the DON stated the expectation would be if a resident has a choking episode to notify the physician.	F0580		
F0725 SS = D	Sufficient Nursing Staff CFR(s): §483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e)	F0725	F725 Sufficient Staffing 1. Resdt #24 was reviewed for call light times. 2. Like residents were reviewed and assured call lights were attended to timely 3. Nursing and dietary staff were educated on the need to respond to all call lights within 15 minutes with education to shut off the light when enter the room. 4. An audit will be completed on the three residents that use the call light by the DON or Designee weekly for four weeks and then once a month for two months. The results will be reviewed through the QAPI committee as needed.	06/03/2026

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F0725 SS = D	Continued from page 12 of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on facility records, resident interviews, and staff interviews, the facility failed to provide sufficient staff to care for residents in a timely manner. The facility reported a census of 27 residents. Findings include: The Minimum Data Set (MDS) for Resident #24 dated 3/11/26 assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The Census revealed Resident #24 resided in room #104. On 5/04/2026 at 1:10 PM, Resident #24 reported he had a long call light yesterday afternoon. He said the call light was on for 30 minutes. He said he looked at the clock when he put the light on and looked at the clock again when the light was answered. Resident #24's daughter was present in the room and reported usually the call light was used when Resident #24's wife, who also resides in the room, needed to go to the bathroom. Review of Resident #24's call light reports for room #104 from 4/29/26 to 5/6/26 revealed the highest elapsed time was 34 minutes and 50 seconds. The call light report documented Resident #24's call light was on 15 minutes or more on the following dates and times: 4/30/26-4:09 AM= 21 minutes and 45 seconds 4/30/26- 8:31 PM= 19 minutes and 11 seconds 5/1/26- 8:08 AM= 31 minutes and 3 seconds 5/1/26- 8:10 PM= 18 minutes and 14 seconds 5/2/26 - 6:56 AM= 31 minutes and 18 seconds 5/2/26- 1:26 PM= 17 minutes and 34 seconds 5/2/25- 8:18 PM= 21 minutes and 38 seconds 5/3/26- 9:34 AM= 34 minutes and 50 seconds 5/5/26- 7:30 AM= 17 minutes and 56 seconds	F0725		

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F0725 SS = D	Continued from page 13 5/6/26- 7:58 AM= 23 minutes and 9 seconds On 5/6/26 at 11:23 AM, the Director of Nursing (DON) reported the standard response time for call lights was 15 minutes. She reported the facility did not have a call light policy.	F0725		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F0880	F880 Infection Control 1.Resident # 23 was reviewed for proper glove use with incontinent care. 2.An audit of residents that receive incontinent care was reviewed for proper practices. 3.Nursing staff were educated on 5/8/2026 for glove protocol (donning /doffing). 4.An audit will be completed on the three residents that require incontinent care by the DON or Designee weekly for four weeks and then once a month for two months. The results are reviewed through the QAPI committee as needed. The DON is responsible for monitoring and follow-up as needed.	06/03/2026

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F0880 SS = D	Continued from page 14 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, clinical record review, staff interviews, and policy review, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 1 of 1 resident reviewed (Resident #23) for peri care. The facility reported a census of 27 residents. Findings include: Resident #23's Minimum Data Set (MDS) dated 3/17/26 assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS identified Resident #23 was dependent on staff with toileting hygiene and was occasionally incontinent of urine. Resident #23's MDS included diagnoses of Parkinson's disease and Transient Ischemic Attack (TIA). The Care Plan with target date of 6/15/26 revealed	F0880		

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F0880 SS = D	Continued from page 15 Resident #23 had a urinary tract infection (UTI) and an overactive bladder. The care plan directed staff to clean the peri area and to change the disposable brief after each incontinent episode. The May 2026 Medication Administration Record (MAR) revealed Resident #23 was taking Macrodantin (antibiotic) 100 MG (milligrams) twice a day for a UTI with the last dose scheduled the morning of 5/4/26. The Progress Note on 4/28/26 documented Resident #23 was on enhanced barrier precautions due to positive urine culture for ESBL (extended-spectrum b-lactamases). On 5/5/26 at 9:10 AM, observed Staff A, Certified Nursing Assistant (CNA) in Resident #23's room with a gown and gloves on. Staff A placed a harness for the mechanical stand behind Resident #23's back, attached the harness to the mechanical stand, buckled the chest strap and applied the leg strap. Staff B, CNA assisted Resident #23 to a standing position using the mechanical stand and then pushed Resident #23 into the bathroom in front of the toilet. Staff A assisted with pulling down Resident #23's pants with the same pair of gloves she had worn to hook up the mechanical stand. Staff B then lowered Resident #23 onto the toilet with the mechanical stand. Staff A placed a paper towel on the edge of the sink, took multiple incontinent wipes from the container and laid the wipes on the paper towel while still wearing the same pair of gloves. Staff B then raised Resident #23 off the toilet to a standing position with the mechanical stand. Staff A then proceeded to complete peri care with the incontinence wipes using the same pair of contaminated gloves. On 5/5/26 at 9:30 AM, Staff A, CNA acknowledged she had touched multiple surfaces with her gloves prior to performing peri care. She agreed that she probably should have changed her gloves before completing the peri care. On 5/6/26 at 12:45 PM, the Director of Nursing (DON) said she expected the staff to have their equipment prepared ahead of time and agreed the gloves should have been changed prior to completing the peri care. The facility policy titled Personal Protective Equipment dated 1/3/25 documented the facility promoting appropriate use of personal protective equipment to prevent the transmission of pathogens to resident, visitors and other staff. The policy directed staff to change gloves and perform hand	F0880		

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F0880 SS = D	Continued from page 16 hygiene between clean and dirty tasks, when moving from one body part to another, when heavily contaminated, or when torn.	F0880		