DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165591	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spurgeon Manor	**1204 Linden Street , Dallas Center, Iowa, 50063**

(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 Ok ✓ Lg	INITIAL COMMENTS Correction date: 4-23-2026 The following deficiencies resulted from investigation of complaints #2972221-C, and facility reported incident #2745343-I conducted April 20, 2026 to April 22, 2026. Complaint #2972221-C did not result in a deficiency. Facility reported incident #2745343-I resulted in a deficiency. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000	As a result of the deficiencies cited during the survey ending 4/22/2026, the facility has prepared and submitted a Plan of Correction and credible allegation of compliance to your office. Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or conclusion set forth on the statement of deficiency. This Plan of Correction is prepared and submitted soley because of requirements under state and federal law. This Plan of Correction constitutes my credible allegation of compliance. Spurgeon Manor respectfully requests that it be certified as having achieved substantial compliance as of 4/23/2026.	✓ April 23, 2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F0656		

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
Crystal Dyer	Administrator	5-1-2026

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F0656 SS = D	Continued from page 1 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, staff interviews and policy review the facility failed to develop a care plan to address suicidal ideations and interventions for suicidal precautions for 1 of 3 residents (Residents #1) reviewed for comprehensive care plans. The facility reported a census of 50 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated 1/13/26 identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS identified Resident #1 required partial/moderate assistance with bed mobility and transfers. The MDS included diagnoses of vascular dementia with anxiety disorder and depression. A Hospital Psychiatry Consult Note dated 1/6/26 documented Resident #1 presented from the assisted living care facility for suicidal gestures. Resident #1's daughter was present and reported there had been discussion with the assisted living care facility to transition Resident #1 to a higher level of care given the number of falls she has had despite optimizing her environment. Resident #1 was	F0656	To correct this deficiency, the care plan for Resident 1 has been updated to address suicidal ideations with resident centered interventions and include recommendations from the PASRR. To prevent this from recurring, a PIP has been created to improve care plan accuracy, timeliness of updates, and lack of appropriate interventions. This team meets on a weekly basis and will trial different methods of ensuring that the IDT has information added or removed from the care plan timely. This will be monitored by the DON or designee completing at least three random care plan audits per week for accuracy. Audit completion will be reported on weekly during the nursing leadership meeting.	April 23, 2026

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F0656 SS = D	Continued from page 2 informed of this which precipitated her using a pen to cut her wrist and using the lens of her glasses to attempt to cut her wrist. The note documented there had been history of one other suicidal gesture using a plastic cup to express her frustration per family report while transitioning care. The note documented clinical impression was non-suicidal self-harm and recommended discharging back to the care facility. A Progress Note titled Admission Note dated 1/7/26 at 2:50 PM, documented Resident #1 admitted from the emergency room for suicidal ideation. Review of the Interim Plan of Care dated 1/7/26 and the Comphrensive Care plan initiated on 1/8/26 did not address suicidal ideation or gestures. The plan of care lacked direction or interventions on suicide precautions, what to do if Resident #1 expressed suicidal ideation or attempted self harm. A Progress Note dated 1/24/26 at 5:40 PM documented Resident #1 was in the recliner rubbing a drink coaster across her wrist. Staff A, Licensed Practical Nurse (LPN) asked what she was doing and she stated she was trying to kill herself. Staff A took the coaster away and provided one on one. A Progress Note dated 1/24/26 at 5:48 PM documented Resident #1 was sitting in her recliner, she took off her glasses, twisted them and broke them. Resident #1 made statements about wanting to die. Resident #1 assisted to bed to lie down. Resident #1's daughter notified and one on one provided. A Progress Note dated 1/24/26 at 6:54 PM documented Resident #1 had been in bed with Staff A providing one on one. Resident #1 took off her rings and tried to put them in her mouth to swallow them. Staff A took the rings. Resident #1 then took off her earrings and tried to put them in her mouth and Staff A intercepted the earrings. Resident #1 then reached for the telephone cord on the floor and Staff A took the cord away. Resident #1 kept saying that she wanted to kill herself and just die. The note documented one on one was not working with the nurse sitting with Resident #1. A Progress Note dated 1/24/26 at 7:18 PM revealed Staff A notified the Provider, daughter and called for an ambulance. A Progress Note dated 1/24/26 at 7:32 PM revealed Resident #1 left the facility via ambulance. The Clinical Census revealed Resident #1 was	F0656		

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F0656 SS = D	Continued from page 3 admitted to the hospital on 1/24/26 and returned to the facility on 2/10/26. Review of the Comprehensive Care Plan revealed the care plan was not updated when Resident #1 return from the hospital on 2/10/26. The care plan was updated on 2/18/26 to include interventions related to self harm. On 4/21/26 at 11:40 AM, the Director of Nursing (DON) acknowledged she had updated Resident #1's care plan to include interventions related to self harm on 2/18/26. The DON said she would have expected self harm and interventions to be addressed prior to 2/18/26 on the baseline care plan and comprehensive care plan. On 4/21/26 at 2:25 PM, the MDS Coordinator acknowledged the comprehensive care plan was not updated when Resident #1 returned from the hospital. She said she had 19 assessments due that week and no help to update the care plans. The facility policy titled Comprehensive Care Plans revised 2025 documented it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. f	F0656		

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N0105 SS = D	481- 50.7 (10A,135C) Additional notification CFR(s): 50.7(5) 481-50.7 (10A,135C) Additional notification. The director or the director ' s designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III): 50.7(5) When a resident attempts suicide, regardless of injury. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on facility document review and staff interviews, the facility failed to report in a timely manner a suicide attempt to Iowa Department of Inspections, Appeals and licensing (DIAL) for 1 of 1 resident (Residents #1). The facility reported a census of 50 residents. Findings include: A Facility Self Report to DIAL by the Administrator with a submission date of 2/16/26 revealed on 1/24/26 at approximately 5:40 PM, Resident #1 was observed by Staff A, Licensed Practical Nurse (LPN), to be rubbing a coaster across her wrist. The nurse took the coaster away and spent one on one time with Resident #1. At approximately 7:00 PM, while Staff A was present, Resident #1 took her rings and earrings off, tried to eat them and stated she wanted to die. Staff A removed the items that could be used for self harm, contacted the Provider, ambulance and sent Resident #1 to the hospital for psychiatric treatment. On 4/20/26 at 5:00 PM, the Administrator acknowledged the self report was filed late. The Administrator stated she was not aware at the time that suicide attempts were reportable. On 4/21/26 at 8:07 AM, the Administrator reported the facility did not have a policy regarding self reports.	N0105	Upon learning that suicide attempts were reportable, the incident was immediately reported to DIAL. At the time of the incident, Spurgeon Manor staff followed the nursing protocol for a suicide attempt correctly and the resident was kept safe. To prevent recurrence, the facility has implemented a self-reporting policy that clearly states what types of events need reported, and the time frames to do so. Compliance with the self-reporting policy will be monitored at QA meetings with the interdisciplinary team.	April 23, 2026

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	5-1-2026