STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165384	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheffield Care Center	**100 BENNETT DRIVE , SHEFFIELD, Iowa, 50475**

(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: 8/27/25 The Sheffield Care Center is not in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities due to the following deficiencies written during the annual recertification survey conducted August 18th, 2025 - August 21st, 2025. Total census: 37	F0000		
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 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.	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

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F0656 SS = D	Continued from page 1 (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, observations and staff interviews the facility failed to implement care plan interventions related to not locking smoking materials for one resident (Resident #27). The facility reported a census of 37 residents. Findings include: 1. Resident #27's Minimum Data Set (MDS) assessment dated 7/26/25 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of cerebrovascular accident (CVA or stroke), anxiety and depression. The Care Plan Focus initiated 5/7/24 related to smoking. The Focus reflected Resident #27 smoked for a long-time but recently decided to quit due to the cost of cigarettes however, he did occasionally smoke. Resident #27 had a history of extinguishing his cigarettes on his wheelchair, then keeping the cigarette butts, and storing them in his wheelchair bag. The Interventions directed to store Resident #27's smoking supplies in the north nurses' station. The Smoking - Safety Screen dated 7/26/25 indicated Resident #27 needed the facility to store lighter and cigarettes. On 8/18/25 at 12:03 PM Resident #27 stated he smoked	F0656		

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F0656 SS = D	Continued from page 2 and rolled his own cigarettes in his room. Resident #27 explained he went outside to smoke around 20-30 times a day. He added he could go unsupervised. On 8/20/25 at 9:45 AM observed Resident #27 go outside to smoke. Resident #27 lit his own cigarette and distinguished it in the proper container. Resident #27 didn't stop at the nurses' station to get his smoking materials and didn't drop them off at the nurse's station after he finished smoking. On 8/20/25 at 10:00 AM, Resident #27 stated he kept his cigarettes and lighter in his bag on his wheelchair, so he didn't forget to take them with him when he went outside. On 8/20/25 at 10:40 AM Staff G, Certified Nurse Aide (CNA), reported Resident #27 kept his lighter and cigarettes on him. The Care Plans, Comprehensive Person-Centered policy revised December 2016 instructed to develop and implement a comprehensive, person-centered Care Plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional for each resident. a. The Care Plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 2. Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care. 3. The resident will be informed of his or her right to participate in his other treatment. 4. An explanation will be included in a resident's medical record if the participation of the resident and his/her resident representative for developing the resident's Care Plan is determined to not be practicable. The care plan process will: a. Facilitate resident and/or representative involvement b. Include an assessment of the resident's strengths and needs c. Incorporate the resident's personal and cultural preferences in developing the goals of care.	F0656		

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F0656 SS = D	Continued from page 3 5. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 6. Assessments of residents are ongoing, and Care Plans are revised as information about the residents and the residents' condition change. 7. The Interdisciplinary Team must review and update the care plan: a. When a resident had a significant change in their condition b. When the resident didn't meet the desired outcome 8. The resident has the right to refuse to participate in the development of his/her Care Plan, medical, and nursing treatments. The nurse would document the refusals in the resident's clinical record in accordance with established policies. An interview on 8/20/25 at 3:30 PM the Director of Nursing (DON) acknowledged she missed updating Resident #27's Care Plan related to locking his smoking materials.	F0656		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An	F0657		

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F0657 SS = D	Continued from page 4 explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, staff interview, and facility policy review the facility failed to update a resident's Care Plan to accurately reflect the resident's needs for 2 of 2 residents reviewed (Residents #8 and #32). The facility reported a census of 37 residents. Findings include: 1. Resident #8's Minimum Data Set (MDS) assessment dated 5/7/25 identified a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment. The MDS included diagnoses of non-Alzheimer's dementia, depression, and hypertension (high blood pressure). The Nurse Progress Note dated 6/27/25 at 4:44 PM reflected Resident #8 fell and complained of left hip and leg pain. The Intervention listed the facility sent him to the emergency room for evaluation. The Fall Investigation dated 6/27/25 at 4:31 PM indicated Resident #8 had an unwitnessed fall. The facility sent him to the emergency room (ER) for evaluation. The Intervention reflected the facility would update his Care Plan upon return from the hospital. The Skilled Note dated 7/6/25 at 2:38 AM identified Resident #8 used a seat alarm. The Fall Investigation Report dated 7/25/25 at 5:04 AM indicated Resident #8 had an unwitnessed fall in his room. The previous fall interventions in place at the time of the fall listed grippers socks and seat alarm. The Intervention directed to change Resident #8's scenery if he appeared restless, and move him to the north dining room in the recliner to watch TV.	F0657		

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F0657 SS = D	Continued from page 5 The Care Plan Focus revised 5/14/24 reflected the last revised Intervention as 5/14/24. The Care Plan lacked information related to changing his scenery and an Intervention related to the 6/27/25 fall. 2. Resident #32's MDS assessment dated 6/24/25 identified a BIMS score of 2, indicating severe cognitive impairment. The MDS included diagnoses of benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland that commonly occurs in older men), Alzheimer's disease, and Parkinson's disease. On 8/19/25 at 10:30 AM, observed Staff E, Certified Nursing Assistant (CNA), and Staff F, CNA, provide Resident #32 perineal (peri) care and catheter care. The Clinical Physician Orders reviewed 8/20/25 included an order dated 8/4/25 to change his catheter every month and as needed (PRN). Resident #32's Care Plan lacked documentation of use of an indwelling urinary catheter. The Care Plans, Comprehensive Person-Centered policy revised December 2016 instructed to develop and implement a comprehensive, person-centered Care Plan included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. The Policy directed the following: a. The Care Plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. b. Care Plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. c. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. d. The Interdisciplinary Team must review and update the care plan: i. When a resident had a significant change in condition. iii. When the resident readmitted to the facility from a hospital stay.	F0657		

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F0657 SS = D	Continued from page 6 An interview on 8/20/25 at 3:30 PM the Director of Nursing (DON) acknowledged she missed updating the Care Plan to identify Resident #32's catheter and Resident #8's fall with fracture.	F0657		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, staff interviews, and policy review the facility failed to provide adequate nursing supervision to prevent accidents for 1 of 3 residents reviewed (Resident #13) for falls. The facility failed to complete a thorough root cause analysis (RCA) and failed to implement new and/or effective fall interventions after a fall occurred. The facility reported a census of 37 residents. Findings Include: Resident #13's Minimum Data Set (MDS) assessment dated 7/23/25 identified a Brief Interview for Mental Status (BIMS) score of 5 indicating severely impaired cognition. Resident #13 required partial/moderate assistance with bed mobility and transfers. The MDS documented Resident #13 used a walker and wheelchair for mobility. The MDS included diagnoses of cerebrovascular accident (CVA) (stroke), non-Alzheimer's dementia, hemiplegia (muscle weakness or partial paralysis on one side of the body), repeated falls, unsteadiness on feet, transient alternation of awareness, dizziness and giddiness, low back pain, and muscle spasm of back. The MDS identified Resident #13 had one fall since the prior assessment which resulted in an injury. The MDS coded Resident #13 used a chair alarm and bed alarm on a daily basis. The Care Plan Focus revised 7/23/25 identified Resident #13 had a risk for falls. The Care Plan directed the following Interventions:	F0689		

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F0689 SS = D	Continued from page 7 a. 6/20/22: Staff to assure fall interventions in place, clear environment, adequate lighting, and proper footwear b. 7/7/25: Staff to ensure fall mat under Resident #13 when in bed or chair, make sure the alarm worked and if not to notify the charge nurse c. 7/7/25: Resident #13 to wear gripper socks when in bed. The Care Plan documented Resident #13 would remove socks when in bed - 7/7/25 d. 1/6/25: Resident #13 to use a motion sensor to alert staff of movements Resident #13's Fall Risk Assessment Scored documented the following scores: a. 10/27/24 = 13 b. 1/26/25 = 27 c. 5/10/25 = 20 d. 7/30/25 = 20 The Fall Report Note dated 11/30/24 at 12:20 AM, reflected the staff found Resident #13 lying on her left side in front of the bathroom door with her walker by her side. The note documented Resident #13 did not have gripper socks on and the staff found them in her bed. Resident #13 said she was going back to bed after using the bathroom. Resident #13 complained of slight discomfort to her head without abnormalities. The note documented the new intervention as for staff to assure Resident #13 had gripper socks on throughout the night. The Fall Investigation form dated 11/30/24 documented the root cause of Resident #13's fall as she didn't have on proper footwear. The Fall Report Note dated 2/12/25 at 3:57 PM indicated when Resident #13 stood up unassisted, she fell to the floor in the dining room, and sat on her buttocks with her legs out in front. The note documented Resident #13 had a 10 centimeter (cm) by (x) 14 cm bruise that started to form. The note listed an intervention to educate staff to assure Resident #13 had the alarm under her at all times. The facility form titled 5 Why's Root Cause Analysis dated 2/12/25 identified the root cause of the fall as Resident #13 had impaired cognition, got up unassisted	F0689		

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F0689 SS = D	Continued from page 8 and didn't ask for help. In addition, it indicated Resident #13 had shoes on and had her alarm in place. The Report Note dated 3/30/25 at 5:36 AM reflected the staff found Resident #13 on the floor in her room lying on her right side near the top of her bed with both of her lower extremities extended out away from the bed. The note documented the bed alarm didn't sound and Resident #13's roommate alerted staff of her fall. The note listed the intervention as to apply gripper socks at bed time and for staff to check bed alarm placement when in bed. The facility form titled 5 Why's Root Cause Analysis dated 3/30/25 documented the root cause of the fall as Resident #13 being cognitively impaired and got up unassisted. In addition, the root cause documented Resident #13 had her gripper socks on with gripper strips on the floor in front of her bed. The Progress Note dated 7/6/25 at 12:09 AM identified the staff found Resident #13 lying on the floor on her right side in her room. She had a bed alarm in place but, it didn't work. The note documented Resident #13 had bare feet, because she removed her gripper socks in bed because her feet got too hot. The note documented Resident #13 sustained the following injuries from the fall: -right side of the head: 3 cm x 2.1 cm red raised area -right upper arm: 4 cm x 2.5 cm reddened area with 4 bruises in the proximal area of bruise. -top of the right foot: 4.4 cm x 4.1 cm bruise -left shin: 7.8 cm x 3.2 cm reddened bruise -distal area of the right elbow: 1.8 cm x 2.8 cm abrasion The note documented the intervention as staff to ensure that the bed alarm worked. If the alarm didn't work they needed to arrange for her to have a different resting place for close supervision. The facility form titled 5 Why's Root Cause Analysis dated 7/6/25 listed the root cause of the fall as Resident #13 had impaired cognition, she required assistance with mobility, and she got up unassisted without using her call light. The Fall Report Note dated 7/20/25 at 9:00 AM reflected the found Resident #13 sitting on her bottom with her	F0689		

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F0689 SS = D	Continued from page 9 legs extended and arms resting at her side in the common area in front of the TV console. The note documented Resident #13 had a skin tear to her right wrist that measured 3 cm x 2 cm. The nurse applied steri-strips. The note listed the fall intervention as to put the alarm under Resident #13 at all times and not just at bedtime. The facility form titled 5 Why's Root Cause Analysis dated 7/20/25 documented the root cause analysis of the fall as Resident #13 had impaired cognition and tried to transfer herself unassisted. The note indicated the staff didn't know why she tried to get up. On 8/20/25 at 12:10 PM, Staff H, Certified Nursing Assistant (CNA), reported Resident #13's alarm went into use at all times about a month or so ago because she continued to try and get up by herself. Staff H reported the staff transfer the alarm pad from her chair to her bed or to the couch. She said when the light started flashing on the alarm pad the battery needed to be changed. Staff H stated the facility had older alarms that didn't work, but they recently got new ones and she thought Resident #13 had one of the new alarms. During the interview with Staff H, the alarm monitor sounded at the nurses' desk. The alarm volume sounded very low, Staff H increased the volume on the alarm monitor. On 8/20/25 at 12:15 PM, the Director of Nursing (DON) acknowledged she completed the fall documentation for Resident #13 on 2/12/25 and verified she didn't have the alarm in place at the time of the fall. The DON reported they discussed resident falls and root cause analysis at a weekly meeting. When asked how they monitored Resident #13's alarm, the DON replied she thought they had the alarm on the Treatment Administration Record (TAR). She reviewed Resident #13's TAR and acknowledged it didn't contain Resident #13's bed alarm to be signed off by the nursing staff. She said that was her fault, and she would take one for the team. The DON described Resident #13 as difficult due to her cognitive impairments and that's why she had the alarm to prevent falls. She said the facility only had so much they could do. The DON acknowledged they attempted other fall interventions besides the bed alarm. On 8/20/25 at 3:12 PM, the Administrator reported the facility didn't have an alarm policy in place. On 8/20/25 at 3:14 PM, the DON reported she reviewed Resident #13's falls. She didn't find any additional fall interventions. She acknowledged the facility	F0689		

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F0689 SS = D	Continued from page 10 didn't conducted a thorough root cause analysis and the staff could have dug deeper into the falls. She said a resident always had a reason to try to get up. The Administrator was present and said they didn't like to use alarms, and the DON described alarms as a crutch for the staff. When asked regarding the fall risk assessment score, the DON responded the higher the score, the higher the risk for falls. On 8/20/25 observed Resident #13's cordless sensor had an alarm pad life good for 45 days. The pad lacked a start date and end date filled in. The warning label on the sensor pad documented the manufacturer didn't claim the device would stop elopements and/or falls. On 8/21/25 at 9:30 AM, the Social Worker reported herself as the person responsible for programming the alarms. She reported if a pad malfunctioned, the aides brought her the pad and she would replace it. The Social Worker acknowledged the facility didn't replace the alarm pad every 45 days per the manufacturer directions. She said she just changed the pads when they stopped working. The Social Worker acknowledged the sensory alarm pad had life of 45 days. She reported the facility used some of the alarm pads for over a year without issues, and some of the pads malfunctioned after 1 week of usage. She stated she educated the nursing staff that the alarms are not a fall intervention and wouldn't prevent a fall. The Social Worker said she expected the nurses to have additional fall interventions in place. She acknowledged the staff shouldn't use the alarms as interventions, and should try to figure out why the resident attempted to get up. She reported she had these types of conversations with the nursing staff, but didn't know for sure what the staff documented. The Fall Risk Assessment Policy revised December 2007 directed the staff to identify environmental factors that may contribute to falling. The staff and attending physician would collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable. The Falls - Clinical Protocol policy revised September 2012 directed the staff to attempt to define the possible causes of a resident's fall within 24-hours of the fall. The policy further directed if they had an unclear cause of a fall, if the fall may have a significant medical cause, or if the resident continued to fall despite attempted interventions, a physician would review the situation, and help identify contributing causes. The policy instructed if the	F0689		

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F0689 SS = D	Continued from page 11 facility couldn't identify or correct underlying causes, the staff would try various relevant interventions, based on an assessment of the nature or category of the fall, until their falls reduces, stops, or until the facility identified a reason the falls continued.	F0689		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observations, facility record review, staff interviews, and the facility policy, the facility failed to provide adequate care for a urinary catheter for 1 of 1 resident reviewed (Resident #32). The facility reported a census of 37 residents.	F0690		

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F0690 SS = D	Continued from page 12 Findings include: Resident #32's MDS assessment dated 6/24/25 identified a BIMS score of 2, indicating severe cognitive impairment. The MDS included diagnoses of benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland that commonly occurs in older men), Alzheimer's disease, and Parkinson's disease. The Nurse Progress Note dated 8/1/25 at 5:14 AM identified Resident #32 had a urinary catheter. The Clinical Physician Orders reviewed 8/20/25 listed an order dated 8/4/25 to change Resident #32's urinary catheter every month and as needed (PRN). On 8/18/25 at 10:22 AM, observed Resident #32's urinary catheter bag lying on the floor underneath his bed. On 8/19/25 at 1:45 PM witnessed Resident #32's urinary catheter bag hanging on the bed, lying on the floor without a dignity bag. The Catheter Care policy revised September 2014 defined the purpose of the procedure as to prevent catheter-associated urinary tract infections. The policy directed to make sure to keep the catheter tubing and drainage bag off the floor. On 8/19/25 at 2:35 PM the Director of Nursing (DON) reported they expected the catheter bag to be in a dignity bag and not touching the floor.	F0690		
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C);1819(Social Security Act §1919 [42 U.S.C. 1396r] §1919(b)(4)(C) Required nursing care; facility waivers.- §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after October 1, 1990, a nursing facility- (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week.	F0727		

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F0727 SS = F	Continued from page 13 Social Security Act §1819 [42 U.S.C. 1395i-3] §1819(b)(4)(C) REQUIRED NURSING CARE.- §1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility … must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week. §483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(c)(4) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by: Based on facility record review, staff interviews, and policy review, the facility failed to ensure a Registered Nurse (RN) worked 8 consecutive hours a day, 7 days a week. On 2/1/25 and 8/1/25 the facility failed to ensure they had an RN on duty for at least 8 hours for the entire 24 hours. The facility reported a census of 37 residents. Findings include: Review of the Nursing schedules and Timecards lacked a RN on 2/1/25 and 8/1/25. On 8/19/25 at 3:00 PM, the Director of Nursing (DON) verified she didn't work on 8/1/25. She said she didn't think about needing RN coverage. She said if she could get a day off, she takes it. On 8/19/25 at 3:56 PM, the Administrator verified the facility didn't have RN coverage on 8/1/25. She reported the DON did the best she could with RN coverage. She said the facility only had 3 RNs on staff and used agency staff for RN coverage as needed. On 8/19/25 at 6:26 PM, the Administrator reported she expected the facility to have 8 hours of RN coverage, 7 days per week. On 8/20/25 at 8:30 AM, the Administrator verified the facility didn't have RN coverage on 2/1/25.	F0727		

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F0727 SS = F	Continued from page 14 The facility's undated policy titled Registered Nurse defined the purpose of the policy as to ensure the facility had an RN available for supervision in the facility. The policy directed the facility must use the services of a RN for at least 8 consecutive hours a day, 7 days a week.	F0727		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, policy review, and staff interviews, the facility failed to keep the medication cart locked or under direct observation of authorized staff for a minimum of 7 minutes in an area where residents could access it. The facility reported a census of 37 residents. Findings include: Findings include: On 8/18/25 at 12:26 PM, observed the south side medication cart in the hallway near the nurse's station	F0761		

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F0761 SS = D	Continued from page 15 unlocked and unsupervised. During that time, witnessed the following: a.12:26 PM - 1 housekeeper walked past the unlocked medication cart. b.12:27 PM - 1 housekeeper walked past the unlocked medication cart. c.12:30 PM - 2 housekeepers walked past the unlocked medication cart. d.12:33 PM - Staff B, Licensed Practical Nurse (LPN), approached the medication cart. Staff B verified the medication cart was unlocked. Review of the undated facility policy titled, Storage of Medications, directed compartments containing medication are locked when not in use. Trays or carts used to transport such items are not to be left unattended. Compartments include, but are not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes. During an interview 8/21/25 at 8:27 AM, the Director of Nursing confirmed they expected medications to be locked when unsupervised.	F0761		
F0865 SS = F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey	F0865		

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F0865 SS = F	Continued from page 16 Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.	F0865		

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F0865 SS = F	Continued from page 17 §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is NOT MET as evidenced by: Based on review of the facility's Quality Assurance Performance Improvement (QAPI) plan, the facilities past surveys, and staff interview, the facility failed to correct their own deficiencies for 2 of 2 areas of concern. Findings include: The survey identified the following concerns at the current survey, previously cited at surveys in the past year:	F0865		

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F0865 SS = F	Continued from page 18 a. Abuse, Neglect, and Exploitation Training b. Infection Prevention and Control The facility's QAPI Plan revised April 2014 instructed the facility shall develop, implement, and maintain an ongoing facility wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems. In addition, the QAPI plan included the following objectives: a. Provide a means to identify and resolve present and potential outcomes related to resident care and services. b. Reinforce and build upon effective systems and processes related to delivery of quality care and services. c. Provide structure and processes to correct identified quality and/or safety deficiencies. d. Establish systems and processes to maintain documentation relative to the QAPI programs, as a basis for demonstrating the facility had an effective ongoing program. On 8/21/25 at 10:30 AM, the Administrator reported she didn't know of the concerns with the repeated deficiencies until identified during this survey. The Administrator reported the facility would review their current process for each area of concern and provide staff education/training. She said the concerns would be reviewed and monitored through the facility's QAPI program.	F0865		
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,	F0880		

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F0880 SS = D	Continued from page 19 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: (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.	F0880		

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F0880 SS = D	Continued from page 20 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, interviews and policy review, the facility failed to ensure infection control practices were followed during 3 resident observations (Resident #1 and Resident #32). Staff A, Registered Nurse (RN) failed to disinfect her hands between changing gloves while completing Resident #1's wound treatments. Staff F, Certified Nurse Aide (CNA), failed to complete hand hygiene between changing gloves during Resident #32's catheter and perineal (peri). In addition, the facility staff reused the same 2 personal protective gowns when caring for Resident #32 on enhanced barrier precautions (EBP) for one week before washing. The facility reported a census of 37 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated 7/30/25 identified a Brief Interview for Mental Status (BIMS) score as 15, indicating intact cognition. The MDS included diagnoses of diabetes mellitus, cellulitis of left toe and non-pressure ulcer to left lower leg. The MDS reflected Resident #1 had applications of ointments/medications other than to his feet and applications of nonsurgical dressings to his feet in the lookback period. Resident #1's Clinical Physician Orders included the following: a. 8/19/25: Iodosorb and gauze to the left second toe only, soak wound for 10 minutes with Vashe or saline soaked gauze. Change 3 times per week. Clean right first toe with Vashe or saline with dressing only (no longer doing Iodosorb to R first toe) one time a day every Tuesday, Wednesday, Friday, Sunday for wound healing and every 24 hours as needed for wound healing. b. 7/22/25: Cleanse and apply a Mepilex to the left leg wound on bath days and as needed one time a day every Tuesday, Friday and Sunday for wound 3 times per week.	F0880		

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F0880 SS = D	Continued from page 21 On 8/19/25 at 11:21 AM observed Staff A, Registered Nurse (RN), complete wound treatment to Resident #1's right first toe and left leg. Staff A changed their gloves after removing the dirty dressing from Resident #1's left second toe. Staff A failed to completed hand hygiene before she applied new gloves. After completing the wound treatment to the first toe, Staff A changed gloves but failed to complete hand hygiene before applying the new gloves. The facility policy revised August 2015 and titled, Handwashing/Hand Hygiene, documented the following: a. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water after removing gloves. b. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. c. Perform hand hygiene before applying non-sterile gloves. During an interview on 8/19/25 at 11:30 AM, the Director of Nursing (DON) reported they expected staff to complete hand hygiene when changing gloves. 2. Resident #32's MDS assessment dated 6/24/25 identified a BIMS score of 2, indicating severe cognitive impairment. The MDS included diagnoses of benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland that commonly occurs in older men), Alzheimer's disease, and Parkinson's disease. On 8/19/25 at 10:30 AM, observed Staff E, CNA, and Staff F, CNA, provide Resident #32 peri care and catheter care. Both CNA's performed hand hygiene and applied gloves to their hands. Staff E removed the front of the brief and performed Resident #32's front peri care and catheter care. Staff E removed their gloves and applied a new pair, without completing hand hygiene, before pulling up the front of Resident #32's brief. On 8/19/25 at 10:30 AM watched Staff E and Staff F apply a black gown that hanged on the back of Resident #32's door. Staff F stated they used the gowns for the EBPs for Resident #32. Staff F stated when they finished, they hang the gown back on the door, as they reused the gowns. Staff F stated they did that for all the residents who needed EBPs.	F0880		

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F0880 SS = D	Continued from page 22 On 8/19/25 at 1:30 PM witnessed Staff B, Licensed Practical Nurse (LPN), remove a black gown from the back of Resident #32's door and put it on to provide g-tube (a type of feeding tube) care. When Staff B completed the care, she placed the black gown on the back of the door. Interview on 8/19/25 at 11:50 AM the Director of Nursing (DON) stated the staff did reuse the gowns. The DON stated the staff reuse the gowns for the same resident, not for other residents. The DON stated she needed to contact housekeeping to see how they are cleaned. Interview on 8/19/25 at 12:10 PM the DON stated housekeeping changed the gowns on Monday mornings. Interview on 8/19/25 at 2:00 PM Staff I, Housekeeper, stated she took them to laundry and washed them separately on Monday morning and replaced them in the room. Interview on 8/19/25 at 2:15 PM Staff J, Environmental Services, described the black gowns as disposable. Staff J stated housekeeping collected them on Monday mornings and threw them away, then replaced them with new gowns. Staff J stated they had the gowns in the laundry room so if the staff needed a new one, they went to the laundry room to get a new one. Staff J stated she didn't know why they did it that way, that is just what they told her to do. Interview on 8/19/25 at 2:35 PM the DON shrugged her shoulders and stated she didn't know, they just did it that way. She stated her and the Administrator discussed it and thought it would be okay, but she was open for ideas. The undated website Iowa Health and Human Services described the one and done as the best practice for limiting the spread of hospital acquired infections. With routine use, one person used personal protective equipment (PPE), one time for one patient encounter, discard or fully cleans the equipment, as directed.	F0880		
F0943 SS = E	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must	F0943		

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F0943 SS = E	Continued from page 23 also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is NOT MET as evidenced by: Based on personnel file reviews, facility policy review, and staff interviews, the facility failed to provide dependent adult abuse certification training within 6 months of hire for 2 of 5 employees reviewed (Staff C, Dietary Aide, and Staff D, Housekeeper). The facility identified a census of 37 residents. Findings include: 1. Staff C's personnel file documented a hired date of 12/2/24. The personnel file lacked documentation Staff C had completed Dependent Adult Abuse Mandatory Reporter Training within 6 months of hire. 2. Staff D's personnel file documented a hired date of 10/7/24. The personnel file included a Dependent Adult Abuse Mandatory Reporter Training Certificate completed 5/30/25. On 8/19/25 at 1:42 PM, the Business Office Manager (BOM) verified Staff C didn't complete the Dependent Adult Abuse Mandatory Reporter Training and acknowledged Staff D completed their Dependent Adult Abuse Certification late. The BOM said the facility expected new hires to complete Dependent Adult Abuse Mandatory Reporter Training within 6 months of hire. On 8/19/25 at 1:50 PM, the Administrator reported she expected the staff to complete Dependent Adult Abuse Mandatory Reporter Training within 6 months of hire. The facility policy titled Abuse Prevention Policy revised December 2016 documented the facility required staff training/orientation programs that include such topics as abuse prevention, identification and	F0943		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165384	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheffield Care Center	**100 BENNETT DRIVE , SHEFFIELD, Iowa, 50475**

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F0943 SS = E	Continued from page 24 reporting abuse, stress management, and handling verbally or physically aggressive resident behavior. On 8/19/25 at 4:20 PM, the Administrator reported the facility didn't have a specific policy related to dependent adult abuse training. She said they always followed the State mandated within 6 months of hire.	F0943		

Sheffield Care Center

September 22, 2025

Plan of Correction:

F0656 Develop/Implement Care Plan

Smoking

Elements detailing how you will correct the deficiency as it relates to the individual:

Care plan was updated immediately. August 21, 2025.

How you will act to protect residents in similar situations:

Care plan will be reviewed on all quarterly smoking assessments for residents who do choose to smoke.

Include measures you will take or systems you will alter to ensure that the problem does not recur:

Smoking Assessments will be reviewed by QA team quarterly, to assure care plan matches smoking assessment.

How you plan to monitor performance to make sure that solutions are permanent:

QA Committee will monitor that assessments are completed quarterly, and care plan matches smoking assessment following exit of Survey, and as needed going forward.

F0657 Nursing Care/Comprehensive Care plan

Care plan was not updated to reflect indwelling catheter.

Care Plan was not updated to reflect resident fall with fracture

Elements detailing how you will correct the deficiency as it relates to the individual:

Care plan was updated immediately. August 21, 2025.

How you will act to protect residents in similar situations:

Nursing Education provided updating care plans upon return from hospital.

Include measures you will take or systems you will alter to ensure that the problem does not recur:

QA committee will review care plans on a quarterly MDS assessment to review that care plans have been updated.

How you plan to monitor performance to make sure that solutions are permanent:

QA will monitor care plans on a quarterly basis to review that care plans have been updated.

F0689 Free of Accident Hazards/Supervision/Devices

Elements detailing how you will correct the deficiency as it relates to the individual:

Care plan was updated immediately. August 21, 2025.

How you will act to protect residents in similar situations:

Nursing education provided appropriate interventions, and identifying root cause of falls. CNA fall report was implemented to include CNA's on identifying root causes of resident falls, to allow them to discuss and identify a root cause and to be aware of the intervention the nurse is implementing.

Include measures you will take or systems you will alter to ensure that the problem does not recur:

QA/Medicare will be reviewing CNA root causes, and review nursing fall interventions on a weekly basis to review interventions that have been implemented, reviewing that they are an appropriate intervention and that they have been implemented.

How you plan to monitor performance to make sure that solutions are permanent:

QA/Medicare Committee will monitor fall interventions on a quarterly basis to ensure proper interventions have been implemented.

F0690 Bowel Bladder/Incontinence/Catheter/UTI

Catheter bag touching the floor/no dignity bag

Elements detailing how you will correct the deficiency as it relates to the individual:

Dignity bag was provided on 8/21/2025. Dignity bags were ordered for future indwelling catheters to have in stock.

How you will act to protect residents in similar situations:

Nursing Education provided at all staff in-service on August 27, 2025.

Include measures you will take or systems you will alter to ensure that the problem does not recur:

QA will review quarterly all indwelling catheters to assure they have a dignity bag.

How you plan to monitor performance to make sure that solutions are permanent:

Audit was provided to CNAs to review shiftily for the next month, and QA will review quarterly and as needed.

F0727 RN/7days week/ Full Time DON

Two days without RN coverage.

Elements detailing how you will correct the deficiency as it relates to the individual:

How you will act to protect residents in similar situations:

Administrator will review daily that 8 Hour RN coverage is met by reviewing schedule. Signing off on the schedule monthly.

Include measures you will take or systems you will alter to ensure that the problem does not recur:

DON will provide monthly schedule to be reviewed prior to posting for each month to administrator.

How you plan to monitor performance to make sure that solutions are permanent:

QA will monitor on quarterly basis RN Coverage was met.

F0761 Label/Store Drugs and Biologicals

Unlocked Med Cart

Elements detailing how you will correct the deficiency as it relates to the individual:

Med cart was locked immediately upon notification.

How you will act to protect residents in similar situations:

Quarterly Audits will be completed by Director of Nursing to assure med cart is always locked. Staff Education was provided at Inservice on August 27, 2025, to educate staff on importance of Medication Carts remaining locked.

Include measures you will take or systems you will alter to ensure that the problem does not recur:

QA will review quarterly audits to make sure we are 100% in compliance with Med Carts remaining locked.

How you plan to monitor performance to make sure that solutions are permanent:

QA will monitor quarterly and will complete random checks of medication carts.

F0865 QAPI Program/Plan

Repeat Deficiency- Dependent Adult Abuse/Infection Control

Elements detailing how you will correct the deficiency as it relates to the individual:

1) Purchased a Laptop for New Hires to have dependent adult abuse completed prior to starting.
2) Staff Education provided at all staff Inservice on August 27, 2025, to educate importance of hand washing.
3) Education of staff August 27, 2025, on Infection Control-Dignity covers on Indwelling catheters. Dignity covers were ordered to have for future use for infection control.

How you will act to protect residents in similar situations:

QA will review quarterly that dependent adult abuse of all staff is completed within 6 months of hire.

Include measures you will take or systems you will alter to ensure that the problem does not recur:

QA will review Dependent Adult abuse certifications and assure staff are up to date quarterly.

Audits will be completed on Indwelling catheter dignity bags to ensure they are in use for all indwelling catheters and will be reviewed by QA committee.

Audits will be completed on handwashing technique during cares for 100% compliance.

How you plan to monitor performance to make sure that solutions are permanent:

QA will review all certification quarterly for 100% compliance. QA will audit indwelling catheters and handwashing techniques during cares.

F0880 Infection Control

Handwashing/Enhanced Barrier

Elements detailing how you will correct the deficiency as it relates to the individual:

1) Staff Education was provided at All Staff Inservice education on handwashing and sanitizing hands between glove changes.
2) Disposable gowns were placed in rooms that have indwelling catheters, and staff were educated on August 27, 2025, to dispose of gowns after use. Educated gowns will only be used 1 time and need to be disposed of.

How you will act to protect residents in similar situations:

Housekeeping will keep gowns stocked in rooms with indwelling catheters. Quarterly Audits will be completed quarterly to assure gowns are being disposed of after every use.

Include measures you will take or systems you will alter to ensure that the problem does not recur:

QA will review quarterly to assure 100% compliance.

How you plan to monitor performance to make sure that solutions are permanent:

QA will review all certification quarterly for 100% compliance. QA will audit indwelling catheters dignity bags and handwashing techniques during cares.

F0943 Abuse Neglect and Exploitation Training

Incomplete Dependent Adult Abuse Training

Elements detailing how you will correct the deficiency as it relates to the individual:

Lap top was ordered to be used for Dependent Adult Trainings. New Hires will have to complete prior to starting.

How you will act to protect residents in similar situations:

Quality Assurance will audit quarterly to assure 100 % compliance with Dependent Adult Abuse Trainings.

Include measures you will take or systems you will alter to ensure that the problem does not recur:

QA will review quarterly dependent adult abuse trainings to assure 100% compliance.

How you plan to monitor performance to make sure that solutions are permanent:

QA will review all certification quarterly for 100% compliance.