STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165546	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tabor Manor Care Center	209 MAIN STREET , TABOR, Iowa, 51653

(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	INITIAL COMMENTS Correction date: 01/09/2026 The following deficiencies resulted from investigation of complaint #2663246-C and facility reported incident #2662462-I conducted November 10, 2025 to November 13, 2025. Complaint #2663246-C resulted in a deficiency. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000		
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 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	F0580		

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
Mitchell Doorenbos	Administrator/owner	12/19/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	**3000 Risen Son Blvd , Council Bluffs, Iowa, 51503**

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F0658 SS = E	Continued from page 1 Resident #1's Medication Administration Record (MAR) 11/25 revealed the following entries: 11/1/25 No data for Olmesartan Medoxomil Tablet 20 mg; 1 tablet in the morning for HTN order date 10/31 and discharge (D/C) date 11/4/25. 11/1/25 No data for Protonix Tablet Delayed Release 40 mg; 1 tablet in the morning for gastroesophageal reflux (GERD) order date 10/31 and D/C date 11/4/25.11/1/25 No data for weight: daily x3 in the morning for 3 days.11/1/25 Hydralazine HCl Oral Tablet 25 mg; 1 tablet twice a day (BID) for HTN; hold if systolic blood pressure (SBP) less than 100 or pulse less than 60 order date 10/31/25 and D/C date 11/4/25. The resident's pulse in the morning (AM) was 59 and the medication was provided. 11/1/25 No data for Levetiracetam Oral Tablet 500 mg; 1 tablet by mouth BID for seizures order date 10/31/25 and D/C date 11/4/25.The facility failed to provide 3 medications as ordered by the physician, follow the orders for obtaining daily weights for 3 days, and provided medication when outside the prescribed parameters. 2. The MDS for Resident #2 dated 10/31/25 provided a BIMS score of 4/15 indicating severe cognitive impairment. The document revealed the resident had diagnoses of coronary artery disease (CAD), HTN, neurogenic bladder, Non-Alzheimer's Dementia and depression. The document disclosed Resident #2 had an indwelling catheter and took antidepressant and anticonvulsant medications. The Care Plan updated 10/9/25 contained a focus area of HTN revised on 9/15/22 with an intervention to give HTN medications as ordered, initiated 9/15/22. The document provided a focus area of CAD revised on 9/15/22 with interventions of giving all cardiac medications as ordered by physician initiated on 9/15/22 and giving medications for hypertension and document response to medication and any side effects initiated on 9/15/22. A focus area for use of antidepressant medications related to depression was revised on 9/30/22 with interventions of administration of medications as ordered revised on 9/30/22 and monitor/document/report target behaviors of sadness and slowed behavior revised on 9/30/22. A focus area of osteoporosis torticollis revised on 9/26/23 identified an intervention of administration of medications as ordered initiated on 9/15/22. A focus area of depression related to frequently refusing medications revised on 6/25/24 identified an intervention of administering medications as ordered initiated on 4/6/23. An identified focus area of diagnosis of Multiple Sclerosis (MS) Torticollis revised 12/5/23 contained interventions of administration of medications as ordered created	F0658		

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F0658 SS = E	Continued from page 2 9/15/22 and monitor/document/report signs/symptoms of depression initiated 9/15/22. Resident #2's MAR 10/25 revealed the following entries: 10/5 and 10/14/25 refusals of Polyethylene Glycol 3350 Powder; 17 gram in the morning for bowel management order date 2/12/25 and D/C date 11/8/25. 10/5 and 10/14/25 refusals of Valproic Acid Oral Solution 250 mg/ml; give 2.5 ml one time a day (QD) order date 2/12/25 and D/C date 11/8/25.10/5 and 10/14/25 refusals of Wellbutrin XL Oral Tablet Extended Release 24 Hour 300 mg; 1 tablet QD for depression order date 2/12/25 and D/C date 11/8/25.10/5 and 10/14/25 refusals of AM dose of Chlorhexidine Gluconate Mouth/Throat Solution 0.12%; give 15 ml BID for periodontal disease order date 2/12/25 and D/C date 11/8/25.10/5 and 10/14/25 refusals of AM dose of D-Mannose Oral Capsule 500 mg; 1 capsule BID for urinary health order date 2/12/25 and D/C date 11/8/25. 10/5 AM and 10/2 refusals of AM dose of Lactobacillus Oral Tablet; 1 tablet BID for infectious disease order date 2/12/25 and D/C date 11/8/25. 10/2 AM, 10/3 PM 10/5-10/6 AM, 10/8-10/10 AM, 10/10 bedtime (HS), 10/13-10/17 AM, 10/22 AM, 10/24 AM and HS, 10/26 HS, 10/27 AM refusals of Pro Stat AWC-High calorie/protein/wound BID for pressure injury; 30 cc BID mix in 4 oz juice order date 3/10/25 and D/C date 11/8/25.10/2 and 10/14/25 refusals of AM and noon,10/20/25 noon dosages of Gabapentin Capsule 300 mg; 1 capsule TID for MS order date 2/12/25 and D/C date 11/8/25.10/4/25 AM dose of Midodrine HCl Tablet 10 mg; 1 tablet three times daily (TID) for low blood pressure (BP) take 4 hours prior to bed; hold if SBP>140 order date 3/25/25 and D/C date 11/8/25. Resident with BP 147/103 with medication provided. 10/11-10/12/25, 10/19 and 10/28/25 4:00 PM doses of Midodrine HCl Tablet 10 mg; 1 tablet three times daily (TID) for low blood pressure (BP) take 4 hours prior to bed; hold if SBP>140 order date 3/25/25 and D/C date 11/8/25. Resident with BP 146/65, 157/70, 172/77, 148/74 with medication provided on all days.10/31/25 noon dose of Midodrine HCl Tablet 10 mg; 1 tablet three times daily (TID) for low blood pressure (BP) take 4 hours prior to bed; hold if SBP>140 order date 3/25/25 and D/C date 11/8/25. Resident with BP 142/84 with medication provided. Resident #2's MAR 11/25 revealed the following refusals: 11/2-11/3 HS doses of Calcium-Vitamin D Oral Tablet 500 mg; 1 tablet at bedtime for supplement order date 2/12/25 and D/C date 11/8/25.11/2-11/4 HS doses of Donepezil HCl Oral Tablet 10 mg; 1 tablet at bedtime for dementia order date 2/12/25 and D/C date of 11/8/25.11/3-11/4 doses of Polyethylene Glycol 3350 Powder; 17 grams in the morning for bowel management order date 2/12/25 and D/C	F0658		

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F0658 SS = E	Continued from page 3 date 11/8/25.11/3-11/4 doses Valproic Acid Oral Solution 250 mg/ml; give 2.5 ml one time a day (QD) order date 2/12/25 and D/C date 11/8/25.11/3-11/4 doses Wellbutrin XL Oral Tablet Extended Release 24 Hour 300 mg; 1 tablet QD for depression order date 2/12/25 and D/C date 11/8/25.11/2 HS-11/4 AM doses Chlorhexidine Gluconate Mouth/Throat Solution 0.12%; give 15 ml BID for periodontal disease order date 2/12/25 and D/C date 11/8/25.11/2 HS-11/4 AM doses D-Mannose Oral Capsule 500 mg; 1 capsule BID for urinary health order date 2/12/25 and D/C date 11/8/25. 11/2 HS-11/4 AM doses Lactobacillus Oral Tablet; 1 tablet BID for infectious disease order date 2/12/25 and D/C date 11/8/25. 11/2 HS-11/4 AM doses Pro Stat AWC-High calorie/protein/wound BID for pressure injury; 30 cc BID mix in 4 oz juice order date 3/10/25 and D/C date 11/8/25. 11/3 AM-11/4 noon doses of Gabapentin Capsule 300 mg; 1 capsule TID for MS order date 2/12/25 and D/C date 11/8/25.11/3/25 AM and 4:00 doses of Midodrine HCl Tablet 10 mg; 1 tablet three times daily (TID) for low blood pressure (BP) take 4 hours prior to bed; hold if SBP>140 order date 3/25/25 and D/C date 11/8/25. Resident #2's MAR 11/25 documented on 11/3/25 during 2-10 PM shift the resident exhibited anxiety, nervousness or crying/sadness with offering of fluids, calm environment, and warm blanket that were ineffective. The electronic medical record (EMR) Progress Notes revealed there was no notification to the primary care physician (PCP) for the refusals in October or November. The Progress Notes disclosed on 11/4/25 the resident's daughter indicated the resident did not look quite right and was taking the resident to the hospital. The 11/4/25 note further included the resident had refused all medications the previous 2 days and refused all nutrition and hydration this date. The facility failed to notify the primary care provider (PCP) of the resident's refusal of medications both on single instances and the continuous refusal over the course of 3 days and provided medication when outside of the prescribed parameters. The facility document, Hospital Referral dated 11/5/25, for Resident #2 revealed the resident was admitted to the hospital on 11/4/25 with a diagnosis of a complicated urinary tract infection and altered mental status. On 11/12/25 at 12:15 PM Staff D, Primary Care Physician (PCP) for Resident #2 stated she expected to be notified of a resident's refusal of medications. Staff D stated if a resident refused 1 scheduled medication a	F0658		

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F0658 SS = E	Continued from page 4 fax notification would be sufficient but if a resident refused multiple scheduled medications a phone call was warranted. Staff D stated her practice had an advanced practice registered nurse (APRN) on staff who could make facility rounds to address concerns. The staff stated the nurse practitioner was in the building during the course of the resident's refusals in November and was not notified of the medication refusals. Staff D stated she first became aware of the resident's situation when she received a text message stating the resident's daughter was in the facility wanting to take her to the hospital as she "wasn't quite right", was crying and the resident had refused medications during the course of 3 days which was out of the normal for the resident. Staff D stated with the resident prone to UTI's this needed to be addressed immediately and could have possibly prevented the hospitalization. On 11/12/25 at 1:35 PM the Interim Director of Nursing (IDON) acknowledged the PCP had not been notified of the resident's refusals of medications over the course of 3 days and should have been notified. 3. The MDS for Resident #3 dated 8/13/25 provided a BIMS score of 13/15 indicating normal cognition. The document revealed the resident had diagnoses of anemia, atrial fibrillation (A-Fib), orthostatic hypotension, renal insufficiency/renal failure, UTI in the last 30 days and cerebrovascular accident. The resident had an indwelling catheter and was provided anticoagulant, antibiotic and opioid medications. Resident #3's MAR 7/25 revealed the following entry:7/9/25 Metoprolol Succinate ER Tablet Extended Release 24 hour 25 mg; 1 tablet in the morning for HTN/superventricular tachycardia (SVT) hold if SBP<100 or pulse<60 order date 4/9/25 and D/C date 8/1/25. Resident with BP of 96/69 with medication provided. The facility failed to follow physician orders by providing medication outside of the prescribed parameters. Resident #3's MAR 8/25 and 9/25 revealed the following entries:8/8-8/28/25 doses of Metoprolol Succinate ER Tablet Extended Release 24 hour 25 mg; 1 tablet in the morning for HTN/superventricular tachycardia (SVT) hold if SBP<100 or pulse<60 order date 4/9/25 and D/C date 8/1/25 were provided.Review of Resident #3 vitals for BP and pulse, MAR and Progress Notes revealed no documentation for BP and/or pulse for 8/18, 8/23, 8/25, 8/27, 8/29, 9/2-9/6, 9/8 and 9/11-9/12/25. The facility failed to document the BP and pulse for a medication with prescribed parameters.	F0658		

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F0658 SS = E	Continued from page 5 Resident #3 10/25 MAR revealed the following entry:10/24/25 Metoprolol Succinate ER Oral Tablet Extended Release 24 hour 50 mg; 1 tablet in the morning for HTN order date 9/12/25 was held. The resident's order did not contain parameters for holding the medication; BP 91/46.Resident #3's 11/25 MAR revealed the following entry:11/5/25 Metoprolol Succinate ER Oral Tablet Extended Release 24 hour 50 mg; 1 tablet in the morning for HTN order date 9/12/25 was held. The resident's order did not contain parameters for holding the medication; BP 99/52. The facility failed to notify the physician and obtain an order for holding a medication. On 11/10/25 at 4:15 PM Staff A, Licensed Practical Nurse (LPN), stated if there were no entries on a MAR she would assume the medication/treatment had not been provided. On 11/12/25 at 9:50 AM Staff B, Registered Nurse (RN), stated she had completed the Resident #2's treatment on the morning of 11/4/25 and the resident had refused her medication. The staff stated the resident had a history of occasionally refusing medications, but it was unlike the resident to refuse medications for multiple shifts. Staff B stated she was not aware of the PCP being notified of the refusals and she had notified the PCP of the refusals. The staff stated if the MAR had blanks present she would think the medications had not been provided. The staff further revealed the nurse's MAR remained red if medication/treatment had not been provided during that shift providing the nurse with a reminder to complete the medication pass or treatment. On 11/12/25 at 1:35 PM the Interim Director of Nursing (IDOM) stated the MAR should contain some sort of documentation as to whether the medication had been provided. The staff stated if a medication order has parameters the medication should never be provided. The IDON stated if there were parameters for a medication the parameters must be entered prior to the administration of the medication. The staff stated if a medication does not have parameters a nurse might hold a medication until contact is made with the physician to obtain an order to hold the medication. The staff stated if a medication typically has parameters (HTN medications) those were determined by the prescribing physician. The IDON acknowledged the PCP should be notified of resident refusal of medications. The staff stated the facility will attempt 3 times before indicating refusal and will call families with some residents to assist with medication administration and then notify the physician of refusals.	F0658		

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F0658 SS = E	Continued from page 6 On 11/12/25 at 1:55 PM the Administrator stated he did not believe there would be a reason for lack of documentation on the MAR. The Administrator stated medications should not be provided outside of the prescribed parameters or holding a medication without parameters without a physician's approval. The Administrator stated that the PCP should be notified of a resident's refusal of medication(s) and would prefer a note in the Progress Notes with the details of the refusal. The facility's Documentation of Medication Administration Policy revealed a nurse or Certified Medication Aide (CMA) documents all medications administered on the MAR immediately after it is given and reason(s) why a medication was withheld, not administered or refused. The facility's Change in a Resident's Condition or Status Policy revealed the nurse will notify the attending physician or physician on call of a refusal of treatment or medications 2 or more consecutive times and significant change in the resident's physical/emotional/mental condition. The facility did not have a specific policy for following physician orders.	F0658		
F0690 SS = E	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	F0690		

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F0690 SS = E	Continued from page 7 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 clinical record review, observations, staff interview, and policy review the facility failed to provide a professional standard of quality of care by not completing catheter cares for 3 of 3 residents reviewed (Resident #1, #2, #3). The facility reported a census of 19 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #1 dated 11/3/25 provided a Brief Interview for Mental Status (BIMS) score of 6/15 indicating severe cognitive impairment. The document revealed the resident had diagnoses of atrial fibrillation (A-fib), heart failure, hypertension (HTN), urinary tract infection (UTI) - last 30 days and respiratory failure. The document disclosed Resident #1 had an indwelling catheter and took anticoagulant, diuretic, opioid, hypoglycemic and anticonvulsant medications. Resident #1's Care Plan revised 11/4/25 provided a focus area of indwelling catheter revised on 11/4/25 with interventions of Enhanced Barrier Precautions initiated on 10/25/25 and monitor/record/report signs/symptoms of UTI including cloudiness, altered mental status and change in eating patterns with initiation date of 10/24/25. The Clinical Census revealed Resident #1 was admitted on 10/24/25, discharged 10/28/25, admitted on 10/31/25 and discharged on 11/3/25. The resident's Treatment Administration Record (TAR) 10/25 revealed an order for a urinary catheter: output every shift with an order date of 10/25/25 and discharge (D/C) date of 10/28/25. The document contained no entries for the following dates: 10/26	F0690		

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F0690 SS = E	Continued from page 8 6a-2p and 10/27/25 6a-2p. The resident's TAR 11/25 revealed an order for a urinary catheter: output every shift with an order date of 10/31/25 and D/C date of 11/4/25. The document contained no entry for 11/2 2p-10p. The facility failed to document catheter output. The Electronic Medical Record (EMR) Fluid Intake Task recorded the following data:10/27/25 1:50 PM consumed 250 10/28/25 1:57 PM the resident refused10/31/25 8:48 PM consumed 24011/2/25 5:30 PM consumed 10011/3/25 8:30 AM consumed 30011/3/25 12:30 PM consumed 100The EMR Nutritional Intake Task recorded the following data:10/27/25 1:50 refusal10/27/25 1:50 PM 26-50%10/28/25 1:57 PM refusal10/31/25 8:50 PM 51-75%11/2/25 5:30 PM 0-25%11/3/25 8:30 AM 0-25%11/3/25 12:30 PM 0-25% The facility failed to follow the Care Plan for reporting of change in eating patterns as a sign/symptom of UTI. The EMR Progress notes revealed the following entries:10/28/25 10:10 AM The resident was not alert but arousable with a pulse of 47, O2 97%, blood sugar 164 and was sent to the hospital.10/28/25 1:47 PM the resident was being admitted with a UTI and low heart rate. 10/31/25 4:57 PM the resident was readmitted to the facility.11/3/25 6:51 PM the resident was acting unusually; blood pressure (BP) 66/33, pulse 68, right side of mouth drooping; order received to send to the hospital.11/3/25 11:09 PM the resident was admitted with diagnoses of hypotension and hypomagnesemia.The facility provided document, Hospital Record 10/28/25, revealed the resident was seen in the Emergency Department (ED) for evaluation of altered mental status. The family reported altered mental status, cloudy urine, concerns with BP and temperature. The report included the resident had an Indwelling Foley Catheter with overt purulence noted in the urine. The document contained the following lab data: Glucose 135 (70-100mg/dl), Chloride 111 (96-110 mmol/L), Albumin 2.6 (3.5-5.0 gm/dl), GFR Estimate 57 (>=90 mL/min/1.73 m2),Urinalysis with culture abnormal: appearance cloudy (clear), Bilirubine, UA moderate (negative), Ketones, UA trace (negative), blood small (negative), protein >=300 mg/dl (negative), Urobilinogen, UA 4.0 (0.2-1.0 EU/dl), nitrate positive (negative), leukocyte moderate (negative), RBC 5-10 (<=5/HPF), WBC >100 (<=5 HPF), Squam Epithelial 5-10 (<=5/HPF)Glucose reagent strip abnormal: Glucose Reagent Strip 156 (70-110 mg/dl)CBC auto differential abnormal: hemoglobin 11.9 (12.0-16.0 gm/dl)Medical decision making in the ED included borderline BP 83/37, temperature of 95.2 degrees and	F0690		

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F0690 SS = E	Continued from page 9 overt purulence noted in the catheter. The resident was admitted with severe sepsis with UTI without hematuria. The document included a reference of the resident having recurrent UTIs and prior admission for sepsis related to UTI. 2. The MDS for Resident #2 dated 10/31/25 provided a BIMS score of 4/15 indicating severe cognitive impairment. The document revealed the resident had diagnoses of coronary artery disease (CAD), HTN, neurogenic bladder, Non-Alzheimer's Dementia and depression. The document disclosed Resident #2 had an indwelling catheter and took antidepressant and anticonvulsant medications. The Care Plan updated 10/9/25 revealed a focus area for suprapubic catheter due to neurogenic bladder initiated on 1/12/23 and revised on 10/9/25 with UTI on 10/7 with antibiotics as ordered. Interventions included catheter care every shift initiated 11/2/20, monitor/record/report signs/symptoms of UTI including cloudiness, altered mental status, change in behavior, change in eating patterns initiated 11/2/20 and record output every shift initiated 11/2/20. The Clinical Census revealed the resident was readmitted to the facility on 5/1/25, discharged on 11/4/25 and readmitted on 11/8/25. Resident #2's 10/25 TAR contained an order for a urinary catheter: output every shift with an order date of 2/12/25 and D/C date of 11/8/25. The document lacked documentation on 10/4 6a-2p, 10/17 6a-2p and 10/31/25 2p-10p. Resident #2's 11/25 TAR contained an order for a urinary catheter: output every shift with an order date of 2/12/25 and D/C date of 11/8/25. The document lacked documentation on 11/2 10p-6a and 11/3/25 10p-6a. The facility failed to document catheter output. The EMR Fluid Intake Task recorded the following data: 11/4/25 refusal of all fluids.11/9/25 8:24 PM 48011/10/25 9:25 AM 300 The EMR Nutritional Intake Task recorded the following data:From 10/15 to 11/2/25 resident consumed 21/27 meals of 26-100%On 11/2/25 the resident refused 1 meal and consumed less than 25%On 11/3/25 the resident consumed less than 25% for breakfast and refused lunch and supper.On 11/4/25 the resident consumed less than 25% for breakfast and refused lunch. The facility failed to follow the Care Plan for reporting of change in eating patterns as a sign/symptom of UTI.	F0690		

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F0690 SS = E	Continued from page 10 The EMR Progress Notes contained an entry on 11/4/25 of the resident being transferred to the hospital and admitted for a UTI. The facility provided document, Hospital Referral dated 11/5/25, revealed the resident was admitted with a diagnosis of Complicated Urinary Tract Infection. On 11/12/25 at 12:15 PM Staff D, Primary Care Physician, stated she had not been notified of Resident #2's decrease in nutrition and hydration on the days previous to the hospitalization. The staff stated if the resident had decreased intake for nutrition and/or fluids it warranted a phone call as that was a change in condition. 3. The MDS for Resident #3 dated 8/13/25 provided a BIMS score of 13/15 indicating normal cognition. The document revealed the resident had diagnoses of anemia, atrial fibrillation (A-Fib), orthostatic hypotension, renal insufficiency/renal failure, UTI in the last 30 days and cerebrovascular accident. The resident had an indwelling catheter and was provided anticoagulant, antibiotic and opioid medications. The Care Plan revised 8/21/25 revealed a focus area of indwelling catheter revised on 7/2/25 with interventions of monitor/record/report signs/symptoms of UTI including cloudiness, altered mental status, change in eating patterns initiated on 4/9/25 and record output every shift initiated 7/2/25. The Clinical Census revealed the resident was discharged on 7/31/25 to the hospital and readmitted on 8/7/25. Resident #3's 9/25 TAR revealed an order for a urinary catheter: output every shift with an order date 8/7/25. The document contained the following documentation: 9/28/25 6a-2p no documentation 9/30/25 6a-2p 50 cc outputThe EMR Progress Notes contained no supporting documentation for lack of documentation for 9/28 6a-2p and decreased output on 9/30/25 6a-2p. Resident #3's 10/25 TAR revealed an order for a urinary catheter: output every shift with an order date 8/7/25. The document contained the following documentation: 10/4/25 6a-2p no documentation10/14/25 6a-2p no documentation10/17/25 6a-2p no documentation10/30/25 6a-2p no documentation10/31/25 2p-10p no documentationThe EMR Progress Notes contained no supporting documentation for lack of documentation for lack of documentation on 10/4, 10/14, 10/17, 10/30	F0690		

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F0690 SS = E	Continued from page 11 and 10/31/25. Resident #3's 11/25 TAR revealed an order for a urinary catheter: output every shift with an order date 8/7/25. The document contained the following documentation: 11/2/25 10p-6a no documentation11/3/25 10p-6a no documentationThe EMR Progress Notes contained no supporting documentation for lack of documentation for lack of documentation on 11/2 and 11/3/25. The facility failed to document catheter output for the months of September, October and November 2025. On 11/10/25 at 4:15 PM Staff A, Licensed Practical Nurse (LPN) stated if the MAR lacked documentation that meant the task was not completed. On 11/12/25 at 9:35 AM Staff B, LPN, stated if there was no documentation on the MAR for a treatment she would assume it had not been completed. On 11/12/25 at 9:50 AM Staff C, Registered Nurse (RN), stated if treatments were not completed it would be blank on the MAR. The staff further stated the treatment would be shown in red during the shift until documentation was completed. On 11/12/25 at 1:35 PM the Interim Director of Nursing (IDON) stated she expected that catheter output would be recorded each shift as per physician orders. On 11/12/25 at 1:55 PM the Administrator stated if an order for catheter output was on the order sheet he expected it to be completed and if the facility was unable to complete the order as written then notification needed to be made to the physician and the order changed if necessary. The Administrator expected supporting documentation to be made to support the MAR when necessary. The facility's Catheter Care, Urinary Policy, disclosed the collection bag should be emptied at least every 8 hours and follow the facility's procedure for measuring and documenting input and output. The document further revealed to report unusual findings to the physician including unusual appearance and signs/symptoms of UTI. The document provided documentation in the medical record should include the name and title of the individual(s) providing the care and characteristics of the urine including color, clarity, and odor.	F0690		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F0880		

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F0880 SS = D	Continued from page 12 §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: (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	F0880		

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F0880 SS = D	Continued from page 13 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 observation, Electronic Health Record (EHR) reviews, staff interviews, and policy reviews the facility failed to implement appropriate hand hygiene and infection control practices to mitigate the spread of pathogens during resident cares for 2 of 3 residents (Resident #2, #3). The facility failed to utilize Enhanced Barrier Precautions (EBP) and complete hand hygiene. The facility reported a census of 19. Findings include: 1. The MDS for Resident #2 dated 10/31/25 provided a BIMS score of 4/15 indicating severe cognitive impairment. The document revealed the resident had diagnoses of coronary artery disease (CAD), HTN, neurogenic bladder, Non-Alzheimer's Dementia and depression. The document disclosed Resident #2 had an indwelling catheter and took antidepressant and anticonvulsant medications. The Care Plan updated 10/9/25 revealed a focus area for suprapubic catheter due to neurogenic bladder initiated on 1/12/23 and revised on 10/9/25 with UTI on 10/7 with antibiotics as ordered. Interventions included catheter care every shift initiated 11/2/20, monitor/record/report signs/symptoms of UTI including cloudiness, altered mental status, change in behavior, change in eating patterns initiated 11/2/20 and record	F0880		

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F0880 SS = D	Continued from page 14 output every shift initiated 11/2/20 and use of EBP related to suprapubic catheter with use of signage outside the resident's room, gown and glove for high contact resident care activities revised on 4/12/25. The Care Plan failed to identify the need for EBP due to Stage 2 Pressure Ulcer. Resident #3's 11/25 Treatment Administration Record (TAR) revealed an order for EBP related to urinary catheter; EBP sign outside of resident's room. Gown and gloves for high contact resident care activities. Face shield should be used for any tasks that have high potential of splash or spray eerie shift for infection control with order date of 2/12/25 and discharge (D/C) date of 11/8/25. The document also contained an order for treatment of Stage 2 Pressure Ulcer with an order date of 10/31/25 and D/C date of 11/8/25. Resident #3's 11/25 Treatment Administration Record (TAR) revealed an order for EBP related to urinary catheter; EBP sign outside of resident's room. Gown and gloves for high contact resident care activities. Face shield should be used for any tasks that have high potential of splash or spray eerie shift for infection control with order date of 11/8/25. The document also contained an order for treatment of Stage 2 Pressure Ulcer with an order date of 11/8/25. Observed on 11/10/25 at 1:15 a U.S. Department of Health and Human Services Centers for Disease Control and Prevention EBP sign posted outside of Resident #2's room with Personal Protective Equipment (PPE) present. Observed on 11/12/25 at 7:10 Staff E, Certified Nursing Assistant (CNA), complete care for Resident #2. The staff completed hand hygiene, donned a gown and gloves and entered the resident's room. The staff completed peri care maintaining infection control practices. Following the completion of catheter care Staff E removed gloves and gown, completed hand hygiene and went to obtain assistance for transferring the resident. Staff F, CNA, came into the room donning gloves with a dependent mechanical lift. Staff E donned new gloves. Staff E and Staff F placed the dependent lift sling under the resident, completed the transfer, and positioned the resident in a wheelchair. Staff E continued with grooming tasks. Staff E and Staff F failed to follow EBP with the completion of a transfer and grooming tasks without wearing a gown. 2. The MDS for Resident #3 dated 8/13/25 provided a	F0880		

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F0880 SS = D	Continued from page 15 BIMS score of 13/15 indicating normal cognition. The document revealed the resident had diagnoses of anemia, atrial fibrillation (A-Fib), orthostatic hypotension, renal insufficiency/renal failure, UTI in the last 30 days and cerebrovascular accident. The resident had an indwelling catheter and was provided anticoagulant, antibiotic and opioid medications. The Care Plan revised 8/21/25 revealed a focus area of indwelling catheter revised on 7/2/25 with interventions of monitor/record/report signs/symptoms of UTI including cloudiness, altered mental status, change in eating patterns initiated on 4/9/25 and record output every shift initiated 7/2/25. An additional focus area identified a pressure injury related to immobility revised on 7/2/25 contained an intervention of EBP related to catheter and wounds with sign outside the resident's room; gown and gloves used for high contact resident care activities with a face shield used for any tasks that have a high potential for splash or spray revised on 8/15/25. Resident #3's 11/25 TAR revealed an order for EBP related to urinary catheter and wounds with a sign outside the resident's room; gown and gloves used for high contact resident care activities with a face shield used for any tasks that have a high potential for splash or spray with an order date of 8/15/25. The document lacked documentation on 11/3/25 10p-6a. Observation on 11/10/25 at 1:00 PM a U.S. Department of Health and Human Services Centers for Disease Control and Prevention EBP sign posted outside of Resident #3's room with PPE present. Observed on 11/12/25 at 7:50 AM Staff G, CNA, complete hand hygiene, don gown and gloves and obtain a barrier prior to entering the Resident #3's room. The staff completed peri care and catheter care following appropriate infection control techniques. Staff G removed her gloves and donned new gloves without hand hygiene prior to emptying the catheter bag. The Interim Director of Nursing (IDON) was present during the observation. On 11/12/25 the IDON stated EBP should be followed with catheters, pressure ulcers, wounds and incisions. The staff expected PPE to be worn with these individuals when completing direct care tasks with the use of gowns and always wearing gloves. When asked for clarification regarding gloves, the staff stated whenever in the room when not completing tasks gloves should be worn with the example of observing care. The IDON stated hand hygiene should be completed upon entry and exit into a	F0880		

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F0880 SS = D	Continued from page 16 resident's room, incontinence cares and between glove changes. On 11/12/25 the Administrator expected the staff to follow EBP when required. The Administrator expected staff to complete hand hygiene when changing gloves. The facility's EBP Policy revealed EBP is utilized to prevent infection and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities. EBP apply to residents with a CDC-targeted MDRO, have a wound or indwelling medical device and contact precautions do not otherwise apply. The document disclosed targeted use of gown and gloves with face protection if there is a risk of splash or spray during tasks including dressing, transferring, hygiene or grooming, device care and wound care. The document revealed staff were trained prior to caring for residents on EBPs. The facility's Handwashing/Hand Hygiene disclosed is the primary means to prevent the spread of healthcare-associated infections. The document revealed hand hygiene is indicated prior to application of non-sterile gloves and immediately after glove removal. The U.S. Department of Health and Human Services Centers for Disease Control and Prevention EBP sign on Resident #2 and Resident #3's doors revealed providers and staff must wear gloves and gown during high contact resident care activities including dressing, bathing, transferring, hygiene, changing briefs or assisting with toileting, device care and wound care.	F0880		

PLAN OF CORRECTION

Facility: Tabor Manor Care Center

Provider: 165546

Date survey completed: 11/13/2025

Correction date: 01/09/2026

F0580:

Resident #1 experienced a fall from a mechanical lift and was assessed by EMS concluding a transfer to an ED. Facility policy dictate notifying physician and family. Staff C stated to administrator and Director of Nursing that she could not find a phone number on the transfer face sheet she had printed off.

1. The identifying concern included the POA/Daughter's number was not on the transfer face sheet, which concluded the POA/Daughter had not been notified for two hours.
    A. Intervention for this immediate concern; IDT reviewed all aspects of the POA/Daughter's number. It was noted that the POA/Daughter's number was in the EHR under other. This was corrected immediately.
    B. Systemic Changes Implemented to prevent Recurrence.

    The IDT Team went through all residents EHR to verify numbers were under the correct classification.

All Nursing staff were re-educated on the importance of notifying families in a timely manner and the location of this information to assure policy and protocol is being adhered to.

C. Monitoring and Quality Assurance.

The IDT will review all new admissions for compliance with POA/family numbers located in the proper location of the EHR. All notifications to families will be reviewed by the EHR Team. A report will be submitted to the Quality Assurance Team.

F0686:

Upon identification of missed wound care measurements, the Director of Nursing immediately reviewed all current residents with wounds to ensure measurements were accurately documented. Any missing or incomplete wound measurements were obtained and entered into the TAR. A full-house review of all residents with documented wounds was completed to ensure that each had complete and accurate wound measurements recorded. Any missing measurements were obtained promptly and into TAR. No additional concerns were identified.

Systemic Changes Implemented to Prevent Recurrence:

A. Updated skin assessment policy.

The facility's skin assessment policy was revised to incorporate assessment frequency based on individual Braden Scores, ensuring resident-specific risk-based monitoring

consistent with CMS guidance. All licensed nurses received a copy of the revised policy and education on proper wound assessment and documentation, including measurement requirements.

B. Monthly Braden Scores Review and IDT Review.

Braden scores will be updated monthly for every Resident. Interdisciplinary Team will audit the updated scores monthly to confirm that skin assessment frequency and prevention measures align with resident risk levels.

C. Electronic TAR update.

The electronic TAR was updated to include a required measurement field for all wound treatments to ensure complete documentation. All existing wound treatments were updated to include measurement requirements. Any new wound treatment orders will include a wound measurement field at the time of entry.

D. Monitoring and Quality Assurance

1. Wound measurement audits: The DON or designee will audit all wound measurement documentation weekly for 4 weeks. After the initial 4 weeks, audits will be completed monthly, and any findings will result in immediate re-education and correction.
2. TAR Review; The electronic TAR entries for wound care will be reviewed during each audit to ensure that all wound treatments contain complete measurement documentation.

3. IDT Oversight: Results of audits will be reviewed during monthly IDT meetings. Audit frequency will continue unless IDT determines modifications are necessary. Any nurse found to have incomplete wound documentation will receive immediate one-on-one re-education. All new nursing staff will receive training in wound measurement documentation and braden-based skin assessment frequency during orientation.