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 06/23/2026

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 Ok ✓ Lg	INITIAL COMMENTS Correction date: 07/23/2026 The following deficiencies resulted from investigation of complaints #2963881-C, #2968341-C, #3032807-C, and facility reported incidents #3039904-I and #3049242-M conducted June 16, 2026 through June 23, 2026. Findings for facility reported incident #3049242-M will be sent to the facility at a later date under separate cover. Complaints #3032807-C resulted in a deficiency.Facility reported incident #3039904-I resulted in a deficiency. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000		
F0600 SS = E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observations, clinical record review, facility investigative file review, staff interviews and facility policy review the facility failed to keep residents free from neglect. On 6/7/2026 the nurse on duty failed to administer Resident #4, #5, #6, #7, and #10 insulins as ordered by their physician. Certified Medication Aides (CMAs) reminded the nurse of those resident's orders not completed and the Electronic Health Record (EHR) changed the orders	F0600		

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 Worcester	Administrator	07/14/2026

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 06/23/2026

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:_____ The following deficiencies resulted from investigation of complaints #2963881-C, #2968341-C, #3032807-C, and facility reported incidents #3039904-I and #3049242-M conducted June 16, 2026 through June 23, 2026. Findings for facility reported incident #3049242-M will be sent to the facility at a later date under separate cover. Complaints #3032807-C resulted in a deficiency.Facility reported incident #3039904-I resulted in a deficiency. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000		
F0600 SS = E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observations, clinical record review, facility investigative file review, staff interviews and facility policy review the facility failed to keep residents free from neglect. On 6/7/2026 the nurse on duty failed to administer Resident #4, #5, #6, #7, and #10 insulins as ordered by their physician. Certified Medication Aides (CMAs) reminded the nurse of those resident's orders not completed and the Electronic Health Record (EHR) changed the orders	F0600		

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

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 06/23/2026

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
F0600 SS = E	Continued from page 1 to red, alerting staff the orders had not been carried out. The facility reported a census of 41 residents. 1. According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 4/27/2026, documented Resident #4 had a Brief Interview of Mental Status (BIMS) score of 10. A BIMS score of 10 indicated mild cognitive impairment. The MDS documented he received insulin injections during the last 7 days. The MDS listed the following diagnoses of Resident #4: paraplegia, diabetes mellitus, stroke, seizure disorder, and depression. A Care Plan Focus Area with an initiation date of 12/8/2023 documented Resident #4 had a diagnosis of Diabetes Mellitus. The Care Plan directed staff to administer his diabetes medication as ordered by the doctor. Staff are to monitor/document for side effects and effectiveness. A second Care Plan Focus Area with an initiation date of 4/15/2025 documented Resident #4 used insulin related to his diabetes diagnoses. The Care Plan directed staff to administer his insulin as ordered and to monitor for adverse effects. Record review revealed Resident #4's blood sugar on 6/7/2026 at 7:41 AM was 91 milligrams per deciliter (mg/dL). Review of Resident #4's June 2026 Medication Administration Record (MAR) revealed the following orders were not signed out as being given on the morning of 6/7/2026: a) toujeo injection (long-acting insulin to treat diabetes mellitus), 31 units (U) daily at 8:00 AM, b) flasp injection solution aspart (fast-acting meal time insulin to diabetes mellitus), inject per sliding scale, three times a day (TID) before meals. If his blood sugar was between 60 and 150, no insulin required to be given. Record review revealed there were no progress notes documented related to why the two insulin orders were not signed out as being given or held. On 6/17/2026 at 7:52 AM Staff C Licensed Practical Nurse (LPN) stated Resident #4's blood sugar was 142 mg/dL and would not require sliding scale. She primed his toujeo injection pen with 3 units (U) then set the pen to 31U. The insulin was administered to his left arm.	F0600		

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 06/23/2026

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
F0600 SS = E	Continued from page 2 2. According to the quarterly MDS assessment tool with a reference date of 4/27/2026, Resident #5 had a BIMS score of 7. A BIMS score of 7 suggested mild cognitive impairment. The MDS documented he received insulin injections during the last 7 days. The MDS listed the following diagnoses of Resident #5: diabetes mellitus, stroke, anxiety, and bipolar disorder. The Care Plan Focus Area with an initiation date of 9/3/2026 documented Resident #5 had diabetes mellitus. The Care Plan directed staff to administer his diabetes medication as ordered by the doctor. Staff are to monitor/document for side effects and effectiveness. A second Care Plan Focus Area with an initiation date of 3/12/2026 documented Resident #5 used insulin related to his diabetes diagnoses. The Care Plan directed staff to administer his insulin as ordered and to monitor for adverse effects. Record review revealed Resident #5's blood sugar on 6/7/2026 at 8:59 AM was 160mg/dL. Review of Resident #5's June 2026 MAR revealed the following order was not signed out as being given on the morning of 6/7/2026: Novolog (treatment of diabetes) injection flexpen, per sliding scale before meals. If the resident's blood sugar is between 151 and 200, staff were directed to give 2U of insulin. Record review revealed there were no progress notes documented related to why the insulin order was not signed out as being given. On 6/17/2026 at 8:07 AM Staff D Registered Nurse (RN) stated Resident #5's blood sugar was 261mg/dL and would need 6U of Novolog insulin. She primed the pen with 3U of insulin the set the pet to 6U. She administered the insulin to his left lower quadrant. 3. According to the quarterly MDS assessment tool with a reference date of 5/11/2026, Resident #6 had severely impaired cognitive skills for daily decision making. The MDS documented he received insulin injections during the last 7 days. The MDS listed the following diagnoses of Resident #6: diabetes mellitus, cancer, coronary artery disease, stroke, seizure disorder, malnutrition, and depression. The Care Plan Focus Area with an initiation date of 9/3/2026 documented Resident #6 had diabetes	F0600		

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 06/23/2026

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
F0600 SS = E	Continued from page 3 mellitus. The Care Plan directed staff to administer his diabetes medication as ordered by the doctor. Staff are to monitor/document for side effects and effectiveness. A second Care Plan Focus Area with an initiation date of 3/12/2026 documented Resident #6 used insulin related to his diabetes diagnoses. The Care Plan directed staff to administer his insulin as ordered and to monitor for adverse effects. Record review revealed Resident #6's blood sugar on: a) 6/7/2026 at 7:54 AM was 376mg/dL b) 6/7/2026 at 10:49 AM was 422mg/dL c) 6/7/2026 at 4:26 PM was 450mg/dL d) 6/7/2026 at 4:27 PM was 450mg/dL e) 6/7/2026 at 9:25 PM was 600mg/dL f) 6/7/2026 at 10:11 PM was 600mg/dL g) 6/7/2026 at 11:38 PM at 600mg/dL Review of Resident #6's June 2026 MAR revealed the following orders were not signed out as being given at 6:30 AM and 11:30 AM on 6/7/2026: a) Insulin Glargine 15U daily, b) Insulin Aspart flexpen per sliding scale before meals and bedtime. If the resident's blood sugar is between 350 and 399, staff were directed to give 20U of insulin. The following Progress Notes were documented for Resident #6: On 6/7/2026 at 4:44 PM Staff A RN documented resident's blood sugar read "HI." His insulin order was checked and administered 24 units of sliding scale insulin. Resident's vital signs were checked and they were within normal limits (WNL). Resident confused, which he has been since he returned from the hospital this last time. Resident was not sweating or clammy, no tremors noted. He was not lethargic or slurring words. Resident #6 was encouraged to drink fluids and resident took in 180 milliliters of water. Will observe and recheck blood sugar. On 6/7/2026 at 11:35 PM Staff E LPN documented	F0600		

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 06/23/2026

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
F0600 SS = E	Continued from page 4 Resident #6's physician was informed of his blood sugar running "HI" on this date. Verbal order obtained for 10U of Novolog insulin now, one time only. If continues to run "HI" send to the Emergency Room (ER) for evaluation and treatment. On 6/8/2026 at 2:57 AM Staff E documented resident's blood sugar was 332mg/dL. On 6/8/2026 at 11:08 AM Staff A documented she checked Resident #6's blood sugar and read "HI." On 6/8/2026 at 11:09 AM Staff A documented she administered 24 U of sliding scale, insulin aspart flexpen. On 6/8/2026 at 11:58 AM Staff A documented around 11:10 AM a call was placed to the physician's office and spoke with the nurse regarding resident's increase in confusion, hi blood sugars, and the blood sugars not responding to insulin. Received an order to send to ER. Call placed to son and Power of Attorney (POA) and informed of resident condition and order to send to ER. On 6/28/2026 at 3:30 PM the hospital called the facility and reported Resident #6 had a urinary tract infection (UTI); was given antibiotics and fluids and ready to return to the facility. 4. According to the admission MDS assessment tool with a reference date of 6/3/2026, Resident #7 had a BIMS score of 11. A BIMS score of 11 suggested mild cognitive impairment. The MDS documented she received insulin injections during the last 7 days. The MDS listed the following diagnoses of Resident #7: anorexia, diabetes mellitus, UTI, thyroid disease, and schizophrenia. The Care Plan Focus Area with an initiation date of 6/3/2026 documented Resident #7 had diabetes mellitus. The Care Plan directed staff to administer her diabetes medication as ordered by the doctor. Staff are to monitor/document for side effects and effectiveness. A second Care Plan Focus Area with an initiation date of 6/3/2026 documented Resident #7 used insulin related to his diabetes diagnoses. The Care Plan directed staff to administer her insulin as ordered and to monitor for adverse effects. Record review revealed Resident #7's blood sugar on: a) 6/7/2026 at 7:11 AM was 237mg/dL	F0600		

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 06/23/2026

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
F0600 SS = E	Continued from page 5 b) 6/7/2026 at 10:41 AM was 294mg/dL Review of Resident #7's June 2026 MAR revealed the following orders were not signed out as being given on the morning of 6/7/2026: a) Fiasp flexpen 15U with breakfast, b) Fiasp flexpen 4U with lunch. Record review revealed there were no progress notes documented related to why the insulin orders were not signed out as being given. On 6/17/2026 at 9:52 AM Staff C stated Resident #7's blood sugar was 222 mg/dL. She primed the insulin pen and set the pen to 9U. She administered the insulin to the resident's left lower quadrant. 5. According to the quarterly MDS assessment with a reference date of 6/1/2026, Resident #10 had a BIMS score of 8. A BIMS score of 8 suggested mild cognitive impairment. The MDS documented she received insulin injections during the last 7 days. The MDS listed the following diagnoses of Resident #10: encounter for palliative care, heart failure, renal failure diabetes mellitus, dementia, malnutrition, and depression. The Care Plan Focus Area with an initiated date of 12/20/2024 documented Resident #10 had diabetes mellitus. The Care Plan documented staff are to administer diabetes medications as ordered by the physician. Staff are also to monitor/document for side effects and effectiveness. A second Care Plan Focus Area with an initiated date of 10/10/2025 documented Resident #10 used insulin related to diabetes. The Care Plan documented staff are to administer sulin as ordered and to monitor for adverse effects. Record review revealed Resident #10's blood sugar on: 6/7/2026 at 7:20 AM was 119mg/dL Review of Resident #10's June 2026 MAR revealed the following order was not signed out as being given on the morning of 6/7/2026: Lantus subcutaneous solution, give 40U once a day. Record review revealed there were no progress notes documented related to why the insulin order	F0600		

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 06/23/2026

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
F0600 SS = E	Continued from page 6 were not signed out as being given. The facility investigation included the following: Staff G Certified Medication Aide (CMA) handwrote the following statement: on 6/7/2026 I got to the facility around 2:15 PM/2:20 PM. Staff F CMA did tell me that Staff A had not passed insulin. Staff F left the facility at 2:00 PM. I checked Resident #6's blood sugar at 3:30 PM, 4:45 PM, 6:40 PM and 8:00 PM. All the readings said HI. I asked Staff A what we could do. She said check it again in a little bit but I am going him 24U. This was at 4:30 PM. After Staff A left at 6:00 PM, I let Staff E Licensed Practical Nurse (LPN) now what happened. She ended up giving him another 24U at 9:00 PM. Staff G signed and dated her statement on 6/10/2026. Staff F handwrote the following statement: on 6/9/2026 I worked South medication cart while Staff A worked West/Southwest medication cart. I retrieved all blood sugars on South Hall and turned them in to Staff A by 8:00 AM. Around 9:30 AM I noticed zero insulins were charted as administered. I approached Staff A and said don't forget about the insulins on my medication cart and she said I won't. By 11:00 AM when I started retrieving lunch time blood sugars, Staff A still had not signed off any insulin administrations, nor had she asked me for my keys to retrieve the insulin pens. By 11:30 AM, I gave Staff A the lunch time blood sugars, where Resident #6's blood sugar was reading at 422mg/dL. I once again reminded Staff A that insulins had not been done. Around 1:30 PM Staff A approached me and stated she completely forgot to administer insulins on the South Hall medication cart. When I left for the day around 2:05 PM, she still failed to administer a single insulin on the South-Hall cart. Staff F signed and dated her statement on 6/11/2026. On 6/9/2026 an internal investigation into insulin administration revealed the following: -Resident #4 did not receive his toujeo on 6/7/2026 at 8:00 AM, resident is stable, no adverse effects occurred. -Resident #5 did not receive his sliding scale insulin on 6/7/2026 at 8:00 AM for a blood sugar of 160 mg/dL, resident is stable, no adverse effects occurred. -Resident #6 did not receive sliding scale insulin on the following dates: 6/3/2026 at noon for a blood sugar of 168 mg/dL, 6/7/2026 at 8:00 AM for a	F0600		

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 06/23/2026

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
F0600 SS = E	Continued from page 7 blood sugar of 376 mg/dL, 6/7/2026 at noon for a blood sugar of 422 mg/dL. Resident did go to the ER on 6/8/2026 for elevated blood sugar. He has been stable since. -Resident #10 did not receive her Lantus on 6/7/2026 at 8:00 AM, resident is stable, no adverse effects occurred. Investigation Summary-Missed Insulin Administration:-an investigation was initiated regarding resident #6 following reports of elevated blood glucose levels over several days, resulting in a transfer to the emergency room for evaluation. -On Monday 6/8/2026 an approximately 8:30 AM, Staff A entered the Director of Nursing's (DON) office and reported that Resident #6's blood glucose readings had remained in the 400's throughout the weekend. Staff A was instructed to contact the resident's primary care provider (PCP) regarding the continued elevated blood glucose levels and obtain further orders. Staff A reported that the resident's vitals were stable, the resident was alert and was eating breakfast at that time. -At approximately 11:15 AM Staff A notified the DON that the PCP had returned the call and ordered the resident to be sent to the emergency room for evaluation. The resident was transported to the hospital, diagnosed with a urinary tract infection (UTI) and sent back to the facility. -An investigation was subsequently initiated after Staff F and Staff G reported concerns that Staff A may not have administered Resident #6's insulin on 6/7/2026 (Sunday). Staff expressed concern that the resident's persistently elevated blood glucose levels may have been related to missed insulin administration. -A review of the electronic medication record for Resident #6 was conducted. Documentation showed that Staff F recorded a before-breakfast blood glucose reading of 376 mg/dL. No documentation was found indicating administration of either scheduled long-acting insulin or sliding scale insulin by Staff A following this reading. -Staff A subsequently documented a before lunch blood glucose reading of 422 mg/dL. Again, no documentation was found indicating administration of sliding scale insulin or scheduled insulin following this blood glucose result. The first documented insulin administration by Staff A occurred at supper time.	F0600		

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 06/23/2026

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
F0600 SS = E	Continued from page 8 -Video footage was reviewed for Resident #6. Footage confirmed that the resident was present in the dining room during both breakfast and lunch meal periods. Review of footage did not show Staff A approaching the resident in the dining room to administer insulin or entering the resident's room to administer medications during the corresponding medication administration timeframes. -A broader review of insulin administration records during the same period was conducted. Findings identified additional residents with missing insulin administration documentation: Resident #4 scheduled morning and noon insulin doses not administered/documented, Resident #5 scheduled morning insulin dose not administered/documented, Resident #7 scheduled morning and noon doses not administered/documented. -Video footage for Resident #4 was also reviewed. Footage confirmed that the resident remained in bed during breakfast. Review did not show Staff A entering the resident's room to administer insulin during the morning medication pass. Footage further confirmed that Resident #4 attended lunch in the dining room, however Staff A was not observed administering insulin to the resident in the dining room or entering the resident's room before or after the meal to administer them medication. -Based on MAR review and video surveillance findings, evidence supports that multiple scheduled insulin administrations were not completed and/or documented during the identified medication pass periods. The findings involve resident #6 and additional residents #4, #5 and #7. Further investigation and review of facility policies, medication administration practices, resident outcomes and staff accountability measures are warranted. -Nurse timeline: 1. Staff A arrives at 6:30 AM on 6/7/2026 2. remains at station until 7:00 AM when she starts on the medication cart 3. in the dining room until 9:30 AM when Staff A pushed the medication cart back to the front. 4. Staff A back in the dining room at 11:50 AM. 5. At 12:15 PM Staff A sat down in the dining room and can be seen typing on the computer and writing	F0600		

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 06/23/2026

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
F0600 SS = E	Continued from page 9 in the narcotic book. 6. Staff A administered insulin to a different resident at 12:42 PM then sat back down. 7. Back at the front desk at 1:45 PM. 8. Left the building and sat in her car from 1:49 PM until 2:08 PM. Additional Investigation Findings: -During the course of the investigation, an additional concern was identified related to the insulin administration practices by Staff A. -While reviewing blood glucose records, the Administrator identified an unusually elevated blood sugar resident for Resident #6 following a shift worked by Staff A. As a result, the DON conducted a review of camera footage and compared observations to the MAR. -Review of the MAR indicated that on 6/3/2026, Staff A documented a blood glucose check for Resident #6 at 11:58 AM and documented administration of 4U of sliding scale insulin. -Video footage was reviewed for the corresponding timeframe. Footage confirmed that Resident #6 was present in the dining room at the time the blood glucose check and insulin administration were documented. Review of the footage did not show Staff A obtaining the blood glucose reading or administrating insulin to Resident #6. -Additional timeline review revealed the following: 1. Staff A was observed outside of the facility from approximately 10:57 AM until 11:24 AM. 2. During that timeframe, Resident #6 was with his wife. 3. Resident #6 and his wife attended an MDS meeting until approximately 11:46 AM. 4. Between 11:42 AM and 11:53 AM Staff A was observed at the nurse's station speaking with coworkers. 5. Resident #6 remained near the lobby area until approximately 11:52 AM when he asked his roommate to assist him to the dining room. 6. No blood glucose check or insulin administration	F0600		

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 06/23/2026

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
F0600 SS = E	Continued from page 10 was observed before, during or after the medication pass. 7. Footage was also reviewed to determine whether another nurse may have performed the blood glucose check or administrated insulin. Review confirmed the other nurse on duty did not administer insulin or obtain a blood glucose reading for Resident #6 during the identified timeframe. - Based on review of the MAR documentation and corresponding video surveillance, findings indicate that a blood glucose check and administration of 4U of sliding scale insulin were documented as completed; however, video footage does not support that either task were performed. No evidence was identified to indicate that another nurse completed the blood glucose check or insulin administration on behalf of Staff A. Disciplinary Action: Staff A started employment at the facility on 10/21/2025. On Sunday 6/7/2026 Staff A did not give insulin to Resident #4, #5, #6, and #7. This involved AM and noon insulin, blood sugars were taken and reported to Staff A. Staff F reminded Staff A at 9:30 and when given blood sugars at 11:30 AM she was reminded again; still no insulin given. At 11:30 AM Resident #6's blood sugar was 422 mg/dL and at bed time it was over 600. Monday, 6/8/2026 Resident #6 primary physician was notified of the high blood sugar, and he was sent to the emergency room. The facility watched camera footage to confirm that insulin was not attempted on Sunday 6/7/2026. We also looked at 6/3/3026 as Resident #6's blood sugar was up to 600 at bedtime. Based on camera footage it was marked off as given but based on camera footage it was not given. Due to these concerns the facility is terminating employment. On 6/17/2026 at 9:54 PM Staff F stated on 6/7/2026 she completed her blood sugars on the medication cart she was working on and gave them to Staff A about 7:30 AM. At about 9:00 AM Staff F noticed the insulin orders were red on the MARs of the residents on her medication cart. She went to Staff A and told her not to forget to give the insulins for those residents. Staff A told her oh I won't. At around 11:00 AM Staff F completed her lunch blood sugars on the same residents. She again reminded Staff A to not forget to give the insulins. At 1:30 PM she noticed the breakfast and lunch insulins were not given. She again approached Staff A about this and she told Staff F she forgot to do them. Staff C stated when her shift ended at 2:00 PM the insulin had not been administered. She let Staff G CMA	F0600		

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 06/23/2026

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
F0600 SS = E	Continued from page 11 know when she took over her medication cart. During a follow-up interview on 6/23/2026 at 9:30 AM Staff F stated 6/7/2026 was not a busy day for them, there were no falls, nothing to offset the day. They had one nurse and one CMA doing medications and treatments that day. When asked what Staff A was doing, she was sitting all day. Staff F stated she was in charge of the 100 hall (South), medication cart. Staff A was in charge of the 200/400 hall medication cart. Staff F stated Staff A usually worked the 100-hall medication cart but wanted to be on the 200/400 (West/Southwest) hall so she could learn it. When asked what residents on Staff F's cart did not get insulins on 6/7/2026 she stated Resident #5 and Resident #6. Staff F indicated Staff A had been known to take longer when passing her medications. Staff F stated Staff A had mentioned being on medication for back pain and that she did not feel comfortable working while on the medications. On 6/18/2026 at 9:11 AM Staff G stated Staff F told her Staff A had not given insulins on the 100-hall medication cart during her shift. Staff G told she would pester Staff A about it. She started to check her blood sugars about 3:30 PM on 6/7/2026 and Resident #6's blood sugar read "HI." At 4:30 AM Staff A gave Resident #6 24U of his sliding scale insulin, rechecked his blood sugar at 4:45 PM and it continued to read "HI." When she told Staff A this, she was gathering the insulin pens. She watched her give the 24U of insulin because she bugged her about doing something. At 8:00 PM his blood sugar still read "HI" and she reported this to Staff E. She also let Staff E know he had been reading "HI" all day. Staff E gave him 24U of insulin. Staff G stated every time she told Staff A Resident #6's blood sugar read "HI" she would advise her to keep rechecking it. Staff G asked then what do we do, Staff A let her know she would have to give him insulin. Staff G said she had to bug Staff A about what to do when it kept reading "HI." Staff A did not call that doctor about his "HI" blood sugars. Staff G stated Resident #6 that day was slurring his words; his vitals were normal but he was just not making any sense at all. She had taken care of Resident #6 to know if he was slurring his words, it was because his blood sugar was either hi or low. When asked how Staff A was a nurse, she stated as a person she is great but as a nurse she would not trust her. She likes to waste time when giving medications, takes forever on breaks in her car. She would go out to her car for an hour when she's supposed to be passing medications, then gets behind on her medication times. Staff G stated she should not be a nurse; she likes to sit around; her medications are	F0600		

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 06/23/2026

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
F0600 SS = E	Continued from page 12 late and who knows if they are on time or given all at once. During a follow up interview on 6/23/2026 at 9:40 AM Staff G stated on 6/7/2026 she worked on the 100-hall medication cart and Staff A 200/400 hall medication cart. Staff A usually worked on the 100-hall medication cart. When she worked 2:30 PM until Staff A left at 6:30 PM that day, it was hectic and there were no falls during her shift with Staff A. When asked what it meant when a blood sugar reads “HI” she stated if the blood sugar is higher than 500mg/dL. On 6/18/2026 at 12:06 PM the Director of Nursing (DON) stated it was brought to her attention by Staff F on 6/8/2026 (Monday) that Staff A had not administered resident’s insulins on 6/7/2026. The DON received the MARs and noted the insulins were not signed out as being given. She started her investigation and was able to confirm this because they were not signed out on the MARs. On 6/8/2026 Staff A had approached her because Resident #6’s blood sugar was high and had been over the weekend. Staff A stated I don’t know what to do and she told Staff A to call the physician to have him sent to the hospital. After this, the DON started to look further in to things. She reviewed camera footage and was able to see Staff F checked resident’s blood sugar but did not see Staff A administer their insulins as ordered. She gave all this information to the Administrator and informed him it needed to be reported. The Administrator started to look at blood sugar records and noticed on 6/3/2026, Resident #6’s blood sugar was really high but Staff A had documented she gave his ordered sliding scale insulin at 11:30 AM. They reviewed the camera footage and found she had not administered his insulin as she documented. The DON also noted Resident #6 was in a care conference meeting with the DON and his wife during the time she would have given his ordered insulin. Resident #6 did end up going to the hospital on 6/8/2026 and returned to the facility that same day with antibiotics for a urinary tract infection (UTI). The DON stated it was not unusual for Resident #6 to have high and low blood sugar readings. When Staff A came in for her shift on 6/11/2026 they brought her in and asked what happened on 6/7/2026 for her to not give those insulins. Staff A told them she did not remember. That was concerning because she sent Resident #6 to the hospital and she could not remember what happened. When they asked about the falsifying that she gave Resident #6 his insulin on 6/3/2026 while he was in a meeting with staff and she was seen on the camera at the nurse’s desk talking. When they looked at the camera footage from 10:00 AM to 2:00	F0600		

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 06/23/2026

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
F0600 SS = E	Continued from page 13 PM that day, she did not cross paths with Resident #6, Staff A just put her head down. They terminated her employment and let her know they would be reporting this to the Iowa Board of Nursing. Staff A became quiet and left the facility. Prior to this Staff A had disciplinary actions related to poor attendance and excessive breaks. The DON reported no concerns with medication administration issues prior to this. When asked what it meant when a resident's blood sugar reads "HI," she stated the blood sugar is over 500. The nurse should complete an assessment on that resident and call their physician. The DON verified that when an order is not completed in a resident's EHR, it does turn red. When they completed their investigation the orders for Resident #4, #5, #6 and #7 were red; indicating they were not completed. During a follow up interview on 6/23/2026 at 1:01 PM the DON stated they do have staff on call on the weekends: Administration staff for non-nursing related issues and herself and the MDS Coordinator for nursing related issues. They are on call on the week nights and weekends. The weekend of 6/5/2026 the Assistant Administrator/Billing Manager and the MDS Coordinator were on-call. On 6/18/2026 at 6:25 PM Staff A stated she started at the facility in October 2025. She was asked to talk about what took place during her shift on 6/7/2026. Staff A stated she was working on a hall she never worked on, was overwhelmed and in a lot of pain that day. She took her scheduled hydrocodone medication that day because she has a bad back. When asked what happened that day when four residents did not receive their insulins, she stated I don't know, I don't know what to say. She acknowledged she did forget to give the insulins, she was the only nurse in the building and worked a hall she had been on a lot, I don't know there is no excuse of it. When asked if she saw any orders in red in the EHR of residents, she stated she remembered seeing red orders when she went through to finish things up. She acknowledged the CMA came to her around lunch time asking her not to forget to give insulins and she did not give them. Staff A stated when she was told Resident #6's blood sugar was "HI" she went down and rechecked it, and gave 24U of insulin per his sliding scale orders. When asked if she called his physician as his order indicated if his blood sugar was over 400, she stated she did not recall then later stated she does not think she did. Staff A stated she looked for parameters but did not see anything on the MAR for that. She then stated she did not know how to get ahold of his physician and that day was crazy. When Staff A was read the orders from Resident #6's MAR	F0600		

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 06/23/2026

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
F0600 SS = E	Continued from page 14 she stated she did not remember seeing that. Staff A stated she did send a fax but acknowledged you would normally call the physician but she did not know how to get ahold of them. When asked if the facility had any of their staff on-call that weekend, she stated the MDS Coordinator was on call. When asked if they could have helped locate the physician's contact information, she stated they could have helped her with this. When asked what other residents did not receive their insulins that day, she stated #4, #5, and #7. Staff A was asked why this happened she stated I do not know what to say, she had never done that as nurse. She added, I don't think I will be working as a nurse anymore if that is something I did; I should not be working as a nurse. She again stated it was a rough day, only nurse doing all the things. Did not recall if there were any falls that day, she stated it was just a rough day. Staff A stated she remembered seeing Resident #6's order on 6/3/2026 as she went through to finish up her documentation. She signed off the order as being done but did not know why she did that because she knew she did not give the insulin as ordered. On 6/23/2026 at 10:45 AM the Administrator stated Staff A was a mediocre nurse and not one he would consider one of his top nurses. When asked what that meant, he stated she met the criteria as far as medication pass went but had to be re-educated periodically on proper documentation. On 6/23/2026 at 4:50 PM Staff E stated when she worked on 6/7/2026, Staff A did not report to her that Resident # 4, #5, #6, and #7 did not receive their insulins. Had she known that she would have monitored the residents closely; especially Resident #6 because he is brittle. She remembered his blood sugar ran high that night and she had suspicion the resident did not get his insulin, but had no proof. She thought maybe something was going on with him, she ended up get an order to give additional insulin. This brought his blood sugar down but he still went out to the hospital the next and was sent back on an antibiotic for a UTI. When asked how Staff A was as an employee, she stated at times she would get overwhelmed but if you take your time and prioritize you can get a lot of what needs done, done. Staff E stated when orders are not completed in the EHR, they turn red until completed. The facility provided a document titled Protocol for Medication Administration that was updated on 1/8/2026. The protocol documented the purpose is to ensure that all medications are administered by a qualified individual within state and licensing	F0600		

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 06/23/2026

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
F0600 SS = E	Continued from page 15 guidelines/regulations and in accordance with policy and procedures and physician's orders. All medications must be administered by a nurse or a medication aide in accordance with the physician's orders. The nurser is responsible and accountable for all medications that she/he administers (this is also in reference to any medication aide). Routine medications must be administered within 1 hour after the time that it is ordered to be administered. The nurse or medication aide must never document a medication prior to the administration of the medication. The facility provided a document titled Abuse Prevention, Identification, Investigation, and Reporting Policy with a revision date of 11/2026. The policy documented all residents have the right to be free from verbal, sexual, and mental abuse, neglect, misappropriation of resident property, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Upon initial employment, each employee shall be provided with a copy of the facility's policies and procedures relating to abuse identification and reporting requirements. Key definitions: neglect of a dependent adult means deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a dependent adult's life or physical or mental health. Neglect is the failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, mental anguish or mental illness.	F0600		
F0760 SS = E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on observations, clinical record review, staff interviews and facility policy review the facility failed to ensure residents were free from significant medication errors. Staff failed to administer Resident	F0760		

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 06/23/2026

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
F0760 SS = E	Continued from page 16 #4, #5, #6, #7, #10 insulin as ordered by their physician. Findings included: 1. According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 4/27/2026, documented Resident #4 had a Brief Interview of Mental Status (BIMS) score of 10. A BIMS score of 10 indicated mild cognitive impairment. The MDS documented he received insulin injections during the last 7 days. The MDS listed the following diagnoses of Resident #4: paraplegia, diabetes mellitus, stroke, seizure disorder, and depression. A Care Plan Focus Area with an initiation date of 12/8/2023 documented Resident #4 had a diagnosis of Diabetes Mellitus. The Care Plan directed staff to administer his diabetes medication as ordered by the doctor. Staff are to monitor/document for side effects and effectiveness. A second Care Plan Focus Area with an initiation date of 4/15/2025 documented Resident #4 used insulin related to his diabetes diagnoses. The Care Plan directed staff to administer his insulin as ordered and to monitor for adverse effects. Record review revealed Resident #4's blood sugar on 6/7/2026 at 7:41 AM was 91 milligrams per deciliter (mg/dL). Review of Resident #4's June 2026 Medication Administration Record (MAR) revealed the following orders were not signed out as being given on the morning of 6/7/2026: a) toujeo injection (long-acting insulin to treat diabetes mellitus), 31 units (U) daily at 8:00 AM, b) flasp injection solution aspart (fast-acting meal time insulin to diabetes mellitus), inject per sliding scale, three times a day (TID) before meals. If his blood sugar was between 60 and 150, no insulin required to be given. Record review revealed there were no progress notes documented related to why the two insulin orders were not signed out as being given or held. On 6/17/2026 at 7:52 AM Staff C Licensed Practical Nurse (LPN) stated Resident #4's blood sugar was 142 mg/dL and would not require sliding scale. She primed his toujeo injection pen with 3 units (U) then	F0760		

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 06/23/2026

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
F0760 SS = E	Continued from page 17 set the pen to 31U. The insulin was administered to his left arm. 2. According to the quarterly MDS assessment tool with a reference date of 4/27/2026, Resident #5 had a BIMS score of 7. A BIMS score of 7 suggested mild cognitive impairment. The MDS documented he received insulin injections during the last 7 days. The MDS listed the following diagnoses of Resident #5: diabetes mellitus, stroke, anxiety, and bipolar disorder. The Care Plan Focus Area with an initiation date of 9/3/2026 documented Resident #5 had diabetes mellitus. The Care Plan directed staff to administer his diabetes medication as ordered by the doctor. Staff are to monitor/document for side effects and effectiveness. A second Care Plan Focus Area with an initiation date of 3/12/2026 documented Resident #5 used insulin related to his diabetes diagnoses. The Care Plan directed staff to administer his insulin as ordered and to monitor for adverse effects. Record review revealed Resident #5's blood sugar on 6/7/2026 at 8:59 AM was 160mg/dL. Review of Resident #5's June 2026 MAR revealed the following order was not signed out as being given on the morning of 6/7/2026: Novolog (treatment of diabetes) injection flexpen, per sliding scale before meals. If the resident's blood sugar is between 151 and 200, staff were directed to give 2U of insulin. Record review revealed there were no progress notes documented related to why the insulin order was not signed out as being given. On 6/17/2026 at 8:07 AM Staff D Registered Nurse (RN) stated Resident #5's blood sugar was 261mg/dL and would need 6U of Novolog insulin. She primed the pen with 3U of insulin the set the pet to 6U. She administered the insulin to his left lower quadrant. 3. According to the quarterly MDS assessment tool with a reference date of 5/11/2026, Resident #6 had severely impaired cognitive skills for daily decision making. The MDS documented he received insulin injections during the last 7 days. The MDS listed the following diagnoses of Resident #6: diabetes mellitus, cancer, coronary artery disease, stroke, seizure disorder, malnutrition, and depression.	F0760		

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 06/23/2026

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
F0760 SS = E	Continued from page 18 The Care Plan Focus Area with an initiation date of 9/3/2026 documented Resident #6 had diabetes mellitus. The Care Plan directed staff to administer his diabetes medication as ordered by the doctor. Staff are to monitor/document for side effects and effectiveness. A second Care Plan Focus Area with an initiation date of 3/12/2026 documented Resident #6 used insulin related to his diabetes diagnoses. The Care Plan directed staff to administer his insulin as ordered and to monitor for adverse effects. Record review revealed Resident #6's blood sugar on: a) 6/7/2026 at 7:54 AM was 376mg/dL b) 6/7/2026 at 10:49 AM was 422mg/dL c) 6/7/2026 at 4:26 PM was 450mg/dL d) 6/7/2026 at 4:27 PM was 450mg/dL e) 6/7/2026 at 9:25 PM was 600mg/dL f) 6/7/2026 at 10:11 PM was 600mg/dL g) 6/7/2026 at 11:38 PM at 600mg/dL Review of Resident #6's June 2026 MAR revealed the following orders were not signed out as being given at 6:30 AM and 11:30 AM on 6/7/2026: a) Insulin Glargine 15U daily, b) Insulin Aspart flexpen per sliding scale before meals and bedtime. If the resident's blood sugar is between 350 and 399, staff were directed to give 20U of insulin. The following Progress Notes were documented for Resident #6: a) On 6/7/2026 at 4:44 PM Staff A RN documented resident's blood sugar read "HI." His insulin order was checked and administered 24 units of sliding scale insulin. Resident's vital signs were checked and they were within normal limits (WNL). Resident confused, which he has been since he returned from the hospital this last time. Resident was not sweating or clammy, no tremors noted. He was not lethargic or slurring words. Resident #6 was encouraged to drink fluids and resident took in 180 milliliters of water. Will observe and recheck blood	F0760		

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 06/23/2026

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
F0760 SS = E	Continued from page 19 sugar. b) On 6/7/2026 at 11:35 PM Staff E LPN documented Resident #6's physician was informed of his blood sugar running "HI" on this date. Verbal order obtained for 10U of Novolog insulin now, one time only. If continues to run "HI" send to the Emergency Room (ER) for evaluation and treatment. c) On 6/8/2026 at 2:57 AM Staff E documented resident's blood sugar was 332mg/dL. d) On 6/8/2026 at 11:08 AM Staff A documented she checked Resident #6's blood sugar and read "HI." e) On 6/8/2026 at 11:09 AM Staff A documented she administered 24 U of sliding scale, insulin aspart flexpen. f) On 6/8/2026 at 11:58 AM Staff A documented around 11:10 AM a call was placed to the physician's office and spoke with the nurse regarding resident's increase in confusion, hi blood sugars, and the blood sugars not responding to insulin. Received an order to send to ER. Call placed to son and Power of Attorney (POA) and informed of resident condition and order to send to ER. g) On 6/28/2026 at 3:30 PM the hospital called the facility and reported Resident #6 had a urinary tract infection (UTI); was given antibiotics and fluids and ready to return to the facility. 4. According to the admission MDS assessment tool with a reference date of 6/3/2026, Resident #7 had a BIMS score of 11. A BIMS score of 11 suggested mild cognitive impairment. The MDS documented she received insulin injections during the last 7 days. The MDS listed the following diagnoses of Resident #7: anorexia, diabetes mellitus, UTI, thyroid disease, and schizophrenia. The Care Plan Focus Area with an initiation date of 6/3/2026 documented Resident #7 had diabetes mellitus. The Care Plan directed staff to administer her diabetes medication as ordered by the doctor. Staff are to monitor/document for side effects and effectiveness. A second Care Plan Focus Area with an initiation date of 6/3/2026 documented Resident #7 used insulin related to his diabetes diagnoses. The Care Plan directed staff to administer her insulin as ordered and to monitor for adverse effects. Record review revealed Resident #7's blood sugar	F0760		

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 06/23/2026

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
F0760 SS = E	Continued from page 20 on: a) 6/7/2026 at 7:11 AM was 237mg/dL b) 6/7/2026 at 10:41 AM was 294mg/dL Review of Resident #7's June 2026 MAR revealed the following orders were not signed out as being given on the morning of 6/7/2026: a) Fiasp flexpen 15U with breakfast, b) Fiasp flexpen 4U with lunch. Record review revealed there were no progress notes documented related to why the insulin orders were not signed out as being given. On 6/17/2026 at 9:52 AM Staff C stated Resident #7's blood sugar was 222 mg/dL. She primed the insulin pen and set the pen to 9U. She administered the insulin to the resident's left lower quadrant. 5. According to the quarterly MDS assessment with a reference date of 6/1/2026, Resident #10 had a BIMS score of 8. A BIMS score of 8 suggested mild cognitive impairment. The MDS documented she received insulin injections during the last 7 days. The MDS listed the following diagnoses of Resident #10: encounter for palliative care, heart failure, renal failure diabetes mellitus, dementia, malnutrition, and depression. The Care Plan Focus Area with an initiated date of 12/202/2024 documented Resident #10 had diabetes mellitus. The Care Plan documented staff are to administer diabetes medications as ordered by the physician. Staff are also to monitor/document for side effects and effectiveness. A second Care Plan Focus Area with an initiated date of 10/10/2025 documented Resident #10 used insulin related to diabetes. The Care Plan documented staff are to administer sulin as ordered and to monitor for adverse effects. Record review revealed Resident #10's blood sugar on: 6/7/2026 at 7:20 AM was 119mg/dL Review of Resident #10's June 2026 MAR revealed the following order was not signed out as being given on the morning of 6/7/2026: Lantus subcutaneous solution, give 40U once a day.	F0760		

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 06/23/2026

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
F0760 SS = E	Continued from page 21 Record review revealed there were no Progress Notes documented related to why the insulin order were not signed out as being given. On 6/17/2026 at 9:54 PM Staff F stated on 6/7/2026 she completed her blood sugars on the medication cart she was working on and gave them to Staff A about 7:30 AM. At about 9:00 AM Staff F noticed the insulin orders were red on the MARs of the residents on her medication cart. She went to Staff A and told her not to forget to give the insulins for those residents. Staff A told her oh I won't. At around 11:00 AM Staff F completed her lunch blood sugars on the same residents. She again reminded Staff A to not forget to give the insulins. At 1:30 PM she noticed the breakfast and lunch insulins were not given. She again approached Staff A about this and she told Staff F she forgot to do them. Staff C stated when her shift ended at 2:00 PM the insulin had not been administered. She let Staff G CMA know when she took over her medication cart. During a follow-up interview on 6/23/2026 at 9:30 AM Staff F stated 6/7/2026 was not a busy day for them, there were no falls, nothing to offset the day. They had one nurse and one CMA doing medications and treatments that day. When asked what Staff A was doing, she was sitting all day. Staff F stated she was in charge of the 100 hall (South), medication cart. Staff A was in charge of the 200/400 hall medication cart. Staff F stated Staff A usually worked the 100-hall medication cart but wanted to be on the 200/400 (West/Southwest) hall so she could learn it. When asked what residents on Staff F's cart did not get insulins on 6/7/2026 she stated Resident #5 and Resident #6. Staff F indicated Staff A had been known to take longer when passing her medications. Staff F stated Staff A had mentioned being on medication for back pain and that she did not feel comfortable working while on the medications. When asked if she reported to anyone about the insulins not being given, she stated she let the Assistant Administrator/Billing Manager know the next day but did not hear anything from him. On 6/18/2026 at 9:11 AM Staff G stated Staff F told her Staff A had not given insulins on the 100-hall medication cart during her shift. Staff G told she would pester Staff A about it. started to check her blood sugars about 3:30 PM on 6/7/2026 and Resident #6's blood sugar read "HI." At 4:30 AM Staff A gave Resident #6 24U of his sliding scale insulin, rechecked his blood sugar at 4:45 PM and it continued to read "HI." When she told Staff A this, she was gathering the insulin pens. She watched her give the 24U of insulin because she bugged her	F0760		

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 06/23/2026

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
F0760 SS = E	Continued from page 22 about doing something. At 8:00 PM his blood sugar still read “HI” and she reported this to Staff E. She also let Staff E know he had been reading “HI” all day. Staff E gave him 24U of insulin. Staff G stated every time she told Staff A Resident #6’s blood sugar read “HI” she would advise her to keep rechecking it. Staff G asked then what do we do, Staff A let her know she would have to give him insulin. Staff G said she had to bug Staff A about what to do when it kept reading “HI.” Staff A did not call that doctor about his “HI” blood sugars. Staff G stated Resident #6 that day was slurring his words; his vitals were normal but he was just not making any sense at all. She had taken care of Resident #6 to know if he was slurring his words, it was because his blood sugar was either hi or low. When asked how Staff A was a nurse, she stated as a person she is great but as a nurse she would not trust her. She likes to waste time when giving medications, takes forever on breaks in her car. She would go out to her car for an hour when she’s supposed to be passing medications, then gets behind on her medication times. Staff G stated she should not be a nurse; she likes to sit around; her medications are late and who knows if they are on time or given all at once. During a follow up interview on 6/23/2026 at 9:40 AM Staff G stated on 6/7/2026 she worked on the 100-hall medication cart and Staff A 200/400 hall medication cart. Staff A usually worked on the 100-hall medication cart. When she worked 2:30 PM until Staff A left at 6:30 PM that day, it was hectic and there were no falls during her shift with Staff A. When asked what it meant when a blood sugar reads “HI” she stated if the blood sugar is higher than 500mg/dL. On 6/18/2026 at 12:06 PM the DON stated it was brought to her attention by Staff F on 6/8/2026 (Monday) that Staff A had not administered resident’s insulins on 6/7/2026. The DON received the MARs and noted the insulins were not signed out as being given. She started her investigation and was able to confirm this because they were not signed out on the MARs. On 6/8/2026 Staff A had approached her because Resident #6’s blood sugar was high and had been over the weekend. Staff A stated I don’t know what to do and she told Staff A to call the physician to have him sent to the hospital. After this, the DON started to look further in to things. She reviewed camera footage and was able to see Staff F checked resident’s blood sugar but did not see Staff A administer their insulins as ordered. She gave all this information to the Administrator and informed him it needed to be reported. The Administrator started to look at blood sugar records and noticed on 6/3/2026, Resident	F0760		

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 06/23/2026

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
F0760 SS = E	Continued from page 23 #6's blood sugar was really high but Staff A had documented she gave his ordered sliding scale insulin at 11:30 AM. They reviewed the camera footage and found she had not administered his insulin as she documented. The DON also noted Resident #6 was in a care conference meeting with the DON and his wife during the time she would have given his ordered insulin. Resident #6 did end up going to the hospital on 6/8/2026 and returned to the facility that same day with antibiotics for a urinary tract infection (UTI). The DON stated it was not unusual for Resident #6 to have high and low blood sugar readings. When Staff A came in for her shift on 6/11/2026 they brought her in and asked what happened on 6/7/2026 for her to not give those insulins. Staff A told them she did not remember. That was concerning because she sent Resident #6 to the hospital and she could not remember what happened. When they asked about the falsifying that she gave Resident #6 his insulin on 6/3/2026 while he was in a meeting with staff and she was seen on the camera at the nurse's desk talking. When they looked at the camera footage from 10:00 AM to 2:00 PM that day, she did not cross paths with Resident #6, Staff A just put her head down. They terminated her employment and left her know they would be reporting this to the Iowa Board of Nursing. Staff A became quiet and left the facility. Prior to this Staff A had disciplinary actions related to poor attendance and excessive breaks. The DON reported no concerns with medication administration issues prior to this. When asked what it meant when a resident's blood sugar reads "HI," she stated the blood sugar is over 500. The nurse should complete an assessment on that resident and call their physician. The DON verified that when an order is not completed in a resident's EHR, it does turn red. When they completed their investigation the orders for Resident #4, #5, #6 and #7 were red; indicating they were not completed. On 6/18/2026 at 6:25 PM Staff A stated she started at the facility in October 2025. She was asked to talk about what took place during her shift on 6/7/2026. Staff A stated she was working on a hall she never worked on, was overwhelmed and in a lot of pain that day. She took her scheduled hydrocodone medication that day because she has a bad back. When asked what happened that day when four residents did not receive their insulins, she stated I don't know, I don't know what to say. She acknowledged she did forget to give the insulins, she was the only nurse in the building and worked a hall she had been on a lot, I don't know there is no excuse of it. When asked if she saw any orders in red in the EHR of residents, she stated she	F0760		

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 06/23/2026

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
F0760 SS = E	Continued from page 24 remembered seeing red orders when she went through to finish things up. She acknowledged the CMA came to her around lunch time asking her not to forget to give insulins and she did not give them. Staff A stated when she was told Resident #6's blood sugar was "HI" she went down and rechecked it, and gave 24U of insulin per his sliding scale orders. When asked if she called his physician as his order indicated if his blood sugar was over 400, she stated she did not recall then later stated she does not think she did. Staff A stated she looked for parameters but did not see anything on the MAR for that. She then stated she did not know how to get ahold of his physician and that day was crazy. When Staff A was read the orders from Resident #6's MAR she stated she did not remember seeing that. Staff A stated she did send a fax but acknowledged you would normally call the physician but she did not know how to get ahold of them. When asked if the facility had any of their staff on-call that weekend, she stated the MDS Coordinator was on call. When asked if they could have helped locate the physician's contact information, she stated they could have helped her with this. When asked what other residents did not receive their insulins that day, she stated #4, #5, and #7. Staff A was asked why this happened she stated I do not know what to say, she had never done at as nurse. She added, I don't think I will be working as a nurse anymore if that is something I did; I should not be working as a nurse. She again stated it was a rough day, only nurse doing all the things. Did not recall if there were any falls that day, she stated it was just a rough day. The facility provided a document titled Protocol for Medication Administration that was updated on 1/8/2026. The protocol documented the purpose is to ensure that all medications are administered by a qualified individual within state and licensing guidelines/regulations and in accordance with policy and procedures and physician's orders. All medications must be administered by a nurse or a medication aide in accordance with the physician's orders. The nurser is responsible and accountable for all medications that she/he administers (this is also in reference to any medication aide). Routine medications must be administered within 1 hour after the time that it is ordered to be administered. The nurse or medication aide must never document a medication prior to the administration of the medication.	F0760		

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 06/23/2026

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
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 (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in	F0580		

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 06/23/2026

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
F0580 SS = D	Continued from page 26 §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, observation, staff interviews and facility policy review the facility failed to notify the physician when Resident #6 had a change in condition. The facility also failed to notify the physician as written per orders for Resident #6. The facility reported a census of 41 residents. Findings include: On 6/19/2026 at 9:15 AM observed a closet across the front nurse's station where the copy/fax machine was located. On the inside of the door are a list of physicians with their address, fax and phone numbers. According to the Quarterly Minimum Data Set (MDS) assessment tool with a reference date of 5/11/2026, it documented Resident #6 had severely impaired cognitive skills for daily decision making. The MDS documented he received insulin injections during the last 7 days of the review period. The MDS listed the following diagnoses of Resident #6: diabetes mellitus, cancer, coronary artery disease, stroke, seizure disorder, malnutrition, and depression. The Care Plan Focus Area with an initiation date of 9/3/2026 documented Resident #6 had diabetes mellitus. The care plan directed staff to administer his diabetes medication as ordered by the doctor. Staff are to monitor/document for side effects and effectiveness. A second Care Plan Focus Area with an initiation date of 3/12/2026 documented Resident #6 used insulin related to his diabetes diagnoses. The Care Plan directed staff to administer his insulin as ordered and to monitor for adverse effects. Record review revealed Resident #6's blood sugar on: a) 6/7/2026 at 7:54 AM was 376 milligrams per deciliter (mg/dL) b) 6/7/2026 at 10:49 AM was 422mg/dL	F0580		

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 06/23/2026

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
F0580 SS = D	Continued from page 27 c) 6/7/2026 at 4:26 PM was 450mg/dL d) 6/7/2026 at 4:27 PM was 450mg/dL e) 6/7/2026 at 9:25 PM was 600mg/dL f) 6/7/2026 at 10:11 PM was 600mg/dL g) 6/7/2026 at 11:38 PM at 600mg/dL Review of Resident #6's June 2026 Medication Administration Record (MAR) revealed the following order: Insulin aspart flexpen (Novolog, rapid acting insulin) inject subcutaneously per sliding scale before meals and at bedtime. If blood glucose is 400 or greater give 24 units (U). Additional Directions: notify the doctor of blood sugar over 400+. The order had a start date of 1/13/2026. On 6/7/2026 (Sunday) at 4:30 PM Staff A Registered Nurse (RN) documented on Resident #6's MAR a blood sugar of 450mg/dL. She documented she gave the resident 24U of insulin aspart. A Progress Note documented on 6/7/2026 (Sunday) at 4:44 PM by Staff A documented Resident #6's blood sugar read at HI. Checked order and administered 24U of sliding scale insulin. Resident's vital signs were checked and within normal limits (WNL). He is confused which has been since he returned from the hospital this last time. No sweating or clammy skin noted. Resident #6 was not experiencing tremors, not lethargic or slurring his words. He was encouraged to drink fluids and he took in 180 milliliters of water. Will observe and recheck blood sugar. Record review revealed a facsimile (fax) dated 6/7/2026 (Sunday) was sent to Resident #6's physician with the following reason for faxing documented: at 11:30 AM accucheck was 422. Resident has had an increase in confusion and gets agitated easily. Has called his wife multiple times today and requested her to come pick him up so he can get his truck out of the field. On the top left side of the fax a date/time stamp read 6/7/2026 at 11:24 AM. Staff A signed as the sender's signature. On 6/8/2026 (Monday) the physician ordered an urine analysis with culture and sensitivity. On 6/18/2026 at 6:25 PM Staff A stated she started at the facility in October of 2025. She stated on afternoon when Resident #6's blood sugar was reading HI, she went down and rechecked it, gave	F0580		

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 06/23/2026

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
F0580 SS = D	Continued from page 28 him his insulin as ordered on his sliding scale order. When asked if she called his physician as his order indicated if his blood sugar was over 400, she stated she did not recall then later stated she does not think she did. Staff A stated she looked for parameters but did not see anything on the MAR for that. She then stated she did not know how to get ahold of his physician and that day was crazy. When Staff A was read the orders from Resident #6's MAR she stated she did not remember seeing that. Staff A stated she did send a fax but acknowledged you would normally call the physician but she did not know how to get ahold of them. When asked if the facility had any of their staff on-call that weekend, she stated the MDS Coordinator was on call. When asked if they could have helped locate the physician's contact information, she stated they could have helped her with this. On 6/19/2026 at 9:15 AM Staff B RN stated each resident's physician is listed in their Electronic Health Record (EHR). When asked about the list located in the closet across from the nurse's station, she stated you can use those too. She stated if you have to call on the weekends, the clinic you are calling will have a message on their machine of who is on call for that person. On 6/23/2026 at 1:01 PM the Director of Nursing (DON) was asked where staff could find a resident's physician's doctor contact information, she stated it would be in the resident's EHR under each under resident profile. They do have the list in the closet across from the nurse's station but it does not list which resident is under each physician. When asked if the fax Staff A sent to Resident #6 would have been the appropriate way to notify him of the resident's status, she stated with a change like that, Staff A should have called especially since the resident had confusion and agitation. The facility provided a document titled Change in Condition Policy with a revision date of 4/23/2026 stated the purpose of this policy is to ensure that residents that have changes in condition have a focused assessment promptly with appropriate interventions and/or notification of the physician. Policy: If it is noted that a resident has a change in condition, nursing staff will promptly acquire a full set of vitals, cognition assessment and focused assessment. Contact the physician with abnormal findings. The	F0580		

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 06/23/2026

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
F0580 SS = D	Continued from page 29 physician must be notified by the phone for a change in condition that is life threatening, falls, change in level of consciousness. If it is after hours or on the weekend, the on-call physician must be notified. The facility provided a document titled Nursing Assessment dated 1/24/2023. The purpose is to ensure that proper assessments are completed and documented on chronic illnesses, skin concerns, re-hospitalization and change of condition. When a resident voices a concern, staff brings a concern the nurse will do a full assessment that shall be documented and the physician should be notified of abnormal findings.	F0580		
F0640 SS = D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:	F0640		

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 06/23/2026

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
F0640 SS = D	Continued from page 30 (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, a list of discharged residents, staff interviews and Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual the facility failed to complete a death Minimum Data Set (MDS) after 1 of 3 residents (Resident #2) expired. The facility reported a census of 41 residents. Findings include: According to the admission Minimum Data Set (MDS) assessment tool with a reference date of 3/27/2026 documented Resident #2 was admitted to the facility on 3/20/2026 from the hospital and had received hospice care. The following diagnoses were listed for Resident #2: palliative care, cancer, coronary artery disease, heart failure, thyroid disorder, and genetic related intellectual disability. A Progress Note dated 4/18/2026 at 1:45 PM documented Resident #2's Power of Attorney (POA) called the nurse to his room stating he had expired. Time of death was called at 12:52 PM. On 6/17/2026 at 9:29 AM the facility provided a document titled Admission/Discharge To/From	F0640		

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 06/23/2026

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
F0640 SS = D	Continued from page 31 Report with range date of 3/1/2026-6/17/2026. The document listed Resident #2 expired on 4/18/2026. Review of the MDS tab in Resident #2's Electronic Health Record (EHR) on 6/18/2026 at 8:09 AM revealed two MDS assessments had been completed and accepted: 3/20/2026 Entry assessment and 3/27/2026 Admission Assessment. The MDS tab lacked a Death in Facility MDS assessment. On 6/18/2026 at 12:06 PM the Director of Nursing (DON) stated MDS assessments are a collaborative thing completed between herself, the MDS Coordinator, Social Worker and Dietary Manager. The DON was shown the MDS tab for Resident #2 and she acknowledged the Death in Facility MDS assessment had not been completed. She added it should be completed within the following day. On 6/18/2026 at 12:46 PM the MDS Coordinator stated she just completed Resident #2's Death in Facility MDS assessment, she is waiting for the DON to sign off on it. She acknowledged she forgot to complete it after he passed away. Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.20.1, updated October 2025 revealed a Death in Facility should be completed no later than 7 calendar days after the death.	F0640		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F0842		

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 06/23/2026

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
F0842 SS = D	Continued from page 32 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F0842		

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 06/23/2026

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
F0842 SS = D	Continued from page 33 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, staff interviews and facility policy review the facility failed to ensure 1 of 7 residents' (Resident #6) records were accurate. The facility reported a census of 41 residents. Findings include: According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 5/11/2026, Resident #6 had severely impaired cognitive skills for daily decision making. The MDS documented he received insulin injections during the last 7 days. The MDS listed the following diagnoses of Resident #6: diabetes mellitus, cancer, coronary artery disease, stroke, seizure disorder, malnutrition, and depression. The Care Plan Focus Area with an initiation date of 9/3/2026 documented Resident #6 had diabetes mellitus. The Care Plan directed staff to administer his diabetes medication as ordered by the doctor. Staff are to monitor/document for side effects and effectiveness. A second Care Plan Focus Area with an initiation date of 3/12/2026 documented Resident #6 used insulin related to his diabetes diagnoses. The Care Plan directed staff to administer his insulin as ordered and to monitor for adverse effects. Record review of Resident #6's June 2026 Medication Administration Record (MAR) revealed the following orders signed out as being completed by Staff A Registered Nurse (RN): Accucheck before meals and at bed time: on 6/3/2026 at11:30 AM his blood sugar was 168. Insulin Aspart Flexpen, inject subcutaneously per sliding scale before meals and at bed time. Staff were directed to give 4U of insulin if the blood sugar is between 150-199.	F0842		

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 06/23/2026

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
F0842 SS = D	Continued from page 34 Review of the facility's investigative file revealed the following: -Review of the MAR indicated that on 6/3/2026, Staff A documented a blood glucose check for Resident #6 at 11:58 AM and documented administration of 4U of sliding scale insulin. -Video footage was reviewed for the corresponding timeframe. Footage confirmed that Resident #6 was present in the dining room at the time the blood glucose check and insulin administration were documented. Review of the footage did not show Staff A obtaining the blood glucose reading or administrating insulin to Resident #6. -Additional timeline review revealed the following: 1. Staff A was observed outside of the facility from approximately 10:57 AM until 11:24 AM. 2. During that timeframe, Resident #6 was with his wife. 3. Resident #6 and his wife attended an MDS meeting until approximately 11:46 AM. 4. Between 11:42 AM and 11:53 AM Staff A was observed at the nurse's station speaking with coworkers. 5. Resident #6 remained near the lobby area until approximately 11:52 AM when he asked his roommate to assist him to the dining room. 6. No blood glucose check or insulin administration was observed before, during or after the medication pass. 7. Footage was also reviewed to determine whether another nurse may have performed the blood glucose check or administrated insulin. Review confirmed the other nurse on duty did not administer insulin or obtain a blood glucose reading for Resident #6 during the identified timeframe. - Based on review of the MAR documentation and corresponding video surveillance, findings indicate that a blood glucose check and administration of 4U of sliding scale insulin were documented as completed; however, video footage does not support that either task were performed. No evidence was identified to indicate that another nurse completed the blood glucose check or insulin administration on behalf of Staff A.	F0842		

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 06/23/2026

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
F0842 SS = D	Continued from page 35 On 6/18/2026 at 6:25 PM Staff A stated she remembered seeing Resident #6's order on 6/3/2026 as she went through to finish up her documentation. She signed off the order as being done but did not know why she did that because she knew she did not give the insulin as ordered. On 6/18/2026 at 12:06 PM the Director of Nursing (DON) stated staff had reported a concern about Staff A not administering insulins to residents on 6/7/2026. The DON received the MARs and noted the insulins were not signed out as being given. She started her investigation and was able to confirm this because they were not signed out on the MARs. She reviewed camera footage and was able to see Staff F Certified Medication Aide (CMA) checked resident's blood sugar but did not see Staff A administer their insulins as ordered. She gave all this information to the Administrator and informed him it needed to be reported. The Administrator started to look at blood sugar records and noticed on 6/3/2026, Resident #6's blood sugar was really high but Staff A had documented she gave his ordered sliding scale insulin at 11:30 AM. They reviewed the camera footage and found she had not administered his insulin as she documented. The DON also noted Resident #6 was in a care conference meeting with the DON and his wife during the time she would have given his ordered insulin. When Staff A came in for her next scheduled shift, when they brought up her falsifying documentation on 6/3/2026. They let her know they saw the camera footage of her at the nurse's station and Resident #6 being in a care conference. They let her know they were able to see she did not cross paths with Resident #6 from 10:00 AM until 2:00 PM. Staff A did not say anything, she just put her head down. On 6/23/2026 at 10:45 AM the Administrator stated the DON completed an investigation in to another issue with Staff A not administering insulin to residents. She brought the information to him and he dug a little deeper and noticed on 6/3/2026 Resident #6's blood sugar started to elevate after Staff A had signed out as giving his insulin that afternoon. After they review camera footage, they noted she did not give Resident #6 his insulin even though she had signed it out as being given. The facility provided a document titled Protocol for Medication Administration that was updated on 1/8/2026. The protocol documented the purpose is to ensure that all medications are administered by a qualified individual within state and licensing	F0842		

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 06/23/2026

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
F0842 SS = D	Continued from page 36 guidelines/regulations and in accordance with policy and procedures and physician's orders. All medications must be administered by a nurse or a medication aide in accordance with the physician's orders. The nurser is responsible and accountable for all medications that she/he administers (this is also in reference to any medication aide). Routine medications must be administered within 1 hour after the time that it is ordered to be administered. The nurse or medication aide must never document a medication prior to the administration of the medication.	F0842		

PLAN OF CORRECTION

Facility: Tabor Manor Care Center.

Provider: 165546

Date Survey Completed: 06/23/2026

Correction Date: 07/23/2026

This is Tabor Manor's credible allegation of compliance with the 2567, Correction Date 07/23/2026.

F0600:

1. Resident #4's PCP was notified of the incident of staff A not administering insulin on the morning of 06/07/2026, B.S. was monitored by Medication Tech. Staff A was terminated from her employment and a formal complaint filed with the Board of Nursing. All nurses were reeducated on the importance of following physician orders, facility policies, notification of physician in the proper manner, documentation, and notification of on call personnel. Director of Nursing / MDS Coordinator will monitor MAR twice a week specifically on Monday after the weekend for compliance with physician orders and policies. QAPI will monitor through PiP's in the QAPI system.
2. Resident #5's PCP was notified of the incident of staff A not administering insulin on the morning 06/07/2026, B.S.

monitored by Medication Tech. Staff A was terminated from her employment and a formal complaint filed with the Board of Nursing. All nurses were reeducated on the importance of following physician orders, facility policies, notification of physician in the proper manner, documentation, and notification of on call personnel. Director of Nursing / MDS Coordinator will monitor MAR twice a week specifically on Monday after weekend for compliance with physician orders and policies. QAPI will monitor through PiP's in the QAPI system.

3. Resident #6's PCP was notified at 11:30 on the evening of 06/07/26 by staff E. Orders to administer more insulin and monitor, as staff A did not take this step. Resident #6 was sent out to ER for evaluation. Staff A was terminated from her employment and a formal complaint filed with the Board of Nursing. All nurses were reeducated on the importance of following physician order, facility policies, notification of physician in the proper manner, documentation, and notification of on call personnel. Director of Nursing / MDS Coordinator will monitor MAR twice a week specifically on Monday after the weekend for compliance with orders and policies. QAPI will monitor through PiP's in the QAPI system.
4. Resident #7's PCP was notified of the incident of staff A not administering insulin on 06/07/26, B.S. was monitored by Medication Tech. Staff A was terminated from employment and a formal complaint filed with the Board of Nursing. All nurses were reeducated on the importance of following physician orders, facility policies, notification of physician

orders in the proper manner, documentation, and notification of on call personnel. Director of Nursing / MDS Coordinator will monitor MAR twice a week specifically on Monday after the weekend for compliance with orders and policies. QAPI will monitor through PiP's in the QAPI system.

5. Resident #10's PCP was notified of the incident of staff A not administering insulin on 06/07/26, B.S. was monitored by Medication Tech. Staff A was terminated from employment and a formal complaint filed with the Board of Nursing. All nurses were reeducated on the importance of following physician orders, facility policies, notification of physician order in the proper manner, documentation, and notification of on call personnel. Director of Nursing / MDS Coordinator will monitor MAR twice a week specifically on Monday after the weekend for compliance with physician orders and policies. QAPI will monitor through PiP's in the QAPI system.

F0760:

1. Resident #4's PCP was notified of the incident of staff A not administering insulin on the morning of 06/07/2026, B.S. was monitored by Medication Tech. Staff A was terminated from her employment and a formal complaint filed with the Board of Nursing. All nurses were reeducated on the importance of following physician orders, facility policies, notification of physician in the proper manner, documentation, and notification of on call personnel. Director of Nursing / MDS Coordinator will monitor MAR twice a week specifically on

Monday after the weekend for compliance with physician orders and policies. QAPI will monitor through PiP's in the QAPI system.

2. Resident #5's PCP was notified of the incident of staff A not administering insulin on 06/07/26, B.S. was monitored by Medication Tech. Staff A was terminated from her employment and a formal complaint filed with the Board of Nursing. All nurses were reeducated on the importance of following physician orders, facility policies, notification of physician in the proper manner, documentation, and notification of on call personnel. Director of Nursing / MDS Coordinator will monitor MAR twice a week specifically on Monday after weekend for compliance with physician orders and policies. QAPI will monitor through PiP's in the QAPI system.
3. Resident #6's PCP was notified at 11:30 on the evening of 06/07/26 by staff E. Orders to administer more insulin and monitor, as staff A did not take this step. Resident #6 was sent out to ER for evaluation. Staff A was terminated from her employment and a formal complaint filed with the Board of Nursing. All nurses were reeducated on the importance of following physician order, facility policies, notification of physician in the proper manner, documentation, and notification of on call personnel. Director of Nursing / MDS Coordinator will monitor MAR twice a week specifically on Monday after the weekend for compliance with orders and policies. QAPI will monitor through PiP's in the QAPI system.
4.

Resident #7's PCP was notified of the incident of staff A not administering insulin on 06/07/26, B.S. was monitored by Medication Tech. Staff A was terminated from employment and a formal complaint filed with the Board of Nursing. All nurses were reeducated on the importance of following physician orders, facility policies, notification of physician orders in the proper manner, documentation, and notification of on call personnel. Director of Nursing / MDS Coordinator will monitor MAR twice a week specifically on Monday after the weekend for compliance with physician orders and policies. QAPI will monitor through PiP's in the QAPI system.

5. Resident #10's PCP was notified of the incident of staff A not administering insulin on 06/07/26, B.S. was monitored by Medication Tech. Staff A was terminated from employment and a formal complaint filed with the Board of Nursing. All nurses were reeducated on the importance of following physician orders, facility policies, notification of physician order in the proper manner, documentation, and notification of on call personnel. Director of Nursing / MDS Coordinator will monitor MAR twice a week specifically on Monday after the weekend for compliance with physician orders and policies. QAPI will monitor through PiP's in the QAPI system.

F0580:

Staff A was terminated from employment and a formal complaint filed with the Board of Nursing. All nurses were reeducated on the importance of following physician orders, facility

policies as it applies to notifications of physician. Director of Nursing / MDS Coordinator will monitor MAR and any concerns that would warrant notification of physician, twice a week specifically on Monday after the weekend for compliance with physician orders and notifications of physician. QAPI will monitor through PiP's in the QAPI systems.

F0640:

The concern with the MDS as it applies to Resident #2 has been corrected and submitted. The MDS Coordinator has been reeducated on the importance of assuring that all deaths in the facility are processed and submitted to CMS. This will be monitored by the Director of Nursing monthly. QAPI will be notified of this concern and monitored.

F0842:

1. Resident #6's PCP was notified of the incident on 06/03/2026, when Staff A documented B.S. and administration of insulin but based on camera footage it was deemed false documentation. Staff A was terminated from her employment and a formal complaint filed with the Board of Nursing. All nurses were reeducated on the importance of following physician order, facility policies, notification of physician in the proper manner, documentation, and notification of on call personnel. Director of Nursing / MDS Coordinator will monitor MAR twice a week specifically on

Monday after the weekend for compliance with orders and policies. QAPI will monitor through PiP's in the QAPI system.