

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>165233</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>12/31/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>Regency Park Nursing &amp; Rehab Center of Jefferson</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 RAM ROAD , JEFFERSON, Iowa, 50129</b>	
(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  The following deficiencies resulted from the facility's annual recertification survey conducted on December 29th, 2025 to December 31st, 2025.  See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment  CFR(s): 483.10(i)(1)-(7)  §483.10(i) Safe Environment.  The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.  The facility must provide-  §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.  (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.  §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;  §483.10(i)(3) Clean bed and bath linens that are in good condition;	F0584		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0584 SS = D	<p>Continued from page 1</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to ensure resident's had a safe, clean, comfortable and homelike environment, with 2 recliners showing extensive wear. The facility reported a census of 43 residents.</p> <p>Findings include:</p> <p>On 12/29/25 at 12:40 p.m. observed Resident #50 in her room sitting in a recliner. The arms of the recliner had large areas of the top covering worn off. The area behind the head also worn off. On 12/29/25 at 1:30 p.m. the burgundy recliner in the common area (of the 300, 400 and 500 halls) showed the burgundy covering worn off at the the back of the head area. On 12/31/25 at 7:45 a.m. the Maintenance Staff (MS) brought another chair into Resident #50's room, and said another resident may be moving in. He stated the recliner already in the room would be a facility chair, and said it looked bad, and should be replaced. On 12/31/2025 at 9:16 AM the MS verified the burgundy chair in the common area belonged to the facility. The undated facility policy, Resident Environmental Quality, documented it was the policy of the facility to be designed, constructed, equipped, and maintained to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. The facility must provide each resident with functional furniture appropriate to the resident's needs.</p>	F0584		
F0684 SS = D	<p>Quality of Care</p> <p>CFR(s): 483.25</p> <p>§ 483.25 Quality of care</p>	F0684		

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F0684 SS = D	<p>Continued from page 2</p> <p>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, clinical record review, staff interviews, resident interviews and policy review, the facility failed to complete and document appropriate assessments and interventions for the necessary care and services, to maintain the residents' highest practical physical well-being for 2 of 13 residents reviewed (Resident #12 and #4). The facility failed to document a gastrointestinal assessment and notify the physician when indicated for Resident #12. The facility also failed to implement interventions for Resident #4 with new skin issues. The facility reported a census of 43 residents.</p> <p>Findings include:</p> <p>1. Resident #12's Minimum Data Set (MDS) assessment dated 11/27/25 identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS identified Resident #12 was dependent on staff for toileting hygiene and transfers to the toilet. The MDS documented Resident #12 was frequently incontinent of bowel and constipation was present. The MDS included diagnoses of hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD)(progressive lung condition) and congestive heart failure (heart inability to pump blood causing fluid build up).</p> <p>The Care Plan with a target date of 2/25/26 documented Resident #12 had the potential for alterations in bowel patterns due to diagnosis of constipation and risk for bowel incontinence. The care plan directed staff to follow facility protocol for administration of stool softeners/laxatives/enemas and to observe for signs and symptoms of constipation and report to the Physician as indicated.</p> <p>The Orders- Administration Note dated 12/27/25 documented Miralax powder (laxative) 17 grams was given for constipation for day 5 with no bowel movement (BM). The note documented the medication was ineffective. The clinical record lacked documentation of a GI/bowel assessment.</p>	F0684		

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F0684 SS = D	<p>Continued from page 3</p> <p>The Orders- Administration note dated 12/29/25 at 6:03 AM documented a bisacodyl suppository (stimulant laxative) was given for constipation. The clinical record lacked documentation of a GI/bowel assessment.</p> <p>Review of Task Form titled Bowel Elimination documented Resident #12 did not have a BM from 12/22/25 to 12/29/25 (7 days).</p> <p>On 12/29/25 at 1:32 PM, Resident #12 reported he strained for an hour and half that morning trying to have a bowel movement. He said his stool was hard. He reported the staff gave him some medication to help him go to the bathroom. Observed emesis basin with yellow vomit in the bed. Resident #12 reported he had gotten sick but did not know why. He said he had not eaten breakfast or lunch.</p> <p>On 12/30/25 at 8:30 AM, Resident #12 reported he was a little uncomfortable and continued to have a hard time passing stool. He reported there was half of the stool hanging out of his rectum and he needed some assistance removing the stool.</p> <p>On 12/30/25 at 8:45 AM, Staff C, Licensed Practical Nurse (LPN) reported the Director of Nursing (DON) elevated Resident #12's head of the bed to promote elimination. Staff C reported it was passed on in report that Resident #12 had a suppository yesterday and was effective. She said Resident #12 required a complete bed change due to the amount of BM.</p> <p>On 12/30/25 at 9:05 AM, observed Staff C, LPN assess Resident #12. Resident #12 reported that he was not feeling well and that he needed someone to help him with the stool that was coming out. Staff C listened to Resident #12 bowel sounds and reported his bowel sounds were hyperactive. She asked Resident #12 how his appetite was and he said "terrible". He reported he did not eat anything yesterday. Resident #12 reported to Staff C that his stool was half way out, that he couldn't get it out and needed help.</p> <p>On 12/30/25 at 9:10 AM, Staff D, Certified Nursing Assistant (CNA) and Staff E, CNA entered the room to assist Staff C. The CNAs assisted with changing Resident #12's brief and completing incontinent cares. Resident #12 was incontinent dark BM in the incontinent brief. Observation revealed a piece of formed stool protruding from the rectal area. The CNA removed the stool with an incontinent wipe. After the stool was removed a small amount of brown liquid bm came out of the rectum.</p>	F0684		

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F0684 SS = D	<p>Continued from page 4</p> <p>On 12/30/25 at 9:30 AM, Staff C, LPN revealed the facility had a bowel protocol that was kept in a binder at the nurses desk.</p> <p>The facility form titled BM Protocol revised 6/30/21 documented it was very important to strive for the best possible health for the resident. The protocol documented bowel movements must be monitored and intervention put in place as needed. The facility protocol documented the following:</p> <ol style="list-style-type: none"> <li>1. Milk of Magnesia (MOM) to be given on day 2 without a BM.</li> <li>2. Overnight nurse to give a suppository on day 3 if milk of magnesia was not effective.</li> <li>3. Day shift nurse to complete a bowel assessment and contact the Physician if cathartics are not effective on day 4.</li> </ol> <p>On 12/30/25 at 9:50 AM, the DON reported she expected the staff to follow the facility BM protocol for Resident #12. The DON said she expected on day 2 with no BM for the staff to give MOM, on day 3 with no BM to give a suppository and on day 4 with no BM to give an enema. She said If there were no results after the enema she expected the staff to contact the Physician. She verified and acknowledged the staff was late on providing bowel interventions and did not follow the BM protocol. The DON reported she expected bowel assessments to be completed and documented when bowel interventions were completed.</p> <p>2. Resident #4's MDS dated 10/1/25 identified a BIMS score of 15, indicating intact cognition. The MDS identified Resident #4 required partial/moderate assistance with bed mobility and chair/bed to chair transfers. Resident #4's MDS included diagnoses of peripheral vascular disease (circulation problem in the legs), diabetes mellitus, chronic obstructive pulmonary disease (COPD)(progressive lung condition) and Parkinson's. The MDS documented Resident #12 was at risk for developing pressure ulcers/injuries and had moisture associated skin damage.</p> <p>The Wound Treatment Plan dated 10/9/25 documented a new skin area to Resident #4's left heel. The note documented the etiology of the left heel wound was friction/shearing. The area measured 2.1 centimeters (cm) x 1.8 cm x 0.1 cm with the following tissues identified: 30% pink epithelial, 70% clear fluid filled blister. The wound treatment plan directed to cleanse</p>	F0684		

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F0684 SS = D	<p>Continued from page 5 the left heel wound with cleanser of choice, apply skin prep topically every shift and as needed (PRN).</p> <p>The Wound Treatment Plan dated 10/16/25 documented a new area to Resident #4's right heel. The note documented the etiology of the right heel wound was friction/shearing. The area measured 1.0 cm x 0.5 cm x 0.1 cm with the following tissue identified: 30% pink epithelial, 20% red epithelial, 50% clear fluid filled blister. The wound treatment plan directed to cleanse the right and left heel wounds with cleanser of choice, apply skin prep and allow it to dry, then cover with a foam border. Change three times per week and PRN.</p> <p>The Care Plan dated 10/27/25 revealed Resident #4 was at risk for impaired skin integrity related to diabetes mellitus, Parkinson's and COPD. The care plan documented Resident #12 had discoloration to his left heel. The care plan lacked documentation regarding skin impairment to the right heel.</p> <p>Review of the Clinical Record lacked documentation a skin intervention was implemented to prevent friction/shearing on 10/9/25 when the left heel wound was identified. The clinical record revealed 7 days later on 10/16/25 an additional wound developed on the right heel related to friction and shearing.</p> <p>On 12/30/25 at 2:00 PM, the Assistant Director of Nursing (ADON) reported Resident #4's heel wounds were considered to be caused by trauma. The ADON reported the facility thought the areas developed due to Resident #4 causing friction and shearing to the back of his heels when trying to move in his wheelchair.</p> <p>On 12/31/25 at 8:30 AM, the Director of Nursing (DON) reported the staff were supposed to come up with a new skin intervention when a new skin issue had been identified. The DON verified additional skin interventions were not implemented when Resident #4's left heel ulcer was identified on 10/9/25.</p> <p>A facility policy titled Documentation of Wound Treatments dated 2025 documented the facility to complete accurate documentation of wound assessments and treatments, including response to treatment, change in condition and changes in treatment. The policy documented additional wound documentation to include effectiveness of current interventions and modification of interventions.</p>	F0684		
F0695 SS = D	<p>Respiratory/Tracheostomy Care and Suctioning</p> <p>CFR(s): 483.25(i)</p>	F0695		

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F0695 SS = D	<p>Continued from page 6</p> <p>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.</p> <p>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, record review, staff interviews, and policy review, the facility failed to change oxygen tubing and water humidifier for 1 of 1 residents reviewed (Resident #12) for respiratory services. The facility reported a census of 43 residents.</p> <p>Findings Include:</p> <p>Resident #12's Minimum Data Set (MDS) assessment dated 11/27/25 identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS included diagnoses of hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD)(progressive lung condition) and congestive heart failure (heart inability to pump blood causing fluid build up). The MDS documented Resident #12 received oxygen while a resident within the last 14 days.</p> <p>A Physician order dated 11/7/25 directed Resident #12 to wear oxygen per nasal cannula to keep oxygen saturation above 90% as needed related to COPD. The order directed no more than 3 liters of oxygen for diagnosis of COPD.</p> <p>The Care Plan with a target date of 2/25/26 documented Resident #12 had altered respiratory status and required continuous oxygen. The care plan directed staff to administer oxygen via nasal cannula as ordered. The care plan lacked direction on when to change the oxygen tubing or water bottle.</p> <p>On 12/29/25 at 1:36 PM, observed Resident #12's oxygen concentrator running at 2 liters. The oxygen cannula/tubing was hanging from the shelf on the wall. Resident #12 reported that he only wore the oxygen during the day when his oxygen levels were below 90%. He said he wore the oxygen at night routinely. Observed the oxygen tubing and water bottle dated 12/5/25 and the water bottle was empty/dry.</p>	F0695		

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F0695 SS = D	<p>Continued from page 7</p> <p>Review of the November and December 2025 Medication Administration Record (MAR) or Treatment Administration Record (TAR) lacked direction on how often to change the oxygen tubing and water bottle.</p> <p>On 12/30/25 at 10:00 AM, the DON reported she expected the oxygen tubing to be changed weekly and documented on the MAR. She said the tubing was normally changed on Fridays. She said Resident #12 had not been utilizing his oxygen when he first came to the facility so the order to change the tubing might have been missed. When asked how often the water bottle should be changed and water added to the bottle, she said she did not have a good answer for that. She said she would have to look at the policy. She said she would expect staff to add water to the bottle as needed.</p> <p>The facility policy titled Oxygen Concentrator dated 2025 documented the care of the concentrator included changing the oxygen tubing and mask/cannula weekly and as needed if it became soiled or contaminated and to change the humidifier bottle when empty, or weekly.</p>	F0695		
F0812 SS = E	<p>Food Procurement,Store/Prepare/Serve-Sanitary</p> <p>CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements.</p> <p>The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p>	F0812		

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F0812 SS = E	<p>Continued from page 8</p> <p>Based on observations, staff interviews and policy review, the facility failed to prepare and serve food under sanitary conditions to reduce the risk of contamination and food borne illness. The facility identified a census of 43 residents.</p> <p>Findings include:</p> <p>On 12/30/25 at 10:52 AM, observed the Dietary Manager puree a grilled turkey reuben sandwich while wearing gloves. When finished with pureeing the sandwich, the Dietary Manager removed her gloves and then proceeded to wash out the dishes used to puree the sandwich in the sink, put the dirty dishes in the dishwasher and then continued to puree the next food items without washing her hands.</p> <p>On 12/30/25 at 11:30 AM, observation revealed the Dietary Manager wore gloves to get the room trays ready to be delivered to the unit. During the process, the Dietary Manager touched each grilled turkey Reuben sandwich with her gloved hands, then served the potatoes and peas with a utensil, then with her gloved hands took a cookie out of the plastic container and put the cookie on the tray. The Dietary Manager touched multiple items on the steam table and opened the refrigerator door and removed items from the refrigerator wearing the same pair of gloves. After room trays were assembled, she proceeded to wear the same pair of gloves and finished cooking a grilled cheese sandwich on the stove. The Dietary Manager obtained a spatula from a drawer wearing the same gloves and then returned to the stove. She removed her gloves and did not wash her hands. She then dated and labeled a condiment container that was sitting on the counter and put the container in the refrigerator. She returned to the stove, removed the grilled cheese using the spatula, wrapped the grilled cheese in a piece of aluminum foil and placed it on the hot cart. She then pushed the hot cart down the hallway to the North end of the building to continue meal service. The Dietary Manager used hand sanitizer and applied gloves. The Dietary Manager picked up the sandwiches with her gloved hands from the steam table without using a utensil and put the sandwich on a plate to cut it with a knife. She then with her gloves hands served the potatoes and peas with a utensil and then took a cookie from the plastic container wearing the same gloves. The Dietary Manager wore the same pair of gloves throughout the meal service in the north dining room touching multiple items including food items and nonfood items. When finished serving in the North dining room, the</p>	F0812		

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F0812 SS = E	<p>Continued from page 9 Dietary Manager removed the gloves and proceeded to move the hot cart to the South dining room. The Dietary Manager washed her hands in the kitchen and applied gloves. The Dietary Manager continued to serve the sandwiches and cookies with gloved hands and not utensils.</p> <p>On 12/30/25 at 12:00 PM, the Dietician reported it was an expectation for the dietary staff to use utensils when serving food items such as sandwiches and cookies. The Dietician reported she would expect the staff to wash their hands before and after gloving.</p> <p>The facility policy titled Food Preparation and Service revised October 2017 documented gloves must be worn when handling food directly, however, gloves can become contaminated and/or soiled and must be changed between tasks. The policy documented gloves are single-use items and shall be discarded after each use.</p>	F0812		
F0880 SS = D	<p>Infection Prevention &amp; Control</p> <p>CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control</p> <p>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program.</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify</p>	F0880		

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NAME OF PROVIDER OR SUPPLIER <b>Regency Park Nursing &amp; Rehab Center of Jefferson</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 RAM ROAD , JEFFERSON, Iowa, 50129</b>	
(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
F0880 SS = D	<p>Continued from page 10 possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by:  Based on observation, staff interviews, the Centers for Disease Control and Prevention (CDC) and the facility policy review, the facility staff failed to follow infection control practices in order to prevent and control the onset and spread of infection within the</p>	F0880		

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F0880 SS = D	<p>Continued from page 11 facility by not wearing the required personal protective equipment for 1 of 2 residents (Resident #4) reviewed for catheter care. The facility also failed to keep dirty linens off the floor. The facility reported a census of 43 residents.</p> <p>Findings include:</p> <p>1. Resident #4's Minimum Data Set (MDS) dated 10/1/25 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #4's MDS included diagnoses of benign prostatic hyperplasia (enlargement of prostate gland), renal (kidney) disease and obstructive uropathy (blockage in urinary tract preventing normal urine flow). The MDS revealed Resident #4 had an indwelling catheter (thin tube used to drain urine).</p> <p>The Care Plan with a target date of 12/31/25 documented Resident #4 required enhanced barrier precautions (EBP) due to the presence of an indwelling catheter.</p> <p>On 12/30/25 at 3:05 PM, observed a EPB sign posted on the back of Resident #4 door. The sign directed everyone must clean their hands, including before entering and when leaving the room. The sign directed providers and staff to wear gloves and a gown following high-contact resident care activities which included device care or use related to urinary catheters.</p> <p>On 12/30/25 at 3:32 PM, observed Staff A, Licensed Practical Nurse (LPN) and Staff B, Certified Nursing Assistant (CNA) empty Resident #4's urinary leg bag and perform cares to the suprapubic catheter site. Staff A and Staff B did not wear a gown when completing any of the catheter cares. Staff A and Staff B acknowledged that they did not wear a gown during catheter care. Staff A and B reported they had forgotten but were aware they were supposed to wear the gown.</p> <p>On 12/30/25 at 4:14 PM, the Director of Nursing (DON) reported she expected staff to wear gowns during high-contact activities which included taking care of the catheter.</p> <p>The facility policy titled Enhanced Barrier Precautions dated 3/25/24 documented EPBs are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. The policy documented EPBs employ targeted gown and glove use during high-contact resident care activities when contact precautions do not otherwise apply. Examples of high-contact resident care activities requiring the use of a gown and gloves</p>	F0880		

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NAME OF PROVIDER OR SUPPLIER <b>Regency Park Nursing &amp; Rehab Center of Jefferson</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 RAM ROAD , JEFFERSON, Iowa, 50129</b>	
(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
F0880 SS = D	Continued from page 12 include indwelling device care or use such as a urinary catheter.  2) On 12/30/25 at 8:40 a.m. noted dirty linens (bedding) on the floor in room #301. The resident was not in the room, and no staff were in the room.  On 12/31/25 at 10:20 a.m. the DON confirmed dirty laundry and linens should not be on the floor.  The undated facility policy for Handling Soiled Linen documented linen should not be allowed to touch the uniform or the floor.	F0880		