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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165233	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Park Nursing & Rehab Center of Jefferson	**100 Ram Road , Jefferson, Iowa, 50129**

(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: 6-20-26 The following deficiencies resulted from investigation of complaints #3003653-C, #3012201-C, and facility reported incidents #3000989-I conducted June 01, 2026 to June 04, 2026. Complaints #3003653-C and #3012201-C did not result in a deficiency. Facility reported incident #3000989-I resulted in a deficiency. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record reviews, facility investigation review, staff interviews, and policy review, the facility failed to provide adequate nursing supervision to prevent a resident to resident altercation for 2 of 4 residents reviewed (Resident #1 and Resident #2). The facility reported a census of 43 residents. Findings include:	F0689		

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 ✓
Jamie Cates	Administrator	6/19/2026

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F0689 SS = D	Continued from page 1 1. Resident #1's Minimum Data Set (MDS) assessment dated 5/3/26 identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS identified Resident #1 was independent with bed mobility and all transfers. The MDS included diagnoses of non-alzheimer's disease, bipolar disorder and schizophrenia. The Care Plan with a target date of 5/27/26 documented Resident #1 may have episodes of behaviors and potential for behaviors as evidenced by being combative, negative verbalizations, name calling, refusal of medications/care, resistance to care, attempts to leave building, crying episodes, screaming out, attention seeking behaviors, hallucination and delusions. The care plan directed staff to intervene as necessary to protect the rights and safety of the other residents. 2. Resident #2's Minimum Data Set (MDS) assessment dated 5/6/26 identified a Brief Interview for Mental Status (BIMS) score of 01, indicating severely impaired cognition. The MDS identified Resident #2 was independent with bed mobility and all transfers. The MDS included diagnoses of non-Alzheimer's disease and unspecified dementia with agitation. The Care Plan with a target date of 8/4/26 documented Resident #2 has the potential to be physically/verbally aggressive as evidenced by hitting, kicking, biting, spitting on staff/other residents, screaming out, and using profanity. The care plan identified Resident #2 was involved in two resident to resident altercations in April 2026. The care plan directed staff to provide one on one supervision as needed at times of agitation. The Progress Note dated 4/26/26 at 1:20 PM revealed Resident #2 entered Resident #7's room and was yelling to get out of her house. Staff A, Licensed Practical Nurse (LPN) stepped between the resident and attempted to verbally redirect Resident #2 out of Resident #7's room when Resident #2 slapped Staff A on the arm with an open hand. Staff B, certified nursing assistant (CNA) directed Resident #2 out of the room to calm down and take her afternoon medications. The Incident Report (IR) titled Resident to Resident dated 4/26/26 at 1:30 PM documented Staff C, CNA was coming on shift, walked into the unit dining room and saw Resident #2 hit Resident #1 one time on the top of the head with an open hand. Staff C	F0689		

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F0689 SS = D	Continued from page 2 reported Resident #2 was telling Resident #1 to get out of her house. Staff A, LPN documented she witnessed Resident #2 yelling at another CNA saying he doesn't pay to be here. The IR documented the immediate action was for one on one supervision with Resident #2 until further notice. The undated facility investigation titled DIAL Summary Report documented prior to the incident, Resident #2 was sitting in the recliner and Resident #1 was sitting at the table in an open room which included both the common area and dining room. Staff B, CNA had stepped out of the dining room to go to the bathroom. When Staff C, CNA arrived for her shift in the memory care unit, Staff C witnessed Resident #2 hit Resident #1 on the top of the head one time. The conclusion/root cause analysis documented a brief lapse in supervision during shift change, combined with the open layout of the unit, allowed interaction to occur before staff could intervene. The hand written statement dated 4/28/26 by Staff B, CNA documented at the time of the incident she was using the bathroom. Before Staff B left to use the bathroom, Resident #1 was sitting at the table and Resident #2 was sitting in her recliner. On 6/1/26 at 12:49 PM, Staff C, CNA reported she walked into the unit to report for work and saw Resident #2 standing by Resident #1 in the dining room. She said Resident #2 took her open hand and popped Resident #1 in the forehead area. Staff C reported Resident #2 was agitated and made comments that it was her home. She said Resident #1 made the comment that Resident #2 had hit him. Staff C reported if she needed help she would push the button for help. She said the button was on the keys that she carried in her pocket. When asked what she does when she needs to go to the bathroom, she said she would push the button and another staff member would come back to the unit to replace her. She said the employee bathrooms are located outside the unit. On 6/1/26 at 12:55 PM, Staff B, CNA reported Resident #2 was in the recliner watching TV and Resident #1 was sitting at the table in the dining room when she went to the bathroom. She said the staff outside the unit are not always able to relieve you when you need to go to the bathroom so she would use the resident's bathrooms in the unit. She said she used the bathroom in Room 206. She said she was only gone a couple of minutes, long enough to go to the bathroom. She said Staff C, CNA told her that Resident #2 was over by Resident #1 and	F0689		

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F0689 SS = D	Continued from page 3 Resident #2 had hit Resident #1 on the head. Staff B reported prior to the incident, Resident #2 tried to enter Resident #7's room and Staff A, LPN and herself had tried to redirect her out of the room. She said Resident #2 thought Resident #7 had not paid rent. She said she took Resident #2 back to her room and she laid down for a little bit. She said Resident #2 came back up the hallway and ended up in the living room in the recliner. On 6/1/26 at 1:50 PM, Staff A, LPN reported 20-30 minutes prior to the incident on 4/26/26, Resident #2 was in Resident #7's room. She said Resident #2 was upset that Resident #7 was in her house and not paying to be there. She said Resident #2 was redirected out of the room and immediately calmed down when Resident #7 was not in her vision. She said she instructed Staff B, CNA to stay with Resident #2 and to call her if she needed any help. She said about 15-20 minutes later, Staff C, CNA who was reporting to work walked into the dining room and saw Resident #2 yelling at Resident #1 and Resident #2 hit Resident #1 on the head. She said Staff B, CNA was not in the dining room during the incident. Staff A said she thought it was the same type issue as Resident #2 thought Resident #1 was in her house. On 6/2/26 at 12:01 PM, Staff D, CNA reported working in the memory care unit was not an easy task. She said it was very difficult due to Resident #2's agitation and Resident #8 trying to escape constantly. She said Resident #9 wants constant attention and yells out. When asked if she felt she was able to provide adequate supervision, she said not really. She said breaks are hit and miss. She said she would call for staff to relieve her but half of the time you don't get a response. She said in the unit you feel locked in and nobody cares about you. On 6/2/26 at 3:00 PM, the Director of Nursing (DON) stated it was an expectation when the staff member in the memory care unit needed to use the bathroom to call for assistance so a staff member could relieve them. She verified the employee bathrooms are outside the unit. The facility policy titled Accidents and Supervision dated 2025 documented the resident environment to remain as free of accident hazards as possible. Each resident to receive adequate supervision and assistive devices to prevent accidents. The policy documented supervision was an intervention, a means of mitigating accident risk and the facility would provide adequate supervision to prevent accidents. Adequacy of supervision was defined by	F0689		

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F0689 SS = D	Continued from page 4 type and frequency and based on the individual residents' assessed needs and identified hazards in the resident environment.	F0689		

Plan of Correction

Regency Park Jefferson

100 Ram Drive

Jefferson, Iowa 50129

This facility denies the alleged facts as set forth constitute a deficiency under interpretations of Federal and State law.

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law.

F0689 SS=D

All residents will be provided with adequate nursing supervision to prevent a resident-to-resident altercation. Resident # 1 and resident #2 will remain as free of accident hazards as possible. Resident #2 remains on 1 on 1 during waking hours. Resident #2 had adjustment on gabapentin for pain management. Resident #1 will receive social services visit visits to maintain a positive psychosocial status.

All residents have the potential to be affected.

All nursing staff have been re-educated to the facility policy for Accidents and Supervision. All nursing staff were educated on 6/19/2026. Nursing

administration and/or QA team will complete audits on adequate supervision weekly x 1 week, weekly x 4 weeks and then monthly x 2 months. Facility will monitor for compliance ongoing thereafter. Results will be forwarded to the QAPI team for review.

- ✓ **Facility alleges substantial compliance as of 6/20/2026.**