STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165438	A. BUILDING _____ B. WING _____	C 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STACYVILLE COMMUNITY NURSING HOME	413 SOUTH BROAD STREET STACYVILLE, IA 50476

(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
F 000 ✓ ok/cp	INITIAL COMMENTS Correction date: 6-28-2025 The Stacyville Community Nursing Home is not in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities due to the following deficiencies written during the facility's annual recertification survey and investigation of complaints #127981-C, #128038-C, #128503-C, and #128658-I, conducted June 2, 2025 to June 5, 2025. The investigation of complaints #127981, #128038, #128503 didn't result in a deficiency. The investigation of facility reported incident #128658-I didn't result in a deficiency. Total census: 22	F 000	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 alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies was executed solely because provisions of state and federal law require it. 1. Resident #9 discharged from facility on 6/11/25. 2. The Administrator conducted a 90-day retrospective review of incident logs and grievance reports to ensure no other allegations went unreported. 3. SSD completes interviews with all residents during their care conferences to elicit any unreported issues related to abuse, neglect, or misappropriation. No additional concerns were identified.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides	F 609	4. The Abuse Reporting Policy was revised to include a clearly defined reporting timeline and procedural flow for allegations of misappropriation. 5. Staff were retrained on 06/11/25 regarding mandated reporting requirements. 6. A new "Allegation Reporting Checklist" was implemented on 06/20/25 to track compliance with internal and external reporting. 7. The DON or designee will review all incident logs daily for 6 weeks to ensure timely reporting. 8. Results of these audits will be reviewed at monthly QAPI meetings.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 6-26-25

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165438	A. BUILDING _____ B. WING _____	C 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STACYVILLE COMMUNITY NURSING HOME	413 SOUTH BROAD STREET STACYVILLE, IA 50476

(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
F 609	Continued From page 1 for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on electronic health record (EHR)review, policy review, resident, and staff interviews the facility failed to report an allegation of abuse within the required time frame to the Iowa Department of Inspection, Appeals, and Licensing (DIAL) for 1 of 1 resident reviewed (Resident #9). The facility reported a census of 22 residents. Findings Include: Resident #9's Minimum Data Set (MDS) assessment dated 3/11/25 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of renal (kidney) insufficiency (poor functioning), stroke and end stage renal disease (ESRD). The MDS documented Resident #9 received dialysis services outside of the facility. During an interview on 6/2/25 at 12:10 PM, Resident #9 reported he had money missing and someone took his money. Resident #9 reported approximately $250 missing from his room over a month ago and another $57 within the past week. Resident #9 stated he reported the missing funds to the staff on each occasion.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165438	A. BUILDING _____ B. WING _____	C 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STACYVILLE COMMUNITY NURSING HOME	413 SOUTH BROAD STREET STACYVILLE, IA 50476

(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
F 609	Continued From page 2 A review of the EHR Profile tab listed Resident #9 as his own responsible party. The Care Plan Focus initiated 12/9/24 listed the facility provided Resident #9 a lock box. Resident #9 had an undetermined amount of money that he refused to let the staff count. The Intervention directed the following: a. Resident #9 would keep the lock box in his room and safeguard it. He refuses to allow staff to safely lock up the money in a secure location. b. Resident #9 refused to allow staff to count the money in his possession. The review of the facility reported incidents to DIAL lacked reports of Resident #9's missing money for 2/11/25 and 5/27/25, after he reported the incident to the staff. During an interview on 6/4/25 Staff B, Certified Nursing Assistant (CNA), revealed she knew Resident #9 reported his money missing. Staff B explained she reported it to the nurse that Resident #9 reported missing money. During an interview on 6/4/25 at 10:00 AM Staff C, Social Services, verified Resident #9 reported to him on 5/27/25 that he had $57 missing. He had the money sitting out in the open in a bank envelope in his room. Staff C reported the missing money to the Administrator the next morning. Staff C confirmed Resident #9 reported a previous incident of missing money. Staff C provided a summary/investigation of report Resident #9's missing money after he reported to him on 2/11/25. The investigation documented Resident #9 reported someone stole $400 from his room.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165438	A. BUILDING _____ B. WING _____	C 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STACYVILLE COMMUNITY NURSING HOME	413 SOUTH BROAD STREET STACYVILLE, IA 50476

(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
F 609	Continued From page 3 During an interview on 6/4/25 at 10:57 AM the Administrator and Staff C reported they started an ongoing investigation on 5/27/25 for Resident #9's reported missing money. The Administrator stated she talked with Resident #9 about keeping his money locked up in his facility provided lockbox. The Administrator acknowledged she didn't report Resident #9's previous or current incidents of missing money to DIAL. A review of the undated facility Abuse Policy defined: "Misappropriation of Resident property" as the deliberate (on purpose) misplacement, and exploitation (wrongful temporary or permanent use of a Resident's belongings or money without the resident's consent). The policy directed staff to report all allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin, and misappropriation immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative. All allegations of resident abuse shall be reported to the Department of Health and Human Services (DHHS) no later than 2 hours after the allegation is made, if the allegation resulted in serious bodily injury, or no later than 24 hours if the allegation involved neglect, exploitation, mistreatment, injuries of unknown origin, and misappropriation, but do not result in serious bodily injury. If there is a reasonable suspicion that the allegation of abuse also constitutes a crime committed against the resident by any person, whether or not facility employed the alleged perpetrator, the Elder Justice Act required the facility report the situation to law enforcement.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165438	A. BUILDING _____ B. WING _____	C 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STACYVILLE COMMUNITY NURSING HOME	413 SOUTH BROAD STREET STACYVILLE, IA 50476

(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
F 609	Continued From page 4 While the federal regulations required all abuse allegations reported to DIAL within 2 hours, the Elder Justice Act has a different reporting timeframe to the police/sheriff. If the allegation of abuse (that resulted from a crime) resulted in serious bodily injury to a resident, a report must be made to law enforcement no later than 2 hours after the allegation is made. If the allegation of abuse does not result in serious bodily injury, the facility must report to law enforcement no later than 24-hours. The policy defined serious bodily injury as an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, mental faculty, or required surgery, hospitalization, or physical rehabilitation. If the person in charge is the alleged abuser, the staff member shall directly report the abuse to the DHHS immediately, pursuant to the deadlines established above. If the allegations of dependent adult abuse involve a caretaker not employed by the facility (e.g., family member, visitor), a report must also be made immediately to DHHS.	F 609		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and	F 637	*F637 Comprehensive Assessment After Significant Change* 1. Resident #17 expired 06/03/2025 2. No additional residents were found to have missed required SCSA completion. 3. The facility revised its Admission and Status Change Protocol on 6/23/25 to include a specific checklist flag for hospice enrollment triggering an automatic SCSA within 14 days. 4. The MDS Coordinator and IDT team received training on 06/11/25, focusing on triggers for SCSA per RAI guidelines, including hospice election and other significant status changes. 5. The DON or designee will audit all new hospice admissions and significant change events weekly for 4 weeks to verify completion of timely SCSA. 6. Audit results will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) Committee. 7. If 100% compliance is achieved for 1 month, monitoring will shift to quarterly reviews for 1 year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165438	A. BUILDING _____ B. WING _____	C 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STACYVILLE COMMUNITY NURSING HOME	413 SOUTH BROAD STREET STACYVILLE, IA 50476

(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
F 637	Continued From page 5 requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on electronic health record (EHR) review, clinical record review, the Centers for Medicare and Medicaid Services (CMS) Long term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview the facility failed to complete a Significant Change Status Assessment (SCSA) Minimum Data Set (MDS) assessment after a resident elected to start hospice for 1 of 1 residents (Resident #17) reviewed on hospice services. The facility reported a census of 22 residents. Findings include: Resident #17's Clinical Census reviewed 6/3/25 documented hospice as their primary payer effective 4/30/25. The Health Status Note dated 4/30/25 at 12:27 PM reflected Resident #17 admitted to hospice care services. The MDS 3.0 Summary page in Resident #17 EHR revealed the facility failed to complete the SCSA MDS when hospice services had been elected. The Hospice Election Statement signed by Resident #17's Representative on 4/30/25 listed they elected hospice to start that day. During an interview on 6/4/25 at 11:08 AM Staff A, MDS Coordinator, reported she started working at the facility on 5/5/25. She acknowledged Resident #17 elected hospice prior to her starting at the	F 637		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165438	A. BUILDING _____ B. WING _____	C 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STACYVILLE COMMUNITY NURSING HOME	413 SOUTH BROAD STREET STACYVILLE, IA 50476

(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
F 637	Continued From page 6 facility. Staff A explained they followed the RAI manual when they completed the required assessments. Staff A reported the facility had 14 days after election of hospice to complete the SCSA assessment. Staff A acknowledged the facility didn't complete Resident #17's SCSA assessment. During an interview on 6/4/25 at 11:15 AM, the Administrator acknowledged the facility followed the RAI manual timelines when they completed the MDS assessments. The Administrator confirmed the facility didn't complete Resident #17's SCSA assessment. The LTC RAI 3.0 User's manual Version 1.19.1 October 2024 identified the manual required the facility complete a SCSA when a terminally ill resident enrolled in a hospice program or changed hospice providers and remained a resident at the nursing home. The RAI Manual specified the SCSA MDS completion date as 14 days from the determination that a significant change in resident status occurred (determination date plus 14 calendar days).	F 637	*F641 Accuracy of Assessments* 1. The MDS for Resident #6 corrected and resubmitted 6/23/2025. 2. Implemented a written policy on **MDS accuracy and completion on 6/23/25**. The policy will include clear guidelines for documenting and certifying assessments, including medication administration during the lookback period. 3. Conducted training for MDS coordinator and relevant staff on the revised policy, including the importance of accurate documentation and certification completed 6/23/25. 4. The Director of Nursing (DON) will conduct a **monthly audit for 6 months** of 10% of all MDS assessments for accuracy and compliance with the facility's new policy, ensuring that insulin administration and other medications are properly documented. 5. Any discrepancies identified in the audit will be addressed, and a report will be submitted to the facility's Quality Assurance and Performance Improvement (QAPI) committee.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165438	A. BUILDING _____ B. WING _____	C 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STACYVILLE COMMUNITY NURSING HOME	413 SOUTH BROAD STREET STACYVILLE, IA 50476

(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
F 641	Continued From page 7 certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews the facility failed to accurately document and submit an accurate Minimum Data Set (MDS) Assessment for 1 of 6 residents reviewed (Resident #6). The facility reported a census of 22 residents. Findings include: Resident #6's Minimum Data Set (MDS) assessment dated 4/7/25 identified a Brief Interview of Mental Status (BIMS) score of 13, indicating intact cognition. The MDS included diagnoses of hypertension (high blood pressure), diabetes, and obesity. Resident #6 received injections of insulin 7 out of 7 days during the lookback period. Resident #6's clinical record lacked	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165438	A. BUILDING _____ B. WING _____	C 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STACYVILLE COMMUNITY NURSING HOME	413 SOUTH BROAD STREET STACYVILLE, IA 50476

(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
F 641	Continued From page 8 documentation of insulin or even an injection given during the lookback period. During an interview on 6/4/25 at 1:43 PM the MDS coordinator reported the previous MDS coordinator coded the medication wrong. During an interview on 6/5/25 the MDS coordinator reported the facility didn't have a policy for MDS accuracy and completion. She reported the facility followed the RAI Manual.	F 641	*F658 Services Provided Meet Professional Standards* 1. **Resident #6**: The physician's order for **Ozempic** administration on **4/4/25** was documented as a missed dose, and a report was made to the prescribing physician for further instructions on 6/23/25. 2. The **policy development** and **staff training** on following physician orders will be completed by 6/27/25.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to follow physician's orders for 2 of 6 residents reviewed (Resident #6 and #11). The facility reported a census of 22 residents. Findings include: 1. Resident #6's Minimum Data Set (MDS) assessment dated 4/7/25 identified a Brief Interview of Mental Status (BIMS) score of 13, indicating intact cognition. The MDS included diagnoses of hypertension (high blood pressure), diabetes, and obesity. Review of Resident #6's Treatment Administration Record lacked documentation of Ozempic given	F 658	3. **Resident #11**: Therapy orders have been reissued. Therapy orders were immediately communicated to the therapy provider. Therapy began on 6/19/25. 4. The facility will develop and implement a policy and procedure for **following physician orders**, including a process for confirming medication and therapy orders are fulfilled and properly documented. 5. Staff will be re-educated on the importance of timely and accurate execution of physician orders. 6. A **tracking system** will be implemented by 6/27/25 to ensure all orders for medications and therapies are communicated to the appropriate parties (e.g., pharmacy, therapy providers).	

			7. The Director of Nursing (DON) or designee will conduct random weekly audits of physician orders and the documentation of those orders for the next 6 weeks to ensure compliance. 8. A **monthly report** will be submitted to the Quality Assurance/Performance Improvement (QAPI) committee, detailing any missed orders and corrective actions taken.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165438	A. BUILDING _____ B. WING _____	C 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STACYVILLE COMMUNITY NURSING HOME	**413 SOUTH BROAD STREET STACYVILLE, IA 50476**

(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
F 658	Continued From page 9 on 4/4/25. Review of Resident #6's Progress Note on 4/4/25 at 3:27 PM documented the Ozempic (GLP1 medication used to treat diabetes and obesity) medication will be coming from the pharmacy that evening. Further review of the Progress Notes lacked documentation that the medication came from the pharmacy and was given. During an interview on 6/4/25 at 3:50 PM the MDS coordinator reported the medication was missed on 4/4/25. It should have been given and was missed. It didn't come in from the pharmacy. During an interview on 6/5/25 8:55 AM, the Administrator reported the facility didn't have a facility policy related to following physician orders. 2. Resident #11's MDS assessment dated 4/29/25 identified a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of hypertension (high blood pressure), depression and dementia. During an interview on 6/2/25 at 12:53 PM, Resident #6 reported she told the Administrator she wanted to ride the bike in therapy again. The Health Status Note dated 4/2/25 at 2:35 PM documented the doctor ordered Physician Therapy (PT) to evaluate and treat because Resident #11 wanted to use the bike in the therapy room. Resident #6's clinical record lacked PT seeing them on or after 4/2/25.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165438	A. BUILDING _____ B. WING _____	C 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STACYVILLE COMMUNITY NURSING HOME	**413 SOUTH BROAD STREET STACYVILLE, IA 50476**

(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
F 658	Continued From page 10 During an interview on 6/3/25 at 1:14 PM the Director of Nursing reported the nursing staff who received the physician orders for therapy are supposed to notify the facility's contracted therapy group. The staff missed Resident #6's order on 4/2/25 and didn't call it in.	F 658		