STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165401	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sibley Specialty Care	**700 Ninth Avenue North , Sibley, Iowa, 51249**

(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 facility reported incident #2585551-I conducted October 22, 2025. 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 review, staff interviews, facility record review and facility policy review the facility failed to provide adequate nursing supervision to prevent a resident from exiting the building for 1 of 3 residents reviewed (Residents #1). The facility reported a total census of 40 residents. Findings include: The Minimum Data Set (MDS) assessment dated 5/13/25 for Resident #1 documented diagnoses of diabetes mellitus, Non-Alzheimer's Dementia and need for assistance with personal care. The MDS showed the Brief Interview for Mental Status (BIMS) was a 4 indicating severe memory impairment. Review of the Progress Notes dated 8/10/25 at 6:30	F0689	"Past Noncompliance - no plan of correction required"	

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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F0689 SS = D	Continued from page 1 a.m., revealed at 6:35 a.m., the charge nurse received a phone call from the local hospital. Staff at the local hospital stated they witnessed a man thought to be Resident #1, clothed with a blanket in hand walking on the sidewalk. At 6:36 staff was immediately altered and resident head count conducted. Staff searched the entire facility and facility ground and Resident #1 was not found on the premises. Resident #1's roommate stated when he was last in the room, that Resident #1 grabbed a blanket and was going home. During the head count Staff A, Dietary Aide told staff she let Resident #1 out of the facility about five minutes prior because he wanted to check the weather. At approximately 6:40 a.m., the local Sheriff's office was notified and explained the situation, last known location, address of previous home as he was most likely going home. At 6:53 a.m., Resident #1 and wife arrive at the facility with the local Sheriff's office. Resident assessed for injuries, no injuries noted. Vital signs taken and within normal limits. The resident is noted to not recollect any details related to the incident. Review of the local Sheriff's Department report dated 8/10/25 revealed the facility called and reported that one of the residents was let out by accident and walked away. The facility provided Resident #1's previous address and he might be trying to find his way home. Officer patrolled the area and was unable to locate him. At 6:51 AM Officer seen a vehicle back out of the resident's former address and officer followed into facility parking lot and assisted Resident #1 back into the facility. Review of written statement from Staff A signed and dated 8/10/25 revealed I walked into work at 6:27 a.m., and grabbed the table clothes and napkins and realized I did not punch in yet so I punched in at 6:33 a.m., that is when Resident #1 asked me if he could go outside. I asked him what he was going to do and he said he wanted to check the weather. He was fully dressed with shoes and carrying 2 throw blankets. So then I let him out and continued to put the table clothes on. At about 6:40 a.m., I was asked if I knew where Resident #1 is and I told the nurse that I let him outside. Interview on 10/22/25 at 12:40 p.m., with Staff B, Registered Nurse (RN) revealed the incident was during a day shift between 6:30 a.m., and 7:00 a.m.. Staff B was in the hallways giving medications when the phone rang and when it was answered it was the local hospital	F0689		

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F0689 SS = D	Continued from page 2 calling and said there was a gentleman walking by the hospital that looked like Resident #1. While still on the phone with the local hospital Staff B announced over the radio to the staff to split up and look through the facility for Resident #1. Staff B asked the hospital staff what his last known location was. The staff searched inside and outside with no luck then called the local sheriff's office. Stated that at times he will verbalize he wants to go home and has a history of dementia. Staff B stated that when she went to call Resident #1's wife told her she already had him and that the sheriff's office was following them back to the facility. Once Resident #1 returned to the facility she assessed him for injuries and none were noted. Assessed his vital signs and all were within normal limits and had no further episodes of exit seeking that day. Staff B revealed she had asked Staff A if she had seen Resident #1. Staff A revealed she had left him out a few minutes ago and he had his blankets in his hand. She put the code in and let him out. She didn't let the staff know she let him out. Review of facility provided policy titled Wandering and Elopements with a revised date of March 2019 revealed the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Interview on 10/22/25 at 12:23 p.m., with the Administrator revealed Staff A should not have let the resident out and all staff have received extensive training on 8/10/25 since the incident.	F0689		