STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165179	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwalk Nursing and Rehabilitation Center	**921Sunset Drive , Norwalk , Iowa, 50211**

(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 and Investigation of complaint #2578842-C conducted on December 29, 2025 to December 31, 2025. Complaint #2578842-C did not have deficiencies cited. See Code Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000		
F0658 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, staff interview, Nurse Practitioner (NP) interview and facility policy the facility failed to ensure insulin orders transcribed for staff awareness, failed to verify the order accuracy before signing, failed to administer insulin for diabetes management, Resident #5 (R#5). The facility reported a census of 42. The Minimum Data Set (MDS) quarterly assessment for R#5 dated 10/10/26 for R#5 revealed diagnosis of diabetes was coded as receiving insulin during last 7 days. The Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicated intact cognitive impairment. The Care Plan initiated 12/20/23 documented R#5 has diagnosis of diabetes, is at risk for frequent infections, alteration of skin, visual impairment, hyper/hypoglycemia, renal failure and cognitive/ physical impairments. The lab report dated 6/23/25 documented resident	F0658		

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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F0658 SS = D	Continued from page 1 hemoglobin A1C (a blood test measuring your average blood sugar over the last 60 to 90 days) was 6.8 indicated high on the lab order. The Medication Administration Record for R#5 dated December 2025 documented the following orders for #5's diabetes. a. Lantus insulin, inject 5 unit subcutaneously in the morning related to type 2 diabetes. Start 3/20/25 b. Lantus insulin, inject 20 unit subcutaneously at bedtime related to type 2 diabetes. Start 3/20/2025 c. Blood sugar checks two times a day (BID) related to type 2 diabetes, start 10/30/25. d. Novolog insulin Injection solution 100 unit/millimeter, inject as per sliding scale (reflecting the blood sugar results) subcutaneously every 8 hours as needed for high blood sugars due to holidays related to type 2 diabetes, start 11/24/25. If blood sugar is 0 - 150 = 0 units no call needed;151 -200 = 2 units no call needed;201 - 250 = 4 units no call needed;251 - 300 = 6 units no call needed;301 - 350 = 8 units no call needed;351 - 400 = 10 units no call needed unless symptomatic;401 - 600 = 12 units and call the nurse practitioner. The Medication Administration Record (MAR) for December 2025 revealed the following blood sugar results that required insulin per the sliding scale order by Nurse Practitioner, (NP) Staff A, the insulin was not administered as follows. On 12/2/25 the AM blood sugar was 156, the 2 units of insulin ordered was not given On 12/2/25 the PM blood sugar was 189, the 2 units of insulin ordered was not given On 12/3/25 the AM blood sugar was181, the 2 units of insulin ordered was not given On 12/4/25 the PM blood sugar was 236, the 4 units of insulin ordered was not given On 12/5/25 the PM blood sugar was 155, the 2 units of insulin ordered was not given On 12/6/25 the PM blood sugar was 217, the 4 units of insulin ordered was not given On 12/7/25 the PM blood sugar was 295, the 6 units of	F0658		

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F0658 SS = D	Continued from page 2 insulin ordered was not given On 12/8/25 the AM blood sugar was 201, the 4 units of insulin ordered was not given On 12/8/25 the PM blood sugar was 177, the 2 units of insulin ordered was not given On 12/9/25 the AM blood sugar was 199, the 2 units of insulin ordered was not given On 12/10/25 the AM blood sugar was 215, the 4 units of insulin ordered was not given On 12/10/25 the PM blood sugar was 165, the 2 units of insulin ordered was not given On 12/11/25 the PM blood sugar was 253, the 6 units of insulin ordered was not given On 12/12/25 the PM blood sugar was 180, the 4 units of insulin ordered was not given On 12/13/25 the PM blood sugar was 243, the 4 units of insulin ordered was not given On 12/14/25 the PM blood sugar was 173, the 2 units of insulin ordered was not given On 12/15/25 the AM blood sugar was 331, the 8 units of insulin ordered was not given On 12/16/25 the AM blood sugar was 153, the 2 units of insulin ordered was not given On 12/17/25 the PM blood sugar was 206, the 4 units of insulin ordered was not given On 12/18/25 the PM blood sugar was 269, the 6 units of insulin ordered was not given On 12/19/25 the PM blood sugar was 165, the 2 units of insulin ordered was not given On 12/20/25 the PM blood sugar was 200, the 4 units of insulin ordered was not given On 12/21/25 the PM blood sugar was 165, the 2 units of insulin ordered was not given On 12/23/25 the PM blood sugar was 165, the 2 units of insulin ordered was not given On 12/24/25 the AM blood sugar was 159, the 2 units of	F0658		

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F0658 SS = D	Continued from page 3 insulin ordered was not given On 12/24/25 the PM blood sugar was 186, the 2 units of insulin ordered was not given On 12/26/25 the PM blood sugar was 167, the 2 units of insulin ordered was not given On 12/27/25 the AM blood sugar was 197, the 2 units of insulin ordered was not given On 12/27/25 the PM blood sugar was 197, the 2 units of insulin ordered was not given 0n 12/28/25 the AM blood sugar was 180, the 2 units of insulin ordered was not given On 12/28/25 the PM blood sugar was 208, the 4 units of insulin ordered was not given On 12/30/25 at 4:20 PM, Staff A, Nurse Practitioner (NP) relayed, did not know why the sliding scale order was transcribed to include every eight-hour parameter and felt that was an error by the ADON who transcribed the verbal order. Staff A (NP) relayed the insulin should be given as needed any time the blood sugar is high as directed per the sliding scale. Staff A (NP) Relayed R#5 blood sugars were fluctuating and he resisted having blood sugar checks four times a day, was changed to twice a day followed by the sliding scale order to manage hyperglycemic episodes. The additional insulin was intended to be given when the blood sugar was checked routinely, twice a day and as needed in such instances for example when R#5 overate. Staff A (NP) acknowledged understanding that the insulin was not given as intended and also acknowledged, had signed the written transcribed order that documented the timeframe every 8 hours, and reiterated that was incorrectly noted. The NP relayed had many residents to oversee and missed verifying the accuracy of the sliding scare order prior to approving. On 12/30/25 at 4:30 PM Registered Nurse, Staff B relayed the ADON had transcribed the order and she was on vacation and could not get clarification of how the order should be shown on the MAR. RN Staff B relayed since the sliding scale was on PRN (pro-re-nata refers to as needed) medication list, was easily missed. Staff B relayed had just consulted with NP, Staff A and would be correcting the medication record. On 12/30/25 at 5:00 PM the Administrator relayed was working with the nurses to ensure the insulin order was corrected so R#5 would receive additional insulin as he	F0658		

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F0658 SS = D	Continued from page 4 needed for his diabetes. The Administrator acknowledged the sliding scale order was missed by nurses since the order had no time frames and only transcribed as PRN (as needed) on the MAR. The policy titled, titled Verbal orders , revision date 2025 documented, physician orders may be received by telephone, by a licensed nurse or other licensed or registered health, to repeat any prescribed orders back to the physician or health care provider, to use clarification questions to avoid misunderstandings, to enter the order into the medical record, the physician should sign the order on the next visit to the facility or within the time frame	F0658		