STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165222	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corydon Specialty Care	745 East South Street PO Box 387, Corydon, Iowa, 50060

(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: 2/10/2026 The following deficiencies resulted from the facility's annual recertification survey conducted on January 26, 2026 - January 29, 2026. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000	This plan of correction is prepared and submitted as required by law. By submitting the plan of correction, Corydon Specialty Care does not admit that the deficiency listed on the form exists, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The and/or regulatory or administrative proceedings, the deficiency statement, facts, and conclusions that form the basis for the deficiency.	
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, clinical record review, policy review, and staff interview, the facility failed to ensure residents received timely feeding assistance for 2 of 2 residents reviewed for nutrition (Residents #21 and #37). The facility reported a census of 56 residents. Findings: 1. Resident #21's Minimum Data Set (MDS) assessment, dated 12/11/25, identified a Brief Interview for Mental Status (BIMS) score as 5 out of 15, indicating severely impaired cognition. The MDS listed Resident #21 as dependent on staff for eating. The MDS included diagnoses of Alzheimer's, non-Alzheimer's dementia, and Parkinson's disease (a disease which caused stiffness and tremors). The Care Plan Focus dated 10/3/25 related to activities of daily living (ADL's) included an Intervention that Resident #21 required staff assistance of 1 with eating. The Dietary Note dated 12/11/25 at 10:06 AM reflected the staff assisted Resident #21 with eating.	F0677	**F0677 ADL Care Provided for Dependent Residents** Corydon Specialty Care corrected the deficiency by rearranging the assisted dining area to ensure residents requiring supervision or assistance are seated in close proximity to staff. An excess table was removed to improve staff visibility and access. Residents requiring setup, supervision, or physical assistance with meals were identified through review of MDS assessments, care plans, Kardex, and dietary assessments. Nursing and dietary staff were educated on expectations for timely meal assistance and adherence to resident-specific care plans. The Director of Nursing or designee will monitor meal assistance through audits of tray delivery times and daily initiation of assistance for 4 weeks, monthly for 3 months, and quarterly thereafter. Any concerns identified will be addressed through staff re-education and the QAPI process.	2/10/2026

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
Lisa B Kell	Administrato	2/10/26

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F0677 SS = D	Continued from page 1 On 1/26/26 at 12:15 PM, observed Resident #21 with a plate of food (breaded fish and mashed potatoes) in front of her. The staff didn't assist her with eating after the delivery of her plate. Resident #21 didn't eat herself until 12:26 PM when she tore a small bite of fish off the filet with her fingers and placed it in her mouth. Resident #21 didn't eat anything else by herself. The staff didn't assist her until 12:31 PM when Staff A, Certified Nursing Assistant (CNA), began to help her. 2. Resident #37's MDS assessment dated 10/23/25, identified a BIMS score as 4 out of 15, indicating severely impaired cognition. Resident #37 required supervision or touch assistance, a helper provided verbal cues and/or touching/steadying and/or contact guard assistance until the resident finished the activity, with eating. The MDS included diagnoses of Alzheimer's disease, non-Alzheimer's dementia, and unspecified macular degeneration (a condition which resulted in a distortion or loss of central vision). The Care Plan Focus dated 10/3/23 related to ADLs included an Intervention that Resident #37 required setup assistance with verbal cues and oversight as needed for eating. The Nutritional Assessment dated 7/4/25 reflected Resident #37 fed herself with setup assistance/supervision. The Dietary Note dated 1/19/26 at 8:41 AM indicated Resident #37 fed herself with supervision. The untitled Kardex (an at-a glance Care Plan staff used for reference) as of 1/29/26 directed Resident #21 required setup assistance and verbal cues with oversight. On 1/26/26 at 12:22 PM, Resident #37 attempted to remove the lid of her ice cream container. Resident #37 continued to attempt to remove the lid without success until a dietary staff member came over and helped her at 12:31 PM. At the time, Resident #37 attempted with one hand to get the top off without success. At 12:34 PM, Resident #37 struggled to take a bite out of the ice cream container and pushed her ice cream over to a male resident who sat at her table. Resident #37 continued to struggle getting a bite out and at 12:42 PM, she placed a large spoonful of ice cream into her glass of water and then ate it. During that time, Staff A and Staff B, CNA, sat at other tables assisting other residents and didn't appear to notice Resident #37 had	F0677		

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F0677 SS = D	Continued from page 2 ice cream in her water. From 12:22 PM until 12:44 PM, the staff didn't assist or encourage Resident #37 to eat. Resident #37 only ate a few bites of her ice cream with difficulty. At 12:44 PM Staff C, Licensed Practical Nurse (LPN), asked Resident #37 if her lunch was good but didn't assist her. At 12:45 PM, Staff B sat down and assisted Resident #37 with eating. The facility policy "Assistance with Meals", revised 2017, instructed to assist residents with meals in a manner that met the individual needs of each resident. On 1/29/26 at 8:21 AM, via phone, Staff B described Resident #21 as dependent on staff because she couldn't lift the spoon to her mouth. She stated she tried to look over at Resident #37 during meals but didn't know if she did on 1/26/26. On 1/29/26 at 8:36 AM, Staff D, CNA, stated Resident #37 required staff assistance to set up her food including opening ice cream containers. Staff D stated Resident #37 may not be interested in eating but she got mad if staff encouraged her to eat. Staff D stated she did approach Resident #37 and got her to smile and eat. On 1/29/26 at 8:58 AM, Staff E, CNA, stated if staff delivered a resident's tray, they should assist them in a timely manner. She stated Resident #37 required prompting by the staff and it didn't bother her. Staff E stated she observed Resident #37 mix her food, for example she put her cereal in her water. She stated when this occurred, staff would direct her what to eat. She stated they kept an eye on Resident #37 while she ate. On 1/29/26 at 9:13 AM, Staff A stated staff fed one resident then moved on to another resident. She stated they usually had 3 staff in the dining room but if one needed to leave (to provide care for a resident) it could be tough. She stated they kept an eye on Resident #37 during meals as she needed prompts. On 1/29/26 at 10:01 AM, the Director of Nursing (DON) stated staff try to start feeding residents within 10 minutes after staff delivered the tray. She stated Resident #21 needed assistance from staff to eat. She stated if Resident #37 mixed her food, the staff should attempt to intervene. She stated they need to work on staff providing assistance in the dining room.	F0677		