STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapters Living of Council Bluffs	3000 Risen Son Blvd Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, staff interviews, and policy review the facility failed to provide the needed services in accordance with professional standards by not following physician orders for 3 of 3 residents (Resident #1, #2, #4, #3). The facility reported a census of 19 residents.Findings include: 1. The Minimum Data Set (MDS) for Resident #1 dated 11/3/25 provided a Brief Interview for Mental Status (BIMS) score of 6/15 indicating severe cognitive impairment. The document revealed the resident had diagnoses of atrial fibrillation (A-fib), heart failure, hypertension (HTN), urinary tract infection (UTI) - last 30 days and respiratory failure. The document disclosed Resident #1 had an indwelling catheter and took anticoagulant, diuretic, opioid, hypoglycemic and anticonvulsant medications. Resident #1's Medication Administration Record (MAR) 11/25 revealed the following entries: 11/1/25 No data for Olmesartan Medoxomil Tablet 20 mg; 1 tablet in the morning for HTN order date 10/31 and discharge (D/C) date 11/4/25. 11/1/25 No data for Protonix Tablet Delayed Release 40 mg; 1 tablet in the morning for gastroesophageal reflux (GERD) order date 10/31 and D/C date 11/4/25.11/1/25 No data for weight: daily x3 in the morning for 3 days.11/1/25 Hydralazine HCl Oral Tablet 25 mg; 1 tablet twice a day (BID) for HTN; hold if systolic blood pressure (SBP) less than 100 or pulse less than 60 order date 10/31/25 and D/C date 11/4/25. The resident's pulse in the morning (AM) was 59 and the medication was provided. 11/1/25 No data for Levetiracetam Oral Tablet 500 mg; 1 tablet by mouth BID for seizures order date 10/31/25 and D/C date 11/4/25.The facility failed to provide 3 medications as ordered by the physician, follow the orders for obtaining daily weights for 3 days, and provided medication when outside the prescribed parameters. 2. The MDS for Resident #2 dated 10/31/25 provided a BIMS score of 4/15 indicating severe cognitive impairment. The document revealed the resident had diagnoses of coronary artery disease (CAD), HTN, neurogenic bladder, Non-Alzheimer's Dementia and depression. The document disclosed Resident #2 had an indwelling catheter and took antidepressant and anticonvulsant medications. The Care Plan updated 10/9/25 contained a focus area of HTN revised on 9/15/22 with an intervention to give HTN medications as ordered, initiated 9/15/22. The document provided a focus area of CAD revised on 9/15/22 with interventions of giving all cardiac medications as ordered by physician initiated on 9/15/22 and giving medications for hypertension and document response to medication and any side effects initiated on 9/15/22. A focus area for use of antidepressant medications related to depression was revised on 9/30/22 with interventions of administration of medications as ordered revised on 9/30/22 and monitor/document/report target behaviors of sadness and slowed behavior revised on 9/30/22. A focus area of osteoporosis torticollis revised on 9/26/23 identified an intervention of administration of medications as ordered initiated on 9/15/22. A focus area of depression related to frequently refusing medications revised on 6/25/24 identified an intervention of administering medications as ordered initiated on 4/6/23. An identified focus area of diagnosis of Multiple Sclerosis (MS) Torticollis revised 12/5/23 contained interventions of administration of medications as ordered created 9/15/22 and monitor/document/report signs/symptoms of depression initiated 9/15/22. Resident #2's [DATE]/25 revealed the following entries: 10/5 and 10/14/25 refusals of Polyethylene Glycol 3350 Powder; 17 gram in the morning for bowel management order date 2/12/25 and D/C date 11/8/25. 10/5 and 10/14/25 refusals of Valproic Acid Oral Solution 250 mg/ml; give 2.5 ml one time a day (QD) order date 2/12/25 and D/C date 11/8/25.10/5 and 10/14/25 refusals of Wellbutrin XL Oral Tablet Extended Release 24 Hour 300 mg; 1 tablet QD for depression order date 2/12/25 and D/C date 11/8/25.10/5 and 10/14/25 refusals of AM dose of Chlorhexidine Gluconate Mouth/Throat Solution 0.12%; give 15 ml BID for periodontal disease order date 2/12/25 and D/C date 11/8/25.10/5 and 10/14/25 refusals of AM dose of D-Mannose Oral Capsule 500 mg; 1 capsule BID for urinary health order date 2/12/25 and D/C date 11/8/25. 10/5 AM and 10/2 refusals of AM dose of Lactobacillus Oral Tablet; 1 tablet BID for infectious disease order date 2/12/25 and D/C date 11/8/25. 10/2 AM, 10/3 PM 10/5-10/6 AM, 10/8-10/10 AM, 10/10 bedtime (HS), 10/13-10/17 AM, 10/22 AM, 10/24 AM and HS, 10/26 HS, 10/27 AM refusals of Pro Stat AWC-High calorie/protein/wound BID for pressure injury; 30 cc BID mix in 4 oz juice order date 3/10/25 and D/C date 11/8/25.10/2 and 10/14/25 refusals of AM and noon,10/20/25 noon dosages of Gabapentin Capsule 300 mg; 1 capsule TID for MS order date 2/12/25 and D/C date 11/8/25.10/4/25 AM dose of Midodrine HCl Tablet 10 mg; 1 tablet three times daily (TID) for low blood pressure (BP) take 4 hours prior to bed; hold if SBP>140 order date 3/25/25 and D/C date 11/8/25. Resident with BP 147/103 with medication provided. 10/11-10/12/25, 10/19 and 10/28/25 4:00 PM doses of Midodrine HCl Tablet 10 mg; 1 tablet three

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, staff interview, and policy review the facility failed to provide a professional standard of quality of care by not completing catheter cares for 3 of 3 residents reviewed (Resident #1, #2, #3). The facility reported a census of 19 residents. Findings include:1. The Minimum Data Set (MDS) for Resident #1 dated 11/3/25 provided a Brief Interview for Mental Status (BIMS) score of 6/15 indicating severe cognitive impairment. The document revealed the resident had diagnoses of atrial fibrillation (A-fib), heart failure, hypertension (HTN), urinary tract infection (UTI) - last 30 days and respiratory failure. The document disclosed Resident #1 had an indwelling catheter and took anticoagulant, diuretic, opioid, hypoglycemic and anticonvulsant medications. Resident #1's Care Plan revised 11/4/25 provided a focus area of indwelling catheter revised on 11/4/25 with interventions of Enhanced Barrier Precautions initiated on 10/25/25 and monitor/record/report signs/symptoms of UTI including cloudiness, altered mental status and change in eating patterns with initiation date of 10/24/25.The Clinical Census revealed Resident #1 was admitted on [DATE], discharged [DATE], admitted on [DATE] and discharged on 11/3/25. The resident's Treatment Administration Record (TAR) 10/25 revealed an order for a urinary catheter: output every shift with an order date of 10/25/25 and discharge (D/C) date of 10/28/25. The document contained no entries for the following dates: 10/26 6a-2p and 10/27/25 6a-2p.The resident's TAR 11/25 revealed an order for a urinary catheter: output every shift with an order date of 10/31/25 and D/C date of 11/4/25. The document contained no entry for 11/2 2p-10p.The facility failed to document catheter output. The Electronic Medical Record (EMR) Fluid Intake Task recorded the following data:10/27/25 1:50 PM consumed 250 10/28/25 1:57 PM the resident refused10/31/25 8:48 PM consumed 24011/2/25 5:30 PM consumed 10011/3/25 8:30 AM consumed 30011/3/25 12:30 PM consumed 100The EMR Nutritional Intake Task recorded the following data:10/27/25 1:50 refusal10/27/25 1:50 PM 26-50%10/28/25 1:57 PM refusal10/31/25 8:50 PM 51-75%11/2/25 5:30 PM 0-25%11/3/25 8:30 AM 0-25%11/3/25 12:30 PM 0-25% The facility failed to follow the Care Plan for reporting of change in eating patterns as a sign/symptom of UTI. The EMR Progress notes revealed the following entries:10/28/25 10:10 AM The resident was not alert but arousable with a pulse of 47, O2 97%, blood sugar 164 and was sent to the hospital.10/28/25 1:47 PM the resident was being admitted with a UTI and low heart rate. 10/31/25 4:57 PM the resident was readmitted to the facility.11/3/25 6:51 PM the resident was acting unusually; blood pressure (BP) 66/33, pulse 68, right side of mouth drooping; order received to send to the hospital.11/3/25 11:09 PM the resident was admitted with diagnoses of hypotension and hypomagnesemia.The facility provided document, Hospital Record 10/28/25, revealed the resident was seen in the Emergency Department (ED) for evaluation of altered mental status. The family reported altered mental status, cloudy urine, concerns with BP and temperature. The report included the resident had an Indwelling Foley Catheter with overt purulence noted in the urine. The document contained the following lab data: Glucose 135 (70-100mg/dl), Chloride 111 (96-110 mmol/L), Albumin 2.6 (3.5-5.0 gm/dl), GFR Estimate 57 (>=90 mL/min/1.73 m2),Urinalysis with culture abnormal: appearance cloudy (clear), Bilirubine, UA moderate (negative), Ketones, UA trace (negative), blood small (negative), protein >=300 mg/dl (negative), Urobilinogen, UA 4.0 (0.2-1.0 EU/dl), nitrate positive (negative), leukocyte moderate (negative), RBC 5-10 (<=5/HPF), WBC >100 (<=5 HPF), Squam Epithelial 5-10 (<=5/HPF)Glucose reagent strip abnormal: Glucose Reagent Strip 156 (70-110 mg/dl)CBC auto differential abnormal: hemoglobin 11.9 (12.0-16.0 gm/dl)Medical decision making in the ED included borderline BP 83/37, temperature of 95.2 degrees and overt purulence noted in the catheter. The resident was admitted with severe sepsis with UTI without hematuria. The document included a reference of the resident having recurrent UTIs and prior admission for sepsis related to UTI.2. The MDS for Resident #2 dated 10/31/25 provided a BIMS score of 4/15 indicating severe cognitive impairment. The document revealed the resident had diagnoses of coronary artery disease (CAD), HTN, neurogenic bladder, Non-Alzheimer's Dementia and depression. The document disclosed Resident #2 had an indwelling catheter and took antidepressant and anticonvulsant medications.The Care Plan updated 10/9/25 revealed a focus area for suprapubic catheter due to neurogenic bladder initiated on 1/12/23 and revised on 10/9/25 with UTI on 10/7 with antibiotics as ordered. Interventions included catheter care every shift initiated 11/2/20, monitor/record/report signs/symptoms of UTI including cloudiness, altered mental status, change in behavior, change in eating patterns initiated 11/2/20 and record output every shift initiated 11/2/20 The Clinical Census revealed the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, Electronic Health Record (EHR) reviews, staff interviews, and policy reviews the facility failed to implement appropriate hand hygiene and infection control practices to mitigate the spread of pathogens during resident cares for 2 of 3 residents (Resident #2, #3). The facility failed to utilize Enhanced Barrier Precautions (EBP) and complete hand hygiene. The facility reported a census of 19. Findings include:1. The MDS for Resident #2 dated 10/31/25 provided a BIMS score of 4/15 indicating severe cognitive impairment. The document revealed the resident had diagnoses of coronary artery disease (CAD), HTN, neurogenic bladder, Non-Alzheimer's Dementia and depression. The document disclosed Resident #2 had an indwelling catheter and took antidepressant and anticonvulsant medications.The Care Plan updated 10/9/25 revealed a focus area for suprapubic catheter due to neurogenic bladder initiated on 1/12/23 and revised on 10/9/25 with UTI on 10/7 with antibiotics as ordered. Interventions included catheter care every shift initiated 11/2/20, monitor/record/report signs/symptoms of UTI including cloudiness, altered mental status, change in behavior, change in eating patterns initiated 11/2/20 and record output every shift initiated 11/2/20 and use of EBP related to suprapubic catheter with use of signage outside the resident's room, gown and glove for high contact resident care activities revised on 4/12/25. The Care Plan failed to identify the need for EBP due to Stage 2 Pressure Ulcer.Resident #3's 11/25 Treatment Administration Record (TAR) revealed an order for EBP related to urinary catheter; EBP sign outside of resident's room. Gown and gloves for high contact resident care activities. Face shield should be used for any tasks that have high potential of splash or spray eerie shift for infection control with order date of 2/12/25 and discharge (D/C) date of 11/8/25. The document also contained an order for treatment of Stage 2 Pressure Ulcer with an order date of 10/31/25 and D/C date of 11/8/25.Resident #3's 11/25 Treatment Administration Record (TAR) revealed an order for EBP related to urinary catheter; EBP sign outside of resident's room. Gown and gloves for high contact resident care activities. Face shield should be used for any tasks that have high potential of splash or spray eerie shift for infection control with order date of 11/8/25. The document also contained an order for treatment of Stage 2 Pressure Ulcer with an order date of 11/8/25.Observed on 11/10/25 at 1:15 a U.S. Department of Health and Human Services Centers for Disease Control and Prevention EBP sign posted outside of Resident #2's room with Personal Protective Equipment (PPE) present.Observed on 11/12/25 at 7:10 Staff E, Certified Nursing Assistant (CNA), complete care for Resident #2. The staff completed hand hygiene, donned a gown and gloves and entered the resident's room. The staff completed peri care maintaining infection control practices. Following the completion of catheter care Staff E removed gloves and gown, completed hand hygiene and went to obtain assistance for transferring the resident. Staff F, CNA, came into the room donning gloves with a dependent mechanical lift. Staff E donned new gloves. Staff E and Staff F placed the dependent lift sling under the resident, completed the transfer, and positioned the resident in a wheelchair. Staff E continued with grooming tasks.Staff E and Staff F failed to follow EBP with the completion of a transfer and grooming tasks without wearing a gown.2. The MDS for Resident #3 dated 8/13/25 provided a BIMS score of 13/15 indicating normal cognition. The document revealed the resident had diagnoses of anemia, atrial fibrillation (A-Fib), orthostatic hypotension, renal insufficiency/renal failure, UTI in the last 30 days and cerebrovascular accident. The resident had an indwelling catheter and was provided anticoagulant, antibiotic and opioid medications. The Care Plan revised 8/21/25 revealed a focus area of indwelling catheter revised on 7/2/25 with interventions of monitor/record/report signs/symptoms of UTI including cloudiness, altered mental status, change in eating patterns initiated on 4/9/25 and record output every shift initiated 7/2/25. An additional focus area identified a pressure injury related to immobility revised on 7/2/25 contained an intervention of EBP related to catheter and wounds with sign outside the resident's room; gown and gloves used for high contact resident care activities with a face shield used for any tasks that have a high potential for splash or spray revised on 8/15/25.Resident #3's 11/25 TAR revealed an order for EBP related to urinary catheter and wounds with a sign outside the resident's room; gown and gloves used for high contact resident care activities with a face shield used for any tasks that have a high potential for splash or spray with an order date of 8/15/25. The document lacked documentation on 11/3/25 10p-6a.Observation on 11/10/25 at 1:00 PM a U.S. Department of Health and Human Services Centers for Disease Control and Prevention EBP sign posted outside of Resident #3's room with PPE present.Observed on 11/12/25 at 7:50 AM Staff G, CNA, complete hand hygiene, don gown and gloves and obtain a barrier prior to entering the Resident #3's room. The staff completed peri care and catheter care following