STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165530	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Haven Village	133 Indian Hills Drive Glenwood, IA 51534

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 - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on Electronic Health Record (EHR) review, document review, staff interview, family interview and Medication Administration Records - Treatment Administration Records (MAR-TAR) review the facility failed to provide needed services in accordance with professional standards by not obtaining a Urinalysis (UA) in a timely manner and failing to notify the physician of the failed attempt for 1 of 3 residents (Resident #1). The facility reported a census of 62 residents. Findings include: The Minimum Data Set (MDS) for Resident #1, dated 9/23/25 documented a Brief Interview for Mental Status (BIMS) of 11 indicating moderate cognitive impairment. Review of Resident #1's document dated 12/1/25 titled, Physicians Referral Form documented findings / recommendations for a UA and culture if positive. Review of Resident #1's EHR titled, Orders documented a physician's order for a one time UA with culture and sensitivity with a start date of 12/1/25 and an end date of 12/6/25.Review of Resident #1's EHR titled, Lab Administration Report documented a physician's order for a UA with culture and sensitivity one time for UTI signed off as completed by Staff A, Registered Nurse (RN) on 12/7/25.Review of Resident #1's EHR dated 12/1/25 at 3:40 PM titled, Progress Notes entered by Staff A documented a physician's referral form with new orders for UA, culture if positive,Review of Resident #1's EHR dated 12/2/25 at 9:53 AM titled, Progress Notes entered by Staff B, Care Coordinator documented review of referral form from appointment on 12/1/25 with orders for UA, culture if positive.Review of Resident #1's EHR dated 12/7/25 at 7:26 AM titled, Progress Notes entered by Staff A documented completed rounds with Resident #1. Resident #1 was not making herself understood. Confused on where she currently was. Resident #1 had stated she was at the hospital. When Resident #1 was asked her name and started naming off random numbers. A call was placed to Resident #1's daughter. Resident #1's daughter would like to come to the facility and see mother before making any decisions. Review of Resident #1's EHR dated 12/7/25 at 5:16 PM titled, Progress Notes entered by Staff A documented a call was placed to the hospital lab for results on Resident #1's UA. Order obtained for UA per provider request from 12/3/25 and results showed findings of Urinary Tract Infection (UTI). On call provider notified of abnormal UA and change in mental status. Order for Macrobid 100mg twice a day for 7 days. Review of Resident #1's document dated 12/7/25 titled, Urinalysis documented white blood cell results of 51-100 with a reference range of 0-2. Urinalysis further documented possible contamination of specimens. Review of Resident #1's document dated 12/7/25 titled, Nursing Fax Communication documented a physician's order for Macrobid 100mg twice a day for 7 days.On 12/17/25 at 2:43 PM Staff A, RN stated the faxes for a lab will come through on the facility email and nurses are supposed to print them out and have them ready for the next shift. Staff A stated the order was usually sat on the desk in the nurses office. Staff A stated if it was a physician fax it would be written down for what the physician wants. Staff A stated she did not remember the day of 12/7/25. Staff A acknowledged she knew the facility had orders to obtain a UA for Resident #1. Staff A stated the order was usually always sitting on the desk. Staff A stated she did not remember completing a straight catheterization on (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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1. Staff A stated she notified the family, the family came to the facility and took the lab to the hospital. Staff A stated Resident #1 had chronic kidney disease. Staff A stated she did not know if the facility had a procedure for how long before a physician should be notified of the inability to obtain a UA. Staff A stated in this case she knew the facility was trying. Staff A stated night shift was notified the UA was still needed for Resident #1. Staff A repeated she was not sure how long to wait before notifying the physician the UA was unable to be obtained. Staff A stated she would wait up to 48 hours before requesting a straight catheter or notifying the physician that the UA was not obtained. Staff A stated the she had told the Certified Nurse Assistants that were working with her that morning that Resident #1 still needed to have a UA obtained. Staff A stated the family had asked if the UA was obtained when they entered the facility that morning.On 12/17/25 at 9:45 AM Resident #1's granddaughter stated Resident #1 went to the primary care physician for a follow up that was before 12/7/25. Resident #1's granddaughter stated her mother was called from Staff A who stated they wanted to send Resident #1 to the hospital. Resident #1's granddaughter said her mother wanted the family to come up and assess to ensure Resident #1 needed to go to the hospital. Resident #1's granddaughter stated when she arrived Resident #1 knew their names and was not confused. Resident #1's granddaughter explained she had asked Staff A if the facility had obtained the UA and Staff A replied no Resident #1 had not voided enough in the last 5 days. Resident #1's granddaughter then questioned if the output was so low why didn't the facility contact Resident #1's physician. Resident #1's granddaughter stated Staff A explained the facility did get a UA but put it in a stool sample kit and the lab did not take it. Resident #1's granddaughter stated the CNA said if she knew Resident #1 needed a UA she would have put a hat in the bathroom. Resident #1's granddaughter stated if the facility did not get the UA in a timely manner why was the physician not notified. Resident #1's granddaughter stated communication with the staff was very pleasant. Resident #1's granddaughter stated Resident #1 had been waiting 5 days to have a UA obtained, which seemed like a very long time. On 12/17/25 at 3:49 PM Staff C, Certified Medication Assistant (CMA) acknowledged she had worked with Resident #1 on the morning of 12/7/25. Staff C explained that morning she had gone in to get Resident #1 out of bed for the morning. Staff C stated Resident #1 had a change in her speech and the way she was acting. Staff C stated she notified the nurse of the change in Resident #1. Staff C stated Staff A notified the family and the family came up to the facility. Staff C stated she had no idea there was an order for a UA and Staff A had not told her that morning. Staff C stated Staff A requested help with straight catheterization on Resident #1 to provide assistance. Staff C repeated Staff A did not tell her that a UA was needed for Resident #1. Staff A explained she had no idea or else she would have placed a hat in the toilet to obtain the UA when she got Resident #1 up in the morning. On 12/17/25 at 12:55 PM Staff B, Care Coordinator stated when sending orders anything abnormal the staff would fill out SBAR with a summary form and send them to the physician then the physician will fax it back with any orders. Staff B stated once they fax it back it comes to the facility's email, those faxes are printed by the charge nurse or the care coordinator and then summarize what the SBAR was about in a progress note. Staff B explained the care coordinators double checked the order to ensure all the labs are put in and the family is notified. Staff B stated once everyone was notified the care coordinator would enter a progress note for double checking. Staff B stated the order for labs are found on the lab tab on the EHR. Staff B stated the nurses are supposed to review the tab every shift. Staff B stated if the lab was unable to be obtained the expectation was to notify the physician. Staff B stated if a UA is ordered and the resident is occasionally incontinent can be difficult to obtain. Staff B stated if the staff were unable to obtain a UA through clean catch would (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	request for a straight catheterization. Staff A stated she would have expected the UA for Resident #1 would have been obtained in less than 6 days or the physician would have been notified. On 12/17/25 Staff B acknowledged lab orders were documented for a UA completed for Resident #1 on 12/1/25. Staff B also acknowledged the UA was not obtained until 12/7/25. On 12/17/25 at 4:20 PM the DON stated his expectation was the UA would have been obtained prior to 12/7/25 for Resident #1 if the UA was ordered on 12/1/25. The DON stated the facility does not have a policy or procedure for how quickly a lab should be obtained but the facility followed professional standards for obtaining a UA.