

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2025
NAME OF PROVIDER OR SUPPLIER Royal Oaks Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4614 NW 84th Street Urbandale, IA 50322	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on clinical record review and staff interviews, the facility failed to complete follow up assessments following a fall for one of four residents (Res #18) reviewed for falls. Findings include: The Progress Note of Resident #18 dated 8/22/25 at 11:44 am, authored by Staff O, Registered Nurse noted IDT (interdisciplinary team) met to discuss fall on 8/21/25. RCA (root cause analysis) performed. Hoyer (full body mechanical lift) sling to be tucked into sides of wheelchair. Review of subsequent progress notes failed to reveal any fall follow up was completed for Resident #18. On 10/21/25 at 3:44 pm, the Director of Nursing (DON) stated no incident report could be located for Resident #18 for a fall on 8/21/25. She agreed there was no documentation in the resident record of staff having followed up with pain assessments, vital signs or neurological checks as is protocol when there is a resident fall. On 10/21/25 at 4:16 pm, Staff O, RN stated she recalled the fall on 8/21/25 was in the morning. She stated the nurse that was on duty that morning for Station 2, where Resident #18 resides, had walked out on the job later in the morning, after the fall. She stated the clinical team met and discussed the fall and an appropriate intervention to be put into place. She stated the DON at the time, who is no longer employed at the facility, was to document in the resident chart what had happened. On 10/22/25 at 1:40 pm, the DON stated it appeared the nurse on duty at the time of the fall failed to open up an incident report for the fall. She stated the facility at this time would provide education for documentation and follow up. The Administrator stated the facility had no policy for follow up documentation after a fall.</p>

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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<p>F 0725</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on clinical record review, staff and resident interviews, official city records, facility policy review, and guidance from the Centers for Medicare & Medicaid Services (CMS), the facility failed to provide necessary nursing coverage for approximately four hours on two nursing units housing a total of 53 residents, after one of two on duty nurses left the facility unscheduled. During this period of time, the facility failed to provide requested medications to three residents (Res #3, #6, #9). As a result, one resident's pain (Res #3) became so severe that she contacted 911 (emergency services) to obtain assistance with receiving her pain medication. Additionally, the facility failed to assess another resident (Res #6), who had a documented history of multiple anaphylactic reactions requiring intubation, when she reported symptoms of an allergic reaction. On 10/14/25 at 10:10 am, the State Survey Agency informed the facility the failure to assess the residents, provide needed medications, and take action to ensure resident care and safety needs were met created an Immediate Jeopardy situation. The facility removed the immediacy prior to the survey on 10/09/25 when the facility staff implemented the following Corrective Actions: Facility attendance policy, nurse job description, and scheduling process were reviewed. Facility review of current and future staffing patterns to ensure an adequate number of competent licensed nurses and nurse aides being scheduled to meet the needs of the residents. Facility assigning one person from the leadership team to monitor staffing levels daily to ensure adequate nursing staff are available. Facility developed an orientation tool for agency nurses to include procedure for notifying facility leadership for staffing adjustments. Facility's Regional Director of Operations began providing oversight of staffing and providing weekly facility visits for three months. On-Call and emergency staffing process education to all staff. Education to all nursing staff (nurses, medication aides, nurse aides) of the expectation to communicate directly with nursing leadership or administration of emergent staffing changes or when circumstances require a reassignment of staff to cover absences. Additional education to licensed nurses regarding procedure to follow prior to exiting the facility. Education to all nurse aides of the expectation to report resident needs immediately to licensed nurses onsite, nursing leadership, or administration. Posting of the Director of Nursing's phone number visibly at each nursing station for all staff to contact in emergencies. Pain assessments conducted on all facility residents. Plan for audits to be conducted with staff and residents of staffing process. An unplanned Quality Assurance and Performance Improvement meeting conducted to review staffing and medication administration. The scope and severity was lowered from a K to an E at the time of the survey after ensuring the facility implemented the education, assessments, audits, policy reviews/updates, orientation tools and staffing oversight procedures. Findings include: 1. The Minimum Data Set (MDS) Assessment of Resident #3, dated 8/28/25 identified a Brief Interview for Mental Status (BIMS) score of 15, which indicated cognition intact. The MDS documented diagnoses that included: incomplete paraplegia, renal insufficiency, and chronic pain. The MDS recorded the resident received both scheduled and as needed pain medication during the look-back period, as well as non medication pain intervention. The MDS recorded the resident reported they experienced pain on a frequent basis and rated the worst pain at a 5 on a 0 to 10 pain scale, with 10 being the worst pain imaginable. The Care Plan of Resident #3 documented a Focus Area of refusal of care due to her pain tolerance, dated 4/22/25. The Care Plan documented an additional Focus Area of chronic pain, dated 6/10/24. The Care Plan directed staff to administer scheduled and as needed pain medications as ordered. The Care Plan additionally directed staff to assist in being timely with medication delivery per the resident specific interval requests. 2. The MDS of Resident #6 dated 10/12/25 documented a BIMS score of 15, which indicated cognition intact.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The MDS documented diagnoses which included unspecified immunodeficiency. An encounter note by the facility's Advanced Registered Nurse Practitioner (ARNP), dated 10/13/25 documented Resident #6's medical history to include a diagnosis of systemic mastocytosis (a rare condition where the body makes too many abnormal mast cells, a type of immune cell, which build up in the body's organs. The buildup causes various symptoms, as excess cells release too many chemicals, similar to a severe allergic reaction. Treatment is symptom management as there is no cure), and noted she had been intubated (mechanical ventilation for a patient who is unable to breathe on their own) several times as a result of anaphylaxis (severe, potentially life-threatening allergic reaction).Hospital referral information for Resident #6 dated 9/29/25 listed greater than 30 medications Resident #6 is allergic to. The reaction listed for these allergies noted anaphylaxis for greater than 10 of these allergies.3. The MDS of Resident #9 dated 10/1/25 documented a BIMS score of 15, which indicated cognition intact. The MDS documented the resident was independent for walking at least 150 feet in a corridor or similar space. The MDS documented diagnoses that included: cerebral palsy, generalized osteoarthritis, bilateral primary osteoarthritis of the knee, and osteoporosis. The Care Plan of Resident #9 documented a Focus Area of Chronic Pain related to Cerebral Palsy and Osteoarthritis, dated 7/15/25. It directed staff to administer medications as ordered by the physician. The Medication Administration Record (MAR) of Resident #3 for October of 2025 documented medications for pain management to include the following:Acetaminophen, scheduled three times a day (common name: Tylenol)Tizanidine, scheduled three times a day (a muscle relaxer)Baclofen, scheduled four times a day (a muscle relaxer)Gabapentin, scheduled four times a day (an anticonvulsant, often prescribed to treat nerve pain)Tramadol, scheduled four times a day (a synthetic opioid)Diazepam, ordered as needed (for muscle spasms for pain unrelieved by the scheduled medications)The MAR reflected that on the night shift of October 8, 2025 the resident recorded her pain at a 5 out of 10. Per the Medication Admin Audit Report, this pain level was recorded at 7:34 pm. At this time, the resident's scheduled gabapentin, tizanidine, baclofen and tramadol were administered. Additionally, at 8:21 pm, the resident's as needed diazepam was administered.The MAR documented the next scheduled medications to be Tizandine scheduled for early (per the Director of Nursing, this is between 4:00 - 6:00 am), Baclofen, scheduled for early, Gabapentin scheduled for early, and Tramadol scheduled for 4:00 am.The Medication Audit Report documented the Tramadol, Baclofen, and Gabapentin were next administered at 6:38 and 6:39 am and the Tizanidine was administered at 7:23 am, all by members of the scheduled day shift which started at 6:00 am, though all four of the medications were scheduled to be given by the night shift.Per the Patient Care Report provided by the city Fire Department, dated 10/9/25 at 5:49 am, emergency units arrived to the facility after a 911 call was placed by Resident #3 due to staff not providing her medications. The report also detailed that the dispatcher who took the call reported other people could be heard laughing in the background so a police officer was also requested to respond. Upon arrival, the report stated Resident #3 informed crews that she had not been given her pain medication that was supposed to be given around 3:00 am. It detailed the resident was visibly upset and was crying. The resident informed the crew of chronic pain in her legs and that she had not received medications hours past the scheduled time. She also reported when she asked staff for her medications due to being in pain, they laughed at her from the hallway and told her the nurse was gone and had left around 2:00 in the morning so there was nobody there that could give her the medications.The report documented after locating staff, it was found that the nurse for 2 hallways, including the one which Resident #3 resides on, had left around 2:00 am and there had been no follow-up with the patient's medications since then. The incident report provided by the city Police Department dated 10/9/25 at 5:49 am detailed the</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>police officer arrived at the facility at approximately 6:00 am and met with the fire fighters/paramedics at the room of the Resident #3. The resident reported she had called 911 because she was in chronic pain and the nursing staff on duty were not giving her medication as required. The report documented the officer asked a group of employees who was in charge and was told Staff D, Registered Nurse (RN) was covering the other side of the building and stated the nurse who was covering Resident #3's side of the building had left at approximately 2:00 am. The officer asked the staff who had been in charge for the last four hours and was told nobody had been in charge. The staff advised that the nurse who had left had not given the keys to anyone and there was no access to the medication cart. The nurse who had been in charge, Staff F, RN, had been scheduled to work until 6:00 am and was the only one who had access to the medication cart. Per the report, Resident #3 reported to the police officer there was an issue with the nurses and she missed her medication and was late getting her valium (diazepam) which threw off her medication routine the rest of the day causing her to be in pain. The Resident stated to the police officer her medications were due between 3:00-3:30 in the morning but she was unable to get her medication due to no one covering her unit/side of the building. The report detailed the resident appeared to be in pain and was continuing to have spasms as he spoke to her. The body camera footage of the police officer, provided by the city, was reviewed. On the body camera footage, time stamped 10/9/25 at 06:03:10 am, Staff D, RN, Staff B, Certified Nurse Aide (CNA) and Staff G, CNA were present speaking to the police officer. When the officer asked who was in charge, Staff D, RN responded that the nurse had left around 2:00 am. Staff B, CNA then stated the nurse that left didn't give the keys to her (Staff D) and Staff D, RN then stated nobody (was in charge). The officer asked the name of the nurse who left, and Staff D, RN went to the nursing desk to obtain the schedule. Staff B, CNA again told the officer the nurse who left had not left the keys with staff or counted the medication cart. At time stamp 06:04:03 am, Staff D, RN told the officer she had been on the other unit of the building and provided Staff F, RN's name (who was employed by a nursing agency, not the facility). The officer then asked what was needed to get Resident #3 her medications. Staff D stated she could not touch it. Someone in the background could be heard asking who the on call person was. Staff D, RN stated the on-call person was Staff E, LPN and stated she thought the other nurse had called Staff E prior to leaving the facility. Staff D, RN then said Staff F had told her she had called Staff E but did not give any report or anything, she just walked out. The other staff member in the background said to call the on call person. Staff D, RN then walked behind the desk to the phone to call on the on call manager. At this time (time stamped 06:05:30 am) the officer walked back down the hall towards the fire fighters/paramedics. As the police officer and the EMS (emergency medical services) staff were speaking to one another, Res #3 could be heard loudly crying out in pain on the body camera footage (06:05:32 am). The officer told the EMS crew the staff would not open the drug cart until the other nurse who had reportedly been called arrived. Loud distress sounds consistent with pain continued to be heard on the body camera (06:06:06 am). As the emergency responders continued to discuss the situation, the ongoing loud, persistent crying and screaming of Resident #3 was heard (06:07:46). The officer returned to the nursing station desk (06:08:14), and told Staff H, RN, who had arrived for day shift, that there was a resident who didn't get her pain meds and she needed them. Staff D, RN at this time was on the phone telling the on call manager that the prior nurse reported she had called the on call staff before she left. Staff D, RN was heard stating she was not touching the medication cart until it was counted (06:09:32). Staff H, RN then stated she would count the medication cart. At 06:21:27, Staff H, RN entered the resident's room, told the resident her name, stated she had just gotten there, and gave her a medication cup, telling</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>members reported needing assistance. Staff C, CNA was working the overnight shift on October 8 at Station 3. A single nurse was assigned to both Station 2 and Station 3 as Station 3 has few residents. On 10/13/25 at 12:41 pm, Staff C, CNA stated when she arrived for the shift, she introduced herself to Staff F, RN as she had not worked with her before. She said it was a busy night and the residents of Station 3 were ringing the call lights a lot. She stated somewhere around 2:00 am, she told Staff F that there were some residents who were requesting medications. She said it was 30 or 40 minutes later, and she went and asked another CNA where the nurse was, and he said he was looking for her too. She said she returned to her station and waited another 10 minutes or so then went down to Station 1 and asked the staff there. She said they told her Staff F, RN had walked out. She stated she asked who was taking over and told them that Resident #6 was requesting an epi pen. Staff C said she then returned to her unit and checked again on Resident #6. She stated Res #6 was still up and was really anxious for a while but she eventually calmed down and said she would use her own epi pen. She said Res #6 was agitated but she administered the pen herself, then watched TV for an hour or so and said she was fine. Staff C, CNA clarified she had asked Staff D, RN if there was another nurse coming and she said that Staff F had left but Staff E was coming in. She stated Staff E had been in the building till sometime between 11:00 pm and midnight earlier in the shift. She said after she returned to her unit, things were fine until she saw the police arrive. She said Resident #6 had been really mad at first and had said she was having a reaction to the medications she was taking. At first Staff F, RN was still there and she reported this to Staff F. It was when she rang again later on when she could not find Staff F. She stated two other residents were asking for medications around the same time. One wanted some benadryl and one wanted something for pain and neither of them rang again the rest of the night so she assumed Staff F had given them the requested medications. She said the only resident who was having concerns after Staff F left on Station 3 was Resident #6. Staff I, LPN came on duty for the day shift of October 9, 2025 at Station 1. On 10/13/25 at 2:07 pm, Staff I, LPN stated she had arrived at around 5:45 am on 10/9/25. She stated Staff B, CNA had told her that Staff F, RN had left several hours earlier. She said she then went to speak to Staff D, RN, who told her she was the only nurse in the building. She said Staff D told her Staff F had left, and left the keys. She said Staff D also told her Resident #9 had walked down from Station 2 asking for her pain medication and she told her she couldn't give them to her. Staff I stated she responded to Staff D that it was resident neglect. She reported Staff D told her no, she could not give the medications and Staff I then asked her if anyone had been called to come in. She said Staff D told her that Staff F had called the on-call manager but nobody ever came, she had not counted the medication carts and she didn't know anything about the residents at Station 2 or Station 3. Staff I reported shortly after that someone came and told them that the police were in the building. Someone came down and asked who the nurse was and to come with him. She reported Staff D went with him and sometime later then she (Staff I) went down to Station 2 as well. She said the officer told her there was a resident in extreme pain and hadn't gotten her pain medication. She remembered Staff H was counting the cart so she could get the medication for Resident #3. She stated she didn't remember who else was there, and added she just could not believe that Staff D had done that, that it just baffled her. She said Staff D showed no sympathy for the residents needing medications or for anything else that happened on that end. She said they called Staff E, the Assistant Director of Nursing and Staff E had spoken to the Director of Nursing. She said later Staff E told her she had only received a text message during the night after two in the morning from Staff F telling her she was leaving for a family emergency, but she was sleeping and didn't see the text until later. She clarified that to her knowledge,</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Staff D, RN had not attempted to contact anyone between when Staff F left and when the EMS services and day shift arrived. Resident #9 did not wish to speak to the State Surveyor. Review of her MAR for October of 2025 (performed on 10/15/25 at 10:00 am) revealed an order for Percocet (A combination medication of Oxycodone/Acetaminophen, a narcotic given for pain). The MAR failed to reveal the scheduled 4:00 am dose for 10/9/25 had been administered. On 10/13/25 at 2:21 pm, Resident #3 stated she has a lot of chronic pain which can get really bad. She reported she takes baclofen, tramadol and gabapentin daily. She stated most times on the night shift, staff would bring her medications to her around 3:00 or 3:30 am. She stated it was about 3:45 am on 10/9/25 when she rang her call light and requested her medications. She stated she was in a lot of pain that morning. She felt the CNA who answered her call light was mad because she was screaming in pain. She stated she also asked her to refill her water and to empty her catheter and the staff member laughed at her. She stated the staff member slammed the door and left. She said it got to be later and later, nearing 6:00 am and she was in a lot of pain, and knew it was getting to be close to shift exchange. She said someone said the nurse had left at 2:00 in the morning. And the other nurse could not take over the cart. She stated that if Staff D had been scheduled on her hall, she never would have left her like that so she didn't understand it. She reported that is when she called 911 and requested an ambulance. She said the EMS crew arrived quickly, but she was so far behind in her pain control that nothing was helping. She remembered taking a diazepam before bed and had woken back up around 10:30 pm and started having pain then. She reported she had a salve she used for pain and it gave her some relief until around 3:00 am when she was again in a lot of pain. She stated she had told the night shift nurse that she wanted her medications around 3:00 or 3:30 am when she had spoken to her earlier in the shift. She said the EMS crew seemed shocked by how much pain she was in. On 10/13/25 at 2:51 pm, Resident #6 described the events of the early morning hours of October 9th. She stated she was getting very itchy and felt her face start to swell up. She reported this to the CNA and the nurse at that time came in and administered Benadryl. (Her October MAR documented she received 100 mg of Benadryl on 10/9/25 at 2:09 am, administered by Staff F, RN). She reported she tried to go to sleep after receiving the Benadryl and felt her right eye was swelling shut. She took a selfie on her phone at 2:09 am and when she wasn't able to get to sleep, repeated the photo at 2:40 am, with her face appearing slightly further swollen than in the first photo. She said she was going crazy with how badly she was itching and rang her call light again and reported to the CNA she needed an epi pen injection. She stated a nurse never came down to assess her or administer medication. She said that luckily she had her own epi pen in her purse in her room so she eventually administered it herself and began to feel better within 10 minutes of the injection. She reported her symptoms as a lot of itching and a swollen face and eye. She denied shortness of breath but reported she felt a lump in her throat. Resident #6 said Staff C was very nice to her and she asked if she had told the nurse she needed her. She said Staff C asked if the nurse had come to see her and sat with her in the lounge area for a while. She said she never did see a nurse the rest of the night shift. On 10/13/25 at 3:01 pm, Staff E, LPN, Assistant Director of Nursing (ADON) stated she was the manager on-call for October 8th and October 9th. She said she had worked in the building until 11:30 pm or later on the 8th. She went home and went to sleep. She stated Staff F sent her a text around 2:00 in the morning but it did not wake her. She said she woke up when Staff D called her around 6:00 in the morning and told her the police were in the building. She reported Staff D told her that she hadn't given any medications for Stations 2 or 3 because she had not counted the medication carts. She added Staff D was no longer an employee of the facility. She recalled Staff D told her she saw the other nurse leaving sometime around 2:00 am,</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2025
NAME OF PROVIDER OR SUPPLIER Royal Oaks Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4614 NW 84th Street Urbandale, IA 50322	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0725</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>carrying a bag on her shoulder. Staff E stated no employee called her until the call around 6:00 am. During those early morning phone calls, staff confirmed to her the day shift nurses had arrived and all the carts had been counted with correct medications. She stated when she arrived, the Medical Director was in the building and he told her that Resident #6 had an issue on the night shift and he told her the resident had self administered an epi pen. She stated she then went to speak to Resident #6. She described the look on Resident #6's face as that the resident appeared terrified. She stated when the Director of Nursing (DON) arrived, the facility started their internal investigation and the Medical Director wrote orders for a cocktail of medications for Resident #6 to take during an allergic reaction. Staff D, RN was assigned as the nurse for Station 1 for the night shift of October 8, 2025. On 10/13/25 at 3:15 pm, Staff D, RN stated her shift began at 2:00 pm on October 8th, scheduled to work 16 hours until 6:00 am on October 9th. She stated Staff F, RN was also scheduled to work 16 hours on Station 2. She stated she had two CNAs working with her, Staff B and Staff G during the overnight shift. She stated that sometime around 2:00 am, she happened to be at the desk, and she saw Staff F, RN walking out the door with her purse. She said Staff F told her that her son was sick and she needed to leave and that she had called the on-call and she was on her way in. She said Staff F was in a rush, she didn't give her any kind of report. She stated she should have called and told her what was going on but she just rushed out. Staff D said her expectation was that the on-call was on her way in like Staff F had told her she was. She stated the entire shift was busy and she didn't get a break during the entire 16 hours. She felt Staff E was coming in as a replacement and she had a lot of work to do. She stated she did go look for the medication cart keys but did not locate them. She did not call Staff E until several hours later when the police arrived. She said Staff E told her that nobody had called her earlier. The police asked her what happened and she told them the other nurse left at 2:00 am and left her alone in the building. She again stated how Staff F did not count the carts or give a report, she just ran away. She denied that any other staff ever asked her for medications at the other end of the building. When asked whether Staff C had spoken to her about Resident #6, she said that Staff C had told her she had reported to the prior nurse that she needed to see Resident #6, but Staff F did not ask her to follow up. When asked about Resident #9 coming to her and requesting medications, she stated Resident #9 tends to ask for her medications early and she was too busy to help her when she came to the desk. She stated she had planned to help Resident #9 at the time the police officers arrived. (Resident #9's medication was scheduled at 4:00 am, the police arrived at 6:00 am). On 10/13/25 at 3:31 pm, the Director of Nursing (DON) stated sometime after 6:00 or so, the ADON, Staff E, called her and told her the police were in the building. She said she was told that one of the residents had called the police for not getting her medications and there was only one nurse in the building. She stated other nurses arrived for shift exchange around that same time. She said during their internal investigation, they found Staff F, RN had apparently left sometime around 2:00 am and had told the other nurse, Staff D, RN that she was leaving. She described that Staff D had claimed that Staff F then just left the building and left the medication cart keys in the narcotic count books on top of each medication cart. She said that Staff D told her Staff F she had called the on-call. She said they reviewed the call log for the on-call manager's phone and there was no phone call in the log in the time frame of Staff F leaving the facility. She said that Staff D, instead of calling someone herself, she just didn't even check on the residents at Stations 2 and 3 and just left that end without a nurse. She stated at that time, Staff D was suspended due to patient neglect. She stated Resident #3 did receive all of her medications. She said Resident #3 has a history of requesting medications earlier than they are scheduled. She added Staff</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>F was placed on the Do Not Return list through the staffing agency she is employed through and Staff D did end up being terminated. She acknowledged that Resident #6 did have an allergic reaction, which began prior to Staff F leaving. She stated that Resident #6 had an autoimmune disorder which causes a lot of allergies. She stated when Resident #6 symptoms came on, a nurse didn't get there in time and she self administered her epi pen. She added the medical director wrote new orders that morning, and the facility did a self administration safety assessment. She stated Resident #6 had given herself an epi pen many times (prior to facility admission) and knows how to do it. She added Res #6 keeps an epi pen at her bedside and there is also one in the medication cart. She said they added a special bell in her room that she rings only in the event of an allergic reaction and also that Res #6 has the DON phone number and can call her at any time. The DON clarified that they had asked Staff D if she had gone down to check on residents on the other side and she stated she had not. She said they asked her why and she stated she was too busy on her side and had too much going on. She said they also asked her if anybody had come and reported anything to her and she stated no, and again said she was too busy. She reported they then asked Staff D if she had called anyone to come help and she replied no because Staff F had told her that the ADON had been called and nobody came. The DON described that they reiterated to Staff D, did she call anyone and she replied no. The Corrective Action Form of Staff D stated, Staff D was notified by the other nurse in the facility around 2:00 am that she was leaving. This left Staff D as the only nurse in the building until the next shift came in at 6:00 am. Staff D did not call the on-call nurse to have another nurse come to the building. Staff D refused to provide care for any residents that were outside of h[TRUNCATED]</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on clinical record review, staff interviews and review of facility policy, the facility failed to maintain complete medical records in accordance with professional standards for three of four residents reviewed (Res #1, #13, #18). Findings include: The Progress Note for Resident #1 dated 2/20/25 identified a witnessed fall and indicated neurological checks were initiated. Additional Progress Notes dated through 2/23/25 referenced continued neurological monitoring. Similarly, an Incident Report for Resident #13 dated 2/19/25 reported a fall. The corresponding Nursing Note dated 2/19/25 at 12:03AM documented neurological checks were initiated at the time of the fall. On 10/20/25 at 10:58 am, the Administrator stated the facility was unable to produce the neurological check sheets for Res #1 or Res #13. She stated the neuro checks were done on pen and paper and were lost. The Progress Note of Resident #18 dated 8/22/25, authored by Staff O, Registered Nurse noted IDT (interdisciplinary team) met to discuss fall on 8/21/25. RCA (root cause analysis) performed. Hoyer (full body mechanical lift) sling to be tucked into sides of wheelchair. On 10/21/25 at 3:44 pm, the Director of Nursing stated no incident report could be located for Resident #18 for a fall on 8/21/25. She stated she could see one incident report for May and another later in August, neither being related to a fall. On 10/21/25 at 4:16 pm, Staff O, RN stated she recalled the fall on 8/21/25 was in the morning. She stated the nurse that was on duty that morning for Station 2, where Resident #18 resides, had walked out on the job later in the morning, after the fall. She stated the clinical team met and discussed the fall and an appropriate intervention to be put into place. She stated the DON at the time, who is no longer employed at the facility, was to document in the resident chart what had happened. She stated Staff P, LPN was the nurse who was on duty, who quit employment that day. On 10/21/25 at 4:26 pm, Staff P, LPN (former employee) stated the fall happened before she left. She stated she assessed the resident immediately after the fall to monitor for pain or any injury, and took her vital signs. She stated the resident had no bruising and no sign of injury and following her assessment, two CNAs transferred the resident off the floor. She stated she had an incident with the DON at the time and stated she was over stimulated and chose to quit employment. She stated after her conversation with the DON she went to Human Resources and resigned her position immediately. She stated as she was leaving, she gave the assessment information of Resident #18 to Staff O, RN and told her she had to leave. On 10/22/25 at 1:40 pm, the DON stated it appeared the nurse on duty at the time of the fall failed to open up an incident report for the fall. She stated the facility at this time would provide education for documentation and follow up. The facility policy titled Medical Records Organization dated 3/2015 documented a policy statement of: Resident medical records will be organized so that information can be easily retrieved. Electronic format is acceptable. Resident Record Order documented records that are not electronic may be maintained in paper format. These items included Resident Assessment Forms.</p>		