STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165602	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Care Center of Fairfield	400 Highland Street Fairfield, IA 52556

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and staff interviews, the facility failed to ensure staff treated residents with dignity by not providing a meal in a timely manner for 1 of 5 residents reviewed for dignity (Resident #41) and failed to ensure the provision of a catheter dignity bag for 1 of 3 residents reviewed for catheters (Resident #42). The facility reported a census of 59 residents. Findings: 1. The Minimum Data Set (MDS) assessment tool, dated 3/16/25, listed the following diagnoses for Resident #41: anxiety, depression, and morbid obesity. A Brief Interview for Mental Status (BIMS) score as 13 out of 15, indicated intact cognition. Review of the Care Plan, dated 4/1/25, revealed a Focus area to address [name redacted] has a behavior problem false allegations regarding staff. Interventions included, in part: Caregivers to opportunities for positive interactions and attention and to stop and talk with the resident. During an interview, on 6/3/25 at 12:58 PM, Resident #41 stated Staff U, Certified Nursing Assistant (CNA) passed trays one morning and she did not get her breakfast tray. She told the nurse about it at 9:15 AM The resident stated she was furious about this. During an interview on 6/10/25 at 11:52 AM, Staff A, Registered Nurse (RN) stated Staff U was not allowed to go into the resident's room. She stated the resident informed her that a couple of weekends ago Staff U passed the breakfast trays and instead of asking another staff to pass her tray, she made her wait to get her meal. On 6/10/25 at 1:33 PM, the Administrator stated residents should be treated with respect and dignity. During a phone interview on 6/11/25 at 11:21 AM, Staff U, CNA stated on the day that the resident did not get breakfast she was not in charge of passing the trays, someone else was. During an interview on 6/11/25 at 12:26 PM the Director of Nursing (DON) stated there should be a check-off system in place so staff did not miss a meal tray.2. The MDS, dated [DATE], revealed a BIMS score of 5 out of 15, which indicated a severe cognitive impairment. The MDS list of diagnoses included Alzheimer's Disease, multiple sclerosis, and bipolar disorder. The MDS indicated Resident #42 utilized an indwelling catheter. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan, revised on 5/05/25, revealed Resident #42 had an indwelling catheter related to neurogenic bladder. During an observation on 6/02/25 at 12:30 PM, Resident #42 sat in a wheelchair in the dining room for the none meal. Other residents present in the dining room. The urinary catheter bag hung underneath the wheelchair seat. Dark yellow urine visible in the catheter bag. The bag did not have a dignity cover. During an observation on 6/04/25 at 8:57 AM, Resident #42 sat in a wheelchair in the dining room for breakfast. Other residents present in the dining room. The urinary catheter bag, without a dignity cover, hung underneath the wheelchair seat. During an interview on 6/10/25 10:06 AM, Staff W, RN stated she had not ever seen catheter bag covers in the facility storage area, but reported covers should be used to promote resident dignity. On 6/10/25 at 2:58 PM, Staff K, Licensed Practical Nurse (LPN), reported she had not seen any catheter bag covers in facility storage, but reported cover should be used to promote resident dignity. On 6/11/25 2:52 PM, the DON stated urinary catheter bags should be covered when a resident is in their room or in common areas to promote dignity. The facility policy Promoting/Maintaining Resident Dignity, revised 8/2024, stated the facility would protect and promote resident rights, treat residents with respect and dignity, and care for them in a manner that maintained their quality of life.

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, facility policy review, resident and staff interview, the facility failed to ensure self medication administration assessments were completed. for 2 of 2 residents reviewed for self medication safety (Resident #23 and Resident #7). The facility reported a census of 59 residents. Findings: 1. Review of the Minimum Data Set (MDS) assessment tool, dated 5/9/25, list of diagnoses for Resident #23 included heart failure, diabetes (a disorder which caused abnormalities in blood sugar), and anxiety disorder. The Brief Interview for Mental Status (BIMS) score as 13 out of 15, indicated intact cognition. Review of the Care Plan, dated 12/27/23, revealed a Focus area to address [Name redacted] is non-compliant with medication administration . Review of the June 2025 Medication Administration Record (MAR) listed metformin (a medication used to treat diabetes) 500 milligrams (mg) 2 tabs twice daily scheduled at 8:00 AM. and 8:00 PM. During an observation on 6/3/25 at 10:51 AM, Resident #23 laid in bed and had a cup of medications bedside. Staff A, Registered Nurse (RN) entered the room and stated the medication was her metformin from the previous night and told the resident staff needed to observe her take her medications. Staff A removed the medications from the room. Review of Resident #23's electronic health record (EHR) revealed a lack of an Self -Medication Administration Assessment. During an interview on 6/11/25 at 12:26 PM, the Director of Nursing (DON) stated residents could not have medications at bedside unless they were care planned to do so. 2. Review of the MDS dated [DATE], revealed Resident #7 had a BIMS score of 14 out of 15, which indicated intact cognition. The list of diagnoses for Resident #7 included multiple sclerosis, paraplegia, seizure disorder, anxiety disorder, depression, and post-traumatic stress disorder. The MDS indicated Resident #7 had no impairment of his upper extremities, with bilateral impairment of lower extremities. Review of the EHR revealed a Nursing note entered on 1/14/25 at 3:50 PM, which documented Resident #7 admitted from [hospital name redacted] .Resident has severe allergy to PCN (penicillin) and fish - staff aware. Review of the EHR, revealed an allergy list for Resident #7 which included: a. Fish: Category: Food. Reaction Manifestation: Throat swelling. Severity: Severe. Date: 1/14/25. b. Shell Fish: Category: Food. Reaction Manifestation: Throat swelling. Severity: Severe. Date: 1/14/25. c. Dust: Category: Environmental. Reaction Manifestation: Shortness of breath. Severity: Moderate. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date: 1/14/25. d. Mold: Category: Environmental. Reaction Manifestation: Throat swelling. Severity: Moderate. Date: 1/14/25. e. Methenamine: Category: Drug. Reaction Manifestation: [not indicated]. Severity: Moderate. Date: 1/14/25 f. Penicillin: Category: Drug. Reaction Manifestation: [not indicated]. Severity: Severe. Date: 1/15/25. Review of the Order Summary, dated 6/9/25, revealed an order for an Epinephrine Inj (injection, commonly called an EpiPen) 0.3 MG. Inject IM (intramuscular) as needed for hypersensitivity reaction. Start Date: 1/14/25. Review of a Nursing note entered on 2/1/25 at 1:43 PM revealed, in part: 3). may keep EpiPen at bedside. May self-administer. Resident updated of new orders. Rx (prescription) has been faxed. Review of the list of Clinical Assessments in the EHR from 1/14/25 to 6/09/25 revealed a lack of a Self-Medication Administration Assessment. During an interview on 6/02/25 at 2:21 PM, Resident #7 stated the facility staff had served him fish multiple times. Resident #7 stated he is highly allergic to fish, and does not have an EpiPen available in his room. He stated he had requested this medication be kept at bedside for use in an emergency. During an interview on 6/05/25 at 12:48 PM, Staff Q, Certified Medication Aide (CMA), stated she has provided care and administered medication to Resident #7. Staff Q stated she is unaware of any allergies Resident #7 may have. Staff Q identified that a resident's allergies would be listed on the MAR. During an interview on 6/05/25 at 2:11 PM, Staff Z, Licensed Practical Nurse (LPN), when queried about an EpiPen for Resident #7 stated he was unable to locate the pen in the medication cart or in the resident's room. Staff Z stated he would need to check Resident #7's medical records to determine indication for use of Epinephrine Pen. During an interview on 6/05/25 at 2:47 PM, the DON stated the facility emergency medication kit does contain an EpiPen. The DON stated the kit is kept in a meeting room on a floor other than the floor where Resident #7 room is located. The DON stated a Self-Medication Assessment had not been completed for Resident #7 related to the EpiPen. At 4:00 PM, the DON reported an EpiPen had been ordered for Resident #7 and would be delivered on 6/6/25. During an interview on 6/10/25 at 2:58 PM, Staff K, LPN stated 2 EpiPen's and 1 trial/test pen had been received for Resident #7 on 6/6/25. Staff K stated a Self-Medication Administration Assessment had yet to be completed for the resident. During an interview on 6/11/25 at 2:52 PM, the DON confirmed that a Self-Medication Administration Assessment had not been documented as completed since receiving trial/test pen on 6/06/25 for Resident #7's self-administration of Epinephrine Pen. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, titled Resident Self-Administration of Medication, date revised 1/2025, revealed intention of this policy to support each resident's right to self-administer medication and informed that a resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record review, and facility policy review the facility failed to provide privacy during an enteral tube feeding for 1 of 1 residents (Resident #53) reviewed for privacy. The facility reported a census of 59 residents. Findings include: Review of the Minimum Data Set (MDS), dated [DATE], revealed Resident #53 had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated a severe cognitive impairment. Per the MDS. Resident #53 dependent on staff for eating and required a gastrostomy tube (tube going through abdomen into stomach to provide nutrition and hydration, commonly called a G-tube, feeding through a G tube is referred to as an enteral feeding). The MDS list of diagnoses included hemiplegia or hemiparesis (paralysis or weakness on one side of the body), traumatic brain injury, and dysphagia (difficulty swallowing). Review of the Care Plan, dated 3/19/25, revealed a Focus area to address [name redacted] requires tube feeding r/t (related to) Dysphagia, Swallowing problem. Potential for dehydration r/t G-Tube. And a Focus area, Date Initiated: 4/4/25 to address [name redacted] has an ADL (activities of daily living) related to hemiplegia, TBI (traumatic brain injury), FX (fracture). Interventions included, in part: EATING: dependent on staff for eating r/t feeding tube. Date Initiated: 4/4/25. During an observation on 6/04/25 at 9:29 AM, Staff N, Licensed Practical Nurse (LPN), entered Resident #53's room with medications prepared to be administered via Resident #53's G-tube. Resident #53's door to room left open. Staff N exposed Resident #53 abdomen and G-tube and proceeded to administer medications through the G-tube. The door remained open throughout the medication administration and G-tube feeding procedure. During Resident #53's tube feeding procedure, a Certified Nursing Assistant approached the open doorway and notified Staff N that another resident was not feeling well, then continued down hallway and door to resident's room remained open. During an interview on 6/10/25 at 10:06 AM, Staff W, Registered Nurse (RN), stated the door to a residents room should be closed when providing cares or nursing procedures to protect a resident's privacy. During an interview on 6/10/25 at 2:58 PM, Staff K, Licensed Practical Nurse (LPN), reported that resident door should be closed when providing cares or nursing procedures to protect a resident's privacy. During an interview on 6/11/25 at 2:52 PM, the Director of Nursing stated her expectation would be for all staff to close the resident doors and provide privacy during all cares provided or nursing procedures to protect a resident's right to privacy. Review of the facility policy, titled Promoting/Maintaining Resident Dignity, revised 8/2024, revealed a Policy statement which declared It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment , that maintains or enhances resident's quality of life by recognizing (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	each resident's individuality. Compliance Guideline #12 directed Maintain resident privacy.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and clinical record review, the facility failed to ensure targeted behaviors were identified for the use of antipsychotic medication for 1 of 6 residents (Resident #11) reviewed for unnecessary medications. The facility reported a census of 59 residents. Findings include: Review of Resident #11's Minimum Data Set (MDS) assessment dated [DATE], revealed the resident scored 6 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment the resident had no hallucinations or delusions, and had no physical, verbal, or other behaviors. The assessment further revealed resident took antipsychotic medication on a routine basis, with gradual dose reduction (GDR) contraindicated. Review of the Care Plan dated 5/2/24, revised 4/9/25, revealed the following: [Resident #11] uses psychotropic medications. 1/3/25 GDR (gradual dose reduction) declined for Risperidone r/t (related to) continued symptoms of mild depression and continued dementia with psychotic features. 4/8/25 decreased to 0.25mg bid (twice a day). Review of Interventions per Resident #11's Care Plan did not address targeted behaviors, or how the resident's psychotic features presented. Review of Resident #11's current Medical Diagnoses revealed both dementia with and without psychotic disturbance. Review of Resident #11's Preadmission Screening and Resident Review from January 2024, when the resident came to the facility, had no mental health conditions diagnosed or suspected now or in the past, revealed the resident took Risperiodone for dementia, and noted the following: Pt. (patient) has a diagnosis of dementia. While inpatient at the hospital, he has not exhibited any behaviors. The current Physician Order dated 4/16/24 revealed, Anti-psychotic: Monitor episodes of labile mood for Risperdal Qshift & Tally by hashmarks. Document non-Pharm Interventions use. 1. Removed patient from Environment 2. Redirected by engagement in Alternative activity. 3. Listen to patient, attempted to calm Familiarized patient with belongings/surroundings 4. Toileted patient 5. Ambulated patient. 6. Escorted patient to room for reduced stimuli 7. Provided patient with food/drink. Document Result Shift (+) effective (-) ineffective. The current Physician Order dated 4/29/25 revealed, Dispersion Tab 0.25 MG (milligram), with directions to take 1 table by mouth twice daily for MD (Major Depressive Disorder). (Related Diagnoses: Dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of Encounter Notes for Resident #11 authored by Nurse Practitioners (GNP) revealed the following: a. 3/11/25: Psychiatric: No increased nervousness or depression. B. 4/15/25: Psychiatric: No increased nervousness or depression. No recent cognitive changes. Delusions at times, but no adverse behaviors. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c.5/6/25: Dementia in other diseases classified elsewhere, moderate, with psychotic disturbance: Chronic, stable. Decrease risperidone to 0.25 mg (milligram) by mouth twice daily. Supportive care at LTC (long term care). Redirect and reorient resident as needed. Use therapeutic communication with resident, explain simply, provide positive feedback, discourage suspiciousness of others. Provide a consistent daily schedule. Alzheimer's disease, unspecified: Chronic, stable. Notify provider of cognitive changes or AMS (altered mental status). Review of Resident #11's Behavior Monitoring and Interventions per Task documentation revealed the following in the past 30 days: two episodes of anxious/restless, and one episode of elopement/exit seeking. Review of the resident's Medication Administration Record (MAR) dated May 2025 revealed the resident received the medication twice per day for the month. Review of the resident's MAR dated June 2025 revealed the resident received the medication twice per day from 6/1/25 to 6/3/25. During an interview on 6/4/25 at 10:50 AM, Staff B, Registered Nurse (RN) queried if Resident #11 had behaviors, and responded were not really behaviors, and resident had confusion. Per Staff B, once in a while the resident would say my shoes are too tight, not that foot, the other foot. Per Per Staff B, they thought the resident could have a temper occasionally. When queried what the resident did when had a temper, Staff B responded resident would yell at them. Per Staff B, generally didn't have any trouble with resident. On 6/4/25 at 11:59 AM, Staff C, Certified Nursing Assistant (CNA) queried about resident behaviors, and explained the resident sometimes missed the urinal and urinated on the bed. Per Staff C, some people counted as behavior, and Staff C thought the resident just missed. Other than that, Staff C explained resident forgot where at. On 6/11/25 at 8:42 AM, Staff H, CNA queried about Resident #11's behaviors, and explained he had not seen resident have any behaviors. Per Staff H, the resident was usually calm and relaxed. Staff H further explained the resident could be irritated a tiny bit, and didn't do anything. During an interview on 6/11/25 at 2:07 PM, the Director of Nursing (DON) explained the following for antipsychotic use: wanted behavior charting if any behaviors, the facility's pharmacy would do the GDR, recommendations, and the NP would agree or disagree. When queried about targeted behaviors, the DON explained generally was put in notes, sand should be under progress notes. The DON explained some had on the MAR, daily behavior or per shift. Review of the Facility Policy titled Use of Psychotropic Medication(s), dated 4/2019 revised 2/2025, revealed the following: Psychotropic medications are to be used only when a practitioner determines that the medication(s) is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication(s) is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s).

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, policy review, and staff interviews, the facility failed to report allegations of abuse per regulatory guidelines for 3 of 3 potential incidents (involving Resident #15 & Resident #21, Resident #165 and a staff member, and Resident #61 & Resident #42) reviewed for abuse. The facility reported a census of 59 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment tool, dated 5/10/25 revealed a list of diagnoses for Resident #21 which included abnormalities of gait and mobility, abnormal posture, and adult failure to thrive. The MDS indicated the resident had a fall without injury during the review period and listed her Brief Interview for Mental Status (BIMS) score as 5 out of 15, which indicated severely impaired cognition. Review of the Care Plan, dated 5/4/23 revealed a Focus area to address [Name redacted] is at risk for falls r/t (related to) gait/balance problems. Review of an Incident Note entered on 5/15/25 at 1:08 PM revealed staff reported another resident (Resident #15) knocked the resident [Resident #21] down in a wheelchair. The resident had a large hematoma (a collection of blood due to injury) to the back of her head and complained of a headache. A Nursing Note entered on 5/15/25 at 2:07 PM, documented the resident had a fall in the hallway and transferred to the ER (emergency room). A Nursing Note entered on 5/15/25 at 4:05 PM documented the resident returned from the ER with no new orders. Review of a Provider Note, dated 5/27/25 revealed the resident walked in the hallway when another resident came by in the wheelchair and knocked her over. This caused her to fall and hit her head and she sustained a large hematoma on the base of her head. The resident tried ice packs but this did not help with the pain. The provider added Tramadol (a narcotic pain reliever) to the resident's medications. 2. Review of the MDS assessment tool, dated 3/25/25 revealed a list of diagnoses for Resident #15 which included hemiplegia (one-sided paralysis), morbid obesity, and history of traumatic brain injury. The MDS listed a BIMS score as 8 out of 15, which indicated a moderate cognition impairment. Review of a Nursing Note, dated 8/18/24 revealed when the resident [Resident #15] left the dining room, he rolled himself out of his wheelchair backwards and did not seem to care that he ran into others. He almost knocked two people out of their chairs trying to leave the room. When staff asked him to be careful he grunted and did this anyway. His peers started to complain that he was going to hurt someone. Review of the Care Plan, dated 11/29/23 revealed a Focus area to address [name redacted] has an ADL (activities of daily living) self-care performance deficit r/t Hemiplegia. Interventions included, in part: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Educated resident on spatial awareness in wheel chair. Assist resident with W/C (wheelchair) mobility until Therapy evaluation is completed for safety. Date Initiated: 5/15/25. b. Mobility: w/c (wheelchair) used for locomotion, propels w/c backwards and staff needed to intervene and push him safely to destinations. Date Initiated: 12/5/24. The Care Plan lacked additional wheelchair safety interventions to ensure the resident and others were safe when he self propelled. Review of a Behavior note entered on 5/15/25, revealed the resident propelled down the hallway in his wheelchair towards his room and another resident went in the opposite direction. He [Resident #15] ran into the other resident [Resident #21] and caused her fall and hit her head on the floor. The CNA (Certified Nursing Assistant, who witnessed the incident) stated it looked intentional. During an interview on 6/10/25 at 10:55 AM, Staff Q Certified Medication Aide (CMA) stated she pushed Resident #15 out into the hallway on the day of the incident with Resident #15 and Resident #21. He [Resident #15] went full speed in his wheelchair and Resident #21 walked out of the bird room. Staff Q stated she told him to be careful. Resident #15 ran into the side of Resident #21's walker. She stated she did not know if he ran into her on purpose but thought he did because she saw him in the past be verbally mean to her. She stated though that she did not know for sure if he ran into her on purpose or if he was just going too fast. During an interview on 6/11/25 at 12:26 PM the Director of Nursing (DON) stated if staff thought the resident was unsafe in a wheelchair, there should be interventions. She stated currently they had an intervention in place that staff would assist him to and from meals. The facility lacked documentation they reported the incident with Resident #15 and Resident #21 prior to 5/16/25. 3. Review of the MDS assessment tool dated 11/23/24, revealed a list of diagnoses for Resident #165 which included non-Alzheimer's dementia, muscle weakness, and hypertension. The MDS listed her BIMS score as 0 out of 15, indicating severely impaired cognition. On 6/10/25 at 11:38 AM, Staff F Certified Medication Aide (CMA) stated Staff U, CNA grabbed Resident #165 by the wrists and pulled her because she wanted to leave the dining room. While she did this, Staff U stated to the resident I told you to wait a minute. She stated she did not say this in a nice manner. She stated after the incident the resident was upset and stated that she did not deserve that. She stated she did not know when this occurred but the resident since passed away. Staff F stated she reported this to a nurse but did not remember who she reported it to. The facility lacked documentation they reported the allegation between Staff U and Resident #165 as of 6/11/25. During an interview on 6/10/25 at 11:52 AM, the Administrator stated if there was an allegation of abuse, they would report this. During an interview on 6/11/25 at 3:55 PM, the Administrator stated with an allegation of abuse, if there was physical proof of the abuse, the facility would report it within 2 hours. She stated if there was an allegation of abuse with no actual injury, they would report within 24 hours. She stated (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Care Center of Fairfield	400 Highland Street Fairfield, IA 52556

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she interviewed all of the nurses and none stated anyone reported anything to them regarding Staff U and Resident #165. 4. Review of the MDS, dated [DATE], revealed Resident #61 with BIMS score of 4 out of 15, which indicated a severe cognitive impairment. The MDS identified Resident #61 independent with transfers and ambulation. The MDS list of diagnoses included dementia with agitation and alcohol dependence with alcohol induced persisting amnesic disorder. Review of the Care Plan, revised 6/4/25, revealed a Focus area to address I have sexually inappropriate behaviors RT (related to): Dementia, history of behaviors, Alzheimer's and evidenced by: Disrobing, Making sexually explicit commends. Interventions included, in part: a. Distract me with activities that have meaning to me. Date Initiated: 5/27/25 b. Redirect me through use of food, drink or conversation. Date Initiated: 5/27/25. c. Staff will let me know that my behaviors is affecting others around me. Date Initiated: 5/27/25. redirect as appropriate, and distract resident with activities. The Care Plan, Date Initiated: 4/14/25 included a Focus area to address The resident is a wanderer r/t impaired safety awareness, goes into other resident's rooms. Review of the electronic health record (EHR) revealed a Behavior Note entered on 6/01/25 at 8:55 PM, which documented res (resident) was touching female res this shift redirected without difficulty res took another res meal at supper as the res was not eating res redirected and res given more food to eat. 5. The MDS, dated [DATE], revealed Resident #42 with BIMS score of 5 out of 15, which indicated a severe cognitive impairment. The MDS identified Resident #42 utilized a wheelchair for mobility and required partial to moderate staff assistance with transfers and cares. The MDS list of diagnoses included Alzheimer's disease, multiple sclerosis, bipolar disorder, and anxiety disorder. Review of the Care Plan, dated 6/4/25 revealed a Focus area to address The resident has potential for psychosocial wellbeing problem r/t occurrence of another resident being inappropriate toward her. Review of Resident #42's Nursing Progress Notes revealed an entry on 6/06/25 at 11:55 AM, in which the Interdisciplinary Team (IDT) met to discuss resident to resident altercation that occurred on 6/01/25 in which another resident had rubbed Resident #42's shoulders and chest, witnessed by staff. The Note informed that follow up had been completed with Resident #42 on 6/02/25 and 6/03/25, which revealed no distress or complaints of pain, and resident unable to recall any events on 6/01/25. Intervention documented as allowing Resident #42 to verbalize feelings and to remove resident to a safe, calm environment. The facility submitted a Self-Reported Incident on 6/02/25 at 10:35 PM for resident to resident allegation of abuse which occurred on 6/01/25 at 5:30 PM. The report indicated staff witnessed another resident rub Resident #42's shoulders and moved hands down to chest/breast area. The Self-Reported Incident revealed that staff immediately separated residents and completed an assessment on each resident. The report documented the facility completed an investigation into incident and concluded that (continued on next page)

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Prestige Care Center of Fairfield	400 Highland Street Fairfield, IA 52556

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the touching of Resident #42 chest/breast was unintentional and that each resident involved were cognitively impaired and lacked identified physical or psychological harm. During an interview on 6/05/25 at 11:32 AM, Staff K, Licensed Practical Nurse (LPN), confirmed witnessing Resident #42 being touched on the shoulders and chest/breast area by another resident on 6/01/25. Staff K stated incident appeared innocent, but decided to separate and assess each resident, and document occurrence in a Nursing Progress Note. Staff K revealed on 6/02/25 the DON asked her about incident and instructed Staff K to come in to facility to write a statement. During an interview on 6/11/25 at 2:52 PM, the DON stated she found out about incident by reviewing nurse documentation in a 72-hour report and stated the allegation of resident to resident abuse was then reported to the State Agency on 6/02/25, one day after the occurrence. Review of the facility policy titled Abuse, Neglect, and Exploitation, revised 1/2025, directed staff to report alleged violations to the Administrator and State Agency immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury.

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and facility policy review the facility failed to ensure an ongoing discharge planning process for 1 of 1 resident reviewed for discharge (Resident #215). The facility reported a census of 59 residents. Findings include: Review of the Minimum Data Set (MDS) assessment dated [DATE] for Resident #215 revealed the resident scored 14 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. The Care Plan for Resident #215 canceled on 4/7/25 revealed, [Resident #215] has no plans to discharge from facility. Review of Resident #215's Care Conference Review form dated 1/16/25 revealed the line titled Discharge Potential had been left blank on the form. Review of documentation emailed by the facility's Administrator on 6/11/25 at 3:30 PM revealed a Notice of Transfer or Discharge form for the resident dated 1/27/25. The form included notice to transfer/discharge the resident on 2/26/25. Per the Transfer or Discharge form, reasons for transfer/discharge included the following: resident's welfare/needs could not be met by the facility, and failure to pay, after appropriate notice, for the resident's stay. The form provided had not been signed by the resident or resident representative. Review of Resident #215's Progress Notes for February 2025 until proposed date of discharge (2/26/25) lacked information about the resident's discharge plan. On 3/18/25 at 1:20 PM, a Nursing Note for the resident revealed the resident sent to the emergency room for psych evaluation and treat. Review of the resident's MDS assessment history revealed a Discharge Return Anticipated assessment dated [DATE]. Per the assessment the discharge was unplanned, and the resident went to an inpatient psychiatric facility. Review of Resident #215's Progress Notes between 3/18/25 and 4/4/25 lacked information about the resident's discharge plan. The Administration Note dated 4/4/25 at 12:39 PM present in the resident's electronic health record revealed, in part, currently classified as a non-payer. She (resident) also refused to sign the bed hold notification provided by the facility .The resident had indicated she will not be returning to the facility. It has been confirmed that she is currently residing in a safe environment Resident may be considered for readmission on ly upon full payment of the outstanding balance and a prepayment of 30 days of care in advance. On 6/10/25 at 10:35 AM, the former Administrator explained the resident had been sent out due to suicidal ideations. The former Administrator explained about 17 to 18 days later, received a call that (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said wanted to send the resident back. Per the former Administrator, at that time the resident had already been discharged , and the current Administrator would not accept the resident back due to non-payment and not being able to meet the resident's needs. Per the former Administrator, the resident had been asked to sign a bed hold, and refused to sign it. When queried if this was considered an involuntary discharge, the former Administrator responded no, the resident already discharged , and explained she had talked to Ombudsmans because the resident wanted to go home to [another state]. When queried if any involuntary discharge paperwork was done for the resident, the former Administrator explained none that was given to her (resident) or signed. Per the former Administrator, the resident would not allow the facility to assist resident with Medicaid, tried to do independently for a year, allowed family to help, Social Services would try to help, resident/family would not provide information. When queried where the resident ended up going, the former Administrator responded she was not sure. On 6/11/25 at 1:41 PM, the facility's Administrator explained the resident could return to the building, needed to pay the bill due, and paid bill in full could come back. Per the Administrator, the resident could safely discharge with family and services. Per the Administrator, the resident would have got discharge notice with the bill. When queried who would give this, the Administrator explained it would be the Administrator (it was noted there was a different Administrator in the building at the time of the resident's discharge). The Administrator stated she knew one was given to resident before she left. The Administrator explained in the past, the resident had been given an intent to discharge. The Administrator explained she had discussed with the former Administrator that the big thing was had to be safe discharge. Due to this, the Administrator explained one discharge option location was not possible. Review of the Facility Policy titled Transfer and Discharge (including AMA (Against Medical Advice)), dated 4/2019 revised 2/2025, revealed the following per the Emergency Transfers to Acute Care Section: Provide orientation for transfer or discharge to minimize anxiety and to ensure safe and orderly transfer or discharge, in a form and manner that the resident can understand.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on clinical record review, facility policy review, and staff interview, the facility failed to revise Care Plans to include significant resident information related to significant weight loss, severe allergies, wheelchair safety and change in advanced directive status for 4 of 21 residents (Resident #7, Resident #15, Resident #44, Resident #52) reviewed for Care Plans. The facility reported a census of 59 residents. Findings: 1. Review of the Minimum Data Set (MDS) assessment tool, dated 11/23/24, revealed the list of diagnoses for Resident #52 included hemiplegia (one-sided paralysis), dysphagia (difficulty swallowing), and chronic pain syndrome. The MDS stated the resident depended on staff for eating assistance and had a feeding tube. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 0 out of 15, indicating severely impaired cognition. The MDS indicated an admission date of 11/18/24. Review of the December 2024 Medication Administration Record (MAR) revealed an order with start date of 11/20/24 to check weights on admission and weekly for four weeks. Review of the electronic health record (EHR) Weight Summary revealed the following weight changes: a. On 11/18/24, weight of 166 lbs (pounds) b. On 11/20/24 12:35 PM, weight of 167 lbs c. On 11/20/24 2:04 PM, weight of 158.8 lbs d. On 11/26/24, weight of 150 lbs e. On 12/17/24 , weight of 147 lbs Review of the Care Plan dated 11/29/24 revealed a Focus area to address [name redacted] is at nutritional risk as diet is MECHANICALLY ALTERED/THERAPEUTIC diet and thickened liquids as ordered. Has feeding tube but not being used for nutrition. UNSPECIFIED SEVERE PROTEIN CALORIE NUTRITION, DYSPHAGIA. Interventions included, in part: a. Monitor/record/report to MD (medical doctor) PRN (as needed) s/sx (signs and symptoms) of malnutrition: Emaciation, muscle wasting significant weight loss: 3lbs in 1 week, > (greater) 5% in 1 month, >7.5% in 3 months, >10% in 6 months. The Care Plan did not address the residents weight loss or include direction to address. During an interview on 6/11/25 at 12:26 PM, the Director of Nursing (DON) stated the Care Plan should address significant weight losses. She stated staff should notify the physician of such losses and complete weights as ordered. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Nutritional Management, dated 4/2019, stated the facility provided care and services to each resident to ensure the maintenance of acceptable parameters of nutritional status. The policy directed staff to notify the physician of significant changes in weight and stated the Care Plan would include individualized interventions to address the specific needs of the residents 2. Review of the MDS assessment tool, dated 3/25/25, revealed a list of diagnoses for Resident #15 which included hemiplegia (one-sided paralysis), morbid obesity, and history of traumatic brain injury. The MDS listed the resident's BIMS score as 8 out of 15, which indicated a moderate impaired cognition. Review of the EHR revealed a Behavior Note entered on 5/15/25 documenting the resident propelled down the hallway in his wheelchair towards his room and another resident went in the opposite direction. Resident #15 ran into the other resident and caused to her fall and hit her head on the floor. The CNA (Certified Nursing Assistant), who witnessed the incident) stated it looked intentional Review of the Care Plan, dated 11/29/23 revealed a Focus area to address [name redacted] has an ADL (activities of daily living) self-care performance deficit r/t Hemiplegia. Interventions included, in part: a. Educated resident on spatial awareness in wheel chair. Assist resident with W/C (wheelchair) mobility until Therapy evaluation is completed for safety. Date Initiated: 5/15/25. b. Mobility: w/c (wheelchair) used for locomotion, propels w/c backwards and staff needed to intervene and push him safely to destinations. Date Initiated: 12/5/24. The Care Plan lacked additional wheelchair safety interventions to ensure the resident and others were safe. During an interview on 6/11/25 at 12:26 PM, the DON stated if staff thought the resident was unsafe in a wheelchair, there should be interventions on the Care Plan. She stated currently they had an intervention in place that staff would assist him to and from meals. 4. Review of the MDS assessment for Resident #44 dated 5/1/25 revealed the resident scored 10 out of 15 on a BIMS exam, which indicated moderately impaired cognition. On 6/9/25 at 2:47 PM, review of Resident #44's Care Plan revealed the following: I have requested that CPR (cardiopulmonary resuscitation)measures ARE to be performed (FULL CODE STATUS). The Intervention dated 4/29/24 revealed, Initiate CPR if you find me pulseless or breathless and continue CPR until Paramedics arrive to take over. Review of the Nursing Note dated 6/3/25 at 3:53 PM revealed, This nurse called to clarify code status as DNR. Resident is not a full code. The Nursing Note dated 6/3/25 at 8:12 PM revealed, Called [Name Redacted] to verify that they did want her to be a DNR and she and res (resident) both agreed to the DNR status. On 6/11/25 at 8:36 AM, review of the resident's Care Plan revealed the resident requested CPR be performed, and the resident was a full code. (continued on next page)

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Prestige Care Center of Fairfield	400 Highland Street Fairfield, IA 52556

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/25 at 1:56 PM, the facility's Director of Nursing (DON) informed of situation and queried how soon would expect the Care Plan to be revised. The DON explained she would message the responsible staff member following the interview. Review of the Facility Policy titled Comprehensive Care Plans, dated 4/2019 and last revised 2/2025, revealed the following: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. 3. The MDS assessment for Resident #7, dated 3/27/25, revealed a BIMS score of 14 out of 15, which indicated intact cognition. The MDS documented an admission date of 1/14/25. Review of the EHR, revealed an allergy list for Resident #7 which included: a. Fish: Category: Food. Reaction Manifestation: Throat swelling. Severity: Severe. Date: 1/14/25. b. Shell Fish: Category: Food. Reaction Manifestation: Throat swelling. Severity: Severe. Date: 1/14/25. c. Dust: Category: Environmental. Reaction Manifestation: Shortness of breath. Severity: Moderate. Date: 1/14/25. d. Mold: Category: Environmental. Reaction Manifestation: Throat swelling. Severity: Moderate. Date: 1/14/25. e. Methenamine: Category: Drug. Reaction Manifestation: [not indicated]. Severity: Moderate. Date: 1/14/25 f. Penicillin: Category: Drug. Reaction Manifestation: [not indicated]. Severity: Severe. Date: 1/15/25. Review of the Order Summary, dated 6/9/25 revealed an order for an Epinephrine Inj (injection, commonly called an EpiPen) 0.3 MG. Inject IM (intramuscular) as needed for hypersensitivity reaction. Start Date: 1/14/25. Review of a Nursing note entered on 2/1/25 at 1:43 PM revealed, in part: 3). may keep EpiPen at bedside. May self-administer. Resident updated of new orders. Rx (prescription) has been faxed. Review of the Care Plan revealed the lack of a Focus area and Interventions to address Resident #7's severe allergies, a Self-Medication Administration Assessment, and location of the EpiPen.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, policy review, and staff and resident interviews, the facility failed to administer medications within the timeframe directed by the manufacturer/pharmacist for 3 of 8 residents (Resident #31, #41, #53) reviewed for medications, and failed to follow professional standards of medication administration by ensuring the same staff member set up medications as who administered them for 1 of 8 residents reviewed for medication administration (Resident #52). The facility reported a census of 59 residents. Findings: 1. Review of the Minimum Data Set (MDS) assessment tool, dated 5/10/25, revealed a list of diagnoses for Resident #31 which included diabetes (a disease which causes abnormalities in blood sugars), heart failure, and morbid obesity. The Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. Review of the Care Plan, dated 3/15/23 revealed a Focus area to address diabetes, with an Intervention to administer diabetes medications as ordered. The June 2025 Medication Administration Record (MAR) listed a 5/20/25 order for insulin apart (a type of insulin, an injectable medication used to lower blood sugar) 24 units three times daily. The Insulin Aspart Injection Patient Information, retrieved from https://www.novo-pi.com/insulinaspart.pdf on 6/16/25, directed to eat a meal within 5-10 minutes after the administration of the dose. During an observation on 6/4/25 at 11:38 AM, Staff A, Registered Nurse (RN) administered 24 units of insulin aspart to Resident #31. Observation following this administration revealed the resident did not receive a meal or ingest any snacks as of 12:05 PM, At 12:05 p.m., the Staff A stated she had a window of 30 minutes for him to eat. At 12:09 PM, Staff F Certified Nursing Assistant (CNA) offered the resident a snack. 2. Review of the MDS assessment tool, dated 3/25/25, revealed a list of diagnoses for Resident #52 which included hemiplegia (one-sided paralysis), dysphagia (difficulty swallowing), and chronic pain syndrome. The MDS assessed the resident at risk for development of a pressure ulcer, with no unhealed ulcers at the time of the assessment. The MDS listed the resident's BIMS score as 0 out of 15, which indicated a severe cognitive impairment. Review of Resident #52's June 2025 MAR revealed the following medication orders: a. A 12/4/24 order for lorazepam (an anti-anxiety medications) 0.25 milliliter(ml) [0.5 milligrams(mg)] via G-tube (a gastrostomy tube, which is a tube inserted directly into the stomach via a surgical opening in the abdomen used to instill medications, nutrition and hydration) twice daily b. A 5/20/25 order for oxycodone (a narcotic pain medication) 0.5 ml (10 mg) via G-tube three times daily c. A 4/11/25 order for Peg 3350 [NAME] (polyethylene glycol powder - a type of laxative) 17 grams (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	into 4-8 ounces of liquid via g-tube twice daily d. A 11/18/24 order baclofen (a muscle relaxant) 10 mg per G-tube three times daily e. A 11/19/24 order for gabapentin (a pain medication) 6 ml (300 mg) three times daily. Review of the June MAR revealed an entry on 6/4/24 at 2:00 PM for the above medications initialed by Staff X Certified Medication Assistant's (CMA) with a check mark to indicate the administration of the medications. During an interview on 6/4/25 at 2:23 PM, Staff A, RN stated Staff X, CMA set up the medications she would administer via g-tube to Resident #52. Staff X held a cup of liquid and said he utilized tap water to mix with the medications. Staff A stated the medications in the cup were the resident's lorazepam, oxycodone, PEG 3350, baclofen, and gabapentin. Staff A then took the medications from Staff X, went to the resident's room, and administered the medications via G-tube. Staff A stated sometimes the CMA set the medications up and sometimes she did. She stated she observed the CMA set up the medications. During an interview on 6/11/25 at 8:26 AM, Staff H, CMA stated he would not set up medications for the nurse to administer. 3. Review of the MDS assessment tool, dated 3/1/25, revealed a list of diagnoses for Resident #41 which included diabetes, heart failure, and anxiety. The BIMS score as 12 out of 15, indicated a moderate cognitive impairment. Review of the June 2025 MAR revealed an order for levothyroxine (a medication used to treat thyroid disorder) 137 micrograms daily scheduled at 6:00 AM, Start Date: 2/7/25. Per the MAR all other morning medications scheduled at either 7:00 AM. or 8:00 AM. During an interview on 6/3/25 at 12:58 PM, Resident #41 stated she was supposed to get her thyroid medication an hour before other medications but received it with two other pills. During an interview on 6/10/25 at 9:46 AM, Staff P, RN stated staff should administer levothyroxine by itself. During an interview on 6/10/25 at 11:52 AM, Staff A, RN stated the night shift nurses were supposed to administer the levothyroxine but there were times when they did not do that and the day shift administered them with other medications. During a phone interview on 6/11/25 at 11:23 AM, Staff V, Pharmacist stated levothyroxine was definitely intended to be given by itself so there was no difference in metabolism. He stated when they set up medications for facilities, they created a separate medication time for that medication. During an interview on 6/11/25 at 12:26 PM, the Director of Nursing (DON) stated nurses should administer rapid acting insulin within 15 minutes of the time the resident would eat. She stated CMAs should not set up medications for the nurse. The DON stated staff should administer levothyroxine between 5:00 AM and 6:00 AM 4. Review of the MDS assessment, dated 3/31/25, revealed Resident #53 had a BIMS score of 5 out of (continued on next page)

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Prestige Care Center of Fairfield	400 Highland Street Fairfield, IA 52556

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	15, which indicated severe cognitive impairment. The list of diagnoses included: dysphagia and traumatic brain injury. The MDS indicated Resident #53 required a G-tube for medications, and 51% of total calorie intake. Review of the Care Plan, dated 4/04/24, revealed a Focus area to address Resident #53 potential for alteration in neurological status related to traumatic brain injury. Interventions included, in part: Give medications as ordered. Monitor/document for side effects and effectiveness. The Care Plan also included a Focus area to address the requirement of a tube feeding r/t dysphagia. Review of the June 2025 MAR revealed the following medications scheduled for the 7:00 AM medication pass: 1. Osmolite 1.2 liquid to be given four times a day. Scheduled times 7:00 AM, 11:00 AM, 2:00 PM, and 8:00 PM. 2. Baclofen 20 mg to be given three times a day. Scheduled times 7:00 AM, 2:00 PM, and 8:00 PM. 3. Escitalopram 10 mg to be given daily at 7:00 AM. 4. Folic Acid 1000 mcg (micrograms) to be given daily at 7:00 AM. 5. Gabapentin 600 mg to be given three times a day. Scheduled times 7:00 AM, 2:00 PM, and 8:00 PM. 6. Senna 8.6mg to be given daily at 7:00 AM. 7. Sentry (multivitamin) tablet to be given daily at 7:00 AM. During an observation on 6/04/25 at 9:29 AM, Staff N, Licensed Practical Nurse (LPN), administered the following medications (crushed and through the G-tube) scheduled for 7:00 AM: baclofen 20 mg, escitalopram 10 mg, folic acid 1000 mcg, gabapentin 600 mg, senna 8.6 mg, and sentry multivitamin tablet. During the observation, Staff N noted to have flushed Resident #53's G-tube with 100 milliliters (mL) of water before and after administration of Osmolite 390 mL. During an interview 6/10/25 at 10:31 AM, Staff Q, CMA, reported that facility protocol instructed staff to give medications within an hour before or an hour after scheduled administration time and explained that the electronic MAR would indicate if a medication was late by change in color. During an interview on 6/10/25 at 2:58 PM, Staff K, LPN reported that facility protocol instructed staff to give medications within an hour before and an hour after the scheduled administration time. Staff K stated if a medication was given late there would be concern that the next scheduled dose would be given too soon. During an interview on 6/11/25 at 2:52 PM, the DON stated the expectation is for nursing staff to give medications within an hour before or after the scheduled time. The DON confirmed 9:30 AM would be considered late for scheduled 7:00 AM medication time. Review of facility policy Medication Administration, dated 4/2025, revealed a Compliance Guideline #12. Compare medication source with the Medication Administration Record to verify resident name, medication name, form, dose, route, and time. The policy instructed for medication to be administered (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	within 60 minutes prior to or after scheduled time unless otherwise ordered by physician

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and resident and staff interviews, the facility failed to ensure the provision of an adequate number of baths for 2 of 2 residents reviewed for bathing assistance(Residents #5 and #43). The facility reported a census of 59 residents. Findings: 1. Review of the Minimum Data Set (MDS) assessment tool, dated 3/24/25, reveal a list of diagnoses for Resident #43 which included heart failure, depression, and obesity. The MDS indicated the resident dependent on staff for showering/bathing assistance. The Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicated intact cognition. Review of the Care Plan, dated 12/31/24, revealed the resident dependent on staff to provide a shower and requested a shower on Tuesday and a bed bath on Friday. During an interview on 6/2/25 at 1:43 PM, Resident #43 stated she received a bath on Tuesdays and Fridays. She stated last Friday (5/30/25), the staff documented in the record that she refused her bath but she did not. Resident #43 stated this was not the first time this happened. She stated she had not had a bath since last Tuesday (5/27/25) because of this. Review of the May and June 2025 Documentation Survey Reports, Bathing Task revealed: The May and June 2025 Documentation Survey Reports revealed the following: a. The resident had a bath on Tuesday 5/13/25 and did not have a subsequent bath until 5/20/25. b. The resident had a bath on Tuesday 5/27/25 and did not have a subsequent bath until 6/6/25. b. The Bath Days section on the Documentation Survey Reports indicated a R (refused) on Monday, 5/19/25. The Bath Days and Bathing tasks documentation on May 30, 2025 blank. Review of the clinical record lacked documentation of a follow-up to the resident's missed baths, and/or refusal. During an interview on 6/10/25 at 10:55 AM, Staff Q, Certified Medication Aide (CMA) stated if a resident refused their bath, aides should document this and inform the nurse. During an interview on 6/11/25 at 12:26 PM, the Director of Nursing (DON) stated if a resident refused a bath, staff should inform the nurse and they should follow up. She stated residents should receive baths at least twice per week. 2. Review of Resident #5's MDS, dated [DATE], revealed a BIMS score of 8 out of 15, which indicated a moderate cognitive impairment. The MDS indicated Resident #5 dependent upon staff for bathing/showering task. The list of diagnoses included type 2 diabetes Mellitus. urinary tract infection (UTI) within last 30 days, Parkinson's disease, non-Alzheimer's dementia, stage 3 pressure ulcer of left heel and unstageable pressure ulcer of other site. Review of the Care Plan, revised 6/02/25, revealed Resident #5 had an Activities of Daily Living (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(ADL) self care deficit related to activity intolerance and dementia. Interventions included: Resident #5 required 2 staff assistance for bathing/showering task. The Care Plan addressed Resident #5 resisted care at times and instructed staff to give clear explanation of all care activities, if resident resisted ADLs, reassure resident, leave and return 5-10 minutes later and try again, report to nurse if Resident #5 is refusing cares or meals. Review of the Electronic Health Records (EHR), Documentation Survey Reports for bathing tasks revealed Resident #5 had shower recorded on 5/29/25 and 7 days later on 6/05/25. During an interview on 6/05/25 at 12:14 PM, Staff Q, CMA reported completing a shower on Resident #5 on 6/05/25 due to the Bath Aide being on vacation. During an interview on 6/11/25 at 1:12 PM, Staff EE, Certified Nursing Assistant (CNA), confirmed working as bath aide for Resident #5, twice per week on Mondays and Thursdays, and reported being on vacation for the week of 6/01/25. Staff EE stated Resident #5 had said no at times but would be easily talked in to taking a shower, resident had not refused showers. Review of the facility policy Resident Showers, revised 1/2025, revealed a Policy statement which declared It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues per current standards of practice. The Policy, Explanation and Compliance Guidelines #1. Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on clinical record review, policy review, and staff interview, the facility failed to assess and intervene for 2 of 2 residents (Resident #36 and #41) with high blood sugar results. The facility reported a census of 59 residents. Findings: 1. Review of the Minimum Data Set (MDS) assessment tool, dated 3/24/25, revealed a list of diagnoses for Resident #36 which included diabetes, hemiplegia (one-sided paralysis), and seizure disorder. The MDS listed a Brief Interview for Mental Status (BIMS) score as 8 out of 15, which indicated a moderate cognitive impairment. Review of the Care Plan, dated 8/30/24, revealed the resident had diabetes and directed staff to observe for signs and symptoms of hyperglycemia (high blood sugar). The June 2025 electronic Medication Administration Record (eMAR) listed an order for Lispro insulin (a type of rapid-acting insulin). The order directed staff to administer 10 units of Lispro for a blood sugar greater then 399 milligrams (mg)/deciliter (dl) and to notify the provider. Review of electronic health record (EHR) Blood Sugar Summary for Resident #36 revealed the following blood sugar readings over 399 mg/dl: a. 4/12/2025 8:24 AM 448.0 mg/dl; b. 4/15/2025 11:26 AM 436.0 mg/dl; c. 4/20/2025 11:51 AM 445.0 mg/dl; d. 4/20/2025 7:48 AM 407.0 mg/dl; e. 4/21/2025 6:00 AM 432.0 mg/dl; f. 4/27/2025 3:28 PM 492.0 mg/dl; g. 5/1/2025 10:01 AM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	430.0 mg/dl. Review of the EHR revealed a lack of documentation of provider notifications or follow-up interventions/assessments related to the above blood sugars greater than 399 mg/dl. 2. Review of the MDS assessment tool, dated 3/1/25, revealed a list diagnoses for Resident #41 which included diabetes, heart failure, and anxiety. The BIMS score of 12 out of 15, indicated a moderate cognitive impairment. Review of the Care Plan, dated 1/7/25 revealed Resident #41 had diabetes and directed staff to monitor effectiveness of medications. Review of the eMAR revealed the following orders to treat diabetes: a. Lantus (type of long acting insulin) SOLOS INJ (injection) 100 ml. Inject 22 units subcutaneously (under the skin) at bedtime .Indications for use: hyperglycemia (high blood sugar) b. Lantus SOLOS INJ 100 ml. Inject 40 units subcutaneously every morning .Indications for use: hyperglycemia (high blood sugar) Review of the EHR Blood Sugar Summary revealed the following blood sugar readings: a. 3/22/2025 8:03 PM 403.0 mg/dl; b. 4/19/2025 7:25 AM 440.0 mg/dl. Review of the EHR revealed a lack of orders to indicate provider notifications guidelines, and follow-up interventions/assessments related to the above high blood sugars. During an interview on 6/10/25 at 9:46 AM, Staff P, Registered Nurse (RN) stated she would call the provider if a resident's blood sugar was below 60 or above 400 mg/dl. During an interview on 6/10/25 at 11:52 AM, Staff A, Licensed Practical Nurse (LPN) stated she would call the provider if blood sugars were less than 60 or more than 450 During an interview on 6/11/25 at 12:26 PM, the Director of Nursing (DON) stated staff should inform the provider if blood sugars were greater than 400 mg/dl. She stated documentation at the facility was terrible. She agreed staff should call the provider and get direction for abnormal blood sugars.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. The MDS assessment tool, dated 5/12/25, listed diagnoses for Resident #13 which included Alzheimer's disease, non-Alzheimer's dementia, and Parkinson's disease(a disorder which caused tremors and difficult mobility). The MDS listed her cognition as severely impaired. A 2/15/25 Care Plan entry stated the resident was at risk for falls related to confusion. On 6/3/25 at 9:56 AM, Resident #13 sat in a shower chair in her room. The door was open and no staff were within sight of her. At 10:12 AM Staff A Registered Nurse(RN) and Staff R Certified Nursing Assistant(CNA) walked by the resident's room and Staff A asked Staff R if she just finished the resident's shower. Staff R said no she had been done. Staff R closed the resident's door and they both walked away. The resident remained in her shower chair until 10:36 AM At 10:36 AM Staff R stated she was not sure what time she completed the resident's shower but stated she required 2 staff members for the transfer and the other staff were at the other end of the hall. At 10:40 AM Staff R and Staff F transferred the resident to bed with a mechanical lift. They assisted her to roll over onto her right side and her right rear leg had red indentations spanning across the back of her thigh. On 6/10/25 at 10:55 AM, Staff Q, Certified Medication Aide(CMA) stated she would not leave a resident in her shower chair. She stated after showers she tried to lay them down as quickly as possible and to get them off their bottoms. On 6/10/25 at 11:12 AM, Staff R, CNA stated normally on the [NAME] Unit there were 3 aides staffed. She stated on the day that Resident #13 was in her shower chair, there were only 2 aides staffed on the floor and there was not enough staff to help the resident. She stated if the facility was fully staffed, there were no problems taking care of the residents but stated they were not always fully staffed. She stated depending on what was going on, residents have waited up to 30 minutes for staff to respond to their call lights. On 6/10/25 at 11:52 AM, Staff A, RN stated she would not want a resident in the shower chair for an extended period of time. On 6/11/25 at 12:26 PM, The DON stated staff should not leave residents in a shower chair alone. 4. The MDS assessment tool, dated 5/10/25, listed diagnoses for Resident #21 which included abnormalities of gait and mobility, abnormal posture, and adult failure to thrive. The MDS stated the resident had a fall without injury during the review period and listed her BIMS score as 5 out of 15, indicating severely impaired cognition. A 5/4/23 Care Plan entry stated the resident was at risk for falls related to gait and balance problems. A 5/15/25 1:08 PM Incident Note stated staff reported another resident(Resident #15) knocked the resident down in a wheelchair. The resident had a large hematoma(a collection of blood due to injury) to the back of her head and complained of a headache. A 5/15/25 2:07 PM Nursing Note stated the resident had a fall in the hallway and transferred to the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	ER. A 5/15/25 4:05 PM Nursing Note stated the resident returned from the ER with no new orders. A 5/27/25 Provider Note stated the resident walked in the hallway when another resident came by in the wheelchair and knocked her over . This caused her to fall and hit her head and she sustained a large hematoma on the base of her head. The resident tried ice packs but this did not help with the pain. The provider added Tramadol(a narcotic pain reliever) to the resident's medications. 5. The MDS assessment tool, dated 3/25/25, listed diagnoses for Resident #15 which included hemiplegia (one-sided paralysis), morbid obesity, and history of traumatic brain injury. The MDS listed the resident's BIMS score as 8 out of 15, indicating moderately impaired cognition. A 8/18/24 Nursing Note stated when the resident left the dining room, he rolled himself out of his wheelchair backwards and did not seem to care that he ran into others. He almost knocked two people out of their chairs trying to leave the room. When staff asked him to be careful, he grunted and did this anyway. His peers started to complain that he was going to hurt someone. A 12/5/24 Care Plan entry stated the resident used a wheelchair for locomotion and propelled the wheelchair backwards and staff needed to intervene and push him safely to destinations. A 5/15/25 Behavior Note stated the resident propelled down the hallway in his wheelchair towards his room and another resident went in the opposite direction. Resident #15 ran into the other resident and caused to her fall and hit her head on the floor. The CNA(who witnessed the incident) stated it looked intentional. A 5/15/25 Care Plan entry stated staff educated him on spatial awareness [NAME] the wheelchair and would assist the resident with wheelchair mobility until therapy evaluated him for safely. The Care Plan lacked additional wheelchair safety interventions to ensure the resident and others were safe. On 6/10/25 at 10:55 a.m., Staff Q, CMA stated on the day of the incident with Resident #15 and Resident #21, she pushed Resident #15 out into the hallway. He went full speed in his wheelchair and Resident #21 walked out of the bird room. Staff Q stated he was going full speed and she told him to be careful. Resident #15 ran into the side of Resident #21's walker. She stated she did not know if he ran into her on purpose but thought he did because she saw him in the past be verbally mean to her. She stated though that she did not know for sure if he ran into her on purpose or if he was just going too fast. On 6/11/25 at 12:26 p.m. the DON stated if staff thought the resident was unsafe in a wheelchair, there should be interventions. She stated currently they had an intervention in place that staff would assist him to and from meals. Review of the Facility Policy titled Accidents and Supervision, dated 4/2019 and last revised 6/2025, revealed the following per the Identification of Hazards and Risks Section: All staff (e.g., professional, administrative, maintenance, etc.) are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident .The facility should make a reasonable effort to identify the hazards and risk (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	factors for each resident. Based on observation, interview, and record review, the facility failed to ensure safe transfer via mechanical lift, and failed to ensure adequate supervision when a resident known to exhibit unsafe tendencies in their wheelchair knocked another resident down for 3 of 10 residents reviewed for accidents (Resident #15, Resident #21, Resident #32). Resident #32 fell from mechanical lift sling, resulting in a hematoma with abrasion to the resident's posterior head. Resident #21 ran into Resident #15's walker with their wheelchair, Resident #15 fell, and sustained a hematoma to the back of the head. Resident #15 did not receive received adequate supervision when the resident was left alone in their room in a shower chair. The facility also failed to ensure oxygen tanks were secured during transport. The facility reported a census of 59 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment dated [DATE] for Resident #32 revealed the resident was rarely to never understood. Per this assessment, the resident was dependent for chair/bed-to-chair transfer. The Care Plan dated 11/27/24 revealed, [Resident #32] has an ADL (activities of daily living) self-care performance deficit r/t (related to) Aggressive Behavior, Dementia. The Intervention dated 11/27/24 revealed, TRANSFER: Mechanical Lift Hoyer with 2 staff assistance and use large sling. The Care Plan dated 11/14/24, revised on 5/7/25, revealed the following: [Resident #32] is risk for falls r/t (related to) dementia, Gait/balance problems, Poor communication/comprehension. The Intervention dated 5/7/25 revealed, 5/7/25 sling malfunctioned and sling removed from service. The Progress Note dated 5/7/25 at 7:19 AM authored by Staff B, Registered Nurse (RN) revealed, During Hoyer lift transfer with this RN and CNA (Certified Nursing Assistant) [Name Redacted] res slid out of Hoyer sling to floor. Landed on upper back and bumped his head on the floor. Assessed for injury, hematoma with abrasion on posterior head. VS (vital signs) obtained. Lifted from floor with 2 staff and sat in his w/c (wheelchair). abrasion cleansed with wound wash. No active bleeding .Intervention remove new Hoyer sling for no further use. Neuros initiated. The Progress Note dated 5/7/25 at 9:45 AM revealed, IDT (interdisciplinary team) met to review resident's witnessed fall. Staff were transferring in hoyer, resident was secure in Hoyer checked by both staff members upon transferring to wheelchair resident jerked while in sling and fell landing on back of head. Abrasion noted on the back of head. Neuros initiated and vitals stable. resident denies any pain. No other injuries noted. New Intervention: Hoyer sling removed. On 6/04/25 at 10:41 AM, Staff B, RN queried about the resident's fall from the lift, and explained the following: Per Staff B, had just received a new [mechanical lift] sling, transferred resident up, and normally [mechanical lift] sling as lifted was to a seated position. Staff B explained it was almost like the kind of sling for bed to bed transfer, explained didn't even seem right, and was brand new sling that never used before. Staff B explained she pulled the [mechanical lift] back, and the other staff member at the wheelchair. Per Staff B, as soon as moved [resident], normally knees would bend, and resident's legs were straight out. Staff B explained the resident slid from the [mechanical lift] onto the floor, and bumped head on the floor. Staff B explained called [former Administrator], made former Administrator lay in the sling, put her in the sling, response was couldn't use that sling, and was taken away and said couldn't use it. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Staff B, RN queried what kind of sling it was, responded was green in color, and Staff B couldn't tell the manufacturer's name on it. Staff B explained she ran the [mechanical lift] when happened. Per Staff B, she felt horrible, and further explained the problem was fixed immediately. Staff B acknowledged when raised resident up, was flat. When queried if had used the sling for anyone else, Staff B responded no. When queried if the resident got hurt, Staff B responded had bump to the back of head. On 6/4/25 at 11:49 AM, Staff C, Certified Nursing Assistant (CNA) explained the following about the incident: Per Staff C, she was getting the resident up and ready for the day, and noticed the resident had a different sling. Staff C explained she went and looked for a different sling, and it was a bed to bed transfer sling instead of a bed to chair sling. Per Staff C, she noticed the sling used laid the resident more flat. Staff C explained she called the nurse into assist with the transfer, and as were lifting the resident up Staff C said, It looks like he's going to fall/ Should I put him back down? Staff C explained she told this to [Staff B], the nurse at the time, and Staff B responded, No, that's just how he looks in the sling. Staff C explained continued with with the transfer. Per Staff C,CNA as soon as pulled the resident out from over the bed, the resident slid out from the back of the sling and landed on the floor. When queried what hit the floor, Staff C responded the head. When queried how the resident responded, Staff C explained resident said a quiet Ow. Staff C explained the resident didn't talk much in general, and other than that, didn't say anything. Per Staff C, the resident was conscious the whole time, the nurse stayed with the resident, and confirmed Staff B was present the whole time for the transfer. When queried if she had transferred the resident before this incident, Staff C, CNA acknowledged she had. When queried what type of sling was used for resident before the incident, Staff C explained sling with 4 corners that had hooks on them, blue, green, and purple. Per Staff C, CNA the sling used (at time of incident) had hooks on the side of the sling instead of the top corner. Staff C explained the sling used wasn't very secure, and further explained she would not use it again if had to. When queried where the sling used had come from, Staff C responded had run out of slings, maintenance contacted, and from what understood found somewhere around the building. Per Staff C, this sling present when Staff C got there in the morning, she queried Staff B where the sling had come from, and response provided was on previous day, had to ask maintenance to find one. Per Staff C, she'd only used the slings before with the 4 corners, and those had worked perfectly fine. When queried what made Staff C, CNA feel the resident was going to fall, Staff C responded as she lifted the resident, saw [resident's] legs a smidge too high, and as lifted [resident] up, his head kept going down instead of coming up above hips like should be. Per Staff C, had Staff B report it to the Administrator, Administrator came up, explained put Administrator up in sling to demonstrate what happened. Review of the [Facility Name] Post Fall Skin assessment dated [DATE] revealed the resident had new redness, new skin tears, and new bruise. The Post Fall Skin Assessment further revealed the following: due to fall; hematoma with abrasion, bruising to posterior head. On 6/3/25 at 11:51 AM, two staff assisted Resident #32 with transfer from bed to wheelchair. The sling used was blue in color, and had a purple binding. The sling connected to the mechanical lift via loops at the top and bottom of the sling. The resident was raised up in the sling, then transferred (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Care Center of Fairfield	400 Highland Street Fairfield, IA 52556

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F 0689 Level of Harm - Actual harm Residents Affected - Few	from bed to wheelchair. Observation on 6/4/25 at 12:46 PM revealed Resident #32 in a wheelchair in the dining room of the area where the resident resided. The resident had a sling present underneath them in their wheelchair. The sling was blue in color, with purple binding around the edges of the sling. On 6/11/25 at 1:59 PM, the facility's Director of Nursing (DON) queried what staff should do if had concern when started to raise resident in lift, and responded to lower the resident back down, and assess the equipment. 2. Observation on 6/3/25 at 9:47 AM on the [NAME] area of the facility revealed Staff A, Licensed Practical Nurse (LPN), walked down the hall with an oxygen tank, then set the oxygen tank down hard on the floor. The oxygen tank not observed in a holder. Observation on 6/3/25 at 9:51 AM on the [NAME] area of the facility revealed Staff A carried an oxygen tank down the hallway without a holder. Observation further revealed Staff A stood in the hallway and held the tank with one hand. Observation on 6/10/25 at 9:38 AM revealed Staff A, LPN walked out by the nursing desk and held an oxygen tank in her hand. Staff A set the tank down on the floor. The tank stood upright behind the nursing desk and was not in a holder. Staff A worked with the tank, and could hear air flow out of the tank. On 6/11/25 at 1:57 PM, the facility's Director of Nursing (DON) queried about previous observations, and responded it should be on wheels, should be carried, and definitely should be in an appropriate handler if going down the hall. The DON explained she would do education. Review of the Facility Policy titled Oxygen Safety, dated 4/2019 and last revised 4/2025, revealed the following: Protect cylinders from damage by not storing in locations where heavy objects may strike them or fall on them, or where they can be tipped over by foot traffic or door movement.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, facility policy review, resident and staff interviews, the facility failed to use Enhanced Barrier Precautions and infection control techniques during catheter care, and intervene in a timely manner reports of an indwelling catheter leaking for 1 of 1 residents (Resident #7) reviewed with an indwelling catheter. The facility reported a census of 59 residents. Findings include: Review of The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 scored a 14 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS revealed impairment on both sides of the lower extremities. The MDS revealed resident utilized an indwelling catheter, and dependent on staff for toileting. The MDS revealed medical diagnoses for multiple sclerosis, neurogenic bladder, and urinary tract infection in the last 30 days. Review of the Care Plan, revised on 6/2/25, revealed a Focus area for Enhanced Barrier Precautions (EBP) wounds, indwelling medical device, multi drug resistant organism-colonization/infection with indwelling foley. The Interventions dated 1/15/25 directed use of alcohol-based hand rub; examples of high-contact resident care activities require gown and glove for EBP: EBP precautions: dressing bathing/showering, transferring providing hygiene, changing linens, changing briefs or toileting device care, central line, urinary catheter The Care Plan revised on 3/31/25, revealed a Focus area for Activities of Daily Living (ADL) self-care performance deficit. The Interventions included, in part: TOILET USE: dependent on staff for toilet use. The Care Plan, revised on 1/25/25, revealed a Focus area for indwelling catheter related to neurogenic bladder. During an observation on 6/9/25 at 11:43 AM, Staff F, Certified Nurse Aide (CNA), performed catheter/peri cares. During the catheter/peri cares, Staff F used the same side of the washcloth multiple times before changing the side of the washcloth. Staff F used the same side of the washcloth to clean different area of the genital area before switching the side of the washcloth. Staff F changed her gloves multiple times throughout cares and when applied new gloves, did not perform hand hygiene between donning and doffing gloves. Staff F cleaned Resident #7 buttocks and wiped from the lower back to the bottom of the buttocks using the same side of the washcloth multiple times before switching sides of the washcloth. When Staff F changed her washcloth, Resident #7 laid back down on the incontinent pad that was removed when a new incontinent brief applied. Staff F did not rinse off the resident's buttocks after using the washcloths from a basin filled with soapy water. Staff F did not wipe the resident's genitals or buttocks with a dry towel after cleaning Resident #7. During an interview on 6/9/25 at 1:40 PM, Staff F queried on how she performed catheter/peri cares, and she stated she wiped the front area first and used 3 washcloths. Staff F stated she knew she messed up because she didn't use 3 washcloths to rinse Resident #7 off. Staff F asked if she needed to do anything between changing gloves and Staff F stated it depended on if the gloves were soiled. Staff F stated you could use alcohol based sanitizer if you wanted to but it was okay if she didn't if her gloves were not soiled. Staff F asked how she wiped with the washcloth and Staff F stated she (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	went from front to back on the genital area and went from the back to the bottom on the buttock area. Staff F stated she folded the washcloth with each section she wiped with peri cares. When queried if she used the same side of the washcloth multiple times before turning the washcloth to a different side, Staff F stated she didn't turn the washcloth with every wipe because she was nervous. Staff F queried on what personal protective equipment (PPE) she wore with catheter care and Staff F stated she should of wore a gown since Resident #7 had a catheter. During an interview on 6/9/25 at 1:56 PM, Staff B, Registered Nurse (RN) confirmed use of hand hygiene when changing gloves. During an interview on 6/9/25 at 3:38 PM Staff K, Licensed Practical Nurse (LPN) queried on how a resident needed wiped during peri cares and she stated from front to back. During an interview on 6/9/25 at 4:14 PM, the Director of Nursing (DON) stated the facility had a lack of education and they were preparing for a skills fair for the nurses and CNAs. The DON confirmed hand sanitizer needed used between changing gloves. The DON confirmed the washcloth should be flipped to a different side with each wipe and the CNA needed to wipe from front to back during peri cares. During an interview on 6/02/25 at 2:19 PM, Resident #7 stated he was without an indwelling urinary catheter anchoring strap and stated when he requested a strap from nursing staff he was told anchoring strap could not be found or was not available. During an observation 6/03/25 at 11:19 AM, Resident #7 in bed, urinary catheter bag hung from side of bed with white pillow case tied around the bag for a cover. Noted yellow colored staining on bottom 1/3 of the white pillow case covering the urinary catheter bag. On 6/03/25 at 11:30 AM, State Survey notified Staff BB, Registered Nurse (RN) Resident #7's catheter bag appeared to have a leak. Staff BB stated she would report concern to floor nurse, Staff W. During an observation and interview on 6/03/25 at 12:09 PM, Staff W, Registered Nurse (RN), entered Resident #7's room and stated she would check his catheter. During an interview on 6/04/25 at 3:57 PM, Resident #7 stated his catheter bag had not been changed and continued to leak overnight. During an interview on 6/10/25 at 10:06 AM Staff W, RN, reported Resident #7 was to have indwelling urinary catheter changed every 30 days or as needed and stated Resident #7 had catheter changed yesterday (6/09/25) due to leaking. During an interview on 6/11/25 at 9:55 AM, Resident #7 reported that he continued to be without an anchoring strap for indwelling urinary catheter tubing, and the tubing was taped which caused irritation and pulling of catheter tubing. Tape noted to Resident #7 left upper thigh used to secure the catheter tubing. During an interview on 6/11/25 at 2:52 PM, the DON stated it is expected nursing staff use the proper device to anchor catheter tubing due to potential for irritation and pulling of tube. DON stated she would have expected Resident #7's urinary catheter tubing and/or bag be changed immediately if leaking to prevent potential for infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review the facility policy, titled Catheter Care Policy dated 3/25 revealed the following: Policy Explanation section included, in part: 6. Legs bags will be attached to the resident ' s thigh or calf making sure to have slack on the tubing to minimize pressure and tension. Ensure straps are snug but not tight. Compliance Guidelines: 7. Perform hand hygiene. Male: 14. Gently grasp penis, draw foreskin back if applicable. 15. Using circular motion, cleanse the meatus with a clean cloth moistened with water and perineal cleaner (soap). 16. With a new moistened cloth, starting at the urinary meatus moving down, cleanse the shaft of the penis. 17. With a new moistened cloth, starting at the urinary meatus moving outward, wipe the catheter making sure to hold the catheter in place so as to not pull on the catheter. 18. Dry area with towel. Review of the facility policy, titled Enhanced Barrier Precautions, dated 4/20/24 revealed: Definition for Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. The Policy Explanation and Compliance Guidelines directed, in part: 2. Initiation of Enhanced Barrier Precautions: b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO. 3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident ' s room. Note:face (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	protection may also be needed if performing activity with risk of splash or spray (i.e.,wound irrigation, tracheostomy care). b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident ' s room. 4. High-contact resident care activities include: g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on clinical record review, policy review, and staff interview, the facility failed to notify the physician and carry out interventions in a timely manner after a significant weight loss for 1 of 5 residents reviewed for weight loss (Resident #52). The facility reported a census of 59 residents. Findings: 1. Review of the Minimum Data Set (MDS) assessment tool, dated 11/23/24, listed diagnoses for Resident #52 which included hemiplegia (one-sided paralysis), dysphagia (difficulty swallowing), and chronic pain syndrome. The MDS stated the resident depended on staff for eating assistance and had a feeding tube. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 0 out of 15, indicating severely impaired cognition. Review of the December 2024 Medication Administration Record (MAR) revealed an admission date of 11/18/24 and listed an 11/20/24 order to check weights on admission and weekly for four weeks. Review of the Care Plan, dated 11/29/24 revealed entries stated the resident was at nutritional risk due to a mechanically altered diet. The Care Plan directed staff to notify the provider of a significant weight loss such as 3 lbs in 1 week, more than 5% in 1 month, more than 7.5 % in 3 months, or more than 10% in 6 months. Review of the electronic health record Weight Summary revealed the following weights: a. 11/18/24 166 lbs (pounds) b.11/20/24 12:35 PM 167 lbs c.11/20/24 2:04 PM. 158.8 lbs d.11/26/24 150 lbs e.12/17/24 147 lbs The facility lacked documentation they clarified the discrepancies between the two weights obtained on 11/20/24. The facility lacked physician notification of a significant weight change from 166 lbs on 11/18/24 to 150 lbs on 11/26/24, calculated at a 9.64 % loss. The facility lacked documentation of a weight obtained during the week of 12/11/24 and lacked documentation of physician notification (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the weight changes until 12/20/24. The facility lacked documentation of interventions carried out to address the resident's weight loss prior to 12/20/24. During an interview on 6/5/25 at 10:10 AM, Staff B Registered Nurse (RN) stated there was no way to tell which weight was correct on 11/20/24. On 6/5/25 at 10:34 AM, Staff N Licensed Practical Nurse (LPN) stated the shower aide obtained weights and the nurses monitored this. She stated if there was a gain of 5 lbs or a loss of 3 lbs in a week, they would notify the provider. When asked about the weights during the period of 11/20/24 and 11/26/24, she stated she would have called the provider. During an interview on 6/5/25 at 10:45 AM., the Registered Dietician (RD) stated she was on leave from the facility from July 2024 until December 2024. She stated during that time, there was another RD who did not do what she was supposed to. She stated she would have notified the provider if there was a change from 158 lbs to 150 lbs. She stated the RD who filled in was not monitoring the weight losses and weight gains and her notes were lacking. She stated she would have implemented interventions right away. During an interview on 6/11/25 at 12:26 PM. the Director of Nursing (DON) stated the Care Plan should address significant weight losses. She stated staff should notify the physician of such losses and complete weights as ordered. Review of the facility policy Nutritional Management dated 4/2019, stated the facility provided care and services to each resident to ensure the maintenance of acceptable parameters of nutritional status. The policy directed staff to notify the physician of significant changes in weight and stated the Care Plan would include individualized interventions to address the specific needs of the residents.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 5. During a continuous observation on 6/5/25 at 3:05 PM, in the Bonnefield Unit call lights visualized activated above the door for Resident #12 and Resident #38 room. At 3:11 PM, Staff M, CNA, came out of the shower room with Resident #17. Staff M pushed the resident in a shower chair down the hall and passed by Resident #12 and Resident #38's room. Staff M heard commenting to Resident #17 that she was going to take her to her room and then see what the others needed. Staff M took Resident #17 into her room and shut the door At 3:11 PM, Resident #14 activated her call light. No staff observed in hallway. At 3:17 PM, Staff M, CNA, exited Resident #17's room, walked down the hallway past Resident #12's and Resident #38's room to the shower room, entered the shower room, and exited with a blow dryer. Staff M, CNA, returned back to Resident #17's room. At 3:23 PM, Staff M, CNA, exited Resident #17's room, knocked on and entered Resident #14's room, talked briefly with the resident, left Resident #14's room and entered Resident #38's room. Resident #38 requested assistance to use the toilet. Staff M, CNA, told the resident she would be right back to assist her. At 3:24 PM, Staff M entered Resident #12's room. Resident #12 requested assistance with repositioning his pillow. Staff M, CNA, assisted Resident #12, left Resident #12's room. At 3:25 PM, Staff M returned to Resident #38's room and shut the door. Continuous observation ended at 3:27 PM. Review of the MDS for Resident #12, dated 4/11/25, revealed a primary diagnosis of heart failure. The BIMS score of 8 out of 15, indicated a moderate cognitive impairment. The MDS assessed Resident #12 dependent on staff for mobility and repositioning. Review of MDS for Resident #38, dated 5/29/25, revealed a primary diagnosis of hemiplegia following a stroke. The BIMS score of 15 out of 15, indicated cognition intact. The MDS assessed Resident #38 dependent on staff for toileting and required maximum assistance for transfers and personal hygiene. Review of the policy, titled Call Lights: Accessibility and Timely Response, dated 6/2025, identified the following: .All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified .if assistance is needed with a procedure, summon help by using the call light. Stay with the resident until help arrives. Based on observation, clinical record review, facility policy review, and staff and resident interviews, the facility failed to provide sufficient staff to assist residents in a timely manner for 1 of 1 residents (Resident #13) reviewed for transfer assistance, and 5 of 7 residents ((Residents #7, #12,#38, #41, #59) reviewed for call lights. The facility reported a census of 59 residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings: 1. Review of the Minimum Data Set (MDS) assessment tool, dated 5/12/25, revealed a list of diagnoses for Resident #13 which included Alzheimer's disease, and Parkinson's disease (a disorder which caused tremors and difficult mobility). The MDS listed her cognition as severely impaired. Review of the Care Plan, dated 2/15/25 revealed a Focus area to address [name redacted] is at risk for falls r/t (related to) confusion. Review of the Care Plan, dated 11/18/24 revealed a Focus area to address [name redacted] has an ADL (activities of daily living) performance deficit r/t Alzheimer's dementia. Interventions included, in part: TRANSFER: requires a Mechanical Lift (Hoyer - a brand name of a type of lift that has become a general trademark) with medium sling and 2 staff assistance for transfers. Date Initiated: 11/18/24. During an observation on 6/3/25 at 9:56 AM, Resident #13 sat in a shower chair in her room. The door was open and no staff were within sight of her. At 10:12 AM Staff A Registered Nurse (RN) and Staff R Certified Nursing Assistant (CNA) walked by the resident's room and Staff A asked Staff R if she just finished the resident's shower. Staff R said no she had been done. Staff R closed the resident's door and they both walked away. The resident remained in her shower chair until 10:36 AM at which time Staff R stated she was not sure what time she completed the resident's shower but stated she required 2 staff members for the transfer and the other staff were at the other end of the hall. At 10:40 AM Staff R and Staff F transferred the resident to bed with a mechanical lift. They assisted her to roll over onto her right side and her right rear leg had red indentations spanning across the back of her thigh. During an interview on 6/10/25 at 10:55 AM, Staff Q, Certified Medication Aide (CMA) stated she would not leave a resident in her shower chair. She stated after showers she tried to lay them down as quickly as possible and to get them off their bottoms. During an interview on 6/10/25 at 11:12 AM, Staff R, CNA stated normally on the [NAME] Unit there were 3 aides staffed. She stated on the day that Resident #13 was in her shower chair, there were only 2 aides staffed on the floor and there was not enough staff to help the resident. She stated if the facility was fully staffed, there were no problems taking care of the residents but stated they were not always fully staffed. She stated depending on what was going on, residents have waited up to 30 minutes for staff to respond to their call lights. During an interview on 6/10/25 at 11:52 AM, Staff A, RN stated she would not want a resident in the shower chair for an extended period of time. During an interview on 6/11/25 at 12:26 PM, the Director of Nursing (DON) stated staff should not leave residents in a shower chair alone. 2. Review of the MDS assessment tool, dated 3/11/25, revealed a list of diagnoses for Resident #41 which included diabetes, heart failure and anxiety. The MDS listed a BIMS score as 13 out of 15, which indicated intact cognition. Review of the 12/19/24 Care Plan entries revealed the resident required staff assistance with ADL such as bed mobility, dressing, and toilet use. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/3/25 at 12:58 PM, Resident #41 stated on the day shift it was often 30 minutes for staff to answer her light. She timed this by using a clock on the wall. 3. Review of the MDS assessment tool, dated 3/21/25, revealed a list of diagnoses for Resident #59 which included hemiplegia (one-sided paralysis), anxiety, and depression. The BIMS score of 12 out of 15, indicated a moderate cognitive impairment. Review of the Care Plan, dated 3/19/25 revealed the resident required staff assistance with ADLs such as dressing, bathing, and bed mobility During an interview on 6/2/25 at 2:10 PM, Resident #59 stated there was not enough staff and she had to wait 2-3 hours to go to bed. During an interview on 6/10/25 at 9:46 AM, Staff P, RN stated weekends were the worst for staffing. She stated there were times when call light wait time elapsed more than 20 minutes. During an interview on 6/11/25 at 8:59 AM, Staff T, Housekeeping Aide stated residents informed her their call lights were on for over 30 minutes. During an interview on 6/11/25 at 12:26 PM, the DON stated staff should answer call lights within 15 minutes. 4. The Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition. Resident #7 had no impairment of upper extremities, impairment on both sides of lower extremities, and dependent on staff assistance for bed mobility, toileting cares, and transferring. Resident #7 had indwelling urinary catheter and identified as always incontinent of bowel. Diagnoses included Multiple Sclerosis (MS), paraplegia, seizure disorder, Neurogenic bladder, Urinary Tract Infection (UTI), anxiety disorder, depression, and Post Traumatic Stress Disorder (PTSD). The Care Plan revealed an intervention, created on 4/02/25, to be sure call light is within reach and encourage Resident #7 to use it for assistance as needed related to Resident #7 being at risk for falls. On 6/02/25 at 2:21 PM, Resident #7 reported waiting an hour and a half for call light to be answered, 3 days ago on Friday (5/30/25), when he pressed call light after 7:00 PM. Resident #7 stated he believed this was due to a Certified Medication Aide (CMA) being the only staff available on hallway between 7 PM and 10 PM Friday evening. On 6/11/25 at 9:55 PM, Resident #7 had call light activated which appeared as a light above his door in hallway. Resident #7 reported he pressed call light for fresh ice water. On 6/11/25 at 10:25 AM, after 30 minutes of timed call light monitoring, Certified Nursing Assistant entered Resident #7's room to answer call light.

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	165602	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Care Center of Fairfield	400 Highland Street Fairfield, IA 52556

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, facility policy review, and staff interview, the facility failed to post the facility census and nurse staffing information on a daily basis. The facility reported a census of 59 residents. Findings include: Observations on n 6/4/25 at 10:30 AM and 4:00 PM, 6/5/25 at 8:10 AM and 4:00 PM, 6/9/25 at 10:10 AM and 4:15 PM, and 6/10/25 at 8:20 and 9:11 AM revealed a lack of visible posting of the facility census and nurse staffing information in the lobby area. During an interview on 6/10/25 at 9:11 AM, the Administrator reported the daily census and nurse staffing information should be posted in the lobby above the sign in/out table. The Administrator confirmed the absence of a posted daily census and nursing staffing information. The Administrator explained the Staffing Coordinator was responsible for posting this information and that the Staffing Coordinator might have pulled the information down in order to update it. During an interview on 6/10/25 at 11:00 AM, the Staffing Coordinator stated she had not been aware, prior to today (6/10/25) that this was her responsibility to post daily census and nurse staffing information. Review of the policy, titled Nurse Staffing Posting Information, dated 2/2025, identified the facility would make nurse staffing information readily available in a readable format to residents, staff, and visitors at any given time. The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information: a. Facility name b. The current date c. Facility's current resident census d. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift .The facility will post the Nurse Staffing Sheet at the beginning of each shift .Nursing schedules and posting information will be maintained in the Human Resources Department for review for a minimum of 18 months .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, facility policy review, and staff interview, the facility failed to ensure sanitary kitchen conditions in an effort to prevent cross contamination during 2 of 2 meals observed. The facility reported a census of 59 residents. Findings include: During the initial kitchen tour on 6/02/25 at 11:50 AM, the following observations were made: a. The stove had pancake batter spilled on top and over the sides of griddle, additional grime and food crumbs noted across the back and sides of the stove. b. The deep fat fryer had two baskets kept stored above the oil, the wired baskets were coated in grime and the oil appeared dark brown in color. c. The inside of microwave oven had food crumbs and spills on the top, sides, and on the turntable in the microwave. d. The dry storage room floor littered with trash which included plastic spoons, papers, sugar packets, and boxes. e. A stand up freezer next to ice maker had an open paper bag of french fries. The fries were falling out of bag onto bottom of freezer. During an observation and interview on 6/4/25 at 10:40 AM, the Dietary Manager (DM) stated she would be preparing the lunch meal which included a chicken thigh, mashed potatoes and green beans. The DM proceeded to wash her hands and don gloves. During the course of mechanically grinding the chicken and preparing the chicken puree, the DM touched the following objects with her gloved hands: oven mitts, food thermometer, writing pad and pen, blender base and mixing container, walk-in refrigerator door, gallon milk jug, small serving pans, tongs, measuring cups, a drawer with spatulas, a spatula. With the same gloves and after touching all of the previous objects, the Dietary Manager then opened drawers that contained various size serving scoops. The Dietary Manager touched two black-handled scoops on the outside cup part of the scoop, where the end of the scoop went down into the food, one a size #8 scoop and one a size #16 scoop. The Dietary Manager placed the scoops into the chicken pureed mix and portioned out servings for 4 residents. After removing gloves, washing hands and donning clean gloves, the DM prepared mashed potatoes with gravy for the puree diet orders. During the course of preparation, the DM touched the following with her gloved hands with no change of gloves or hand hygiene: pans for pureed chicken, lids for the steam table, door to walk-in refrigerator, cabinet door and bags of dry goods in the cabinet, drawer hands while needed equipment (whisks, spatulas, measuring cups), turn on the water faucet, the stove knobs, and a thermometer, With the same gloves, the DM then opened drawers that contained various size serving scoops. The Dietary Manager then pulled out a black-handled scoop size #8 and a black-handled scoop size #30 and touched both scoops on the outside cup part of the scoop, where the end of the scoop went down into the food. The Dietary Manager placed both the black-handled scoops, sizes #8 and #30, into the prepared pureed mashed potato mix, and portioned out the pureed potato mix to 4 residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same lunch meal observation on 6/4/25, Staff AA, Dietary Aide, got a bowl off a stack of bowls located on 3 tier metal cart by the steam table. Staff AA portioned soup in the bowl and heated the soup to serve a resident. Observation of the bowl located under the bowl used for the resident's soup, revealed a dried white lumpy substance on the outside of bowl. Observation of the 3-tier cart revealed bowls and plates face down on the middle and bottom tiers. The middle and bottom tiers contained dried light-colored food crumbs of various sizes located around the top rim of the face down bowls. Further observation of the kitchen on 6/4/25 revealed build of dirt and debris located on floor in corner by metal cream colored cabinet near the steam table in front of the kitchen; dirt build up on floor around middle wheel base of reach in True triple door refrigerator; dirt and particles of debris built up on floor between stove, fryer area, oven, and under the 3 compartment sink; notable crumbs, debris on lower shelf with clean sheet pans. During an interview on 6/4/25 at 12:50 PM, the DM reported dietary staff followed a daily cleaning schedule. She went to her office to find the schedule. She provided a blank schedule with 14 cleaning tasks. When asked how staff knew what they were responsible for cleaning if they did not have a schedule, the DM reported the staff had a routine and all knew their responsibilities. She reported she was responsible for the tasks of cleaning the front fridge, cleaning the walk-in fridge, cleaning the flat top stove and cleaning the microwave. The remainder of the tasks, including cleaning the two steam tables, sweep and mopping, cleaning all countertops, dumping sanitation buckets, and putting dishes away, were done at least daily and sometimes twice per day, by the morning shift and evening shift. During an interview on 6/5/25 at 8:50 AM, the DM reviewed the cleaning schedule to date for June 2025 with the surveyor. She stated that she misspoke yesterday (6/4/25) regarding her specific responsibilities. The DM explained that staff shared responsibility for all of the cleaning tasks. The Dietary Manager reported she was the person responsible for cleaning the top of the stove, but she did not clean the stove top daily. The DM confirmed the cleaning of the fryer was not on the kitchen cleaning schedule. Review of the policy, titled Hand Washing Guidelines for Dietary Employees, dated 4/2025, identified .dietary employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single service and single use articles and also in the following situations .every time an employee enters the kitchen .after hands have touched anything unsanitary i.e., garbage, soiled utensils/equipment, dirty dishes, etc .while preparing food, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks .after engaging in any activity that may contaminate the hands . Review of the policy, titled Sanitation Inspection, dated 3/2025, revealed the following: .All food service areas shall be kept clean, sanitary, free from litter, rubbish and protected from rodents, roaches, flies and other insects .

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on clinical record review, policy review, and staff and resident interviews, the facility failed to ensure the provision of therapy services for 1 of 2 residents reviewed for specialized services (Resident #23). The facility reported a census of 59 residents. Findings: Review of the Minimum Data Set (MDS) assessment tool, dated 5/9/25,revealed a list of diagnoses for Resident #23 which included heart failure, diabetes (a disorder which caused abnormalities in blood sugar), and anxiety disorder. The Brief Interview for Mental Status(BIMS) score as 13 out of 15, indicated intact cognition. During an interview on 6/3/25 at 10:51 AM, Resident #23 stated she would like to receive therapy services to become more mobile. Review of a 7/29/24 Social Service note, written by Staff G, former Social Services Director, stated the resident wanted physical therapy but did not have a payor source. The note stated the social worker would check on different options. The resident's clinical record lacked documentation regarding follow-up to the resident's wish for therapy between 7/29/24 and the survey week of 6/9/25. During a phone interview on 6/9/25 at 3:40 PM, via phone, Staff G, former Social Services Director stated Resident #23 wanted therapy services but kept changing her payor source. She stated this made it tough to set up therapy. She stated this documentation would be uploaded in her electronic health records. During an interview on 6/11/25 at 12:26 PM, the Director of Nursing stated if a resident wished to participate in therapy, staff should inform the charge nurse and they would discuss getting it set up. The facility policy Reporting of Therapy Services, revised 4/2024, stated the facility would provide specialized rehabilitative services to meet the needs of residents.