STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165611	A. Building B. Wing	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilton Retirement Community	307 Ovesen Drive Wilton, IA 52778

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, clinical record review, policy review, and staff interview, the facility failed to secure medications to prevent a potential hazard for 5 of 5 cognitively impaired, independently mobile residents in the facility's Chronic Confusion and Dementing Illness (CCDI) unit. The facility reported a census of 29 residents.Findings:The Minimum Data Set(MDS) assessment tool, dated 11/20/25, listed diagnoses for Resident #26 which included non-Alzheimer's dementia, vascular dementia (caused by alterations in blood flow), moderate, with mood disturbance, and weakness. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 9 out of 15, indicating moderately impaired cognition. The facility policy Administering Medications, revised April 2019, stated the facility administered medications in a safe manner. The policy stated residents may self-administer their own medications only if determined safe to do so. Care Plan entries, dated 1/17/25, stated the resident had a self-care deficit related to dementia and memory loss. The entries directed staff to administer the medications as ordered.The resident's December 2025 Medication Administration Record(MAR), listed the following medications/order dates:pregabalin (used to treat nerve pain) 100 milligrams(mg) 11/22/24furosemide (used to rid the body of excess fluid) 20 mg 12/24/24cyanocobalamin (Vitamin B12) 500 micrograms(mcg)Vitamin C 1000 milligrams 11/23/24fish oil 1000 milligramsAn undated document, provided by the facility on 12/30/25, listed five residents in the CCDI unit who were independently mobile and cognitively impaired. On 12/30/25 at 7:50 a.m., Staff A Certified Medication Assistant (CMA) placed the following medications in a medication cup for Resident #26:pregabalin 100 mg, furosemide 20 mg .vitamin B12 500 mcg, vitamin C 1000 mg, and fish Oil 1000 mgStaff A, CMA stated that she just made sure that the resident took the medications. At 7:54 a.m., Staff A sat the medication cup next to Resident #26 at the dining room table as she ate her breakfast. Resident #26 sat at a table with Resident #30 on her right and Resident #9 on her left. Staff B Certified Nursing Assistant (CNA) sat across from Resident #26. Staff A then left the area and went to different parts of the unit including another resident's room, the nursing station, and a room behind the nursing station. At 7:57 a.m. Staff A went into the kitchenette, retrieved a plate of food, and sat down at a table approximately 20 feet from the resident. Staff A began to eat and did not have eyes on the resident or the resident's medications. While Staff A retrieved her food and ate, Staff B also walked away from the resident's table to retrieve a tissue and also went behind the nursing station to get a drink. Staff B then went into the kitchenette to retrieve a plate of food for herself. The resident's full medication cup remained at the table. Staff B, CNA then sat down at the table with the residents(including Resident #26) and began to eat. Both Staff A, CMA and Staff B, CNA were back and forth throughout the area during this time frame and neither continually had eyes on the medications. At 8:11 a.m., Resident #26 picked up the medication cup and placed it on her plate. The resident began to take her medications one at a time while Staff A stood behind the nursing station. On 12/30/25 at 1:10 p.m., Staff C, CMA stated there were no residents in the facility that staff (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could leave medications with. She stated she always watched residents take their medications and she would not leave the medications with them. On 12/30/25 at 1:16 p.m., Staff D, Registered Nurse(RN) stated she stood near the residents and watched them take their medications. She stated she would never ever leave medications with a resident. On 12/31/25 1:19 p.m., the Director of Nursing (DON) stated staff should watch residents swallow their medications. He stated it was concerning to learn that staff did not watch the ingestion of the medications and he would follow up on this.