STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165612	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Center at Luther Park	1555 Hull Avenue , Des Moines, Iowa, 50316

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F0000 ✓ OK/CP	INITIAL COMMENTS Correction date: 1/22/2026 The following deficiencies resulted from the facility's annual recertification survey and investigation of complaints #2696701-C conducted December 15, 2025 to December 23, 2025. Complaint #2696701-C resulted in a deficiency. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000	Please see attached P.O.C	
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical	F0605		

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 reverse for further 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
[signature] MHA, LNHA	Administrator	1/15/2026

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F0605 SS = D	Continued from page 1 symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic	F0605		

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F0605 SS = D	Continued from page 2 drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interviews, and policy review the facility failed to ensure staff documented the non-pharmacological interventions attempted prior to the administration of anti-anxiety medication for one of five residents reviewed for unnecessary medications (Resident #39). The facility reported a census of 109 residents. Findings include: A significant change Minimum Data Set (MDS) assessment dated 3/28/25 revealed Resident #39 had diagnoses of non-traumatic brain dysfunction, Alzheimer's disease, dementia and anxiety. The MDS revealed the resident had impaired short-term and long-term memory and severely impaired cognitive skills for daily decision making. The MDS also indicated the resident had inattention and disorganized thinking present, and rejected care 4-6 days during the look-back period. The MDS indicated the	F0605		

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F0605 SS = D	Continued from page 3 resident took an antipsychotic medication. The Care Plan revised 2/25/25 revealed the resident required use of an antipsychotic medication due to behaviors of anxiety and aggression related to senile degeneration of the brain. The behavioral triggers included physical aggression (pushing away) and combativeness toward staff during cares, resistance to cares, pacing and wandering. The care plan directed staff to administer medications as ordered at the lowest therapeutic dosage, and observe for any side effects of the medications. The Treatment Administration Record (TAR) dated 2/2025 and 6/2025 revealed to monitor for antipsychotic medication side effects. The Progress Notes revealed Lorazepam (Ativan) (an antianxiety medication) 0.5 mg (milligrams) given by mouth (PO) as needed (PRN) for anxiety and/or restlessness on the following dates and times: a. On 2/19/25 at 11:10 AM, the resident had on the same shirt for the past two days. Nurse approached resident to change clothing. Resident was restless and anxious. Lorazepam medication administered. b. On 6/30/25 at 9:55 AM, food given. No other non-pharmacological interventions were documented prior to administration of the PRN lorazepam. In an interview 12/22/25 at 11:35 AM, Staff U, Registered Nurse (RN) reported she documented nonpharmacological intervention in the progress notes prior to giving a PRN medication and documented the nonpharmacological interventions that were not effective. In an interview 12/22/25 at 11:45 AM, Staff G, Licensed Practical Nurse (LPN) reported when she signed out an antianxiety medication, she added a note at that time of the interventions that were attempted. He also entered a progress note with the things that were tried but didn't work before he administered an antianxiety medication. Staff G stated he had been told to try three things before he gave a PRN medication, and then document if the nonpharmacological interventions were effective or not. In an interview 12/22/25 at 2:31 PM, Staff A, RN, reported whenever she gave a PRN medication, she clicked on the PRN medication in the electronic health	F0605		

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F0605 SS = D	Continued from page 4 record, and she had to document the reason for the PRN medication. At that time, she typed a note with what things she did before she gave the PRN medication. Staff A stated she could also put in a progress note to document the interventions that staff had done or tried. In an interview 12/22/25 at 2:47 PM, Staff V, LPN, reported she documented the nonpharmacological interventions in the progress notes whenever she gave a PRN antipsychotic or antianxiety medication. In an interview 12/23/25 at 12:34 PM, Staff T, Assistant Director of Nursing (ADON), reported she expected staff to document nonpharmacological interventions before a PRN medication administered. She expected the nonpharmacological interventions documented in the progress note on the EMAR as the staff gave the medication. The listing of “1-2-3” on the MAR should be where the staff documented the interventions that were done prior to the PRN medication administration. An undated Psychotropic Medication Monitoring policy revealed psychotropic medications include antianxiety medications. The facility supported the appropriate use of psychopharmacologic medications that are therapeutic and enabling for residents suffering from mental illness. The use of psychopharmacologic medications for dementia-related behaviors is inappropriate in most cases but rather the use of non-pharmacological interventions based on individual resident needs, preferences and routines is the most appropriate and first-line treatment for dementia-related behaviors. The goal was to determine the underlying cause of residents having difficulty sleeping so the appropriate treatment of environment or medical interventions that could be used prior to psychopharmacologic medication use.	F0605		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.	F0628		

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F0628 SS = D	Continued from page 5 (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F0628		

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F0628 SS = D	Continued from page 6 (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F0628		

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F0628 SS = D	Continued from page 7 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.	F0628		

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F0628 SS = D	Continued from page 8 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, staff interviews, and policy review, the facility failed to notify the resident's representative in writing of a transfer to the hospital and a policy for bed hold including reserve bed payment for 1 of 3 residents reviewed for hospitalization (Resident #3). The facility reported a census of 109 residents. Findings include: The Minimum Data Set (MDS) for Resident #3 dated 11/01/25 indicated Resident #3 had a Brief Interview for Mental Status (BIMS) score of 05 out of 15 which indicated severely impaired cognition. It included diagnoses of kidney failure, non-Alzheimer's dementia, Alzheimer's disease, a hip fracture, and traumatic brain injury. It revealed the resident required setup assistance with eating, maximal assistance with toileting, toilet transfers, dressing, and personal hygiene, and was independent with oral hygiene and all other forms of mobility.	F0628		

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F0628 SS = D	Continued from page 9 The Care Plan revised 9/24/24 included impaired cognitive function/impaired thought processes related to unspecified dementia with confusion and directed staff to discuss concerns about confusion, dementia disease progression, nursing home placement with the resident's family members' names listed. The Progress Notes dated 8/03/25 indicated the resident fell and sustained right hip pain and was transferred to the Emergency Department. It included a progress note at 11:24 AM that indicated a family member was notified of the transfer and a bed hold. The Medical Record did not include a signed or dated, written notification of transfer notification or bed hold policy with reserve payment. On 12/18/25 at 9:35 AM, the Social Services Worker (SW) stated the bed hold was documented in progress notes but the form was not completed. On 12/18/25 at 12:06 PM, Staff F, Registered Nurse (RN) stated the bed hold and representative notification of transfer form were not completed. The facility did not have a policy available for bed hold and transfer notification. A Bed Hold Policy effective 12/2025 revealed the facility shall inform residents or their representative prior to transfer to the hospital of the bed hold policy. The bed hold policy will be provided to the resident or representative within twenty-four hours of an emergency transfer to the hospital.	F0628		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the	F0641		

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F0641 SS = D	Continued from page 10 appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on direct observation, clinical record review, staff interview, policy review and Resident Assessment Instrument (RAI) Manual the facility failed to ensure proper Minimum Data Set (MDS) coding by coding residents as having physical restraints when they did not have physical restraints present, and by not coding a residents mental illness when indicated for three of twenty-two residents reviewed for MDS assessments (Resident #4, #9, and #21). The facility reported a census of 109 residents. The Minimum Data Set (MDS) assessment for Resident's #9 and #21, last completed on 09/06/2025 for Resident #9, and 09/20/2025 for Resident #21, indicate both residents had a physical restraint in the form of a bed rail present, as denoted in question P0100. The care plan for Resident #9, last updated 11/28/2025, documented the resident prefers to have side rails on their bed as it makes them feel safer.	F0641		

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F0641 SS = D	Continued from page 11 The care plan for Resident #21, last revised 12/03/2025, documented the resident prefers to have bed rails on their bed to make them feel safer and because it enhances the residents mobility in bed. A Bed rail assessment for Resident #9, completed on 11/28/2025, documented the bed rail was present at resident request and enhanced the residents mobility in bed. A bed rail assessment for Resident #9, completed on 12/11/2025, documented the bed rail was present at resident request and enhanced the residents mobility in bed. A direct observation on 12/18/2025 revealed the bed rails to be present but noted the bed rails to be partial side-rails that did not restrict a residents ability to get in or out of bed. An interview on 12/18/2025 at 01:36 PM with Staff W, Assistant Director of Nursing (MDS), stated she took fully responsibility with the MDS coding issue. She stated she recently attended an Iowa Health Care Association training where she learned they had been coding bed rails as restraints in error. In an interview on 12/18/2025 at 01:45 PM with Staff X, MDS Coordinator, she expressed confusion on whether or not to code the bed rails as a restraint on question P0100. She stated they do not have an MDS policy but follow the State Resident Assessment Instrument (RAI Manual). The 10/2025 Resident Assessment Instrument states the following for question P0100. "Physical restraints are any manual method or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot easily remove which restricts freedom of movement or normal access to one's body". The assessments present indicate the bedrails in question do not restrict movement, but enhance mobility. The annual MDS assessment dated 11/29/25 revealed Resident #4 had diagnoses of bipolar disorder,	F0641		

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F0641 SS = D	Continued from page 12 psychotic disorder, intermittent explosive disorder, anxiety, and depression. The MDS indicated the resident not currently considered by the state level II PASRR (Preadmission Screening and Resident Review) process to have a serious mental illness or a related condition. The Care Plan revised 5/22/23 revealed the resident had a PASRR Level I completed. The care plan also revealed the resident had diagnoses of anxiety disorder, major depression, dementia with behavioral disturbance. The care plan directed staff to do a PASRR re-evaluation if there was a change in a major mental illness condition. Resident #4's PASRR dated 10/7/25 revealed a Level II outcome. The PASRR included the resident's diagnoses of major depressive disorder, delusional disorder, bipolar disorder, anxiety disorder, and Alzheimer's dementia. In an interview 12/18/25 at 9:35 AM, Staff F, MDS Coordinator, reported she completed the residents MDS assessments at least quarterly. Staff F reported she got information to complete MDS assessments and care plans from the medical records and interviews with the resident. She reviewed the resident's PASRR to see if a Level II PASRR was required, and then she marked the MDS under section A1500 "yes" if the PASRR directed her to mark the question for a PASRR condition. In an email 12/18/25 at 10:54 AM, Staff W, Assistant Director of Nursing, wrote they do not have a policy for MDS assessments, they followed the RAI Manual. The Long-Term Care Facility RAI User's Manual updated 10/2025 revealed the following: a. Review the Level I PASRR form to determine whether a Level II PASRR was required. b. Review the PASRR report provided by the State if Level II screening was required. c. Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II PASRR Conditions. d. Code A, serious mental illness: if resident has been diagnosed with a serious mental illness.	F0641		
F0684 SS = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F0684		

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F0684 SS = E	Continued from page 13 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, staff interviews, and policy review the facility failed to appropriately provide consistent and thorough assessments for COVID positive residents and residents exposed to COVID, for the ordered 10 days, also failed to complete a neurological assessment for a resident with an unwitness fall for 17 of 21 residents reviewed. (Resident #11, #12, #18, #27, #32, #36, #42, #59, #68, #74, #75, #85, #91, #96, #97, #100, #118) Facility reported a census of 109 residents. Findings include: 1. Review of Resident #11's Admission MDS dated 9/30/2025 revealed, resident was admitted to the facility on 9/24/2025 to a private room. A BIMS of 15 (cognitively intact), diagnoses of coronary artery disease, deep vein thrombosis, heart failure, peripheral vascular disease, type 2 diabetes mellitus, and pleural effusion (excess fluid builds up in the space between the lungs and chest wall, restricting lung expansion, causing shortness of breath, chest pain, and cough). Resident #11 requires moderate assistance (helper does less than half the effort, lifts or holds trunk or limbs but provides less than half the effort) with transfers and mobility with the use of a walker or wheelchair. Review of Resident #11's Care Plan, initiated 9/24/2025, included the following focus and interventions: a. Altered cardiopulmonary functioning, potential for shortness of breath, lung congestion, chest pain, decrease in level of consciousness, acute heart failure. Administer cardiac medications as ordered, blood pressure monitoring, use of anticoagulants (blood thinner), observe for signs and symptoms of cardiac decompensation and report to provider. Daily weights for cardiac monitoring as ordered, notify provider of 3 pound weight gain in 1 day or 5 pounds in one week.	F0684		

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F0684 SS = E	Continued from page 14 b. Resident #11 requires the use of diuretics related to congestive heart failure and bilateral lower extremity edema. Administer medications as ordered, notify provider of increase in edema and lung congestion. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #11's symptoms started on 12/3/2025, COVID-19 testing on 12/2/25 with positive results and TBP initiated. Resident #11 was removed from TBP on 12/8/2025 after 5 days of isolation/TBP. Review of Resident #11's December 2025 Medication Administration Record/Treatment Administration Record (MAR/TAR) revealed an order for Covid positive assessment: Monitor temperature, pulse ox (oxygen saturation), assess lung sounds, shortness of breath or labored breathing, for changes in resident's baseline alertness. Monitor for NEW symptoms since isolation started; cough, sore throat, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose, every shift for 10 days. Document "Y" if monitored and none of the above observed. "N" if monitored and any of the above was observed, select chart code "other/see nurses notes" and enter findings of assessment in progress notes. Start date 12/2/2025, Discontinue (D/C) date 12/8/2025 The MAR/TAR failed to provide vitals and assessments for complete 10 days as ordered. Review of Resident #11's Nursing Progress notes failed to provide complete assessments indicating assessed symptoms, lungs sounds, shortness of breath, and any changes to resident's baseline alertness every shift (three times daily) for complete 10 days as ordered. 2. Review of Resident #12's MDS dated 11/1/25 revealed the resident was admitted to the facility on 3/10/2011 to a semi-private room (shared with one roommate). A BIMS of 14 (cognitively intact), diagnoses of Multiple Sclerosis, contractures, neurogenic bladder, hypertension, and anxiety disorder. Resident #12 is dependent on staff assistance for mobility in her wheelchair and assistance with the use of a mechanical lift for transfers. Review of Resident #12's Care Plan revised on 8/27/2025 failed to indicate Resident's risk for COVID. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #12's symptoms started on 12/3/2025, COVID-19 testing on 12/3/25 with positive results and TBP initiated. Resident #12 was removed from TBP on 12/12/2025 after 9 days of isolation/TBP.	F0684		

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F0684 SS = E	Continued from page 15 Review of Resident #12's December 2025 MAR/TAR revealed an order for Covid positive assessment: Monitor temperature, pulse ox (oxygen saturation), assess lung sounds, shortness of breath or labored breathing, for changes in resident's baseline alertness. Monitor for NEW symptoms since isolation started; cough, sore throat, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose, every shift for 10 days. Document "Y" if monitored and none of the above observed. "N" if monitored and any of the above was observed, select chart code "other/see nurses notes" and enter findings of assessment in progress notes. Start date 12/3/2025, Discontinue (D/C) date 12/12/2025. The MAR/TAR failed to provide vitals and assessments for complete 10 days as ordered. Review of Resident #12's Nursing Progress notes failed to provide complete assessments indicating assessed symptoms, lungs sounds, shortness of breath, and any changes to resident's baseline alertness every shift (three times daily) for complete 10 days as ordered. 3. Review of MDS dated 10/4/2025, revealed Resident #27's admission to the facility on 7/31/2024 to a semi-private room (Roommate with Resident #12), BIMS of 15 (cognitively intact) and diagnoses of non-Alzheimer's dementia, Parkinson's disease, anxiety disorder, depression, and psychotic disorder. Review of Resident #27's Care Plan initiated 7/31/2024 failed to indicate Resident's risk for COVID. Review of Resident #27's December 2025 MAR/TAR, failed to indicate COVID monitoring assessment due to resident's exposure and cohorting with COVID positive roommate. Review of Resident #27's nursing progress notes, failed to provide documentation related to Resident #27's exposure and cohorting with COVID positive roommate. Review of facility provided COVID-19 tracking spreadsheet lacked documentation of Resident #27 being tested for COVID. 4. Review of MDS dated 10/27/2025, revealed resident #32 was admitted to the facility 10/21/2025 in a private room, BIMS 13 (cognitively intact) and diagnoses of atrial fibrillation (abnormal heart rhythm) , heart failure, hypertension, and unspecified toxic encephalopathy. (brain dysfunction caused by	F0684		

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F0684 SS = E	Continued from page 16 unknown toxins, can cause confusion, memory loss, personality changes, poor concentration or seizures). Resident #32 is independent with the use of a walker. Review of Care Plan, initiated 11/3/2025, revealed the following focus and interventions for Resident #32: a. Altered cardiopulmonary status with potential for shortness of breath, lung congestion, edema, chest pain, decreased level of consciousness, cyanosis related to congestive heart failure, atrial fibrillation (A-Fib), and hypertension. Avoid overexertion, requiring frequent rest periods during completion of activities. Notify nursing staff of any shortness of breath, chest pain, or irregular heartbeat. Observe for signs and symptoms of cardiac decompensation and report to provider. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #32's symptoms started on 12/1/2025, COVID-19 testing on 12/2/25 with positive results and TBP initiated. Resident #32 was removed from TBP on 12/8/2025 after 5 days of isolation/TBP. Review of Resident #32's December 2025 MAR/TAR revealed an order for Covid positive assessment: Monitor temperature, pulse ox (oxygen saturation), assess lung sounds, shortness of breath or labored breathing, for changes in resident's baseline alertness. Monitor for NEW symptoms since isolation started; cough, sore throat, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose, every shift for 10 days. Document "Y" if monitored and none of the above observed. "N" if monitored and any of the above was observed, select chart code "other/see nurses notes" and enter findings of assessment in progress notes. Start date 12/2/2025 at 2:00 PM, Discontinue (D/C) date 12/8/2025. MAR/TAR failed to provide vitals and assessments for complete 10 days as ordered. Resident#32's Medication Administration Record documented that the resident received Tussin Cough oral syrup 15milligrams per 5 milliliters by mouth on December 9, 2025 at 7:42 p.m., the medication was classified as a PRN medication (given to resident upon request). Review of Resident #32's Nursing Progress notes failed to provide complete assessments indicating assessed symptoms, lungs sounds, shortness of breath, and any changes to resident's baseline alertness every shift (three times daily) for complete 10 days as ordered.	F0684		

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F0684 SS = E	Continued from page 17 5. Review of MDS dated 11/12025, revealed Resident #36's admission to the facility on 11/25/2024 to a semi-private room (roommate with Resident #59), BIMS of 0 (resident is not able to complete the assessment) and diagnoses of A-fib, hypertension, kidney disease, type 2 diabetes mellitus, aphasia (language disorder, impairing language, understanding speech, reading and writing), hemiplegia, seizure disorder, and history of stroke. Resident #36 required maximal assistance for transfers and is independent with a wheelchair for mobility. Review of Resident #36's Care Plan initiated 12/5/2024 failed to indicate Resident's risk for COVID. Review of Resident #36's December 20025 MAR/TAR indicated an order dated 12/11/2025 for COVID MONITORING: Monitor for new cough, sore throat, new Shortness of Breath or difficulty breathing, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose. Document "Y" if monitored and none of the above observed. "N" if monitored and any of the above was observed, select chart code "other/see nurses notes" and enter findings of assessment in progress notes findings every shift for 10 days. Review of Resident #36's Nursing Progress notes failed to provide complete monitoring assessments indicating assessed symptoms, new cough, sore throat, new shortness of breath or difficulty breathing, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose every shift (three times daily) for complete 10 days as ordered. 6. Review of MDS dated 9/27/2025 revealed Resident #42's admission to the facility on 4/7/2025 to a private room, BIMS of 12 (moderate cognitive impairment) and diagnoses of hypertension, kidney disease, type 2 diabetes mellitus, Alzheimer's disease, non-Alzheimer's dementia, anxiety disorder, depression, bipolar disorder, asthma, and sarcopenia (age related progressive loss of muscle mass, strength and function). Resident #42 is dependent on staff for transfers and mobility in her wheelchair. Review of Resident #42's Care Plan, initiated 4/7/2025, included the following focus and interventions: a. Altered cardiopulmonary status with potential for shortness of breath, lung congestion, edema, chest pain, decreased level of consciousness, cyanosis, diaphoresis, complaints of nausea and vomiting related	F0684		

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F0684 SS = E	Continued from page 18 to hypertension and asthma with wheezing. Avoid overexertion, requiring frequent rest periods during completion of activities. Observe for signs and symptoms of cardiac decompensation and report to provider. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #42's symptoms started on 12/3/2025, COVID-19 testing on 12/2/25 with positive results and TBP initiated. Resident #42 was removed from TBP on 12/8/2025 after 5 days of isolation/TBP. Review of Resident #42's December 20025 MAR/TAR indicated an order dated 12/11/2025 for COVID MONITORING: Monitor for new cough, sore throat, new Shortness of Breath or difficulty breathing, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose. Document "Y" if monitored and none of the above observed. "N" if monitored and any of the above was observed, select chart code "other/see nurses notes" and enter findings of assessment in progress notes findings every shift for 10 days. Start date 12/3/2025, D/C 12/9/2025. The MAR/TAR failed to provide vitals and assessments for complete 10 days as ordered. Review of Resident #42's Nursing Progress Notes failed to provide complete assessments indicating assessed symptoms, lungs sounds, shortness of breath, and any changes to resident's baseline alertness every shift (three times daily) for complete 10 days as ordered. 7. Review of Resident #59's MDS dated 9/13/2025 revealed resident #59 was admitted to the facility on 3/29/2024 to a semi-private room (roommate with Resident #36), BIMS of 14 (cognitively intact) with diagnoses of coronary artery disease, heart failure, cardiomegaly (enlarged heart), hypertension, type 2 diabetes mellitus, anxiety disorder, depression, COPD, chronic respiratory failure, obstructive sleep apnea, disease of spinal cord, and requires oxygen. Resident #59 is dependent for transfers with assistance of a mechanical lift and uses a power wheelchair for mobility. Review of Resident #59's Care Plan revised 12/4/2025 provided the following focus and interventions: a. Resident #59 has an altered cardiovascular status related to hypertension, heart failure, and coronary artery disease. Administer cardiac medications as ordered. Daily weights, if 5 pounds gain in one week, administer additional lasix that day. Monitor and report any signs or symptoms of coronary artery	F0684		

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F0684 SS = E	Continued from page 19 disease, chest pain or pressure with activity, shortness of breath, excessive sweating, and dependent edema. Oxygen at 2 liters via nasal cannula continuous. b. Resident #59 is at risk for signs and symptoms of COVID-19. Follow facility protocol for COVID-19 screening and precautions. Observe for signs and symptoms of COVID-19, document and promptly report fever, coughing, sneezing, sore throat, and/or respiratory/breathing issues. c. Initiated 12/11/2025, Resident #59 requires isolation precautions, specifically related to the COVID-19 infection. Observe effectiveness of medications; observe for signs and symptoms and inform provider if worsening. Intervention initiated 12/16/2025; Carry on conversations with Resident #59 during care so that he does not feel isolated; Resident #59 is receiving antibiotics for COVID associated respiratory infection, observe for potential side effects and report to the provider; notify provider of any worsening COVID symptoms; isolation per policy. d. Resident #59 has altered respiratory status, difficulty breathing related to heart failure, respiratory failure, and COPD exacerbation. Assess lung sounds as needed and notify provider of abnormal findings. Monitor for signs and symptoms of respiratory distress and report to provider. Continuous oxygen at 2 liters per minute via nasal cannula. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #59's symptoms started on 12/11/2025. Review of Resident #59's December 2025 MAR/TAR revealed an order for Covid positive assessment: Monitor temperature, pulse ox (oxygen saturation), assess lung sounds, shortness of breath or labored breathing, for changes in resident's baseline alertness. Monitor for NEW symptoms since isolation started; cough, sore throat, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose, every shift for 10 days. Document "Y" if monitored and none of the above observed. "N" if monitored and any of the above was observed, select chart code "other/see nurses notes" and enter findings of assessment in progress notes. Start date 12/11/2025, end date 12/21/25 Review of Resident #59's Nursing Progress notes failed to provide complete assessments indicating assessed symptoms, lungs sounds, shortness of breath, and any changes to resident's baseline alertness every shift	F0684		

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F0684 SS = E	Continued from page 20 (three times daily) for complete 10 days as ordered. 8. Review of MDS dated 12/2/2025, revealed Resident #68 was admitted to the facility on 11/26/2025 to a private room, BIMS of 15 (cognitively intact) and diagnoses of cancer, A-fib, heart failure, hypertension, kidney disease, type 2 diabetes mellitus, and respiratory failure with hypoxia (critical condition where lungs fail to get enough oxygen into the blood). Review of Resident #68's Care Plan, initiated 11/26/2025 included the following focus and interventions: a. Resident #68 requires assistance of 1 with a gait belt and walker for ambulation and transfer. b. Altered cardiopulmonary status with potential for shortness of breath, lung congestion, edema, chest pain, decreased level of consciousness, cyanosis, diaphoresis, complaints of nausea and vomiting related to heart failure and acute respiratory failure. avoid overexertion, requiring frequent rest periods during completion of activities. Instruct resident to notify nursing staff of any complaints of shortness of breath, chest pain, irregular heart rate. Observe for signs and symptoms if resident is unable to report symptoms and notify provider if signs and symptoms exist. c. Oxygen at 2 liters per minute via nasal cannula as needed. d. Observe for signs and symptoms of cardiac decompensation and report to provider. e. Enhanced Barrier Precautions (EBP) due to chronic wounds, gowns and gloves to be worn with all direct care. Proper hand washing before and after all cares. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #68's symptoms started on 11/29/2025, COVID-19 testing on 12/2/25 with positive results and TBP initiated. Resident #68 was removed from TBP on 12/9/2025 after 7 days of isolation/TBP. Review of Resident #68's December 20025 MAR/TAR indicated an order for COVID MONITORING: Monitor for new cough, sore throat, new Shortness of Breath or difficulty breathing, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose. Document "Y" if monitored and none of the above observed. "N" if monitored and any of the above was observed, select	F0684		

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F0684 SS = E	Continued from page 21 chart code “other/see nurses notes” and enter findings of assessment in progress notes findings every shift for 10 days. Start date 12/2/2025, D/C 12/9/2025. The MAR/TAR failed to provide vitals and assessments for complete 10 days as ordered. Review of Resident #68’s Nursing Progress Notes failed to provide complete assessments indicating assessed symptoms, lungs sounds, shortness of breath, and any changes to resident’s baseline alertness every shift (three times daily) for complete 10 days as ordered. 9. Review of MDS dated 10/25/2025 revealed Resident #74’s admission to the facility on 5/5/2025 in a private room, BIMS of 15 (cognitively intact) and diagnoses of hypertension, polyneuropathy (nerve damage in extremities causing weakness, numbness, tingling and burning pain affecting sensory and motor functions), aortic valve stenosis (serious heart condition, aortic valve narrows causing obstructive blood flow), and weakness, Resident #74 is independent with transfers and mobility with the use of a wheelchair. Review of Resident #74’s Care Plan revised 11/10/2025 indicated the following focus and interventions: a. Altered cardiovascular status related to hypertension. Assess for chest pain, enforce the need to call for assistance if pain starts. Monitor, document and report any signs or symptoms of coronary artery disease. b. Initiated 12/14/2025, require care isolation precautions specifically related to the COVID-19 infection. Observe for signs and symptoms and inform provider if worsening. Ensure resident stays in room, away from other people as much as possible (contact and droplet precautions). Monitor vitals and notify provider of abnormalities. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #74’s symptoms started on 12/13/2025. Review of Resident #74’s December 2025 MAR/TAR revealed an order for Covid positive assessment: Monitor temperature, pulse ox (oxygen saturation), assess lung sounds, shortness of breath or labored breathing, for changes in resident’s baseline alertness. Monitor for NEW symptoms since isolation started; cough, sore throat, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose, every shift for 10 days. Document “Y” if monitored and none of the above	F0684		

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F0684 SS = E	Continued from page 22 observed. “N” if monitored and any of the above was observed, select chart code “other/see nurses notes” and enter findings of assessment in progress notes. Start date 12/13/2025 at 2:00 PM, Discontinue (D/C) date 12/23/2025. The residents MAR/TAR lacked documentation of all COVID assessments being completed as ordered. Review of Resident #74’s Nursing Progress notes failed to provide complete assessments indicating assessed symptoms, lungs sounds, shortness of breath, and any changes to resident’s baseline alertness every shift (three times daily) for complete 10 days as ordered. 10. Review of Resident #75 MDS dated 10/11/2025 revealed admission to the facility on 5/17/2024 to a semi-private room (roommate Resident #12), BIM of 3 (severe cognitive impairment) and diagnoses of hypertension, chronic kidney disease, A-fib, and other specified signs and symptoms involving cognitive functions and awareness (brain fog, memory lapses, difficulty concentrating, altered mental status), stenosis of carotid artery, arterial fibromuscular dysplasia, hypertensive heart disease.. Resident #75 requires maximal assistance with transfers and mobility with the use of a gait belt and walker. Review of Resident #75’s Care Plan revised 9/11/2025 indicated the following focus and interventions: a. High risk for COVID exposure due to communal living. Observe for signs and symptoms of COVID. Obtain rapid COVID test as indicated and report results to provider, should Resident #75 have a positive test, isolate per CMS/CDC guidelines. b. Resident #75 has altered cardiovascular status related to stenosis of carotid artery, arterial fibromuscular dysplasia, hypertensive heart disease. Administer medications as ordered. Monitor, document, and report any changes in lung sounds on auscultation, edema and changes in weight as needed. Review of Resident #75’s December 2025 MAR/TAR failed to indicate monitoring for symptoms due to exposure to COVID positive roommate. Review of Resident #75’s nursing progress notes and orders, failed to provide documentation related to Resident #75’s exposure to COVID positive roommate, attempt to separate from roommate or provide interventions to reduce risk of transmission, and ordered monitoring for COVID symptoms.	F0684		

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F0684 SS = E	Continued from page 23 11. Review of MDS dated 10/18/2025 revealed Resident #85 was admitted to the facility on 8/8/2024 to semi-private room (roommate with Resident #100), BIMS of 11 (moderate cognitive impairment) and diagnoses of kidney failure, history of rhabdomyolysis (breakdown of damaged muscle tissue), malnutrition, spondylosis lumbosacral region (degenerative changes in lower back), metabolic encephalopathy (condition causing brain dysfunction leading to confusion, seizures, or coma), bed confinement status, and weakness. Resident #85 is dependent on all transfers and mobility with the use of a mechanical lift and wheelchair. Resident #85's Care Plan, initiated 8/8/2024 indicated the following focus and interventions: a. Resident #85 requires enhanced barrier precautions (EBP) due to an extensive pressure area. Infection Preventionist to educate staff on donning (putting on) and doffing (removing) of equipment. Proper handwashing before and after all cares. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #85's symptoms started on 12/2/2025, COVID-19 testing on 12/2/25 with positive results and TBP initiated. Resident #85 was removed from TBP on 12/8/2025 after 6 days of isolation/TBP. Review of Resident #85's December 2025 MAR/TAR revealed an order for Covid positive assessment: Monitor temperature, pulse ox (oxygen saturation), assess lung sounds, shortness of breath or labored breathing, for changes in resident's baseline alertness. Monitor for NEW symptoms since isolation started; cough, sore throat, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose, every shift for 10 days. Document "Y" if monitored and none of the above observed. "N" if monitored and any of the above was observed, select chart code "other/see nurses notes" and enter findings of assessment in progress notes. Start date 12/2/2025 D/C date 12/8/2025. MAR/TAR failed to provide vitals and assessments for complete 10 days as ordered. Review of Resident #85's Nursing Progress notes failed to provide complete assessments indicating assessed symptoms, lungs sounds, shortness of breath, and any changes to resident's baseline alertness every shift (three times daily) for complete 10 days as ordered. 12. Review of Resident #91's MDS dated 11/22/2025 revealed Resident #91 was admitted to the facility on 4/9/2015 to a semi-private room (roommate Resident	F0684		

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F0684 SS = E	Continued from page 24 #118), BIMS of 0 (resident is not able to complete the assessment) and diagnoses of history of a stroke, hypertension, type 2 diabetes mellitus, arthritis, and aphasia. Resident #91 requires maximal assistance for transfers and mobility with use of a wheelchair. Review of Care Plan revised on 12/16/2025 indicated the following focus and interventions for Resident #91: a. EBP required due to MDRO CRE E. Coli (multi-drug resistant organism, superbug resistant to powerful antibiotics). Gowns and gloves to be worn with all direct care, Infection Preventionist to educate staff on donning and doffing of equipment. Proper handwashing before and after all cares. b. Altered cardiovascular status related to hypertension and history of stroke. Administer medications as ordered. Monitor, document, and report any changes in lung sounds on auscultation, edema and changes in weight as needed. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #91's symptoms started on 12/3/2025, COVID-19 testing on 12/2/25 with positive results and TBP initiated. Resident #91 was removed from TBP on 12/8/2025 after 5 days of isolation/TBP. Review of Resident #91's December 2025 MAR/TAR revealed an order for Covid positive assessment: Monitor temperature, pulse ox (oxygen saturation), assess lung sounds, shortness of breath or labored breathing, for changes in resident's baseline alertness. Monitor for NEW symptoms since isolation started; cough, sore throat, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose, every shift for 10 days. Document "Y" if monitored and none of the above observed. "N" if monitored and any of the above was observed, select chart code "other/see nurses notes" and enter findings of assessment in progress notes. Start date 12/3/2025, D/C date 12/8/2025. MAR/TAR failed to provide vitals and assessments for complete 10 days as ordered. Review of Resident #91's Nursing Progress notes failed to provide complete assessments indicating assessed symptoms, lungs sounds, shortness of breath, and any changes to resident's baseline alertness every shift (three times daily) for complete 10 days as ordered. 13. Review of MDS dated 11/8/2025 revealed Resident #96 was admitted to the facility on 11/9/2020 to a semi-private room (roommate Resident #97), BIMS of 0	F0684		

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F0684 SS = E	Continued from page 25 (resident is not able to complete the assessment) and diagnoses of stroke, hypertension, hemiplegia affecting left side, emphysema, and COPD. Resident #96 requires maximal assistance with transfers and mobility. Review of Resident #96's Care Plan revised 12/8/2025 indicated the following focus and interventions: a. Initiated 10/28/2024, Potential risk for community acquired infection while living in a healthcare setting. Antibiotics as ordered, encourage oral fluids and nutrition as tolerated. Follow standards for outbreak testing and mitigation. Sanitize high touch surfaces to decrease the risk of infection. b. Initiated 12/8/2025, Resident #96 requires isolation precautions specifically related to the COVID-19 infection. Encourage resident to cover their mouth and nose when coughing or sneezing, ensure good infection control measures and PPE are used when working with resident. Contact and droplet isolation, encourage keeping door closed. c. Altered cardiovascular status related to hypertension and history of stroke. Assess for chest pain and shortness of breath and monitor vital signs per protocol. d. Diagnosis of COPD, give aerosol or bronchodilators as ordered monitoring for side effects and effectiveness. Monitor for signs and symptoms of acute respiratory insufficiency. Monitor, document, report any signs and symptoms of respiratory infection. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #96's symptoms started on 12/7/2025, Resident #91 was removed from TBP on 12/12/2025 after 5 days of isolation/TBP. Review of Resident #96's December 2025 MAR/TAR revealed an order for Covid positive assessment: Monitor temperature, pulse ox (oxygen saturation), assess lung sounds, shortness of breath or labored breathing, for changes in resident's baseline alertness. Monitor for NEW symptoms since isolation started; cough, sore throat, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose, every shift for 10 days. Document "Y" if monitored and none of the above observed. "N" if monitored and any of the above was observed, select chart code "other/see nurses notes" and enter findings of assessment in progress notes. Start date 12/7/2025, D/C date 12/12/2025. MAR/TAR failed to provide vitals and assessments for complete	F0684		

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F0684 SS = E	Continued from page 26 10 days as ordered. Review of Resident #96's Nursing Progress notes failed to provide complete assessments indicating assessed symptoms, lungs sounds, shortness of breath, and any changes to resident's baseline alertness every shift (three times daily) for complete 10 days as ordered. 14. Review of MDS dated 11/8/2025 revealed Resident #97 was admitted to the facility on 9/15/2020 to a semi-private room. (Roommate with Resident #96) Resident #97's BIMS 0 (Resident was not able to complete assessment) and diagnoses of heart failure, type 2 diabetes mellitus, Alzheimer's Disease, and seizure disorder. Review of Resident #97's Care Plan revised 8/27/2025 failed to indicate Resident's risk for COVID. Review of Resident #97's December 2025 MAR/TAR failed to indicate monitoring for symptoms due to exposure to COVID positive roommate. Review of Resident #97's nursing progress notes and orders, failed to provide documentation related to Resident #97's exposure to COVID positive roommate, attempt to separate from roommate or provide interventions to reduce risk of transmission, and ordered monitoring for COVID symptoms. 15. Review of MDS dated 10/4/2025, revealed Resident #100's admission to the facility on 8/1/2024 in a semi-private room. (roommate Resident #85, who tested COVID positive on 12/2/2025), BIMS of 13 (cognitively intact) and diagnoses of hypertension, type 2 diabetes mellitus, asthma, and adult failure to thrive. Review of Resident #100's care plan, revised 12/6/2025 indicated the following focus and interventions: a. Altered cardiopulmonary status with potential for shortness of breath, lung congestion, edema, chest pain, decreased level of consciousness, cyanosis, diaphoresis, complaints of nausea and vomiting related to hypertensive heart disease and asthma. Interventions included avoiding overexertion, requiring frequent rest periods during completion of activities. Observe for signs and symptoms of cardiac decompensation and report to provider. b. Initiated 10/29/2024, Potential risk for community acquired infection while living in a healthcare setting. Follow standards for outbreak testing and mitigation and sanitize high touch surfaces to decrease	F0684		

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F0684 SS = E	Continued from page 27 the risk of infection. c. Revised 12/6/2025, resident requires care isolation precautions specifically related to the COVID-19 infection. Encourage resident to cover their mouth and nose when coughing or sneezing, ensure good infection control measures and PPE are used when working with resident. Contact and droplet isolation, encourage keeping door closed. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #100's symptoms started on 12/7/2025, (6 days after roommate tested positive) Resident #100 was removed from TBP on 12/12/2025 after 5 days of isolation/TBP. Review of Resident #100's December 2025 MAR/TAR revealed an order for Covid positive assessment: Monitor temperature, pulse ox (oxygen saturation), assess lung sounds, shortness of breath or labored breathing, for changes in resident's baseline alertness. Monitor for NEW symptoms since isolation started; cough, sore throat, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose, every shift for 10 days. Document "Y" if monitored and none of the above observed. "N" if monitored and any of the above was observed, select chart code "other/see nurses notes" and enter findings of assessment in progress notes. Start date 12/8/2025, D/C date 12/12/2025. MAR/TAR failed to provide vitals and assessments for complete 10 days as ordered. Review of Resident #100's Nursing Progress notes notes failed to provide complete assessments indicating assessed symptoms, lungs sounds, shortness of breath, and any changes to resident's baseline alertness every shift (three times daily) for complete 10 days as ordered. 16. Review of MDS dated 10/4/2025 revealed Resident #118 was admitted to the facility on 11/16/2021 in a semi-private room. (roommate Resident #91), BIMS of 12. (moderate cognitive impairment) and diagnoses of stroke, hypertension, traumatic brain injury and abnormalities of gait and mobility. Resident #118 is dependent on staff with the assistance of a mechanical stand for transfers and wheelchair for mobility. Review of Care Plan revised 8/7/2025 indicated the following focus and interventions for Resident #118: a. Initiated 8/8/2024, high risk for COVID exposure due to communal living. Observe for signs and symptoms of	F0684		

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F0684 SS = E	Continued from page 28 COVID. Obtain rapid COVID test as indicated and report results to provider. Should Resident #118 have a positive test, isolate per CMS/CDC guidelines. b. Altered cardiovascular status related to hypertension. c. Needed oxygen therapy related to shortness of breath. Monitor for signs and symptoms of respiratory distress. Oxygen via nasal cannula as needed to keep SpO2 >90%. Review of Resident #118's December 2025 MAR/TAR failed to indicate monitoring for symptoms due to exposure to COVID positive roommate. Review of Resident #118's nursing progress notes, failed to provide documentation related to Resident #118's exposure to COVID positive roommate, attempt to separate from roommate or provide interventions to reduce risk of transmission, provide COVID testing and monitoring for symptoms. In an interview on 12/17/2025 at 5:05 PM Director of Nursing (DON), stated assessments for residents on COVID monitoring should include documentation on the MAR/TAR as well as a progress note indicating details of the assessment. During an interview on 12/22/2025 at 2:31 PM, Staff A, Registered Nurse (RN) reported whenever document assessment on resident with COVID, the computer system prompts you to put in temp, and VS on the MAR. There is a place to type a note in about the rest of the assessment. She thinks a COVID assessment is done once a shift. In an interview on 12/22/2025 at 2:47 PM, Staff V, Licensed Practical Nurse (LPN) reported it depended upon the type of assessment being done. Assessments are documented for residents with COVID in the progress note. Enter vital signs on the MAR/TAR then enter note in progress notes. If fall assessment, go under assessment and document the assessment there in PCC. In an Interview on 12/23/2025 at 8:38 AM, Staff T, Assistant Director of Nursing (ADON) stated she would expect nurses to complete the COVID assessments in the MAR/TAR as well as a nursing note/documentation of the assessment. During interviews and email communication on 12/17/2025 and 12/18/2025, Iowa Department of Public Health (IDPH) Nurse Clinician, stated when communicating with long	F0684		

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F0684 SS = E	Continued from page 29 term care facilities regarding positive COVID-19, recommendations are to follow the Centers for Disease Control and Prevention (CDC) guidelines. In an email on 12/17/25 at 1:27 PM, IDPH Nurse Clinician provided the following highlights from the CDC Infection Control Guidance that is recommended: 1. Asymptomatic patients with close contact with someone with COVID infection should have a series of three viral tests for COVID-10. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be day 1 (where day of exposure is day 0), day 3, and day 5. 2. TBP for patients with COVID-19 infection: a. At least 10 days have passed since symptoms first appeared AND b. At least 24 hours have passed since last fever without the use of fever-reducing medications AND c. Symptoms (e.g. cough, shortness of breath) have improved. 3. Resident placement with suspected or confirmed COVID-19 infection: a. Ideally, residents should be placed in a single-person room b. If limited single rooms are available, or if numerous residents are simultaneously identified to have known COVID-19 exposures or symptoms concerning for COVI-19, residents should remain in their current location. In email communication on 12/18/2025 at 8:27 AM, IDPH Nurse Clinician, reported CDC resources are emailed to all facilities to ensure containment. The CDC does recommend a broader approach with testing when additional cases are identified. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days. 17. Review of facility provided incident report, reveal Resident #18 had an unwitnessed fall on 7/4/2025, that had been reported to nursing staff on 7/5/2025 by resident #18. Immediate action taken include Resident	F0684		

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F0684 SS = E	Continued from page 30 #18 being placed on fall follow up. Review of Resident #18's MDS dated 6/5/2025 (current at time of fall), revealed BIMS of 12 (moderate cognitive impairment) with diagnoses of bladder cancer, A-fib, and abnormal weight loss. Review of Resident #18's Care Plan initiated on 9/16/2024 revealed at the time of the fall resident was an assist of 1 with four wheeled walker for ambulation. Review of Resident #18's Nursing Progress Notes revealed the following documentation: 7/4/2025 at 8:06 PM, Late Entry: late entry for 7/4/25: resident was heard calling out for help in his bathroom after dinner, this nurse went to assist resident and found him with one foot under the walker with the other foot stretched out beside the toilet as resident was laying on top of the walker, attempts to untangle resident were unsuccessful so resident was lowered to the floor then assisted back to his feet, resident reported that he changed positions to quickly and got twisted up in the walker after going to the restroom, resident stated he felt embarrassed although reported no complaints of pain or discomfort, range of motion within normal limits, resident was assisted to his recliner where he sat until he was ready for bed, resident stated he was comfortable with no c/o pain voiced for remainder of the shift 7/5/2025 at 11:04 AM, Late Entry: Resident reported mild back pain to RA and floor nurse. He stated it was from a fall that happened yesterday 7/4 in his bathroom. He stated he went into the bathroom and turned differently that he usually does and got off balance. Will monitor for continued back pain and routine fall follow up. This was an unwitnessed fall. In an interview on 12/22/25 at 4:05 PM, Staff T, ADON, stated that no neurological assessments were completed on Resident #18 for his fall on 7/4/2025 due to this fall being witnessed. In an interview on 12/23/2025 at 10:20 AM Staff G, LPN stated he had heard noises from Resident #18's room, sounded like hitting the wall. When he entered Resident #18's restroom, his walker was cornered between the toilet and the wall. Resident #18 was laying across/on top of the walker on his left side, left foot on the floor, right foot twisted behind left leg. Staff G, LPN stated he attempted to assist Resident #18 upright, but instead had to lower him to the floor completely then, assist him back up to his feet. Staff G, LPN continued	F0684		

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F0684 SS = E	Continued from page 31 by stating, that fall was tricky, wasn't a typical fall, neuros were not initiated, just initial assessment with vitals. Review of facility provided Accidents and Incident Policy stated, This facility is committed to providing a safe and secure environment for residents, staff, and visitors. The purpose of this policy is to outline procedures and guidelines to prevent accidents and manage hazards effectively within our facility. The primary objective of this policy is to minimize the risk of accidents and hazards, promote the safety and wellbeing of residents, staff, and visitors and establish a framework for responding to incidents promptly and efficiently. Review of facility provided Changes in Condition Policy reviewed 2025, revealed the following: Condition change is defined as: alteration from normal status. A significant change in resident status refers to observed changes in the resident's condition which warrants immediate Licensed Nurse assessment, intervention, and appropriate follow-up. Clinical record documentation, assessment and follow-up is necessary.	F0684		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, staff interview, and policy review, the facility failed to use a gait belt while transferring a resident who required assistance with mobility for 1 of 22 residents (#103). The facility reported a census of 109 residents. Findings include: On 12/16/25 at 1:23 PM, Staff I, Certified Nurse Aide	F0689		

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F0689 SS = D	Continued from page 32 (CNA) was observed watching a visitor attempt to transfer Resident #103 without assistance. When the resident began losing balance, Staff I assisted the visitor with transferring the resident from a recliner to his wheelchair without using the gait belt wrapped around her waist. On 12/16/25 at 1:52 PM, J, CNA stated gait belts should be used to transfer residents who are off balance, can't stand by themselves, or for safety issues. She stated staff uses a gait belt for Resident #103 except when his friend comes. His friend gets him out of the chair himself. On 12/16/25 at 2:01 PM, Staff K, Registered Nurse (RN) stated the resident walks by himself but gets up with assistance. She stated a gait belt should be used with residents who require assistance. On 12/16/25 at 2:09 PM, Staff K, RN stated she doesn't know if the resident's friend was provided education regarding the safety importance of using a gait belt for resident transfers and didn't know where the education documentation would be. The Minimum Data Set (MDS) for Resident #103 dated 11/01/25 revealed a Brief Interview for Mental Status (BIMS) score could not be obtained due to the resident being rarely or never understood. It included diagnoses of non-Alzheimer's dementia, traumatic brain injury, age-related mental decline, visual loss, and syncope (temporary loss of unconsciousness from reduced blood flow to the brain), and collapse. It indicated he was dependent with toileting, required setup assistance with eating, moderate assistance with dressing and chair-to-chair transfers, and maximal assistance with all other Activities of Daily Living (ADLs) and forms of mobility. It also indicated the resident had a fall since admission to the facility and used a wheelchair for mobility in the previous 7-day look-back period. The Care Plan revised 5/07/25 indicated the resident required assist x 1 with FWW (front-wheeled walker) at baseline with use of wheelchair on occasions with poor balance/mobility. It also included the resident's potential for falls related to generalize weakness, decreased mobility, poor safety awareness, and non-compliance with transfer status. It did not include the resident's friend resisting staff assistance with resident transfers nor education provided to the resident's friend on the safety importance of gait belt use for resident transfers. A Resident Care Conference Summary document dated	F0689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Center at Luther Park	**1555 Hull Avenue , Des Moines, Iowa, 50316**

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F0689 SS = D	Continued from page 33 11/12/2025 did not include educating the resident's friend on the safety importance of gait belt use for resident transfers. It also did not include the resident's non-compliance with transfers The Progress Notes did not include any documented education provided to the resident's friend regarding the safety importance of gait belt use for resident transfers. On 12/17/25 at 8:02 AM, Staff L, RN stated a gait belt is required for residents who require staff assistance for transfers for safety. She stated staff should use a gait belt when transferring Resident #103. On 12/17/25 at 8:48 AM, Staff I, CNA transferred Resident #103 with a gait belt. On 12/17/25 at 12:43 PM, Staff M, CNA stated if a resident requires assistance with transfers, a gait belt should be used. On 12/17/25 at 12:55 PM, Staff N, CNA stated a gait belt should be used when a resident requires transfer assistance from staff. On 12/17/25 at 12:59 PM, Staff O, CAN stated a gait belt should be used for resident transfers if they require staff assistance. On 12/17/25 at 1:31 PM, Staff P, Quality Assurance (QA) stated she did not have any documentation of the resident's friend being educated on the importance of using a gait belt for resident transfers. On 12/17/25 at 1:37 PM, the Director of Nursing (DON) stated she would have to look for documentation of any education provided to the resident's friend regarding the importance of using a gait belt with resident transfers. She also stated she had not heard about the resident's friend transferring him. On 12/17/25 at 4:17 PM, the DON stated CNAs should notify charge nurse or the manager, if available. The charge nurse should report it to the manager. A policy titled "Gait Belt, Transfer, Wheel Chair" effective 3/07/07 indicated residents who are unable to transfer or ambulate independently shall be assisted by staff instructed in proper procedures. A gait belt shall be used when a resident needs assistance with balance and/or strength.	F0689		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary	F0812		

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F0812 SS = E	Continued from page 34 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and policy review, the facility failed to label food stored in the refrigerator, failed to properly thaw meat used for lunch meal service, and failed to discard delivery boxes. The facility reported a census of 109 residents. Findings include: On 12/15/25 at 8:35 AM, the following items were observed during kitchen tour: 1) One (1) pack of frozen ham thawing in an aluminum pan full of standing water in the sink. 2) Seven (7) packs of thawed ham in an aluminum pan of standing hot water. 3) Three (3) flattened delivery boxes lying on a kettle (large machine used for making soups, etc) 4) An unlabeled, clear, plastic container with sliced, white, oval items. 5) An unlabeled, clear, plastic container with sliced,	F0812		

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F0812 SS = E	Continued from page 35 light green, disk shaped items. 6) A unit refrigerator with a multicolored, cloth item with a resident label later identified as a coldpak. At 9:10 AM, Staff A, Registered Nurse (RN) stated she did not know who placed the item in the refrigerator. The Certified Dietary Manager (CDM) informed the unit nurse that resident healthcare items cannot be placed in the resident food storage refrigerator. Staff A stated she didn't know where to put it then. On 12/17/25 at 4:35 PM, Staff KK, Nurse Consultant stated items should be dated and labeled when stored and delivery boxes should be stored appropriately. On 12/17/24 at 4:50 PM, the CDM stated the ham located in the standing hot water pan was present because the cook placed the 7 frozen hams in the oven to speed up the thawing process. A policy titled "Food Handling Policy" revised 7/24/24 indicated defrosting will be done by placing the frozen item in the refrigerator until thawed or placed in a cold-water bath for defrosting. It also indicated no soiled cloths, boxes, cartons or other items that may contaminate food will be placed on food preparation surfaces. It further indicated leftover food can be stored for up to three (3) days and a label will be affixed to the container with the following information: a) Name of the food item b) The date food was placed in container c) Indicate if contents include a common allergen such as peanuts, tree nuts or eggs d) Check recipe card provided by main kitchen e) Evening staff will discard leftover food items that have been held for over three (3) days in the refrigerator.	F0812		
F0880 SS = K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help	F0880		

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F0880 SS = K	Continued from page 36 prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F0880		

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F0880 SS = K	Continued from page 37 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, staff and Iowa Department of Public Health (IDPH) interviews, facility policy review, and Centers for Disease Control and Prevention (CDC) guidelines. The facility failed to do the following; ensure staff followed proper infection control practices during resident's cares and transmission based precaution procedures to prevent the spread of COVID-19 by failing to follow facility policy and CDC guidelines, to test residents who had been exposed to other residents positive for COVID-19, separate COVID-19 positive residents from roommates, to wear proper personal protective equipment (PPE) and to properly handle contaminated linens for 20 of 20 residents reviewed (Resident #2, #6, #11, #12, #27, #32, #36, #42, #59, #68, #74, #75, #85, #91, #96, #97, #100, #118, #126, #127). The facilities failure to protect their residents from exposure to high risk infections put the residents at a serious likelihood of harm. The facility reported a census of 109 residents. The State Agency informed the facility of the Immediate Jeopardy (IJ) on December 26, 2025 at 4:59 p.m. The IJ began on November 29, 2025. The facility staff removed the immediacy on December 16, 2025 by implementing the following actions; a. Residents exposed to a resident with covid positive results will be tested immediately, and residents will be tested on a section of the building that had a high rate of positive testing results b. All residents who have been positive will be reviewed on 12/16/25 to determine whether they need to	F0880		

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F0880 SS = K	Continued from page 38 be put back to transmission based precautions for 10 days. c. All residents on the second floor will be tested on 12/16/25. d Residents in the room with covid positive resident will be moved to a different room as soon as the room is available. e. Education will be completed to All staff on mask wearing and linen handling beginning 12/16/25 and on-going shifts. f. Staff working on the highly positive COVID unit will be tested beginning 12/16/25 and on-going shifts The scope was lowered from "K" to "H" at the time of the survey. Findings include: On 12/15/25 at 8:45 AM, Staff B, Licensed Practical Nurse (LPN) and Staff C, LPN were observed on a unit with Covid positive residents sitting at the nurses' station without masks. They both placed the mask over their mouths and noses when the state surveyor approached. During an observation on 12/15/2025 10:45 AM, Staff BB, CNA is observed exiting a residents room, wearing gloves, pushing a patient transfer device (EZ stand), parking along the wall in the hallway and entering a resident's room across the hall while wearing the same gloves. On 12/15/2025 at 10:52 AM, observation revealed droplet precaution sign outside of Resident #59's door with Personal Protective Equipment (PPE) supplies bin outside of room. Resident's room door is open, with resident #59 laying in bed. On 12/15/25 at 10:53 AM, Staff D, Certified Nurse Aide (CNA) was observed on the same unit with with her ear loop mask tucked under her chin. On 12/15/25 at 11:00 AM, Staff E, contracted Physical Therapy Assistant (PTA) was observed on the same unit with her ear-loop mask tucked under her chin while she searched for a N95 mask. She stated the facility had been using N95 masks for Covid positive droplet precaution residents.	F0880		

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F0880 SS = K	Continued from page 39 On 12/15/2025 at 3:20 PM, observed droplet precaution sign and PPE supplies bin outside of Resident #74's room, with resident's room door open. Observation on 12/16/2025 at 1:25 PM, revealed Resident #59's room door open, resident is on TBP for positive COVID, Staff GG, CNA, outside of room donning PPE to include a gown and gloves. Stuff GG, CNA currently wearing a standard surgical mask and enters resident's room. Staff GG, CNA provides cares for Resident #59, the room door is open and the curtain is pulled a quarter of the way across the room, while roommate is on the other side of the room. At 1:30 PM another staff member approaches doorway and asks Staff GG, CNA to assist in another room when done caring for Resident #59. 1:35 PM, Staff GG, CNA exits Resident #59's room, gown, gloves and mask are removed. Leaving resident's door open and carrying unbagged linens with bare hands, stops at PPE drawer in the hallway and gets a new standard surgical mask and puts it on. Staff GG, CNA then proceeds to carry unbagged linen to the soiled laundry bin halfway down the hallway and drops items in. Uses hand sanitizer and enters another room to assist as requested earlier. On 12/16/2025 3:10 PM, Staff HH, CNA is observed carrying personal care supplies from hall B to hall C, wearing a mask, pulled down below her nose only covering her mouth. After delivering supplies to storage cart on hall B, Staff HH, CNA is observed at the entrance to hall B pulling her mask down and drinking out of a water bottle, replacing her mask to cover her mouth and sets water bottle back on hand railing and walks away. On 12/16/2025 at 5:20 PM, DON provided a spreadsheet she stated is used for reporting positive COVID-19 cases to CDC's National Healthcare Safety Network (NHSN) (healthcare-associated infection tracking system) and to Iowa Department of Public Health (IDPH). Review of this document indicated residents who had been tested for influenza and/or COVID-19, resident's symptoms and date reported, the date the test was administered with results, and the date resident was removed from isolation/TBP. On 12/16/25 at 8:17 AM, Staff F, RN was observed in the dining room on the same unit wearing her mask below her nose. She raised it above her nose when the state surveyor approached her. On 12/16/25 at 3:28 PM, Staff G, LPN was observed on the unit with mask requirements at the nurses' station with his mask hanging off of his right ear.	F0880		

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F0880 SS = K	Continued from page 40 On 12/17/25 at 11:02 AM, Staff H, contracted Registered Occupational Therapy (OTR) exited a resident's room wearing a PPE gown and gloves and carrying a green pair of pants. She rolled up the pants, placed it in the laundry bin, and returned to the resident's room wearing the same PPE. At 11:09 AM, she exited the resident's room wearing PPE gown and gloves carrying a clear plastic bag of laundry. She threw it in the laundry bin and returned to the resident's room. At 11:12 AM, Staff H stated she received infection prevention education but didn't remember receiving education about exiting EBP with PPE. She stated when she's providing services to a resident on EBP, she changes gloves after touching the resident, exits the resident's room to place any linen into the laundry bin, then returns to the resident's room. She stated the residents' rooms do not have disinfectant wipes, so she takes the gait belt to the office to clean it. Observation on 12/18/2025 at 11:30 AM, Facility Nurse Practitioner, observed standing at nurses station, not wearing a mask. Staff T, Assistant Director of Nursing (ADON), asked Facility Nurse Practitioner to put on a mask and wear while on the unit. Nurse Practitioner donned a mask. 1. Review of Resident #6's Significant Change Minimum Data Set (MDS) dated 9/10/2025 revealed admission to the facility on 7/17/2025 in a private room receiving hospice level of care. A Brief interview for Mental Status (BIMS) of 7 (severe cognitive impairment), diagnoses including atrial fibrillation (A-fib), coronary artery disease, hypertension, stage 3 chronic kidney disease, type 2 diabetes mellitus, hyperlipidemia, history of stroke with left sided weakness, and chronic obstructive pulmonary disease (COPD). Resident #6 is dependent on staff assistance pushing her wheelchair for mobility, dependent with use of mechanical lift for transfers, and needs substantial assistance rolling side to side in bed, sitting to lying, and lying to sitting on side of bed. Review of Resident #6's Care Plan initiated on 7/17/205 included the following focus and interventions: a. High risk for COVID exposure due to communal living. Observe for signs and symptoms of COVID. Obtain rapid COVID test as indicated and report results to facility provider, should Resident #6 have a positive test, isolate per CMS/CDC guidelines. b. Resident #6 has altered respiratory status/difficulty breathing related to COPD,	F0880		

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F0880 SS = K	Continued from page 41 interventions to include, monitor/document changes in orientation, increased restlessness, anxiety and air hunger. Monitor for signs and symptoms of respiratory distress, headaches, lethargy, confusion, and report to facility provider as needed. Use of oxygen at 2 liters per minute (LPM) via nasal cannula as needed to keep oxygen saturation greater than 90%. c. Resident #6 has altered cardiovascular status. Administer cardiac medications as ordered, monitor vital signs and notify provider of significant abnormalities, monitor/document/report any signs or symptoms of chest pain, chest pressure, heartburn, nausea, vomiting, shortness of breath, excessive sweating, and dependent edema (swelling from excessive fluid accumulation). Review of facility provided COVID-19 tracking spreadsheet indicated Resident #6's symptoms started on 12/2/2025, COVID-19 testing on 12/2/25 with positive results and Transmission Based Precautions (TBP) initiated. Review of Resident #6's Nursing Progress notes revealed the following: 12/2/2025 at 1:19 PM, Staff Z, LPN, documented, Long Term Care Evaluation: vitals temperature (T) 97.1, pulse (P) 62, respirations (R) 18, blood pressure (BP) 117/68, SpO2 94% on room air. Respiratory: No signs of difficulty breathing, no shortness of breath noted, right and left lungs clear, no oxygen, head of bed is not elevated, no cough. 12/2/2025 at 5:25 PM, Staff Z, LPN, documented, resident #6 tested positive for COVID, voicemail left for family. 12/3/2025 at 6:49 AM, Staff A, RN, documented, at 6:35 AM it was brought to my attention Resident #6 appeared to have passed away. Upon inspection and assessment, she has passed. Assistant Director of Nursing (ADON) notified. Called hospice and told then Resident #6 had passed away, also disclosed that resident had a diagnosis of COVID yesterday before her passing. 2. Review of Resident #11's Admission MDS dated 9/30/2025 revealed, resident was admitted to the facility on 9/24/2025 to a private room. A BIMS of 15 (cognitively intact), diagnoses of coronary artery disease, deep vein thrombosis, heart failure, peripheral vascular disease, type 2 diabetes mellitus, and pleural effusion (excess fluid builds up in the space between the lungs and chest wall, restricting	F0880		

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F0880 SS = K	Continued from page 42 lung expansion, causing shortness of breath, chest pain, and cough). Resident #11 requires moderate assistance (helper does less than half the effort, lifts or holds trunk or limbs but provides less than half the effort) with transfers and mobility with the use of a walker or wheelchair. Review of Resident #11's Care Plan, initiated 9/24/2025, included the following focus and interventions: a. Altered cardiopulmonary functioning, potential for shortness of breath, lung congestion, chest pain, decrease in level of consciousness, acute heart failure. Administer cardiac medications as ordered, blood pressure monitoring, use of anticoagulants (blood thinner), observe for signs and symptoms of cardiac decompensation and report to provider. Daily weights for cardiac monitoring as ordered, notify provider of 3 pound weight gain in 1 day or 5 pounds in one week. b. Resident #11 requires the use of diuretics related to congestive heart failure and bilateral lower extremity edema. Administer medications as ordered, notify provider of increase in edema and lung congestion. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #11's symptoms started on 12/3/2025, COVID-19 testing on 12/2/25 with positive results and TBP initiated. Resident #12 was removed from TBP on 12/8/2025 after 5 days of isolation/TBP. Review of Resident #11's Nursing Progress notes revealed the following: 11/30/2025 at 7:42 AM, Staff AA, RN, documented, Resident #11 exhibits cold symptoms; congestion and cough. Reports a sore throat, denies any malaise (feeling discomfort or illness), BP 110/65, P 85, SpO2 94% on room air. Rapid COVID test completed with negative results at this time. On call provider made aware with orders for Guaifenesin (medication used to relieve chest congestion and make coughs more productive) 400mg every 4 hours as needed x 10 days. 12/2/2025 9:10 PM, Staff B, LPN, documented, Resident #11 tested positive for COVID. 12/8/2025 at 5:34 PM, Staff S, LPN, documented, Resident #11 removed from droplet isolation precautions due to resolved active COVID signs and symptoms at this time.	F0880		

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F0880 SS = K	Continued from page 43 3. Review of Resident #12's MDS dated 11/1/25 revealed the resident was admitted to the facility on 3/10/2011 to a semi-private room (shared with one roommate R#75). A BIMS of 14 (cognitively intact), diagnoses of Multiple Sclerosis, contractures, neurogenic bladder, hypertension, and anxiety disorder. Resident #12 is dependent on staff assistance for mobility in her wheelchair and assistance with the use of a mechanical lift for transfers. Review of Resident #12's Care Plan revised on 8/27/2025 failed to indicate Resident's risk for COVID. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #12's symptoms started on 12/3/2025, COVID-19 testing on 12/3/25 with positive results and TBP initiated. Resident #12 was removed from TBP on 12/12/2025 after 9 days of isolation/TBP. Review of Resident #12's Nursing Progress notes revealed the following: 12/2/2025 at 12:38 AM, Staff Y, LPN, documented, resident able to express self to staff, body temperature warm to touch, dry and intact. In bed, head elevated per resident's desires, call light in reach. 12/3/2025 at 8:47 PM, Staff Z, LPN, documented, resident noted coughing, rapid COVID test completed, results positive, BP 121/68, P 118, T 98 and O2 95%. On call provider notified and received an order for mucinex 600mg twice daily x 10 days. 12/8/2025 at 2:46 PM, Staff A, RN, documented, vital signs (T)98.5, (P)108, (R)18, (BP)113/61, SpO2 95% on room air. Lung sounds diminished in the bases bilaterally and expiratory rhonchi in the right upper lobe. Loose, non-productive cough. Resident is alert. No other signs and or symptoms (s/sx) of COVID. 4. Review of MDS dated 10/4/2025, revealed Resident #27's admission to the facility on 7/31/2024 to a semi-private room (Roommate with Resident #12), BIMS of 15 (cognitively intact) and diagnoses of non-Alzheimer's dementia, Parkinson's disease, anxiety disorder, depression, and psychotic disorder. Review of Resident #27's Care Plan initiated 7/31/2024 failed to indicate Resident's risk for COVID. Review of Resident #27's nursing progress notes, failed to provide documentation related to Resident #27's exposure to COVID positive roommate, attempt to separate from roommate or provide interventions to	F0880		

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F0880 SS = K	Continued from page 44 reduce risk of transmission, provide COVID testing and monitoring for symptoms. 5. Review of MDS dated 10/27/2025, revealed resident #32 was admitted to the facility 10/21/2025 in a private room, BIMS 13 (cognitively intact) and diagnoses of atrial fibrillation (A-fib), heart failure, hypertension, and unspecified toxic encephalopathy. (brain dysfunction caused by unknown toxins, can cause confusion, memory loss, personality changes, poor concentration or seizures). Resident #32 is independent with the use of a walker. Review of Care Plan, initiated 11/3/2025, revealed the following focus and interventions for Resident #32: a. Altered cardiopulmonary status with potential for shortness of breath, lung congestion, edema, chest pain, decreased level of consciousness, cyanosis related to congestive heart failure, A-fib, and hypertension. Avoid overexertion, requiring frequent rest periods during completion of activities. Notify nursing staff of any shortness of breath, chest pain, or irregular heartbeat. Observe for signs and symptoms of cardiac decompensation and report to provider. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #32's symptoms started on 12/1/2025, COVID-19 testing on 12/2/25 with positive results and TBP initiated. Resident #32 was removed from TBP on 12/8/2025 after 5 days of isolation/TBP. Review of Resident #32's Nursing Progress notes revealed the following: 11/17/2025 at 6:37 PM, Staff U, RN, documented, Nurse Practitioner is here and new order received, cough drops mouth/throat lozenge every 2 hours as needed, may have at bed side per resident's request. 12/1/2025 at 2:26 PM, Staff B, LPN, documented, called Resident #32's family and notified about Vaseline under the nose for redness. 12/2/2025 at 12:39 PM, late entry created 12/3/1015 at 3:41 PM, Staff B, LPN noted, Resident #32 was tested positive for COVID, family and manager notified. Isolation precautions put in place. 12/2/2025 at 12:44 PM, Staff T, ADON, documented, positive for COVID, isolation in place. 12/3/2025 at 1:04 PM, Staff T, ADON, documented, symptoms started on Sunday (11/30/2025) with a runny	F0880		

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F0880 SS = K	Continued from page 45 nose and increased tiredness. On 12/2/2025 resident #32 was tested with a rapid COVID test and tested positive. 12/8/2025 at 5:12 PM, Staff T, ADON, documented new orders for Tussin (medicine to relieve symptoms of cough and chest congestion cause by the common cold, flue, allergies, or minor bronchial irritations) 15mg every 6 hours as needed. Rapid COVID test completed, results negative. 12/8/2025 at 5:32 PM, Staff S, LPN, documented, resident #32 removed from droplet isolation precautions due to resolved signs of active COVID signs or symptoms at this time. 6. Review of MDS dated 11/12025, revealed Resident #36's admission to the facility on 11/25/2024 to a semi-private room (roommate with Resident #59), BIMS of 0 (resident is not able to complete the assessment) and diagnoses of A-fib, hypertension, kidney disease, type 2 diabetes mellitus, aphasia (language disorder, impairing language, understanding speech, reading and writing), hemiplegia, seizure disorder, and history of stroke. Resident #36 requires maximal assistance for transfers and is independent with a wheelchair for mobility. Review of Resident #36's Care Plan initiated 12/5/2024 failed to indicate Resident's risk for COVID. Review of Resident #36's nursing progress notes, failed to provide documentation related to Resident #36's exposure to COVID positive roommate, attempt to separate from roommate or provide interventions to reduce risk of transmission. Review of Resident #36's Medication Administration Record (MAR) indicated an order dated 12/11/2025 for COVID MONITORING: monitor for new cough, sore throat, new shortness of breath or difficulty breathing, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose. See nurses notes and progress notes findings every shift for 10 days. Vitals were obtained and documented each shift. The ordered nursing progress notes linked to three times daily COVID monitoring provided the following two nursing documentations: 12/11/2025 at 4:50 PM, Staff AA, RN, documented, no cough or difficulty breathing noted. 12/13/2025 at 1:07 AM, Staff Z, LPN, noted, Resident #36 resting quietly with no complaints of discomfort, NO breathing difficulty.	F0880		

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F0880 SS = K	Continued from page 46 On 12/16/2025 at 1:18 PM, Resident #36 was observed self propelling in his wheelchair, exiting his room. Outside of resident #36's room, a three drawer bin with PPE, had a folded blanket, shirt on a hanger, and underwear sitting on top. Resident #36, unmasked, retrieved laundry and blanket and returned to the room. During an interview on 12/16/2025, Staff G, LPN stated in this room, Resident #59 is COVID positive, Resident #36 is not. LPN stated Resident #36 had been tested with negative results. When LPN was asked about facility's procedure for separating roommates when one is COVID positive and the other is negative, LPN stated Resident #36's roommate had a full assessment, nursing staff will monitor Resident #36 with basic vitals. LPN stated Resident #36 had been tested again and was negative, the results for these tests would be documented in the nurses progress notes in Resident #36's records. An interview on 12/16/25 at 3:12 PM, Staff F, RN stated, she has encouraged Resident #36 to spend time outside of his room and encouraged to wear a mask. Nurses are monitoring for signs and symptoms of COVID. Staff F, RN stated she was not sure if Resident #36 had been tested for COVID, at this time Staff F, RN called Staff S, the Infection Preventionist for more information. Staff F, RN continues by stating "I haven't been on the floor in awhile, to know what we're doing." After communicating with Staff S, Infection Preventionist, Staff F, RN stated right now we are focusing on alert charting and monitoring for COVID symptoms, if symptoms start then the resident is tested for COVID. In an interview on 12/16/25 at 3:24 PM, Staff T, ADON, acknowledged Resident #36 cohorting (an infection control strategy where patients with the same contagious condition are grouped together in a specific area to prevent spread to others) with Resident #59 who is COVID positive and stated questions related to the cohorting would need to be redirected to the facility's Infection Preventionist Staff S, for further clarification. 7. Review of MDS dated 9/27/2025 revealed Resident #42's admission to the facility on 4/7/2025 to a private room, BIMS of 12 (moderate cognitive impairment) and diagnoses of hypertension, kidney disease, type 2 diabetes mellitus, Alzheimer's disease, non-Alzheimer's dementia, anxiety disorder, depression, bipolar disorder, asthma, and sarcopenia (age related progressive loss of muscle mass, strength and	F0880		

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F0880 SS = K	Continued from page 47 function). Resident #42 is dependent on staff for transfers and mobility in her wheelchair. Review of Resident #42's Care Plan, initiated 4/7/2025, included the following focus and interventions: a. Altered cardiopulmonary status with potential for shortness of breath, lung congestion, edema, chest pain, decreased level of consciousness, cyanosis, diaphoresis, complaints of nausea and vomiting related to hypertension and asthma with wheezing. Avoid overexertion, requiring frequent rest periods during completion of activities. Observe for signs and symptoms of cardiac decompensation and report to provider. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #42's symptoms started on 12/3/2025, COVID-19 testing on 12/2/25 with positive results and TBP initiated. Resident #42 was removed from TBP on 12/8/2025 after 5 days of isolation/TBP. Review of Resident #42's Nursing Progress notes revealed the following: 12/3/2025 at 1:00 PM, Staff T, ADON, documented, on 12/2/2025 Resident #42 had cough and runny nose. Rapid COVID testing completed results positive. Isolation present. 12/8/2025 5:37 PM. Staff S, LPN, documented Resident #42 removed from droplet isolation precautions due to resolved signs of active COVID signs or symptoms at this time. 8. Review of Resident #59's MDS dated 9/13/2025 revealed resident #59 was admitted to the facility on 3/29/2024 to a semi-private room (roommate with Resident #36), BIMS of 14 (cognitively intact) with diagnoses of coronary artery disease, heart failure, cardiomegaly (enlarged heart), hypertension, type 2 diabetes mellitus, anxiety disorder, depression, COPD, chronic respiratory failure, obstructive sleep apnea, disease of spinal cord, and requires oxygen. Resident #59 is dependent for transfers with assistance of a mechanical lift and uses a power wheelchair for mobility. Review of Resident #59's Care Plan revised 12/4/2025 provided the following focus and interventions: a. Resident #59 has an altered cardiovascular status related to hypertension, heart failure, and coronary artery disease. Administer cardiac medications as	F0880		

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F0880 SS = K	Continued from page 48 ordered. Daily weights, if 5 pounds gain in one week, administer additional Lasix that day. Monitor and report any signs or symptoms of coronary artery disease, chest pain or pressure with activity, shortness of breath, excessive sweating, and dependent edema. Oxygen at 2 liters via nasal cannula continuous. b. Resident #59 is at risk for signs and symptoms of COVID-19. Follow facility protocol for COVID-19 screening and precautions. Observe for signs and symptoms of COVID-19, document and promptly report fever, coughing, sneezing, sore throat, and/or respiratory/breathing issues. c. Initiated 12/11/2025, Resident #59 requires isolation precautions, specifically related to the COVID-19 infection. Observe effectiveness of medications; observe for signs and symptoms and inform provider if worsening. Intervention initiated 12/16/2025; Carry on conversations with Resident #59 during care so that he does not feel isolated; Resident #59 is receiving antibiotics for COVID associated respiratory infection, observe for potential side effects and report to the provider; notify provider of any worsening COVID symptoms; isolation per policy. d. Resident #59 has altered respiratory status, difficulty breathing related to heart failure, respiratory failure, and COPD exacerbation. Assess lung sounds as needed and notify provider of abnormal findings. Monitor for signs and symptoms of respiratory distress and report to provider. Continuous oxygen at 2 lpm via nasal cannula. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #59's symptoms started on 12/11/2025. Review of Resident #59's Nursing Progress notes revealed the following: 12/11/2025 at 10:02 AM, Staff AA, RN, documented, Resident #59 presents with hoarse voice, reports feeling fatigued. Occasional cough, reporting clear to greenish sputum at times, and slight pain with cough. No respiratory distress or effort with breathing. Rapid COVID completed with positive results. Isolation protocol initiated. 9. Review of MDS dated 12/2/2025, revealed Resident #68 was admitted to the facility on 11/26/2025 to a private room, BIMS of 15 (cognitively intact) and diagnoses of cancer, Afib, heart failure, hypertension, kidney disease, type 2 diabetes mellitus, and respiratory	F0880		

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F0880 SS = K	Continued from page 49 failure with hypoxia (critical condition where lungs fail to get enough oxygen into the blood). Review of Resident #68's Care Plan, initiated 11/26/2025 included the following focus and interventions: a. Resident #68 requires assistance of 1 with a gait belt and walker for ambulation and transfer. b. Altered cardiopulmonary status with potential for shortness of breath, lung congestion, edema, chest pain, decreased level of consciousness, cyanosis, diaphoresis, complaints of nausea and vomiting related to heart failure and acute respiratory failure. Avoid overexertion, requiring frequent rest periods during completion of activities. Instruct resident to notify nursing staff of any complaints of shortness of breath, chest pain, irregular heart rate. Observe for signs and symptoms if resident is unable to report symptoms and notify provider if signs and symptoms exist. c. Oxygen at 2 lpm via nasal cannula as needed. d. Observe for signs and symptoms of cardiac decompensation and report to provider. e. Enhanced Barrier Precautions (EBP) due to chronic wounds, gowns and gloves to be worn with all direct care. Proper hand washing before and after all cares. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #68's symptoms started on 11/29/2025, COVID-19 testing on 12/2/25 with positive results and TBP initiated. Resident #68 was removed from TBP on 12/9/2025 after 7 days of isolation/TBP. Review of Resident #68's Nursing Progress notes revealed the following: 11/28/2025 at 10:50 AM, Staff L, RN documented a Skilled Evaluation note stating, no signs of difficulty breathing, no shortness of breath noted. No cough, no signs of respiratory distress or discomfort noted at this time. 11/29/2025 at 8:09 AM, Staff AA, RN documented a Skilled Evaluation note stating, no signs of difficulty breathing, no shortness of breath noted. Right and left lung clear, no oxygen. Cough present with moist/loose non-productive cough noted. Reports cough not new, denies concerns at this time.	F0880		

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F0880 SS = K	Continued from page 50 11/30/2025 at 8:37 AM, Staff AA, RN documented a Skilled Evaluation note stating, no signs of difficulty breathing. Shortness of breath noted, Resident #68 reported shortness of breath upon exertion. Right and left lung clear. No oxygen, head of bed elevated at 30 degrees. Cough present with moist/loose non productive cough noted. Small amount of thin secretions. Residual cough. 11/30/2025 at 5:33 PM, Staff AA, RN documented an Administration note, Albuterol sulfate inhalation nebulation, 3 ml inhaled orally via nebulizer every 6 hours as needed for shortness of breath, SpO2 94% on room air, no respiratory distress observed or reported. 12/1/2025 at 10:07 AM, Staff BB, Certified Medication Aide (CMA) document an Administration note, Albuterol sulfate inhalation nebulation, 3 ml inhaled orally via nebulizer every 6 hours as needed for shortness of breath, wheezing. Resident #68 requested Albuterol nebulizer for shortness of breath and wheezing. Nurse was notified. 12/1/2025 at 10:40 AM, Staff U, RN documented a Skilled Evaluation note stating, SpO2 90% on room air, no signs of difficulty breathing or shortness of breath noted. Right lung upper lobe wheezes on auscultation, lung sounds present on exhalation. Left lung upper lobe wheezes on auscultation, lung sounds present on exhalation. Moist/Loose non-productive cough present with small amounts of clear moderate consistency secretions. As needed nebulizer treatments administered, Nurse Practitioner here and notified of noted wheeze and cough. 12/1/2025 at 11:05 AM, Staff U, RN documented wheezing and shortness of breath noted this morning, as needed nebulizer treatment administered. Nurse Practitioner is here and saw resident. New order received; Mucinex 600mg by mouth twice daily x 7 days. 2 view chest x-ray today. Continue as needed nebulizer treatments. X-ray scheduled with portable x-ray services. 12/1/2025 at 11:59 AM, Staff U, RN documented Nurse Practitioner is here and saw Resident #68; verbal order received for rapid COVID test. Rapid COVID test administered and positive results noted. Nurse Practitioner and ADON aware, Resident #68 in droplet precaution, will continue to monitor. 10. Review of MDS dated 10/25/2025 revealed Resident #74's admission to the facility on 5/5/2025 in a private room, BIMS of 15 (cognitively intact) and diagnoses of hypertension, polyneuropathy (nerve damage	F0880		

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F0880 SS = K	Continued from page 51 in extremities causing weakness, numbness, tingling and burning pain affecting sensory and motor functions), aortic valve stenosis (serious heart condition, aortic valve narrows causing obstructive blood flow), and weakness, Resident #74 is independent with transfers and mobility with the use of a wheelchair. Review of Resident #74's Care Plan revised 11/10/2025 indicated the following focus and interventions: a. Altered cardiovascular status related to hypertension. Assess for chest pain, enforce the need to call for assistance if pain starts. Monitor, document and report any signs or symptoms of coronary artery disease. b. Initiated 12/14/2025, require care isolation precautions specifically related to the COVID-19 infection. Observe for signs and symptoms and inform provider if worsening. Ensure resident stays in room, away from other people as much as possible (contact and droplet precautions). Monitor vitals and notify provider of abnormalities. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #74's symptoms started on 12/13/2025. Review of Resident #74's Nursing Progress notes revealed the following: 12/13/2025 at 9:30 AM, Staff AA, RN, documented, Resident #74 with complaints of loss of taste, also presents with nasal congestion. Denies any cough or shortness of breath. Bp 152/65, T 97.8, P 75, R 20, SpO2 98% on room air. Breathing equal and unlabored. Alert with no change from baseline. Rapid COVID completed with positive results. Isolation precautions initiated. Manager on call made aware, on call provider notified with orders to continue to monitor and notify of any changes. 11. Review of Resident #75 MDS dated 10/11/2025 revealed admission to the facility on 5/17/2024 to a semi-private room (roommate Resident #12), BIM of 3 (severe cognitive impairment) and diagnoses of hypertension, chronic kidney disease, A-fib, and other specified signs and symptoms involving cognitive functions and awareness (brain fog, memory lapses, difficulty concentrating, altered mental status), stenosis of carotid artery, arterial fibromuscular dysplasia, hypertensive heart disease.. Resident #75 requires maximal assistance with transfers and mobility with the use of a gait belt and walker.	F0880		

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F0880 SS = K	Continued from page 52 Review of Resident #75's Care Plan revised 9/11/2025 indicated the following focus and interventions: a. High risk for COVID exposure due to communal living. Observe for signs and symptoms of COVID. Obtain rapid COVID test as indicated and report results to provider, should Resident #75 have a positive test, isolate per CMS/CDC guidelines. b. Resident #75 has altered cardiovascular status related to stenosis of carotid artery, arterial fibromuscular dysplasia, hypertensive heart disease. Administer medications as ordered. Monitor, document, and report any changes in lung sounds on auscultation, edema and changes in weight as needed. Review of Resident #75's nursing progress notes and orders, failed to provide documentation related to the following; Resident #75's exposure to COVID positive roommate, attempt to separate from roommate or provide interventions to reduce risk of transmission, and ordered monitoring for COVID symptoms. 12. Review of MDS dated 10/18/2025 revealed Resident #85 was admitted to the facility on 8/8/2024 to semi-private room (roommate with Resident #100), BIMS of 11 (moderate cognitive impairment) and diagnoses of kidney failure, history of rhabdomyolysis (breakdown of damaged muscle tissue), malnutrition, spondylosis lumbosacral region (degenerative changes in lower back), metabolic encephalopathy (condition causing brain dysfunction leading to confusion, seizures, or coma), bed confinement status, and weakness. Resident #85 is dependent on all transfers and mobility with the use of a mechanical lift and wheelchair. Resident #85's Care Plan, initiated 8/8/2024 indicated the following focus and interventions: a. Resident #85 requires EBP due to an extensive pressure area. Infection Preventionist to educate staff on donning (putting on) and doffing (removing) of equipment. Proper handwashing before and after all cares. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #85's symptoms started on 12/2/2025, COVID-19 testing on 12/2/25 with positive results and TBP initiated. Resident #85 was removed from TBP on 12/8/2025 after 6 days of isolation/TBP. Review of Resident #85's Nursing Progress notes revealed the following:	F0880		

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F0880 SS = K	Continued from page 53 12/2/2025 at 10:56 AM, Staff B, LPN, documented, new order for Mucinex 600mg every 12 hours and COVID test for sinus. 12/3/2025 at 1:02 PM, Staff T, ADON, documented, 12/2/2025 Resident #85 had a runny nose and cough, rapid COVID test completed, results positive. 13. Review of Resident #91's MDS dated 11/22/2025 revealed Resident #91 was admitted to the facility on 4/9/2015 to a semi-private room (roommate Resident #118), BIMS of 0 (resident is not able to complete the assessment) and diagnoses of history of a stroke, hypertension, type 2 diabetes mellitus, arthritis, and aphasia. Resident #91 requires maximal assistance for transfers and mobility with use of a wheelchair. Review of Care Plan revised on 12/16/2025 indicated the following focus and interventions for Resident #91: a. EBP required due to MDRO CRE E. Coli (multi-drug resistant organism, superbug resistant to powerful antibiotics). Gowns and gloves to be worn with all direct care, Infection Preventionist to educate staff on donning and doffing of equipment. Proper handwashing before and after all cares. b. Altered cardiovascular status related to hypertension and history of stroke. Administer medications as ordered. Monitor, document, and report any changes in lung sounds on auscultation, edema and changes in weight as needed. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #91's symptoms started on 12/3/2025, COVID-19 testing on 12/2/25 with positive results and TBP initiated. Resident #91 was removed from TBP on 12/8/2025 after 5 days of isolation/TBP. Review of Resident #91's Nursing Progress notes revealed the following: 12/3/2025 at 10:32 AM, Staff T, ADON, documented, Resident #91 had a cough and runny nose, rapid COVID test positive, isolation in place. 12/8/2025 at 5:36 PM, Staff S, LPN, documented, Resident #91 removed from droplet isolation precautions due to resolved active COVID signs or symptoms at this time. 12/9/2025 at 9:52 PM, Staff CC, LPN, documented Resident #91 discontinued from isolation, with mask on	F0880		

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F0880 SS = K	Continued from page 54 when in hall or going down stairs. 13. Review of MDS dated 11/8/2025 revealed Resident #96 was admitted to the facility on 11/9/2020 to a semi-private room (roommate Resident #97), BIMS of 0 (resident is not able to complete the assessment) and diagnoses of stroke, hypertension, hemiplegia affecting left side, emphysema, and COPD. Resident #96 requires maximal assistance with transfers and mobility. Review of Resident #96's Care Plan revised 12/8/2025 indicated the following focus and interventions: a. Initiated 10/28/2024, Potential risk for community acquired infection while living in a healthcare setting. Antibiotics as ordered, encourage oral fluids and nutrition as tolerated. Follow standards for outbreak testing and mitigation. Sanitize high touch surfaces to decrease the risk of infection. b. Initiated 12/8/2025, Resident #96 requires isolation precautions specifically related to the COVID-19 infection. Encourage resident to cover their mouth and nose when coughing or sneezing, ensure good infection control measures and PPE are used when working with resident. Contact and droplet isolation, encourage keeping door closed. c. Altered cardiovascular status related to hypertension and history of stroke. Assess for chest pain and shortness of breath and monitor vital signs per protocol. d. Diagnosis of COPD, give aerosol or bronchodilators as ordered monitoring for side effects and effectiveness. Monitor for signs and symptoms of acute respiratory insufficiency. Monitor, document, report any signs and symptoms of respiratory infection. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #96's symptoms started on 12/7/2025, Resident #91 was removed from TBP on 12/12/2025 after 5 days of isolation/TBP. Review of Resident #96's Nursing Progress notes revealed the following: 12/6/2025 at 3:36 AM, Staff DD, RN, documented, Resident #96 requested nurse related to "chest pain." On assessment vital signs within normal limits. Skin warm/pink/dry. Resident reports "feeling like I can't catch my breath." Also describes "chest pain" as "sharp, and constant" located an inch to the right of sternum between ribs 5-6. Heart sound regular without	F0880		

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F0880 SS = K	Continued from page 55 extra sound, murmurs, gallops. Lung sounds clear to auscultation, except mild expiratory wheezes and course crackle to bases anteriorly, Resident #96 has history of COPD and centrilobular emphysema. Denies pain getting worse or better with cough/deep breathing. Denies feeling GI upset, indigestion, bloating. Abdomen is soft, flat, and non-tender. With reassurance that vital signs are stable, resident appeared to be generally calm. Requested a snack & V8. Rapid COVID test is POSITIVE. Contacted on-call provider with telephone orders for Portable chest x-ray 2 view, Mucinex twice daily x5 days, Molunupiravir (antiviral) 800mg by mouth every 12 hours x5 days. Resident #96 updated on positive result. 12/6/2025 at 5:39 AM, Staff DD, RN, documented, also received telephone order for albuterol inhaler, 2 puffs every 6 hours as needed. 12/6/2025 at 5:19 PM, Staff EE, LPN, documented, portable x- ray called x2 today, stated they will try to a send technician today. Resident #96 on isolation for COVID-19, started antiviral today. Vitals T 97.3, P 67, R 18, BP 137/76, SpO2 96% RA. 12/6/2025 at 9:27 PM, Staff EE, LPN, documented, on call provider called due to portable x-ray not able to come and do chest x-rays as ordered. Provider on call updated on Resident #96's status including vital signs. Okay for chest x-ray to be done when they are able. Resident #96 has no respiratory distress noted during shift, no shortness of breath or wheezing noted. On and off nonproductive cough noted, continue on COVID antiviral and Mucinex as ordered. Vitals T 97.3, P 77, R 18, BP 147/76, SpO2 96% RA. 12/7/2025 3:32 AM, Staff Z, LPN, documented, Resident #96, called this nurse and reported that she was having trouble breathing, on call provider notified and give orders to send the Resident #96 to the hospital to be evaluated. 911 called and Resident #96 was transferred to hospital. 12/7/2025 12:48 PM, Staff EE, LPN, documented, Resident #96 returned to facility via ambulance at around 10.30 am, Resident #96 had CTA (specialized CT scan) of the chest, abdomen and pelvis with and without IV contrast. Resident #96 has Abdominal Aortic Aneurysm (serious condition where the main artery in abdomen weakens, balloons out, and can potentially rupture) and needs to follow up with Vascular Surgery this week. Also, resident was placed on Plaxvoid (antiviral) twice daily x 5 days for COVID. Resident #96 appears stable upon arrival, alert to self and able to answer simple	F0880		

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F0880 SS = K	Continued from page 56 questions. No cough, SOB or wheezing noted at this time. Lung sound clear to auscultation bilaterally with normal breathing, SpO2 sat at 96% on room air. T 97.3, P 94, R 18, BP 150/90. Res is resting comfortably without any acute distress. 15. Review of MDS dated 11/8/2025 revealed Resident #97 was admitted to the facility on 9/15/2020 to a semi-private room. (Roommate with Resident #96) Resident #97's BIMS 0 (Resident was not able to complete assessment) and diagnoses of heart failure, type 2 diabetes mellitus, Alzheimer's Disease, and seizure disorder. Review of Resident #97's Care Plan revised 8/27/2025 failed to indicate Resident's risk for COVID. Review of Resident #97's nursing progress notes and orders, failed to provide documentation related to the following; Resident #97's exposure to COVID positive roommate, attempt to separate from roommate or provide interventions to reduce risk of transmission, and ordered monitoring for COVID symptoms. 16. Review of MDS dated 10/4/2025, revealed Resident #100's admission to the facility on 8/1/2024 in a semi-private room. (roommate Resident #85, who tested COVID positive on 12/2/2025), BIMS of 13 (cognitively intact) and diagnoses of hypertension, type 2 diabetes mellitus, asthma, and adult failure to thrive. Review of Resident #100's care plan, revised 12/6/2025 indicated the following focus and interventions: a. Altered cardiopulmonary status with potential for shortness of breath, lung congestion, edema, chest pain, decreased level of consciousness, cyanosis, diaphoresis, complaints of nausea and vomiting related to hypertensive heart disease and asthma. Interventions included avoiding overexertion, requiring frequent rest periods during completion of activities. Observe for signs and symptoms of cardiac decompensation and report to provider. b. Initiated 10/29/2024, Potential risk for community acquired infection while living in a healthcare setting. Follow standards for outbreak testing and mitigation and sanitize high touch surfaces to decrease the risk of infection. c. Revised 12/6/2025, resident required care isolation precautions specifically related to the COVID-19 infection. Encourage resident to cover their mouth and nose when coughing or sneezing, ensure good infection	F0880		

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F0880 SS = K	Continued from page 57 control measures and PPE are used when working with resident. Contact and droplet isolation, encourage keeping door closed. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #100's symptoms started on 12/7/2025, (6 days after roommate tested positive) Resident #100 was removed from TBP on 12/12/2025 after 5 days of isolation/TBP. Review of Resident #100's Nursing Progress notes revealed the following: 12/6/2025 at 2:36 PM, Staff FF, LPN, documented, called to Resident #100's room at 1:35 PM with reports that Resident had fallen while this nurse was on break. Another nurse and CNA assisted Resident up and onto toilet. Resident had attempted to toilet self. No visible injuries, range of motion within normal limits. Resident #100 states attempted to transfer to toilet by herself and legs just were so weak she slid down to floor. Resident verbalized did not hit her head and had no pain related to fall. Immediate intervention: Checked for COVID as COVID in building Resident with runny nose and increased weakness. Test positive protocols initiated. 17. Review of MDS dated 10/4/2025 revealed Resident #118 was admitted to the facility on 11/16/2021 in a semi-private room. (roommate Resident #91), BIMS of 12. (moderate cognitive impairment) and diagnoses of stroke, hypertension, traumatic brain injury and abnormalities of gait and mobility. Resident #118 is dependent on staff with the assistance of a mechanical stand for transfers and wheelchair for mobility. Review of Care Plan revised 8/7/2025 indicated the following focus and interventions for Resident #118: a. Initiated 8/8/2024, high risk for COVID exposure due to communal living. Observe for signs and symptoms of COVID. Obtain rapid COVID test as indicated and report results to provider. Should Resident #118 have a positive test, isolate per CMS/CDC guidelines. b. Altered cardiovascular status related to hypertension. c. Needed oxygen therapy related to shortness of breath. Monitor for signs and symptoms of respiratory distress. Oxygen via nasal cannula as needed to keep SpO2 >90%. Review of Resident #118's nursing progress notes,	F0880		

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F0880 SS = K	Continued from page 58 failed to provide documentation related to the following; Resident #118's exposure to COVID positive roommate, attempt to separate from roommate or provide interventions to reduce risk of transmission, provide COVID testing and monitoring for symptoms. 18. Review of Resident #126's discharge MDS dated 12/9/2025 revealed admission to the facility on 12/2/2025 in a private room, BIMS of 13 (cognitively intact) and diagnoses of peripheral vascular disease, type 3 diabetes mellitus, hemiplegia with right side weakness, seizures, expressive aphasia, and history of traumatic brain injury. Review of Care Plan initiated 12/2/205 identified the following focus and interventions: a. EBP due to pressure area on buttocks. Gowns and gloves to be worn with all direct cares. Infection Preventionist to educate staff on donning and doffing of equipment. Proper handwashing before and after all cares. b. High risk for COVID exposure due to communal living. Observe for signs and symptoms of COVID. Should Resident #126 have a positive test, isolate per CMS/CDC guidelines. c. Initiated 12/8/2025, requires isolation precautions specifically related to the COVID-19 infection. Encourage resident to cover mouth and nose when coughing or sneezing, ensure good infection control measures and PPE are used when working with resident. Observe signs and symptoms and inform provider if worsening. Observe for emergency warning signs and notify provider and ensure resident gets medical attention immediately as directed by code status. Ensure resident stays in room, away from other people as much as possible (contact and droplet precautions). Have oxygen available as ordered whenever needed for shortness of breath. Monitor vital signs and notify provider of abnormalities. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #126's symptoms started on 12/6/2025. Review of Resident #126's Nursing Progress notes revealed the following: 12/6/2025 at 2:36 PM, Staff FF, LPN, documented, Resident #126 complained of occasional cough and head cold symptoms. COVID swab done with positive results.	F0880		

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F0880 SS = K	Continued from page 59 19. Review of MDS dated 12/11/2025, revealed Resident #127 was admitted to the facility on 12/5/2025 in a semi-private room without a roommate, BIMS of 15 (cognitively intact) and diagnoses of Afib, coronary artery disease, congestive heart failure, COPD, asthma, cardiomegaly, hypertension, stage 3 kidney disease, and encephalopathy. Resident #127 requires an assist of one with use of gait belt and walker for transfers and ambulation. Review of Care Plan initiated 12/5/2025 indicated the following focus and interventions for Resident #127: a. Altered cardiopulmonary status, avoid overexertion, notify staff of any shortness of breath, chest pain, irregular heartbeat. Observe for signs and symptoms if resident is unable to report and notify provider. Resident requires use of nebulizer treatments; auscultate lung fields as needed and notify provider of any abnormalities. Use of oxygen, 2 liters via nasal cannula at bedtime and as needed for SpO2 <90%. Observe for signs and symptoms of cardiac decompensation and report to provider if symptoms exist. b. High risk for COVID exposure due to communal living. Observe for signs and symptoms of COVID. Obtain a rapid COVID test as indicated and report results to provider. Should Resident #127 have a positive test, isolate per CMS/CDC guidelines. c. Enhanced Barrier Precautions (EBP) due to chronic wounds, gowns and gloves to be worn with all direct cares. Proper hand washing before and after all cares. d. Initiated 12/11/2025, require care isolation precautions specifically related to COVID-19 infection. Listen to lung sounds, noting areas of decreased or absent and presence of adventitious sounds. Observe for signs and symptoms and inform provider if worsening. Contact and droplet isolation, encourage to keep door closed. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #127's symptoms started on 12/9/2025, Resident #127 was removed from TBP on 12/12/2025 after 3 days of isolation/TBP. Review of Resident #127's Nursing Progress notes revealed the following: 12/9/2025 at 3:14 PM, Staff U, RN documented resident was feeling nausea and congested. COVID test administered and positive result noted. Resident is on	F0880		

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F0880 SS = K	Continued from page 60 droplet precaution. During an interview on 12/17/2025 at 4:05 PM, Stall L, RN, reported the PPE worn depended upon the type of isolation a person was in. If COVID, a gown, gloves, mask and face shield should be worn. A regular mask can be worn or N95 mask. In an interview on 12/17/2025 at 3:55 PM, Staff JJ, Environmental Services Supervisor reported they are supposed to wear an N95 mask whenever they enter or work in a room with someone who has COVID. A linen cart with a yellow bag may be in the room but linens are supposed to be bagged up in a yellow bag and secured, and then can be placed into the laundry chute. In an interview on 12/16/2025 at 5:00 PM, DON stated, the facility follows CDC guidance for positive COVID-19 cases. Per the facility's medical director recommendations, as soon as residents show symptoms, those residents are tested for COVID-19 with an antigen nasal swab test, if the resident tests positive they are immediately placed in Transmission Based Precautions (TBP) until their symptoms have improved, once symptoms have improved they are taken off the TBP. During this time COVID-19 positive residents are prescribed medications to treat their symptoms. DON reports to Iowa Department of Public Health (IDPH) weekly to update them on new and current positive COVID-19 residents. DON informed the survey team, there had been employees who had tested positive and stayed home during the time of their illness. DON stated due to COVID-19 positive residents in this unit, staff who have worked on this unit will continue to be scheduled there and not be assigned to the other units to reduce the risk of transmission. During an interview on 12/16/2025 at 5:00 PM, Facility Administrator stated, the facility only tests residents for COVID-19 that are showing symptoms due to the COVID cases within the facility not being widespread. Facility Administrator stated, the facility providers do not prescribe antiviral medications like Paxlovid as it is not covered by most resident's insurance. The Facility Administrator acknowledged one situation, Resident #59 is COVID-19 positive and roommate Resident #36 has not been tested and stated, due to Resident #36 being asymptomatic he has not been tested. Like influenza, not testing unless symptomatic. Facility Administrator continued, Resident #36 and Resident #59 had not been separated due to no available room and if Resident #36 were to show symptoms of COVID-19, he would be tested. The isolation time and separation of positive COVID residents should be based on their	F0880		

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F0880 SS = K	Continued from page 61 symptoms not positive testing. When a resident does show signs or symptoms, they are to be tested and placed in transmission based precautions immediately. During the interview on 12/16/2025 at 5:00 PM, the Facility Administrator and DON were notified of observations of the staff's failure to follow proper infection control practices including; improper wear of PPE, not using correct PPE for residents/room in TBP, improper handling of contaminated linens, and TBP resident's doors left open. The Administrator and DON stated these practices were not acceptable. DON stated her expectations of staff before entering a resident's room that is on TBP, staff member would don an N95 respirator mask, gown, gloves, and goggles or face shield and before exiting the room, PPE would be doffed and place in the yellow infectious waste bin by the resident's door before exiting, using hand hygiene and replacing standard surgical mask before exiting the room. In an interview on 12/23/2025 at 11:14 AM, Facility's Medical Director stated he reviews the facility's Infection Control Policies annually. His expectation of nursing staff for residents who show symptoms of COVID-19, is to follow the usual procedure; the resident is put in isolation and testing is administered. Once the test is confirmed positive, the resident continues TBP and nursing staff follows the infection control procedure. If needed the resident is then prescribed appropriate medications. If the positive resident has a roommate that is neg, the positive resident should be moved to a private room if available. If there is not a room available, the resident that is negative should be screened and monitored, following the usual precautions treating this room as both residents being COVID positive. The Facility's Medical Director stated his expectations for staff caring for residents that are in TBP would be wear the appropriate PPE including, a gown, gloves, mask, goggles or face shield as is expected in the Infection Control Policy. In an interview on 12/23/25 at 11:45 AM, Staff P, QA, stated she has only been at Trinity Lutheran for a short time and is still learning the facility's process. She does hold an Infection Preventionist Certification and is assisting with infection prevention (but is not primary Infection Preventionist) in addition to her primary role as Quality Assurance. Recently she took over the infection module in the facility's electronic health record software, and is currently updating it, but it did not appear this	F0880		

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F0880 SS = K	Continued from page 62 module had been previously used to track positive covid cases. Staff P, QA, stated she was not aware the facility had the capability to separate roommates when one is COVID positive, interventions can be put in place to reduce risk of transmission to the negative roommate, the curtain/dividers in their rooms can help. Staff P stated the isolation/TBP time for COVID positive residents is 10 days and symptom free but they have gone back and forth with the providers about this and currently have been removing residents from isolation/TBP based on symptoms. Staff P, stated for TBP staff are expected to wear a gown, gloves, face shield/goggles, N95 mask for PPE, these should be donned prior to entering the room and doffed at the doorway before exiting, not to wear the contaminated PPE out into the hallway, including removing their N95 mask. Staff P, was not aware of any staff audits being completed related to use of PPE, she has observed staff not following correct precautions when using PPE and has stopped and educated those employees at that time. During interviews and email communication on 12/17/2025 and 12/18/2025, the IDPH Nurse Clinician, stated when communicating with long term care facilities regarding positive COVID-19, recommendations are to follow the CDC guidelines. In an email on 12/17/25 at 1:27 PM, IDPH Nurse Clinician provided the following highlights from the CDC Infection Control Guidance that is recommended: 1. Asymptomatic patients with close contact with someone with COVID infection should have a series of three viral tests for COVID-10. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be day 1 (where day of exposure is day 0), day 3, and day 5. 2. TBP for patients with COVID-19 infection: a. At least 10 days have passed since symptoms first appeared AND b. At least 24 hours have passed since last fever without the use of fever-reducing medications AND c. Symptoms (e.g. cough, shortness of breath) have improved. 3. Resident placement with suspected or confirmed COVID-19 infection:	F0880		

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F0880 SS = K	Continued from page 63 a. Ideally, residents should be placed in a single-person room b. If limited single rooms are available, or if numerous residents are simultaneously identified to have known COVID-19 exposures or symptoms concerning for COVI-19, residents should remain in their current location. In email communication on 12/18/2025 at 8:27 AM, IDPH Nurse Clinician, reported CDC resources are emailed to all facilities to ensure containment. The CDC does recommend a broader approach with testing when additional cases are identified. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days. Review of document dated 12/18/2025 at 11:43 PM, Facility Nurse Practitioner provided the following: Regarding COVID positive patients with roommates: I have been made aware that a patient tested positive for COVID with a roommate that tested negative and was not moved out of the room. However, the negative roommate is considered exposed to the virus and it would not be prudent to move this patient in with another patient that has not been exposed. Doing this would potentially spread the illness to another resident. This is outlined in the CDC recommendations for managing respiratory illnesses in nursing homes. Per CDC recommendations, it is suggested to move the positive resident to another room if available. The CDC also goes on to state "moving residents to a single room is often not practical and in those situations, residents could remain in their current location." This is likely the case at Trinity. Nursing home staff is wearing appropriate PPE and taking necessary precautions to prevent further spread of COVID. Review of the Official State of Iowa Website- Iowa Health and Human Services identified COVID-19 outbreak as three or more COVID-19 positive residents occurring within a 14-day period and is to be reported immediately. Review of facility provided Infection Control Policy and Procedure dated 7/13/2019 revealed the following: The Trinity Center has established an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of communicable	F0880		

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F0880 SS = K	Continued from page 64 disease and infection as per accepted national standards and guidelines. 1. The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious disease, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposure of infectious diseases. 2. All staff are responsible for following all policies and procedures related to the program. 3. Surveillance: a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable disease for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards. b. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assurance and Performance Improvement (QAPI) Committee. c. The RN's and LPNS's participate in surveillance through assessment of residents and reporting changes in condition to the residents' physicians and management staff, per protocol for notification of changes and in-house reporting of communicable disease and infections. 4. Standard Precautions: a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted while providing resident care services. b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. c. All staff shall use personal protective equipment (PPE) according to the established facility policy governing the use of PPE.	F0880		

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F0880 SS = K	Continued from page 65 d. Licensed staff shall adhere to safe injection and medication administration practices, as described in relevant facility policies. e. Environmental cleaning and disinfection shall be performed according to facility policy. All staff have responsibilities related to the cleanliness of the facility and are to report problems outside of their scope to the appropriate department. 5. Isolation Protocol (Transmission-Based Precautions): a. A resident with an infection, symptomatic, or communicable disease shall be placed on transmission-based precautions as recommended by current CDC guidelines. b. Residents on transmission-based precautions should be placed into a private/single room if available/appropriate, or are cohorted with residents with the same pathogen, or share a room with a roommate with limited risk factors, in accordance with national standards. c. Residents will be placed on the least restrictive transmission-based precaution for the shortest duration possible under the circumstances. d. When a resident on transmission-based precautions must leave the resident care unit/area, the charge nurse on that unit/area shall communicate to all involved departments the nature of the isolation and shall prepare the resident for transport in accordance with current transmission-based precaution guidelines. e. Residents with tuberculosis will be discharged to a facility where airborne precautions are able to be initiated. f. Immunocompromised (weakened immune system) and myelosuppressed (bone marrow) residents shall be placed in a private room if possible and shall not be placed with any resident having an infection or communicable disease. g. Visitors coming to visit a resident who is on transmission-based precautions or quarantine, will be informed by the facility of the potential risk of visiting and precautions necessary when visiting the resident. 5. COVID-19 Testing:	F0880		

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F0880 SS = K	Continued from page 66 a. Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible. b. Asymptomatic residents with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. i. Due to challenges in interpreting the result, testing is generally not recommended for symptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. ii. Guidance for work restrictions, including recommended testing for HCP with higher-risk exposures is based on current CDC guidance and facility policy. (See Managing Healthcare Personnel with SARS COV-2 Infection or Exposure). c. Testing considerations for an outbreak of SARS-Cov-2 can be found in the Luther Park Community Coronavirus Testing. d. Performance of pre-admission testing is at the discretion of the facility. e. Performance of expanded screening testing of asymptomatic HCP without known exposures is at the discretion of the facility. f. The facility will have a plan as to how SARS-CoV-2 exposures in the facility will be investigated and managed and how contact tracing will be performed. g. If healthcare-associated transmission is suspected or identified, the facility may consider expanded testing of HCP and residents as determined by the distribution and number of cases throughout the facility and ability to identify close contacts. If an expanded testing (e.g., affected unit as opposed to the entire facility) approach is taken and testing identifies additional infections, testing should be	F0880		

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F0880 SS = K	Continued from page 67 expanded more broadly. If possible, testing should be repeated every 3-7 days until no new cases are identified for at least 14 days. h. Residents and staff who refuse testing or are unable to be tested will be addressed as per facility policy. 6. Equipment Protocol: a. All reusable items and equipment requiring special cleaning or disinfection shall be cleaned in accordance with our current procedures governing the cleaning and disinfection of soiled or contaminated equipment. b. Single-use devices must be discarded after use and are never used for more than one resident. c. Reusable items potentially contaminated with infectious materials shall be placed in an impervious clear plastic bag. Label bag as "CONTAMINATED" and place in the soiled utility room for pickup and processing. d. The contaminated reusable items will be cleaned with a germicidal detergent prior to storing for reuse. 7. Linens: a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent the spread of infection. b. Clean linen shall be always separated from soiled linen. c. Clean linen shall be delivered to resident care units on covered linen carts with covers down. d. Linen shall be stored on all resident care units on covered carts, shelves, in bins, drawers, or linen closets. e. Soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. f. Laundry services staff should not handle soiled linen unless it is properly bagged or appropriate PPE is being used (e.g., gloves). 8.Staff Education: a. All staff shall receive training, relevant to their	F0880		

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F0880 SS = K	Continued from page 68 specific roles and responsibilities, regarding the facility's infection prevention and control program, including policies and procedures related to their job function. b. All staff shall demonstrate competence in relevant infection control practices. c. Direct care staff shall demonstrate competence in resident care procedures established by our facility. 8. Outbreak Mitigation: a. An outbreak at Trinity Center is considered 3 or more positives of the same illness including residents and designated staff on a hall within 72 hours. For example, two residents become positive and a staff member that only works that hall becomes positive within 72 hours of each other. b. If the illness spreads to residents on other units, then masking will be required for the whole floor. For example, one hall is in an outbreak and another hall has a resident that becomes positive with the same illness. c. If illness spreads to both floors, masking will be required for the whole building. d. If no additional positives occur for 14 days, masks can be discontinued on the designated hall or floor. e. EVS will increase disinfection during facility outbreaks. Review of CDC guidance updated 12/11/2025 (also stated in CDC Infection Control Guidance: SARS-COV-2 dated 6/24/2024)revealed the following practices for COVID-19 in Long Term Care Facilities: Health Care Professionals (HCP) who enter the room of a patient with suspected or confirmed COVID-19 infection should adhere to Standard Precautions and us an approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection. (i.e. goggles or face shield that covers the front and sides of the face) A. Duration of Transmission Based Precautions for Patients with COVID-19 infection should continue to wear source control until symptoms resolve or, for those who never developed symptoms, until they meet the criteria to end isolation as listed.	F0880		

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F0880 SS = K	Continued from page 69 1. At least 10 days have passed since symptoms first appeared AND 2. At least 24 hours have passed since last fever without the use of fever-reducing medications AND 3. Symptoms (e.g. cough, shortness of breath) have improved. B. Residents placed in Transmission Based Precautions for acute respiratory infection should primarily remain in their rooms except for medically necessary purposes. If they must leave their room, they should practice physical distancing and wear a facemask for source control. The resident should be removed from Transmission Based Precautions as soon as they are deemed no longer infections to other. C. Preventing Spread of Covid-19 among residents: 1. Apply appropriate Transmission Based Precautions for symptomatic residents based on the suspected cause of their infection. 2. When available, residents can be placed in a single person room to minimize the risk of spread to roommates. Moving residents to a single room is often not practical and in the situations, resident could remain in the current location. In shared rooms: a. Consider ways to increase ventilation. b. Use of facemasks at all times by both residents while in the room may also reduce the risk of spread, but is often impractical and not routinely recommended. c. Symptomatic residents should not be placed in a room with a new roommate unless they have both been confirmed to have the same respiratory infection. d. Roommates of symptomatic residents- who have already been potentially exposed- should not be placed with new roommates, if possible. They should be considered exposed and wear a facemask for source control around others. 20. The MDS assessment dated 10/18/25 revealed Resident #2 had diagnoses of dementia, pulmonary edema, and cardiomegaly (enlarged heart). The MDS documented the resident had dependence on staff for bed mobility and toileting hygiene. The MDS indicated the resident had an indwelling catheter.	F0880		

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F0880 SS = K	Continued from page 70 The Care Plan revised 10/31/25 revealed Resident #2 had an indwelling catheter and had a history of urinary tract infections. The care plan directed staff to check and change the resident in bed. Observation on 12/16/25 at 12:28 PM, Staff Q, certified nursing assistant (CNA) donned a yellow gown and gloves, and emptied Resident #2's catheter bag. Staff Q removed his gloves and washed his hands. At 12:36 PM, Staff R, certified medication aide (CMA) placed a package of disposable wipes on the bed. Staff Q obtained a clean brief and placed it on the overbed table. The package of disposable wipes fell off the bed and onto the floor. Staff R picked the package of wipes off of the floor and held the package in her hand. Staff Q removed the tabs on the resident's brief, then Staff R opened the package of wipes, took the disposable wipes from the package and handed the wipes to Staff Q as Staff Q provided pericare to the resident's front and backside. Staff Q removed his gloves and washed his hands while Staff R placed a clean brief on the resident. In an interview on 12/23/25 at 11:35 AM, Staff S, LPN, reported the disposable wipes that fell on the floor should have been thrown away. In an interview 12/23/25 at 12:34 PM, Staff T, Assistant Director of Nursing (ADON), reported she expected staff place the package of disposable wipes on a clean environment on the bedside table. Staff should not ly the disposable wipes on the bed. Staff T stated the package of disposable wipes that fell on the floor should have been thrown away. An Infection Prevention and Control Program effective 7/13/19 revealed supplies are stored and maintained as clean prior to use. The EBP sign directed staff to wear gloves and a gown for the following: High-Contact Resident Care Activities. a. Dressing b. Bathing/Showering c. Transferring d. Changing Linens e. Providing Hygiene	F0880		

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F0880 SS = K	Continued from page 71 f. Changing briefs or assisting with toileting g. Device care or use: central line, urinary catheter, feeding tube, tracheostomy h. Wound Care: any skin opening requiring a dressing On 12/17/25 at 4:27 PM, DON, stated all staff should follow the CDC guidelines for PPE use. A policy titled “Enhanced Barrier Precautions” effective 5/29/24 directed staff to position a trash can inside resident room near the exit for discarding PPE after removing prior to exit of the room.	F0880		

Plan of correction for annual survey at Luther Park community Center exiting 12/23/25

This serves as the credible allegation of compliance for Trinity Center of Luther Park Desmoine's, Iowa. We assert that all correctives on this plan of correction have been implemented. Regarding the specific deficiencies, we have outlined our corrective actions and continued interventions to ensure compliance with regulations and our plan of action. The staff at Luther Park are committed to delivering high quality health care to its residents to obtain their highest level of physical, mental, and psychosocial functioning. We respectfully submit that Trinity Center of Luther Park care is in substantial compliance as set forth below. We are confident that we will be found in substantial compliance upon re-survey.

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. Trinity Center of Luther Park has completed the following interventions as a result of the survey ending 12/23/25. The facility will be in substantial compliance on 1/22/26.

F 605 SS=D RIGHT TO BE FREE OF CHEMICAL RESTRAINTS

Luther Park of Trinity Center will ensure that each resident will be free from chemical restraints. The Chief Nursing Officer re-educated the nurses on 1/19/26 at an in-service regarding the proper procedure and documentation required when administering PRN psychotropic medications. This education consisted of documenting non-pharmacological interventions PRIOR to administration of a psychotropic medication. In addition, the Director of Clinical Services has created a template/alert within PCC (the facility's Electronic Medical Records) that requires the nurse to document each non-pharmacological attempt made prior to administering the medication. The DON and/or designee will monitor/audit the administration of PRN medications weekly for two months and PRN thereafter to ensure ongoing compliance. Any discrepancies in documentation during the audits will be addressed individually with the nurse not following the policy for documentation. Concerns identified will be reported and addressed in the facility's quality assurance program with immediate intervention as indicated. The Director of Nursing and/or designee will be responsible for ensuring ongoing compliance.

F 628 SS=D DISCHARGE PROCESS

Luther Park of Trinity Center will ensure that prior to discharge, the facility will notify the resident and the resident's representative(s) of the transfer or discharge in writing. A bed hold policy will be given prior to discharge. The facility administrator reeducated the facility's social worker on the policy of obtaining a bed-hold notice upon transfer. Transfers

and discharges will be reviewed in the morning clinical start-up meeting, whereas the social worker will bring a copy of the bed hold notice to review in the meeting. Licensed nurses were re-educated on the bed hold policy at a facility in-service on 1/19/26 to ensure the bed hold notice is sent, including on weekends. Concerns identified will be reported and addressed in the facility's quality assurance program with immediate intervention as indicated. The Social Worker, Director of Nursing, and facility Administrator is responsible for ensuring ongoing compliance.

F 641 SS=D ACCURACY OF ASSESSMENTS

Luther Park Nursing of Trinity Center will ensure that assessments accurately reflect the residents' status, ensuring that qualified health professionals document medical, functional, and psychosocial issues. Residents # 4, #9, and # 21 have had an MDS correction completed. The facility utilizes the RAI manual for guidance in coding MDS assessments. The RAC (Regional Assessment Coordinator) has re-educated the MDS coordinator on properly coding restraints and coding a mental illness. The RAC coordinator will complete random audits to ensure proper coding on assessments. Concerns identified will be reported and addressed in the facility's quality assurance program with immediate intervention as indicated. The Director of Nursing and MDS coordinator are responsible for ensuring ongoing compliance.

F684 SS=E QUALITY OF CARE

Luther Park of Trinity Center will ensure that based on the comprehensive assessment of a resident, the facility will ensure that residents receive treatment and services in accordance with professional standards of practice, and the comprehensive person-centered care plan and resident choices. The Chief Nursing Officer and Director of Nursing reeducated nursing staff on the expectations of documentation when a resident has COVID or any other infectious illness, and in completion of neuro checks post fall on 1/19/26. The Director of Clinical Services has built a template into PCC-Point Click Care (The facilities electronic medical record) alerting nurses to document a full assessment including lung sounds with any infectious disease, including COVID 19. Additionally, this assessment will include a full set of vital signs and O2 saturation monitoring. The Director of Nursing and the Assistant Director of Nursing will review the 24-hour report in the morning Quality Assurance Meeting to ensure the documentation is complete. The Director of Nursing and the Assistant Director of Nursing will review all falls in the morning QA meeting to ensure neuro checks are documented accordingly. Concerns identified will be reported and

addressed in the facility's quality assurance program with immediate intervention as indicated. The Director of Nursing /Assistant Director of Nursing/ and Infection Preventionist are responsible for ensuring ongoing compliance.

F 689 SS=D FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

Luther Park of Trinity Center will ensure that the residents' environment remains as free of accident hazards and that each resident receives adequate supervision to prevent accidents. Resident #103's friend was re-educated via phone during the survey that a gait belt must be used when transferring this resident, which he stated understanding. Additionally, the facility will have the friend sign a negotiated risk agreement. In the future, if staff observe any family member or friend transferring a resident unsafely, immediate education will be provided by the Director of Nursing or support staff and noted in the resident's care plan. Concerns identified will be reported and addressed in the facility's quality assurance program with immediate intervention as indicated. The Director of Nursing and/or Assistant Director of Nursing are responsible for ensuring ongoing compliance.

F 812 SS=E FOOD PROCUREMENT,STORE/PREPARE/SERVE-SANITARY

The Dietary Manager/Food Service Supervisor is hosting Serve safe classes to approximately 19 dietary employees with three different classes being held. The Dietary manager re-educated all dietary employees on the importance of dating and labelling food items correctly, proper thawing of meat, and discarding of boxes immediately during the survey. The dietary manager has ordered specialty labels for food items to be used upon arrival. Food items referenced as an oval item were eggs. The disc-shaped items were cucumbers. The dietary manager educated staff that the name of the food item, besides the date must also be on the label to define what the food item is. Effective immediately, the dietary supervisor and/or designee will implement weekly rounds of all refrigerators, freezers, and storage areas to ensure foods are properly dated and labeled. Concerns identified will be reported and addressed in the facility's quality assurance program with immediate intervention as indicated. The dietary supervisor is responsible for ensuring ongoing compliance.

F 880 SS=K INFECTION CONTROL

Luther Park of Trinity Center will establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infection. At the issuance of the IJ (Immediate Jeopardy) citation, all previously positive residents with COVID 19 were tested negative. All residents on the 2nd floor were also tested and were negative. The facility is in the process of hiring an infection preventionist. At this time, the Director of Nursing will assume this role until an infection preventionist nurse is hired. The Chief Nursing Officer and the Director of Nursing re-educated licensed staff on the testing requirements, laundry handling, and proper donning and doffing during a COVID 19 outbreak on 1/19/26. Additionally, the facility is consulting with Lisa Vitale, nurse clinician with the Center for Acute Disease and Epidemiology, to review the entire process of testing, donning and doffing, PPE requirements, masking, laundry handling and documentation during a COVID outbreak. The facility currently has ZERO COVID 19 cases, however, should a resident test positive in the future, the facility will follow all requirements to ensure there is limited transmission of the virus. Routine rounds will be completed by all department managers to ensure staff are wearing masks appropriately. Weekly audits will be conducted on proper PPE usage for those residents requiring enhanced barrier precautions, and catheter/peri-care by the infection preventionist, DON and ADON X 2 months and randomly thereafter. Additionally, Lisa Vitale from the Center of Disease and Epidemiology is coming to the facility to help with audits in infection control on 1/16/26 and 1/21/26. Concerns identified will be reported and addressed in the facility's quality assurance program with immediate intervention as indicated. The Director of Nursing, and Infection Preventionist is responsible for ensuring ongoing compliance.