STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165336	A. BUILDING _____ B. WING _____	C 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHABILITATION CENTER OF ALLISON	900 7TH STREET WEST ALLISON, IA 50602

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 ✓	INITIAL COMMENTS Correction date: 07/26/2025 The following deficiencies resulted from the facility's annual recertification survey and investigation of facility reported incident #129500-I, conducted on June 23, 2025 to June 26, 2025. Facility reported incident #129500-I resulted in a deficiency. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Makayla Westendorf
TITLE: Administrator
(X6) DATE: 07/11/2025

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

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residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observation, resident and staff interviews, the facility failed to ensure residents are treated with dignity and respect for 2 of 2 residents reviewed (Residents #31 and #143). The facility reported a census of 39 residents.

Findings include:

1. Resident #31's Minimum Data Set (MDS) assessment dated 04/8/25 identified a Brief Interview for Mental Status (BIMS) score 14 out of 15 indicating intact cognition. The MDS documented Resident #31 as independent (Resident completes the activity by themselves with no assistance from a helper for self-care.) for eating, oral hygiene, upper and lower body dressing, and mobility. The MDS documented Resident #31 required supervision or touching

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assistance (helper provides verbal cues and/or touching/steadying and /or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for shower/bathe self and tub/shower transfers. The MDS included diagnoses of coronary artery disease, diabetes mellitus, and leukemia.

The Care Plan Focus identified Resident #31 has behavior problems related to becoming verbally aggressive towards staff and other residents. The following interventions directed staff to:
a. Approach/speak in a calm manner.
b. Assure the resident that concerns are validated and the staff is willing to address legitimate concerns.
c. Communicate clearly and assertively what behaviors are unacceptable and inappropriate.
d. Document behaviors and response to interventions.
e. Intervene as necessary to protect the rights and safety of others.
f. Monitor behavior episodes and attempt to determine underlying cause.

A Progress Note dated 6/21/25 at 6:11 PM described an incident that occurred around lunch time between Staff M, Housekeeper and Resident #31. Resident #31 reported to Staff A, Licensed Practical Nurse (LPN) that Staff M would not leave her room. Staff M reported Resident #31 did not want the light on and stated she needed the light on to clean. Staff A directed Staff M to leave the room. Staff M failed to leave the room and continued dusting. When she finished, she left the room. Staff M failed to respect Resident #31's preferences to leave the light off and to leave the room when requested.

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In an interview on 6/24/25 at 9:31 AM Resident #31 reported she had been watching a movie and wanted to see the end of the movie when the incident with Staff M occurred. Resident #31 verbalized she asked Staff M to turn off the light when she was finished cleaning. She reported Staff M stepped out of the room and failed to turn the light off so she rose and turned off the light. Resident #31 reported Staff M re-entered the room to continue cleaning and turned the light back on. Resident #31 reported she did ask Staff M to come back later.

In an interview on 6/24/25 at 11:40 AM, Staff M verbalized she recalled Resident #31 said it was okay to clean the room. Staff M revealed she had stepped out of the room to get a rag off of her cart. When she re-entered the room, the light had been turned off. Staff M reported she had turned the light back on. Resident #31 reacted by hollering at her that she did not want the light on. Staff M revealed if Resident would have asked, she would have come back at a later time to clean. Staff M acknowledged she had been trained on dependent adult abuse and resident rights.

In an interview on 6/24/25 at 12:17 PM Staff A, LPN reported she had been called down to the resident's room on 6/21/25 at approximately 12:20 PM. Staff M and Resident #31 had not been heard talking when she entered the room. When Staff A informed Resident #31 that she had been called down to the room, Staff M and Resident #31 began bickering about the light being on/off. Staff A revealed to Staff M that she should have come back at a later time and directed Staff M to leave the room.

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In an interview on 6/24/25 at 12:51 PM with Staff N, Housekeeping Supervisor verbalized resident rooms are cleaned once per week unless the room needs it more often. On weekends resident rooms are vacuumed or mopped, check the garbage, restock bathroom and mop the bathroom floor. Staff N acknowledged the light should be on when cleaning. Staff N acknowledged if a resident did not want the room light on, the housekeeper should return at a later time.

On 6/24/25 at 3:10 PM the Administrator acknowledged training videos had been assigned to review resident rights and abuse.

Review of the Iowa Time Card report revealed Staff M had not punched out until 3:05 PM on 6/21/25.

Review of the facility Patient Protection Guidelines, Abuse Prevention, Reporting and Investigation policy revised in May 2025 documented employees are educated upon hire and annually on the abuse prevention program including the immediate reporting of any suspicion of abuse, neglect, exploitation, mistreatment, misappropriation, patient rights, reporting reasonable suspicion of crime, and use of computers/phone/electronic devices specific to audio/video recordings.

2. On 6/24/25 at 9:28 AM Resident #143 was noted to have multiple days' worth of facial hair growth. At that time, he explained he preferred to be clean shaven. Further explained he had a shower scheduled later that morning and would like to be shaven at that time.

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F 550	Continued From page 5 On 6/24/25 at 4:01 PM Resident #143 explained he did have his shower but the CNA failed to shave him. The Care Plan for interventions for Resident #143 included the information that historically he likes to be clean shaven. During an interview on 6/25/25 at 11:05 AM, Staff C explained men should be shaven daily. During observations on 6/25/25 at 10:22 AM and 6/26/25 at 8:51 AM the resident remained unshaven. During an interview on 6/26/25 at 10:24 AM Staff A explained men should be asked if they want to shave daily. On 6/26/25 at 10:26 AM, Staff A and the surveyor went to Resident #143's room. Staff A acknowledged the facial hair growth. She asked the Resident if he prefers to be clean shaven. He explained he asked to be shaved a couple days ago, but it didn't get done. He further explained he has his own razor but was told the facility had a razor they would use to shave him.	F 550		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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	F 600		

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any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on record review, policy review, personnel files review, resident and staff interviews the facility failed to prevent a staff member alleged of potential abuse of a resident (Resident #31) from contact with other residents. The facility reported a census of 39 residents.

Findings include:

Resident #31's Minimum Data Set (MDS) assessment dated 04/8/25 identified a Brief Interview for Mental Status (BIMS) score 14 out of 15 indicating intact cognition. The MDS documented Resident #31 as independent (Resident completes the activity by themselves with no assistance from a helper for self-care.) for eating, oral hygiene, upper and lower body dressing, and mobility. The MDS documented Resident #31 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and /or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for shower/bathe self and tub/shower transfers. The MDS included diagnoses of coronary artery disease, diabetes mellitus, and leukemia.

The Care Plan Focus identified Resident #31 has

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behavior problems related to becoming verbally aggressive towards staff and other residents. The following interventions directed staff to:
a. Approach/speak in a calm manner.
b. Assure the resident that concerns are validated and the staff is willing to address legitimate concerns.
c. Communicate clearly and assertively what behaviors are unacceptable and inappropriate.
d. Document behaviors and response to interventions.
e. Intervene as necessary to protect the rights and safety of others.
f. Monitor behavior episodes and attempt to determine underlying cause.

On 6/21/25 at 2:26 PM the Administrator contacted Iowa Department of Inspections, Appeals and Licensing to submit and initial report for potential dependent adult abuse.

A review of the Progress Noted dated 6/21/25 at 6:11 PM documented an incident had occurred between Staff M, Housekeeper and Resident #31. The Progress Note revealed the nurse was paged by the housekeeper to the resident room. I got there, Resident #31 was pushing her lunch tray away and looked frazzled with flushed cheeks. I asked her if she was ok, she said "yes" I said I was asked to come down here she said "yes, because she won't leave my room" then the housekeeper said "I paged because she put her hands on me" I asked Resident #31 what happened as the housekeeper was dusting and said "she didn't want the light on but I need the lights on to clean" (Lights are off at this time) I said "so she put her hands on you?" The housekeeper said yes as Resident #31 yelled "yes, because she pushed me!" Then the

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housekeeper said "because you grabbed me!" I stopped them and asked the housekeeper to leave the room and told her when the resident says not right now then they need to come back at a later time. She continued dusting, finished, then left the room. I stayed and asked Resident #31 if she was ok, she stated "no" I said tell me what happened. She said "the housekeeper came in and wanted to clean and I didn't want her to turn the light on to do the cleaning but she kept insisting that she had to have the lights on to clean and she couldn't see without the lights!" She said "I grabbed her to get her away from the light then the housekeeper pushed me" I asked if I could see her skin, she said "for what?" I stated "to see if it left any marks" she said "no, she didn't push me that hard" she stated "I just think when I ask if they can wait to do something than it can wait until later. I am in my room today because my teeth, bottom plate, is bothering me and it hurts to chew." I asked if she wanted something for the pain and she stated "no, I don't like to take any more medications then what I have to" I told her I could tell people to stay out of her room this weekend so she could rest if she would like and she said "no, I don't mind if they come to do what they need to do just not when I don't want them in here. They can come back." I told her she is right, asked if she was ok again, she said she will be.
Assessment of Resident including range of motion & Pain: within normal limits
Vital Signs - If FALL include Ortho B/P: 130/79,80, 95%, 98.8, 18, no pain
Describe Any Injury Noted: none noted at this time
List Any Treatment Provided: emotional support
List Relevant Interventions That Were In Place At The Time of The Incident: Removed the housekeeper from the situation

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Preliminary Recommendations, if any, for consideration as further preventative measures:: respect resident wishes
List Responsible Party Notified: daughter
Which Physician Was Notified - Include Date & Time of Notification: Primary Physician notified at 1822

During an interview on 6/24/25 at 9:31 AM Resident #31 recalled the incident from 6/21/25. Resident #31 revealed she had wanted to finish watching a movie and had the lights off in her room. Staff M, Housekeeper had wanted to clean the room. Resident #31 allowed Staff M to enter the room. Staff M left the room and had not shut the light off so Resident 31 shut the light off. Staff M re-entered the room and turned the light on. Resident #31 revealed she rose from her chair to go shut the light off. Staff M had been near the light switch. Resident stated she had reached over Staff M's right shoulder as she was reaching for the light. Resident #31 revealed Staff M had raised her hand up with fingers open, her elbows along her side. Resident #31 acknowledged staff did not extend her arms nor was any force or pressure felt as Resident #31 continued to move forward. Resident did not appear fearful, agitated or anxious as she recalled the incident. Resident acknowledged she had no injuries.

During an interview on 6/24/25 at 11:40, Staff M recalled the incident. Staff M revealed as Resident #31 reached for the light the resident had grabbed her arm. Staff M acknowledged there had been no marks left on her arm. Staff M acknowledged she had raised her hands up as the resident was coming towards her. Staff M could not recall if her hands actually touched the resident. Staff M revealed when her hands were

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up the resident was less than 6 inches away from her. Staff M acknowledged when she left the residents room she continued cleaning other resident rooms. Staff M acknowledged she went in to approximately 18 (all of east hall way and approximately half of the south hallway rooms) rooms. Staff M revealed residents had been in all rooms but 2. Staff M acknowledged no other staff members had accompanied while she continued to clean resident rooms.

During an interview on 6/24/25 at 12:17 PM, Staff A revealed she had directed Staff M to leave Resident #31's room. Staff A acknowledged she separated Staff M from the resident but failed to separate Staff M from all other residents.

During an interview on 6/24/25 at 1:50 PM, Staff D, LPN acknowledged she had been the nurse on call on 6/21/25 and had received a call from Staff A. Staff D directed Staff A to get statements and to call the Administrator. Staff D acknowledged she failed to provide direction to remove Staff M from potential contact with all residents.

During an interview on 6/24/25 at 3:10 PM, the Administrator acknowledged she had been notified around 1:00 PM on 6/21/25. When the Administrator returned the call to the facility, Staff A thought Staff M had already left the facility.

Review of the Personnel File for Staff M revealed a Dependent Adult Abuse training certificate dated 12/30/22.
Review of the Personnel File for Staff A revealed a Dependent Adult Abuse training certificate dated 4/6/25.

Review of the facility policy Patient Protection

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Guidelines, Abuse Prevention, Reporting and Investigation with a revision date of May 2025 directed the following:

Employees are educated upon hire and annually on the abuse prevention program including the immediate reporting of any suspicion of abuse, neglect, exploitation, mistreatment, misappropriation, patient rights, reporting reasonable suspicion of crime, and use of computers/phone/electronic devices specific to audio/video recordings.

Protection
Upon receiving a report of an allegation of resident abuse, neglect, exploitation, injuries of unknown origin or misappropriation, the facility shall immediately implement measures to prevent further potential abuse of resident from occurring while the facility investigation is in process.

If this involves an allegation of abuse by an employee, this will be accomplished by separating the employee accused of abuse from all residents through the following or a combination of the following, if practicable: (1) suspending the employee; (2) segregating the employee by moving the employee to an area of the facility where there will be no contact with any residents of the facility; and in rare instances (3) separating the employee accused of abuse from the resident alleged to have been abused, but allowing the employee to care for and have contact with other residents, only if there is a second employee who remains with and accompanies the employee accused of abuse at all times to supervise all contacts and interactions with residents.

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F 610	Continued From page 12	F 610		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, policy review, and staff interview the facility failed to thoroughly investigate an allegation of abuse. The facility failed to conduct resident and staff interviews for the date of the incident to determine the extent of the allegation or determine if other residents had been affected. The facility reported a census of 39 residents. Findings include: Resident #31's Minimum Data Set (MDS) assessment dated 04/8/25 identified a Brief Interview for Mental Status (BIMS) score 14, indicating intact cognition. The MDS documented Resident #31 as independent	F 610		

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(Resident completes the activity by themselves with no assistance from a helper for self-care.) for eating, oral hygiene, upper and lower body dressing, and mobility. The MDS documented Resident #31 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and /or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for shower/bathe self and tub/shower transfers. The MDS included diagnoses of coronary artery disease, diabetes mellitus, and leukemia.

The Care Plan Focus identified Resident #31 has behavior problems related to becoming verbally aggressive towards staff and other residents. The following interventions directed staff to:
a. Approach/speak in a calm manner.
b. Assure the resident that concerns are validated and the staff is willing to address legitimate concerns.
c. Communicate clearly and assertively what behaviors are unacceptable and inappropriate.
d. Document behaviors and response to interventions.
e. Intervene as necessary to protect the rights and safety of others.
f. Monitor behavior episodes and attempt to determine underlying cause.

The Progress Note Incident Report for 6/21/25 6:11 PM documented by Staff A, LPN revealed Resident #31 stated Staff M, Housekeeper had pushed her while in the residents' room. Staff A completed an assessment of Resident #31 including range of motion and pain and documented to be within normal limits.
Vital signs - blood pressure: 130/79, pulse 80, O2

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saturation 95%, temperature 98.8, and respirations 18, Resident had no pain.
Describe any injury noted: none noted at this time
List any treatment provided: emotional support
List relevant interventions that were in place at the time of the incident: removed the housekeeper from the situation.
Preliminary recommendations, if any, for consideration as further preventative measures: respect resident wishes.
Staff A notified the resident representative and primary physician.

The Investigation Report submitted by the facility had been received on 6/23/25. The facility investigation lacked documentation of interviews with other residents and staff. It further lacked documentation of investigation if Staff M had contact with other residents following the incident. Recommendations in the Investigation Report listed re-education for housekeeping and dietary employees but lacked training or re-education for other department employees.

In an interview on 6/24/25 at 12:17 PM, Staff A reported she had notified the nurse manager on call for 6/21/25 at approximately 12:38 PM. Staff A had been directed to obtain written statements and to call the Administrator. Staff A revealed the Administrator had called back at approximately 2:30 PM and reported to the Administrator that Staff M had finished her shift and left the facility. Staff A acknowledged she failed to keep a potential abuser from contact with other residents.

In an interview on 6/24/25 at 1:50 PM, Staff D, LPN acknowledged she had been the nurse manager on call for 6/21/25. Staff D verbalized

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she had directed Staff A to obtain written statements from everyone and disclosed it was a possible allegation of abuse that would need to be reported. Staff D sent a text message to the Administrator to inform her of the nurse calling in regards to the incident.

In an interview on 6/24/25 at 3:00 PM, the Director of Nursing (DON) acknowledged she had been notified by the Administrator about the incident on 6/21/25 at approximately 2:30 PM. The DON reported she had been out of town and the Administrator did not direct her to do anything. The DON verbalized the Administrator had reported the incident to the Iowa Department of Inspections, Appeals and Licensing.

In an interview on 6/24/25 at 3:10 PM, the Administrator reported she had called the Iowa Department of Inspections, Appeals and Licensing on 6/21/25 at 2:26 PM. The Administrator provided 2 hand written statements from Staff A and Staff M. The Administrator reported she had no other statements on file for the investigation of the incident.

In an interview on 6/25/25 at 9:55 AM, the Administrator reported she had not interviewed any other residents as part of her investigation. The Administrator acknowledged she had spoken with Staff A, Staff M, Staff O, Laundry and Staff P, Dietary Manager and no other staff members that had worked on 6/21/25. The Administrator verbalized she had been continuing her investigation and reiterated she had 5 days to submit a summary.

On 6/26/25 at 1:37 PM the Iowa Department of Inspections, Appeals and Licensing had received

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F 610	Continued From page 16 additional information to the facilities Investigation Report. The Investigation Reported included 1 additional staff statement and re-education of all staff on residents' rights, including the right to refuse care can control of their environment.	F 610		
F 689 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 clinical record review, facility policy review, observation and staff interview the facility failed to keep cigarettes and lighter in a secure place inaccessible to other residents for 1 of 1 residents reviewed (Resident #30). The facility reported a census of 39 residents. Findings Include: Resident #30's Minimum Data Set (MDS) assessment dated 3/31/25 listed an admission date of 3/24/25. The MDS identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. The MDS documented Resident #30 as a current tobacco user. The MDS included diagnoses of depression, Chronic Obstructive Pulmonary Disease (COPD), emphysema, and alcoholic liver disease.	F 689		

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Resident #30's Smoking Program Assessment dated 4/4/25 documented Resident #30 to be a safe smoker and may use/access smoking materials consistent with the facility policy. The assessment documented staff are not required to remain in attendance while the Resident #30 is smoking. Resident #30 agrees to follow smoking rules.

The Care Plan Focus documented tobacco use initiated on 4/4/25 with the following interventions for Resident #30:
a. May smoke without assistance. Wear protective smoking vest or apron.
b. Must keep smoking accessories secured when not in use (lighter and cigarettes located at nurses' station).
c. Must smoke only in designated areas/designated times (unless able to independently get to and from the designated areas).

In an interview with Resident #30 on 6/23/25 at 1:25 PM, he revealed his cigarettes and lighter are kept at the nurses' station.

Observation on 6/25/25 at 8:06 AM, Resident #30 had been standing by Staff A, Licensed Practical Nurse (LPN) in the day room. Resident #30 had on tennis shoes, blue jeans, coat, ball cap and smoking apron. Resident #30 had his walker in front of him and held a cushion with his right hand. Resident #30 proceeded to walk past the nurses' station, through the dining room and exit the building.

In an interview on 6/25/25 at 8:09 AM, Staff A stated she had not provided Resident #30 with his cigarettes and lighter. Staff A revealed Resident

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#30 picks up his cigarettes and lighter that had been placed behind a brochure holder when he desired to smoke. Staff A proceeded to show where the cigarettes and lighter had been kept on the top edge of the north side of the nurses' station behind a clear plastic 8 x 12-inch brochure holder. The brochure holder had been filled with various brochures. The brochure holder had been located approximately 16 inches from the wall. Behind the brochure holder a pack of cigarettes and a blue lighter had been observed. Staff A acknowledged the cigarettes and lighter are kept behind the brochure holder during the day so Resident #30 can grab them at his convenience. Staff A revealed the cigarettes and lighter are kept in the desk drawer on the over night shift.

Observation on 6/25/25 from 8:11 AM to 8:28 AM of Resident #30 revealed the following:
a. At 8:11 AM resident #30 cigarettes were observed behind a brochure holder at the nurses station. Resident #30 grabbed the cigarettes and lighter from the counter.
b. At 8:15 AM Resident #30 exited the facility to smoke in the designated smoking area and smoked.
c. At 8:28 AM Resident #30 returned his lighter and cigarettes to behind the brochure holder without staff knowledge.

In an interview on 6/25/25 at 8:33 AM, the Director of Nursing (DON) acknowledged the cigarette and lighter had been left unattended at the nurses' station.

In an interview on 6/25/25 at 10:36 AM, Staff B, Certified Nursing Assistant (CNA) identified Resident #30 as a current smoker. Staff B

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verbalized his cigarettes and lighter are kept behind the brochure holder at the nurses' station or in a desk drawer.

In an interview on 6/25/25 at 11:05 AM, Staff C, CNA/Certified Medication Aide (CMA) identified Resident #30 as a current smoker. Staff C reported his cigarettes and lighter had been kept on the nurses' station counter behind the brochure holder. Staff C acknowledged she had been instructed on 6/25/25 the cigarettes and lighter are not to be kept sitting out in the open.

In an interview on 6/26/25 at 6:58 AM, Staff D, LPN identified Resident #30 as a current smoker. Staff D acknowledged his cigarettes and lighter are to be stored in a lock box at the nurses station. Staff D reported she had observed the cigarettes and lighter behind the brochure holder on 6/25/25. Staff D acknowledged the cigarettes and lighter had been accessible to other residents.

In an interview on 6/26/25 at 7:30 AM, Staff E, CNA identified Resident #30 as a current smoker. Staff E reported she had observed cigarettes and lighter behind the brochure holder daily.

In an interview on 6/26/25 at 7:37 AM, Staff F, CNA identified Resident #30 as a current smoker. Staff F reported she had observed the cigarettes and lighter sitting on the nurses' station counter every morning.

The facility Smoking Policy with a revision date of January 2024, revealed residents determined to be an independent smoker may smoke without assistance or supervision. Independent smokers must follow smoking guidelines including keeping

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F 689	Continued From page 20 smoking accessories secured when not in use (via lockbox or in control of center staff), smoking only in designated areas/designated times (unless resident is able to independently get to and from the designated smoking area).	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced	F 725		

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by:
Based on resident and staff interviews, the Facility Assessment, Facility Concern Forms (the facility grievance forms), and policy review, the facility failed to have sufficient staff to meet the needs for 2 of 2 residents (Residents #6 and #10). The facility reported a census of 39 resident.

Findings Include:

1. Resident #6's Minimum Data Set (MDS) assessment dated 4/8/25 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented Resident #6 required partial/moderate assistance (the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.) for showers and upper body dressing. The MDS documented Resident #6 had been dependent (the helper does ALL of the efforts. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.) for toileting hygiene, lower body dressing and putting on/taking off footwear. The MDS included diagnoses of hypertension, morbid (severe) obesity due to excess calories, lymphedema, and Guillain-Barre syndrome (a rare autoimmune disorder where the body's immune system mistakenly attacks the peripheral nerves).

The Care Plan focus initiated on 8/28/21 identified Resident #6 required assistance with activities of daily living (ADL's) related to obesity, history of an ankle fracture and limited mobility. The interventions directed the following:
a. Assist resident with shower/bathing per

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schedule. Assist of one with bathing. May request bed bath at times.
b. Toilet: Resident uses urinal in bed. May also use bedpan in bed for bowel movement. Assist of one to place bedpan. Prefer a urinal at the bedside while in bed. Assistance needed with emptying urinal.
c. Dressing & Grooming: staff assist of one
d. Transferring: Resident my transfer with 2 with all functional transfers. Use gait belt and front wheeled walker to commode.
e. Walking: Resident may ambulate in the hallway with front wheeled walker. Assist of 1-2 with use of gait belt and wheelchair. Distance as tolerated.

A Concern Form dated 5/12/25 revealed Resident #6 had voiced a concern with call light response times being slow over the weekend. Resident #6 had voiced his concern to the Administrator. Follow up and resolution occurred on 5/14/25. Results taken included discussion with agency staff, do not return staff and restructuring of who works as the float. Resident #6 had not been satisfied with the resolution and preferred not to have agency in the building. The Concern Form was signed by the Administrator on 5/14/25.

A Concern Form dated 5/15/25 revealed Staff G, Registered Nurse (RN) voiced a concern of not enough third shift staff to the Administrator. Follow up and resolution occurred on 5/27/25. The form documented schedules reviewed with appropriate staffing levels based on census. For a census of 41 facility had been staffing 2 CNA's and 1 nurse. Staff G, RN had not been satisfied with the resolution. Additional follow-up needed. Will continue to monitor schedules on an ongoing basis to ensure 2 CNA's and 1 nurse are

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scheduled.

In an interview on 6/23/25 at 10:54 AM, Resident #6 disclosed he had waited 45-50 minutes for response when he activated his call light. Resident #6 has a clock on the wall across the room that is approximately 10 feet from the head of his bed and approximately 12 feet from his recliner. Resident #6 revealed he had waited up to 45-50 minutes for response from an activated call light. Resident #6 acknowledged he is able to read the clock time.

In an interview on 6/25/25 at 6:05 AM, Staff G revealed there had been several times where there had only been one nurse and one CNA on the overnight shift (10:00 PM to 6:00 AM) to care for all the residents. Staff G revealed residents are waiting longer than 15 minutes for response of activated call lights. Staff G acknowledged when there is only 1 nurse and 1 CNA she ends up working more as the CNA versus the nurse. Staff G felt she is putting her nursing license at risk and stated she had reported concerns to the Director of Nursing (DON) and the Administrator.

In an interview on 6/26/25 at 6:58 AM, Staff D, Licensed Practical Nurse (LPN) acknowledged the facility utilizes outside agency staff to cover open shifts. Staff D revealed call-ins occurred more on the weekends rather than during the week. The facility posts open positions on outside agency sites, have scheduled extra staff on the weekends and ask CNA's and nurses to stay over. Staff D acknowledged at times nursing management had come in to assist with meeting resident needs. Staff D acknowledged the facility staffs as follows:
For Nurses

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First Shift- 2 nurses or 1 nurse and 1 Certified Medication Aide (CMA)
Second Shift 2 nurses or 1 nurse and 1 Certified Medication Aide (CMA)
Third Shift- 1 nurse
For CNA's
First Shift - 3 CNA's plus a float (CNA that helps in all halls) and a bath aide during the week. Bath aide does not work on the weekend.
Second Shift - 2 CNA's plus a float
Third Shift - 2 CNA's
Staff C acknowledged residents at times had to wait longer than 15 minutes for response from staff.

On 6/26/25 at 10:23 AM, the Administrator voiced the facility did not have call light audit reports.

In an interview 6/26/25 at 1:48 PM, the DON revealed staffing is determined by the census of the facility. The DON acknowledged the facility currently staffs the following:
For Nurses
First Shift- 2 nurses or 1 nurse and 1 Certified Medication Aide (CMA)
Second Shift - 2 nurses or 1 nurse and 1 Certified Medication Aide (CMA)
Third Shift- 1 nurse
For CNA's
First Shift -4 CNA's and a bath aide during the week. Bath aide does not work on the weekend.
Second Shift - 3 CNA's plus 1 CNA for half of shift
Third Shift - 2 CNA's
The DON expects call lights response time to be between 5-15 minutes. The DON acknowledged call light response has been greater than 15 minutes and had started a performance improvement plan on call light audits and staffing.

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The facility provided Iowa Time Card Report revealed the following punches for outside agency staff and facility employees:
Staff H, RN punched in at 9:53 PM on 4/1/25 and punched out at 6:30 AM on 4/2/25.
Staff I, CNA punched in at 6:09 PM on 4/1/25 and punched out at 6:30 AM on 4/2/25.
The facility provided Iowa Time Card Report failed to show a second CNA punched in for the overnight shift.

Staff G, RN punched in at 9:54 PM on 4/16/25 and punched out at 6:41 AM on 4/17/25.
Staff J, CNA punched in at 9:56 PM on 4/16/25 and punched out at 11:29 PM on 4/16/25.
The facility provided Iowa Time Card Report failed to show a second CNA punched in for the overnight shift.

Staff G punched in at 9:58 PM on 5/14/25 and punched out at 6:30 AM on 5/15/25.
Staff L, CNA punched in at 1:54 PM on 5/14/25 and punched out at 1:30 AM on 5/15/25.
The facility provided Iowa Time Card Report failed to show 2 CNA's punched in for the overnight shift on 5/14/25.

Staff G punched in at 9:58 PM on 5/22/25 and punched out at 6:41 AM on 5/23/25.
Staff K, CNA punched in at 9:51 PM on 5/22/25 and punched out at 6:12 AM on 5/23/25.
The facility provided Iowa Time Card Report failed to show a second CNA punched in for the overnight shift.

The undated Facility Assessment directed the facility to use the Facility Assessment to:
a. Inform staffing decisions to ensure that there are adequate staff with appropriate competencies

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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and skill sets to care fore its residents needs as identified through resident assessments and plans of care.
b. Consider specific staff needs for each shift (such as day, evening, night), and adjust as necessary based on changes to its resident population.
c. Develop and maintain a plan to maximize recruitment and retention of direct care staff.
General Staffing Guidelines revealed the following for the Nursing Department
Shifts: 8 hour and 12 hours
Shift hours:
1. 6:00 AM -6:00 PM, 6:00 PM -6:00 AM
2. 10:00 PM -6:00 AM, 6:00 AM -2:00 PM, 2:00 PM -10:00 PM
3. Facility 24-hour day starts at 10:00 PM and ends at 9:59 PM on the following day
Contract Services are utilized
Staffing
1 Director of Nursing
1 Assistant Director of Nursing
1 Infection Preventionist/Staff Development
1 MDS Coordinator
7 Full time licensed Nurse (RN/LPN)
5 Part-time licensed Nurse (RN/LPN)
5 Pro Ra Nata (PRN- as needed) Licensed Nurse (RN/LPN)
3 Full time Certified Medication Aide
2 Part-time Certified Medication Aide
11 Full Time Nursing Assistants
8 Part-time Nursing Assistants
4 PRN Nursing Assistants

The Employee Phone List updated on 6/23/25 revealed the following :
1 Director of Nursing/Infection Preventionist
1 Assistant Director of Nursing
1 MDS Coordinator

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7 Licensed nurses
2 PRN licensed nurses
3 Certified Medication Aides
1 PRN Certified Medication Aide
17 CNAs
5 PRN CNAs
The facility failed to staff according to the Facility Assessments General Staffing Guidelines.

2. Resident #10 Minimum Data Set (MDS) assessment dated 3/25/25 identified a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderately impaired cognition. The MDS documented Resident #10 required substantial/maximal assistance (the helper does MORE THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides more than half the effort.) for toileting hygiene, showers, lower body dressing and putting on/taking off footwear. The MDS documented Resident #10 had been dependent (the helper does ALL of the efforts. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.) for sit to stand, chair/bed-to-chair transfer, toilet transfer and tub/shower transfer. The MDS included diagnoses of non-traumatic brain dysfunction, anxiety disorder, depression and seizure disorder or epilepsy.

The Care Plan focus initiated on 6/1/23 identified Resident #10 required assistance with ADL's related to early onset cerebellar ataxia, balance issues. Uses walker and gait belt with staff assist with wheelchair to follow. Resident may complete functional transfers with use of walker and 2 assist. EZ stand as needed. Partial assist with dressing. Resident prefers to be dressed and out

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F 725	Continued From page 28 of bed by 6:00 AM. Prefers to get ready for bed at 9:30 PM. Bilateral grab bar added to bed per therapy request to assist with repositioning. The interventions directed the following: a. Assist resident with shower/bathing per schedule. Substantial assist times 1. b. Transferring: May use sara steady stand or easy stand for transfers to/from bathroom. c. Walking: To ambulate with front wheeled walker with staff assist and 1 staff to follow behind with wheelchair for straight distances. A facility Concern Form dated 6/4/25 revealed Resident #10 had voiced a concern to Staff C. The Concern Form documented Resident #10 had been scared to go to the bathroom due to the time it takes to answer lights sometimes. Results of action taken included a new call light audit process was in the works, do not return agency workers, facility working to hire own staff to get away from agency use. In an interview on 6/23/25 at 1:40 PM, Resident #10 revealed staff do not respond timely to call lights. Resident #10 did not reveal how long call light response had taken, but felt they have low staff and the agency staff doesn't want to work.	F 725		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		

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§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident and staff interviews the facility failed to ensure treatments were stored in a secure location inaccessible to residents for 1 of 1 residents (Resident #21) observed; failed to ensure all medications and treatments were dated when opened. The facility reported a census of 39 residents.

Findings include:

1. A review of Resident #21's Minimum Data Set (MDS) assessment dated 5/21/25 identified a Brief Interview for Mental Status (BIMS) score 15 out of 15 indicating intact cognition. The MDS included diagnoses of stroke, paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), and obesity.

A review of Resident #21's Physician Orders revealed the following orders:

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a. Abdomen skin folds - cleanse with Vashe wound solution (skin cleanser for debriding and irrigating wounds) with gauze, then thoroughly dried. Clean fissures with Vashe and pat dry. Apply interdry strips in abdominal folds. The start date for the order had been documented as 5/16/25.
b. Mupirocin External Ointment 2% (Mupirocin is an antibiotic ointment used to treat bacterial skin infections, including staph and strep infections) - Apply to open sore between folds topically as needed for open sore. Apply to open sore between folds Pro Ra Nata (PRN-as needed)

On 6/24/25 at 8:04 AM, observation in Resident #21's room identified an unsealed clear bag located in front of Resident #21 on her bedside table with a pharmacy label of Mupirocin Ointment USP 2% for Resident #21. The date opened field appeared to be blank and an expiration date listed 6/20/26. The clear bag contained the Mupirocin Ointment USP 2% and the Vashe wound solution. The Vashe wound solution revealed no date opened or date of expiration on the label.

The Safety Data Sheet for Mupirocin Ointment USP 2% with a revision date of January 2016 revealed the following first-aid measures:
a. Inhalation: If breathing is difficult, remove to fresh air and keep at rest in a position comfortable for breathing. Call a physician if symptoms develop or persist.
b. Skin Contact: Rinse skin with water/shower. Get medical attention if irritation develops and persists.
c. Eye Contact: Rinse with water. Get medical attention if irritation develops and persists.

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d. Ingestion: Rinse mouth. If ingestion of a large amount does occur, call a poison control center immediately.
e. Most Important Symptoms/Effects, Acute and Delayed: May cause allergic skin reaction. Indication of Immediate Medical Attention and Special Treatment Needed: Provide general supportive measures and treat symptomatically.

The Safety Data Sheet for Mupirocin ointment USP 2% revealed the following for handling and storage:
a. Precautions for Safe Handling: As a general rule, when handling USP Reference Standards, avoid all contact and inhalation of dust, mists, and/or vapors associated with the material. Clean equipment and work surfaces with suitable detergent or solvent after use. After removing gloves, wash hands and other exposed skin thoroughly.
b. Conditions for Safe Storage, Including Any Incompatibilities: Store in tight container as defined in the USP-NF. This material should be handled and stored per label instructions to ensure product integrity.
c. Store at 20°-25°C (68°-77°F) [see USP Controlled Room Temperature].

The Safety Data Sheet for Vashe wound solution with an issue date of 10/5/2020 revealed the following first-aid measures:
Description of first-aid measures
a. First-aid measures general: First aid measures are not required for this product. The need for first aid is not anticipated under normal conditions of use.
b. First-aid measures after ingestion: Rinse mouth. Do not induce vomiting. Obtain medical attention.

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The Safety Data Sheet for Vashe wound solution recommended the following for handling and storage:
Conditions for safe storage, including any incompatibilities
a. Technical measures: comply with applicable regulations
b. Storage condition: keep container closed when not in use. Store in a dry, cool place. Keep/store away from direct sunlight, extremely high or low temperatures and incompatible materials.
c. Incompatible materials: Strong acids, strong bases, strong oxidizers. Heavy metals, reducing agents, ammonia, either hydrogen peroxide, chlorhexidine gluconate and silver nitrate.
d. Storage temperature: Do not expose product to temperatures below 0 degrees Celsius (C) or 32 degrees Fahrenheit (F) or above 50 degrees C (122 degrees F). Do not freeze. Store at room temperature between 5 degrees C (41 degrees F) and 25 degrees C (77 degrees F) away from direct sunlight.

In an interview on 6/24/25 at 8:04 AM, Resident #21 verbalized the items in the unsealed clear bag had been applied between the folds of her abdomen. Resident #21 reported a staff member left them on the over-bed table.

In an interview on 6/24/25 at 8:11 AM Staff C, Certified Medication Aide (CMA) acknowledged she left the Mupirocin Ointment USP 2% and the Vashe wound solution in the room after both treatments were applied this morning. Staff C reported both items are to be kept locked in the treatment cart.

On 6/24/25 at 8:12 AM, the Director of Nursing

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(DON) verbalized the Mupirocin Ointment USP 2% and the Vashe wound solution should have been dated when opened and stored in the locked treatment cart.

On 6/24/25 at 4:53 PM, the DON verbalized the facility lacked a policy for medication storage and labeling. The DON reported the facility follows manufacturer's guidelines.

Review of the Treatment Administration Record (TAR) for Resident #21 documented the Vashe wound solution had last been applied on 6/26/25. The Mupirocin ointment USP 2% had last been applied on 6/20/25.

2. Inspection of the West hall medication cart on 6/25/25 at 1:46 PM revealed the following opened medications without a date opened on the packaging:
a. ClearLax 17.9 ounces (oz) bottle for Resident #13
b. ClearLax 17.9 oz bottle for Resident #14
c. Polyethylene Glycol 3350 17.9 oz bottle Stock
d. Geri-Tussin DM 16 fluid (Fl) oz Stock
e. Docusate Sodium Liquid 16 Fl oz for Resident #7
f. Chlorhexidine Gluconate Oral Rinse USP, 0.12% for Resident #7
g. Extra Strength Pain Relief 500 mg tablets Stock

Inspection of the West hall treatment cart on 6/25/25 at 2:11 PM revealed the following opened treatments without a date opened on the packaging:
h. Nystatin Cream for resident #12
i. Diclofenac Gel 1% for Resident #13

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Inspection of the South hall treatment cart on 6/25/25 at 2:23 PM revealed the following opened treatments without a date opened on the packaging
j. Vashe Wound Solution for Resident #34

Inspection of the South Medication cart on 6/25/25 at 2:23 PM revealed the following opened medications without a date opened on the packaging:
k. Fluticasone SPR 50 mcg for Resident #10
l. Polyethylene Glycol 3350 Stock
m. Halls cough and throat relief sugar free honey Stock
n. Mucus Relief Stock
o. Morphine Sulfate Solution 100/5 ml fore Resident #30
p. Gold Bond medicated powder 0.15% 10 oz bottle for Resident #6

Inspection of the East Medication cart on 6/25/25 at 2:32 PM revealed the following opened medications without a date opened on the packaging:
q. GaviLax 17.9 oz bottle for Resident #24
r. Gerri-Tussin Stock
Inspection of the East treatment cart on 6/25/25 at 2:37 PM revealed the following opened treatments without a date opened on the packaging:
s. Hydrocort cream 1% for Resident #9
t. Triple antibiotic ointment for Resident #25
u. Biofreeze 4% gel for Resident #19

On 6/25/25 at 2:39 PM, the Assistant Director of Nursing (ADON) reported she completed a medication cart audit on the West, South, and East medication carts on 6/20/25. The audit did not include items listed without open dates. The

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F 761	Continued From page 35 ADON acknowledged all items should have had a date opened documented on the packaging.	F 761		
F 880 SS=D	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 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;	F 880		

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(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.

§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 observation, clinical record review, staff interview, policy review, and the Center for Disease Control (CDC) website review the facility failed to follow Enhanced Barrier Precautions (EBP) during a tube feeding for 1 of 1 resident (Resident #7) reviewed for tube feedings. The facility reported a census of 39 residents.

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Findings include:

The Face Sheet for Resident #7 documented an admission date of 2/3/14. The Face Sheet included diagnoses of dysphasia (impairment to speak or understand speech) and quadriplegia (paralysis of all 4 limbs).

The Physician's Orders for Resident #7 included Jevity 1.5 Cal/Fiber Oral Liquid (nutritional supplement) to be given by G-Tube (tube feeding).

The Care Plan for Resident #7 included EBP to minimize the risk for transmission during high contact care activities. The Care Plan directed staff to wear a gown and gloves while performing high contact activities including use of the resident's feeding tube.

The CDC website directs all residents with an indwelling medical device (feeding tube) requires the use of EBP, to include gloves and gown.

Facility policy titled Enhanced Barrier Precautions last revised 3/2024 directs staff to use EBP for residents with an indwelling medical device. It further directs EBP to include a gown and gloves for high contact activities including use of a feeding tube.

During an observation on 6/25/25 at 10:53 AM, Staff Q, LPN, entered Resident #7's room and prepared to administer his tube feeding. Staff Q failed to put on a gown as required for EBP.

During an interview on 6/25/25 at 1:06 PM, Staff Q acknowledged she forgot to wear a gown.

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Rehabilitation Center of Allison

900 7th Street • Allison, IA 50602 • Ph: (319) 267-2791

Plan of Correction (POC) related to survey completed: June 26th 2025
Date POC submitted to DIAL: 7/11/2025

F000 Correction Date: July 26th 2025

For the required Plan of Correction the facility submits the following:

F550 – Resident Rights/Exercise of Rights

1. The care plan of resident #31 was updated on 6/24/2025 to include her preferences. Resident #143 no longer resides in the facility.
1. Staff re-educated on Resident Rights and De-escalation techniques by 7/26/2025.
2. The Administrator or Designee will conduct weekly audits with staff for three months to test the knowledge of staff on Resident Rights.

F600 – Free from Abuse and Neglect

1. Staff receive education and training on adult dependent abuse prevention upon hire and annually.
2. Re-educated staff on Abuse prevention including reporting requirements by 7/26/2025.
3. Administrator or designee to investigate all allegations of abuse. Identified concerns shall be reviewed with the facilities QAPI team. Recommendations for further corrective action will be discussed and implemented as needed.

F610 – Investigate/Prevent/Correct Alleged Violation

1. Staff and Resident interviews were conducted as a part of the investigation process. The procedures in the entitled document, "Abuse Prevention, Training, and Investigations" contains guidelines for conducting an investigation which the facility may utilize. The facility can accomplish conducting a thorough investigation by other means as necessary and appropriate.
2. Staff received training regarding conducting abuse investigations utilizing regulatory resources and company guidelines by 7/26/25.
3. Administrator or designee to investigate all allegations of abuse. Identified concerns shall be reviewed with the facilities QAPI team. Recommendations for further corrective action will be discussed and implemented as needed.

F689 – Free of Accident Hazards/Supervision/Devices

1. Education provided to resident #30 to utilize the designated lock box for his lighter and cigarette box.
2. Education provided to staff and resident #30 regarding use of lock box. Cigarettes and lighter will be placed in self locking lock box when not in use.
3. The Director of Nursing or designee will conduct audits each week for three months to check for compliance.

F725 – Sufficient Nursing Staff

1. Nursing staff were re-educated on the call light policy by 7/26/2025.
2. Administrator and Director of Nursing were given instruction and access electronic to call light audit information on 7/9/25.
3. Call light times will be reviewed weekly for patterns, trends and timeliness response by the Administrator, Director of Nursing or designee for four weeks. Results will be discussed at the IDT meeting. Appropriate interventions will be implemented as needed. Ongoing frequency of audits will be determined by outcomes.

F761 – Label/Store Drugs and Biologicals

1. There were no adverse effects to resident #21.
2. Nurses and medication aides will be educated on the labeling and storage of medications by 7/26/2025.
3. Director of Nursing or designee to conduct audits weekly for three months on medication storage and labeling.

F880 – Infection Prevention & Control

1. Restocked gowns in resident room to ensure compliance.
2. Staff re-educated on infection control policy for EBP by 7/26/2025.
3. Director of nursing or designee will conduct weekly audits for three months to ensure staff are using appropriate PPE for Enhanced Barrier Precautions.