STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165156	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Dodge Health and Rehabilitation	728 14th Avenue North Fort Dodge, IA 50501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, facility policy review and staff interviews the facility failed to ensure a resident needing a mechanical lift were provided safe and appropriate transfers to prevent injuries for 1 of 1 residents reviewed (Resident #2). The facility reported a census of 61 residents. Findings Include: Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score was a 4, indicating severe cognition. The MDS listed Resident #2 as dependent on the facility staff for all activities of daily living (ADL's). The MDS included diagnoses of non-Alzheimer's dementia, anxiety disorder, aphasia (difficulty speaking), diabetes mellitus, and arthritis. The MDS listed Resident #2's weight as 318 pounds. The Nursing Note dated 9/24/25 at 11:52 AM, reflected Staff A, Certified Nursing Assistant (CNA), called Staff C, Licensed Practical Nurse (LPN), to Resident #2's room because Resident #2 fell out of the mechanical lift. Upon entering the room Staff C observed Resident #2 on the floor laying on the legs of the mechanical lift. Resident #2 denied hitting her head. Staff C called for help to get Resident #2 off the floor. The staff assisted Resident #2 to bed to complete a thorough assessment with the mechanical lift. Resident #2 back in bed, able to do a full assessment. Resident #2 stated she had severe back pain originating on the left side and radiating to the right side. Resident #2 is alert and oriented times (x) 2. Resident #2 able to wiggle both toes. Pulses palpable (can feel pulses on touch) on all extremities. No obvious bruises or injuries noted. Resident #2 sent to the emergency room due to the nature of fall being from at least 4 feet or higher. Order to send to the hospital by physician. A Certified Nurse Aide (CNA) noted Resident #2 had the wrong type of mechanical sling, a purple sling, but should have a blue or black sling due to the purple being too small for her. Therapy confirmed the CNAs used the wrong sling to transfer Resident #2. Resident #2 left with an ambulance for the hospital at approximately 9:50 AM. The Emergency Department (ED) Provider Notes dated 9/24/25 reflected Resident #2 fell from a full body mechanical lift as the staff transferred from her wheelchair to her bed when a piece came loose. She reported back pain but denied knowing what body part she landed on. Resident #2 weighed 325 pounds. The CT (specialized imaging of the body) Thoracic Spine (middle area of the back) impression identified Resident #2 had a mildly depressed T12 (lower part of the middle section of the back) compression fracture (a break or crack in the bones of the back spine that causes the bone to collapse). The facility's Investigation Summary dated 9/24/25 reflected on 9/24/25 Staff B cared for Resident #2 on the morning of the incident. She provided morning (am) cares to include placing the mechanical lift sling under Resident #2 to prepare her for transfer to the wheelchair. After getting Resident #2 ready for transfer, Staff B asked Staff A to assist with transferring her to the wheelchair. After breakfast, as Staff A and Staff B transferred Resident #2 back to bed to change her, she fell when the sling became dislodged from the full-body mechanical lift at Resident #2's left shoulder. Upon investigation the facility determined Staff B placed the wrong size sling under Resident #2 in the morning and hooked up the left side of the sling to the mechanical lift. Staff A moved the machine to the bed and Staff B guided Resident #2. When they got close to the bed Staff B let go Resident #2 and turned her back to get the bed pad ready. As this happened, Resident #2's sling disconnected from the full-boy mechanical lift machine and Resident #2 fell. The Fall Incident Report dated 9/24/25 at 9:30 AM indicated Resident #2 fell from the full-body mechanical lift. When the staff got her from the floor to her bed with the full-body mechanical lift, Resident #2 reported intensified pain in her back. The nurse sent Resident #2 to the hospital due to the height of the fall and the possibility of a head injury. Resident #2 complained of pain at an 8, indicating severe pain. The Incident Report included staff witnesses from the staff who assisted Resident #2 at the time of the fall of the following: a. Staff A reported as they went to change Resident #2 after breakfast, they hooked her up to the full-body mechanical lift. Staff B checked the loops and stated they were good to go. Staff A started lifting Resident #2 up as Staff B held her legs. Then Staff B let go to pull down the bed to get her into it, when Resident #2 fell out of the sling. b. Staff B stated they used the full-body mechanical lift on Resident #2 up and to position her, but they needed a bed pad. So, Staff B turned to put the bed pad on the bed. As she turned around, she heard Staff A gasp and Resident #2 fell out of the sling. Staff she didn't see whether she hit her head or not. She stayed with Resident #2 while Staff A got the nurse. Staff B reported they used a sling too small for Resident #2. She learned that only after Resident #2 fell out of the sling. Staff B stated she used the only sling in the closet and denied knowing the sling had appropriate colors. The Supply Company's Multi-Brand Compatible Slings guide dated June 2021 listed the trim color