

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Fort Dodge Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and facility policy review, the facility failed to ensure residents received safe and appropriate assistance during transfers for 2 of 3 residents reviewed (Residents #4 and #2). The facility's failure to follow established transfer procedures and provide the necessary assistance placed residents at risk for injury and failed to ensure a safe environment. Resident #4 slid from a mechanical lift sling during a transfer and fell to the floor, sustaining a rib fracture. Resident #2 experienced a fall during a transfer when the staff failed to provide the required level of assistance resulting in complaints of shoulder pain. The facility reported a census of 59 residents. Findings include: 1. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. The MDS listed Resident #4 as dependent on staff for all cares and used a wheelchair for mobility. The MDS included diagnoses of Parkinson's disease (a disease process that affects the brain resulting in balance problems), with contractures of left- and right-hand muscles, stiffness of left and right knees, reduced mobility, bipolar disorder, depression and anxiety.</p> <p>The Care Plan Focus dated 5/20/24 reflected Resident #4 had an activity of daily living (ADLs) self-care performance deficit related to limited mobility, impaired balance, pain, and Parkinson's disease. The intervention directed to use a full body mechanical lift with the sling sized per his weight.</p> <p>The Nursing Progress note dated 1/5/26 at 4:00 PM indicated as the Certified Nursing Assistants (CNAs) transferred Resident #4 with the use of a full body mechanical lift, one of the full body sling loops came off the top left corner hook. As a result, Resident #4 slid out of the sling feet first to the floor. When Resident #4 began to slide out of the sling, Staff G, CNA, and Staff H, CNA, managed to assist Resident #4 all the way to the floor with his upper body leaning on Staff G to preventing him from hitting his head on the floor. The Director of Nursing (DON) assessed Resident #4 at the time and found no apparent injury. The staff transferred Resident #4 to bed with the assistance of 4. Resident #4 informed Staff I, LPN (Licensed Practical Nurse), who assisted, his right middle ribs were a little sore but didn't feel anything was broken. The nurse administered Tylenol to Resident #4 and continued monitoring to evaluate for further pain or changes.</p> <p>The Nursing Note dated 1/6/26 at 7:05 PM reflected Resident #4 complained of rib pain. Their provider gave new orders to obtain x-rays.</p> <p>The X-Ray results dated 1/6/26 at 8:51 PM noted the detection of an acute right rib fracture of #10 (lower rib).</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 2/9/26 at 3:20 PM, the Director of Nursing (DON) stated the facility provided education and a step for CNAs to stop and check the sling loops were securely on the lift bars during the full-body mechanical lift transfer process.</p> <p>In an interview on 2/11/26 at 3:05 PM, Staff H explained she ran the controls for the mechanical lift while Staff G guided Resident #4 in the sling. As Resident #4 laid in bed, they attached all four loops on the sling to the four hooks on the mechanical lift. They lifted Resident #4 above the bed, and as she started to rotate the lift towards his chair the left loops closest to her came off. When that happened Resident #4 started sliding down out of the sling with his feet landing on the floor. She managed to hold an area of the sling while Staff G held another area and supported Resident #4 while lowering him to the ground using her legs and torso to support his upper body to prevent him from hitting his head. Staff G radioed to the nursing staff for assistance. The DON came and assessed Resident #4. With the help of the nurses, they lifted Resident #4 and transferred him back into bed.</p> <p>On 2/12/26 at 12:40 PM Resident #4 stated Staff G and Staff H, lifted him above his bed to transfer him. Once he got off the bed and hanging in the sling, he started to slide down with his feet landing first on the floor. Staff G and Staff H lowered him to the floor and made she he didn't hit his head. After the incident, the staff checked him over and assisted him to bed. Later he started to have having rib pain. The got him x-rays and found a fracture. Resident #4 stated they transferred okay but sometimes it felt like the CNAs rushed to get it done.</p> <p>The Facility's Investigation provided Staff G's written statement. The statement documented Staff H helped her change, dress, and hook Resident #4 up to the full-body mechanical lift. Staff H raised Resident #4 into the air over his bed. As they pulled Resident #4 back from the bed the loop on Resident #4's right came undone. She held the left side of the sling with her left hand and the back strap handle with her right hand to guide him during the transfer. Resident #4 began to slide out of the sling feet first. As this happened, she used her right arm and leg to try to guide Resident #4 down to the floor. Once Resident #4 got to the floor, she radioed for help.</p> <p>The In-service Attendance Record listed a course title of Time out to ensure all 4 corners of the lift are attached dated 1/7/26 related to the subject lift time out during lift procedure.</p> <p>The facility provided an undated Mechanical Lift Application and Use document with yellow writing of Master indicated it was a checklist to identify the steps to apply and use a mechanical lift. The steps to apply and use a mechanical lift identified the following key steps: a. Attach the sling to the lift by lowering the sling bar and attaching the sling as directed by the manufacturer, examining and position and stability of all hooks and fasteners. (Highlighted in green on the paper)b. Prepare to engage the lift by standing close to the person, depressing the up button on the lift or remote until there is tension on the sling, adjust the lift brackets so the person is in a sitting position. c. Engage the lift to raise the person 2 inches off the bed, then check that the person is secure and comfortable. Continue to lift the person until free of the surface. d. Transfer the person by unlocking the lift wheels, moving the lift away from the bed toward the chair, positioning the lift with the legs on each side of the chair and locking the lift wheels. e. Lower the person onto the chair by having your coworker move the sling into the correct position over the chair. Lowering the lift until the person is in contact with the seat. Standing next to the person and grasp the lift bracket so it does not move or make contact with the person. f. Remove the lift by lowering the sling bar to unhook the sling. Unlocking the wheels and pulling the lift away from the chair, closing the legs of the lift and applying the lift brakes.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a follow-up interview on 2/26/26 at 2:40 PM Staff G said she hooked up Resident #4 at the head of his bed and raised the head of his bed. She explained the facility had 2 machines both the same in the front and the back. They used a blue sling for Resident #4 when they transferred him. All of the slings are blue mesh slings with a hole where their bottom goes. Staff G said as they lifted him the strap on his right side of his legs came off. When this happened, he slowly slid to the floor. This allowed her to get under him to help guide him to the floor. She reported she wracked her brain trying to figure out what happened. The only thing she could think of was that they didn't get the strap all the way on the hook. Since then, the head of therapy did audits on them. Following the incident, they are supposed to talk through the process step by step as they go, no matter. Staff G explained when it happened only her and Staff H were in the room at the time. They are supposed to have 2 people when they transfer with the Hoyer lift. They make sure they communicate as they go. During a follow-up interview on 2/26/26 at 2:50 PM Staff H reported the bottom right strap for him or left side for her had the strap come off. When this happened, his legs came out then his upper torso. Staff H said he used a green outline blue mesh woven grip sling. Staff H reported she might have hooked up his legs but thought she hooked up his head. She added she thought they may have moved/pivoted him in the wrong direction that caused a displacement in the pressure and caused it to pop off. They have a full-body mechanical hook there with safety hooks in the front of the building. They used the one in the back of the building, that didn't have them. Staff H said they had 3 full-body mechanical lifts in the building, 2 of the same and one different. The 2 that were the same didn't have the safety hooks. She thought the one with the safety hooks was older, and she thought they got the other two from a local facility after they closed.</p> <p>2. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #2 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The MDS included a diagnosis of chronic (long-term) kidney disease.</p> <p>The Care Plan initiated 6/16/25 identified Resident #2 at risk for falls related to taking an antidepressant, an opioid and diuretic medications. Resident #2 had diagnoses of coronary artery disease, atrial fibrillation, congestive heart failure, and anxiety.</p> <p>The Progress Notes dated 2/1/26 at 5:51 p.m. documented while the CNA assisted Resident #2 to transfer from the bed to the wheelchair around 4:30 p.m., they fell backward into the bed. Resident #2 stated while both arms landed on the bed, she felt like her right arm hit something. After the incident, she reported right shoulder pain (at 10 out of 10, indicating the worst pain imaginable) and received her scheduled hydrocodone (narcotic pain medication). Resident #2 had slightly limited range of motion (ROM) on the right upper arm. Resident #2 reassessed for pain at 5:50 p.m. and reported at 7/10. After, super Resident #2 assisted and transferred back to bed without complaint.</p> <p>On 2/11/26 at 2:43 p.m. Staff F, CNA (agency), stated she assisted Resident #2 in getting up. No one told her what assistance they needed. She asked Resident #2 what help she needed, and she said she could get herself up. She stood up and Staff F held onto her pants. She took 1 step and fell back on the bed. She got back up and said her shoulder hurt. She reported it to the nurse, and she had a history of shoulder pain.</p> <p>On 2/12/26 at 8:15 a.m. the DON stated the staff member should have used a gait belt on the resident when assisting her.</p>		