STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165167	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Village	1203 North E Street Indianola, IA 50125

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on clinical record review, resident and staff interview, the facility failed to ensure each resident is treated with dignity and respect and cared for in a manner and environment that promotes maintenance or enhancement of his or hers quality of life for 2 of 3 residents reviewed. (Residents #1 and #2) The facility reported census was 43.Findings include: 1.According to a Minimum Data Set (MDS) with a reference date of 7/5/25, Resident #1 had a Brief Mental Status (BIMS) score of 14 of 15, indicating an intact cognitive status. Resident #1 required maximal to dependent assistance with transfers, mobility, dressing, toilet use and personal hygiene needs and was determined as always incontinent of bladder and occasionally incontinent of bowel. Resident #1's diagnosis included Non-Alzheimer's dementia, Parkinson's, renal insufficiency, diabetes mellitus. In an interview on 9/23/25 at 11:15 a.m. Staff C, housekeeping, stated on 8/26/25 at around 3:00 p.m. she was cleaning the shower room near Resident #1's room. She could hear yelling, so she got closer to the door and could hear more clearly, Resident #1 was telling Staff E, Certified Nurse Aide you're hurting me and Staff E stated I have to wipe you. Staff C stated it is not uncommon for Resident #1 to tell staff they're hurting him when they are doing cares he doesn't like. Staff C stated she has never known Resident #1 to use profanity. Staff C stated it then escalated and Staff E told Resident #1 to shut the fuck up and you're a fuckin jerk. Staff E then told Resident #1 to shut the fuck up again and that's when Staff C stated she left to report the interaction. Staff C stated she first informed the charge nurse, Staff D, who went to the room, while she went and told the DON and ADON. Staff C stated Staff E had always been quiet and she never knew her to use profanity or mistreat a resident.In an interview on 9/23/25 at 11:45 a.m. Staff D, Registered Nurse stated on 8/26/25 at 3:05 p.m. she was approached by Staff C, housekeeper, who reported an aide (Staff E) was telling a Resident #1 to shut the fuck up and yelling at him. Staff D immediately went to the room and noted it was quiet as she entered the room. There was no cursing or yelling. Staff E appeared calm, face unflushed. Resident #1 was still in his bed, seemingly anxious to get out of his bed, but not showing any signs of distress. Staff D offered to help and together they finished care. As they were stepping out of the room, the DON and ADON were at the doorway. Staff E went with the DON and ADON. A little while later Staff E approached her crying, stating I know better than that. Staff D stated she wasn't too familiar with Staff E, but Resident #1 will holler out, but not use profanity.In an interview on 9/23/25 at 1:00 p.m. Staff E, Certified Nurse Aide, stated she was totally in the wrong in what she did on 8/26/25 involving Resident #1. Staff E stated it was change of shift and she was trying to get Resident #1 cleaned up from incontinence. Resident #1 was not being cooperative and he began cursing at me, so I cursed back, telling him to shut the fuck up. Staff E stated it was not an excuse, but I was dealing with a lot. My father in law passed earlier that month and I'm now taking care of my mother and was up the last three nights leading up to the incident. I just should have not come back to work so soon. In an interview on 9/23/25 at 1:30 p.m. Resident #1 was observed sitting in his wheelchair, just after being assisted with toileting, Resident #1 was alert and pleasant. When asked if staff treated him well and were kind, he stated I supposed so. Resident #1 could not recall any incidents in which he was mistreated. 2.According to a Minimum Data Set (MDS) with a reference date of 8/13/25, Resident #2 had a Brief Mental Status (BIMS) score of 13 of 15, indicating an intact cognitive status. Resident #2 required moderate assistance with transfers, mobility, dressing, toilet use and personal hygiene needs and was determined as frequently incontinent of bladder and bowel. Resident #2's diagnosis included Non-Alzheimer's dementia, Compression fracture T5-T6, atrial fibrillation, coronary artery disease, congestive heart failure, renal insufficiency, arthritis, chronic obstructive pulmonary disease, respiratory failure, gastroesophageal reflux disease. In an interview on 9/23/25 at 2:20 p.m. Staff G, Certified Nurse Aide, stated upon arriving to work on 7/24/25 at 6:30 a.m. she entered Magnolia quietly and immediately saw Staff F, Licensed Practical Nurse, standing in the doorway of Resident #2's room, yelling at her to stay in bed. Staff G stated she could hear Resident #2 crying. All the lights were off, including Resident #2's. Staff G stated she made some noise, alerting Staff F that she was there. It was then Staff F's tone changed and she started talking about not being able to find her aides. Staff G stated she would get Resident #2 up for breakfast. Staff G stated she got Resident #2 into her bathroom and started providing care. Her nasal cannula was off and her lips were blue. Resident #2 was crying as Staff G got her toileted, groomed and dressed. Staff G was asked about Staff F and she stated she is why I left overnight shifts. Staff G stated Staff F insisted the residents were not to get up on overnight shift. Staff F did not what people up that may fall. Staff F was rude and wouldn't help aides, but expected aides to