

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2025
NAME OF PROVIDER OR SUPPLIER Community Memorial Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 231 North Eighth Avenue West Hartley, IA 51346	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility record review, staff interviews and facility policy review the facility failed to report an allegation of abuse to the Iowa Department of Inspections & Appeals and Licensing (DIAL) within 2 hours of an allegation of abuse for 1 of 1 residents reviewed for abuse (Resident #1). The facility reported a census of 46 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented diagnoses of Alzheimer's Disease, aphasia and cognitive communication deficit. The MDS showed the Brief Interview for Mental Status (BIMS) score was not assessed as the resident is rarely or never understood. Review of the facility Incident Report titled Alleged Abuse dated 3/8/25 at 6:02 p. m. revealed incident description received a phone call from staff regarding Staff A, Certified Nursing Assistant (CNA) and the approach she was using when she was providing total assistance with Resident #1 supper meal. Review of facility provided documentation titled Self Report of incident occurring on 3/8/25 at 6:05 p.m Review of written statement by Staff B, CNA, dated 3/8/25 at 6:10 p.m., I was feeding across from Staff A when she was feeding Resident #1. When Staff A offered Resident #1 a bite Staff A shoved the spoon into her mouth hitting her tooth and not paying any attention to where her mouth was. Staff A hit Resident #1's tooth hard enough to hear across the table. Staff A shoved another bite in Resident #1's mouth and when she didn't respond she forcefully shook her saying wake up, eat. After supper was over I called the Director of Nursing (DON) and let her know the situation. Interview on 10/6/25 at 3:44 p.m., with Staff B revealed she was feeding at the same table as Staff A and Staff A was roughly shaking Resident #1 saying wake up. Staff B explained Staff A was shaking Resident #1 that her body was shaking and she was not responding to her. Staff A attempted to give Resident #1 a bite of food and hit her tooth which she heard it across the table. Staff B explained she called the DON and told about the situation and Staff A was sent home immediately. Review of the facility intake information the facility submitted a self report on 3/10/25 at 2:24 p.m Review of the facility policy titled Abuse Policy and Procedure with a revision date of 7/2025 revealed all allegations of Resident abuse shall be reported to the Iowa Department of Inspections and Appeals not later than two (2) hours after the allegation is made. Interview on 10/7/25 at 11:34 a.m., with the Administrator revealed he thought the DON at the time had submitted the information to the state office.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2025
NAME OF PROVIDER OR SUPPLIER Community Memorial Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 231 North Eighth Avenue West Hartley, IA 51346	

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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to provide and maintain accurate resident records to reflect an incident occurring in the facility for 1 of 4 residents (Residents #1). The facility reported a census of 46 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented diagnoses of Alzheimer's Disease, aphasia and cognitive communication deficit. The MDS showed the Brief Interview for Mental Status (BIMS) score was not assessed as the resident is rarely or never understood. Review of the facility Incident Report titled Alleged Abuse dated 3/8/25 at 6:02 p.m. revealed incident description received a phone call from staff regarding Staff A, Certified Nursing Assistant (CNA) and the approach she was using when she was providing total assistance with Resident #1 supper meal. Review of facility provided documentation titled Self Report of incident occurring on 3/8/25 at 6:05 p.m. submitted to the state agency on 3/10/25 at 2:24 p.m Interview on 10/6/25 at 3:44 p.m., with Staff B revealed she was feeding at the same table as Staff A and Staff A was roughly shaking Resident #1 saying wake up. Staff B explained Staff A was shaking Resident #1 that her body was shaking and she was not responding to her. Staff A attempted to give Resident #1 a bite of food and hit her tooth which she heard it across the table. Staff B explained she called the DON and told about the situation and Staff A was sent home immediately. Review of Resident #1's Progress Notes lacked documentation of the incident from the incident occurring on 3/10/25. Interview on 10/7/25 at 11:24 a.m., with the Director of Nursing revealed she expects something to be in the chart about the incident.</p>