STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165217	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring Acres Nursing and Rehab Center	1000 Hillcrest Drive Anita, IA 50020

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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interviews, electronic health record (EHR) reviews, and facility policy review the facility failed to provide dignity to 3 of 7 residents (Resident #4, Resident #6, Resident #7). The facility failed to provide dignity to the residents as demonstrated by a staff telling a resident to sit down when the resident indicated the need to use the bathroom, a staff using discriminatory words towards a resident and in front of other residents, and a resident sitting exposed in a common area with other residents. The facility reported a census of 24 residents. Findings Include: 1. The Minimum Data Set (MDS) for Resident #4, dated 4/16/25 identified a Brief Interview for Mental Status (BIMS) score of 6/15 indicating severe cognitive impairment. The resident had diagnoses of Non-Alzheimer's Dementia, anxiety disorder, depression, bipolar disorder, and post traumatic stress disorder (PTSD). Resident #4's Care Plan dated 6/19/25 revealed a Focus Area of Activities of Daily Living (ADL) self-care performance deficit. Interventions for staff use included the resident required staff assistance of 1 for transfers, care, toileting, and dressing. The EHR Progress Note dated 6/17/25 revealed the resident received skilled therapy services, forgets limitations from hip surgery, and gets up without staff assistance and walks without staff assistance. The note dated 5/27/27 revealed Resident #4 required assistance from 1 staff member for transfers, bathroom use, and used a wheelchair to ambulate around the facility. On 6/18/25 at 9:33 AM observed Resident #4 attempting to stand up from her wheelchair indicating she needed to use the bathroom. The Activities Director found the resident indicating the need to use the bathroom, and pushed Resident #4 towards her bedroom due to indicating the need to use the bathroom. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/25 at 9:40 AM observed Staff A push Resident #4 in a wheelchair (w/c) to the nurses station area from the area of the resident's bedroom. The staff positioned the resident in the common area at the nurses station and obtained a book for the resident. Resident #4 attempted to stand up, Staff A told the resident to sit down. The resident indicated she needed to use the bathroom and again attempted to stand up, with Staff A stating she had just been to the bathroom just after breakfast. The resident demonstrated increased anxiety by repeatedly attempting to stand up. The Activities Director walked into the area, stated Resident #4 requested to go to her room to use the bathroom and the staff had taken her down there for that purpose. Staff A again stated she had already taken the resident prior to the Activities Director taking the resident to her room. Staff C walked up and stated she would take Resident #4 to the bathroom. When the resident was told she was being taken to the restroom, the resident became less anxious. Continuous observation beginning at 2:21 PM on 6/18/25 revealed Resident #4 seated in a w/c near Staff A seated at the nurses station. The resident did not have an activity in front of her. The resident initiated standing up and wanting to go talk to someone. Staff A told the resident to sit down. The resident sat down, and then again initiated standing and stated she needed to go to the bathroom. Staff A raised her voice and told the resident to sit down, as she had just been to the bathroom. The resident again stated she needed to use the bathroom and the staff stated she had just taken her to the bathroom, 5 minutes earlier. The resident replied with more like 30. The resident still standing became increasingly agitated when told to sit down again and indicated she would shit my pants and you will have to deal with that. The Business Office Manager (BOM)/CNA approached Resident #4 with her walker and gait belt, and asked the resident if she wanted to go for a walk, to which the resident agreed. The BOM/CNA began walking the resident, and then turned to go to the resident's bedroom as the resident again stated the need to use the bathroom. On 6/18/25 at 2:33 PM observed the BOM/CNA walk with Resident #4 out of her bathroom with the resident indicating she would like to lie down. The staff assisted the resident to bed. On 6/18/25 at 2:38 PM the BOM/CNA confirmed that Resident #4 had told her that she needed to use the bathroom and had indeed used the bathroom prior to lying down for a nap. The staff stated the resident had been discussed in the morning meeting and that when the resident becomes anxious staff need to get her walker and ask her to go for a walk. On 6/19/25 at 8:54 AM PM the Administrator, and Director of Nursing (DON), acknowledged dementia training had not been provided thus far this year. It was due in July 2025. The Administrator stated dementia training is not typically provided as part of orientation, and Staff A started in 2/25. The Administrator stated it was not acceptable to tell a resident they could not use the bathroom, even if the resident had just been to the bathroom. The DON stated she had overheard one of the interactions on 6/18/25 from her office, pulled Staff A and spoke with her about the interaction. 2. The MDS for Resident #6, dated 3/21/25 identified a BIMS score of 15/15 indicating normal cognition. The resident had diagnoses of neurogenic bladder, cerebral palsy, anxiety disorder, depression, bipolar disorder, PTSD, borderline personality disorder, and adjustment disorder with mixed anxiety and depressed mood. Resident #4 depended on staff for all bed mobility, transfers, and self care. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's Care Plan dated 5/22/25 revealed an ADL Focus Area with interventions including dependent on 2 staff for dressing, repositioning, transfers, and toileting. A focus area related to potential to have manipulative behaviors identified an intervention of having 2 staff present at all times in her room. On 6/12/25 at 9:20 AM Staff K, CNA, stated Staff E would tell residents no when asked for assistance and would walk out of resident rooms without assisting them or other staff. On 6/17/25 at 1:35 PM Resident #6 stated Staff E, Agency CNA, had been rude to her and would use discriminatory words. The resident also stated Staff E refused to assist other staff when attending to her care giving various excuses. Resident #6 stated she felt bad when she heard these things. Resident #6 stated she did report the concerns to the previous DON and Administrator. 3. The MDS for Resident #7, dated 5/16/25 identified a BIMS score of 00/15 indicating severe cognitive impairment. Staff input provided the resident had inattention, disorganized thinking and altered level of consciousness that was continuously present and did not fluctuate. The resident had diagnoses of Non-Alzheimer's Dementia, and anxiety. Resident #7's Care Plan dated 5/19/25 revealed a Focus Area of ADL self-care performance. Interventions identified for staff include the assist of 1 in the dining room, and dressing assist of 1. On 6/18/25 at 2:55 PM observed Resident #7 seated in her w/c in the living/dining room area facing out into the room. The room had large picture windows, an entry to the hallways to resident rooms and the nurses station, and an entry from the main entrance to the facility. The resident's right side of her shirt was pulled up exposing her breast. There were 3 other residents seated in the area. During the observation a male resident walked into the room, walked towards the resident, and then walked around her. Two unidentified staff walked past the room without looking in. At 2:58 PM Staff F, CNA, walked into the room and immediately went to the resident, and asked to adjust her shirt. On 6/18/25 at 4:25 PM the DON stated she expected staff to look into rooms as they walked by to ensure residents' needs were being met. On 6/18/25 at 4:35 PM the Administrator and Staff I, Assistant Director of Nursing (ADON)/MDS Coordinator acknowledged Resident #7 should not have been in the living/dining room exposed. The Administrator expected all staff to be aware of their surroundings, and look into rooms when they were walking past to ensure residents were not in need of assistance. On 6/19/25 at 9:36 AM the Administrator stated that staff should treat the residents with dignity and respect at all times. The Administrator stated she had been in the business for over 30 years and this had always been her expectation. The Administrator stated the staff were in the residents' home, and the residents needed to have their needs met and be treated with respect. The facility's undated Dementia Care Training revealed when caring for a resident with dementia staff should use a pleasant and respectful manner when speaking, (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Resident Rights Policy, 12/24, revealed that each resident within the facility had a right to a dignified existence, and communication with and access to persons and services inside the community without discrimination or reprisal. The document further disclosed all staff members were trained on the Resident Right Policy prior to providing care to residents and at least annually to ensure understanding of each resident's rights.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility investigative file review, employee file review, and policy review the facility failed to ensure 1 of 5 residents reviewed (Resident #4) was free from verbal abuse. The facility reported a census of 24 residents. Findings include: According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of [DATE], Resident #4 had a Brief Interview of Mental Status (BIMS) score of 6. A BIMS score of 6 suggested mild cognitive impairment. The MDS documented she was independent with mobility but required supervision or touching assistance to walk 10 feet, 50 feet with two turns, and 150 feet. Resident #4 was always continent of urine and frequently incontinent of bowel. The following diagnoses were listed for Resident #4: dementia, anxiety, depression, bipolar, post-traumatic stress disorder (PTSD), atrial fibrillation, irritability and anger, and cognitive communication deficit. The Care Plan focus area with an initiation date of [DATE] documented Resident #4 had Activities of Daily Living (ADLs) self-care performance deficit related to confusion and dementia. Resident #4 was able to transfer herself independently. Staff were to encourage her to use the call light for assistance. The Care Plan focus area with an initiation date of [DATE] documented Resident #4 had a behavior problem that included yelling at staff and residents. Staff were encouraged to assist the resident in the development of more appropriate methods of coping and interacting, assist her to express her feelings appropriately. The Care Plan focus area with an initiation date of [DATE] documented Resident #4 had impaired cognitive function/dementia or impaired though processes related to dementia. The Care Plan indicated she liked to sit herself on the floor and observe what's going on around her. Staff were encouraged to present just one thought, idea, question or command at a time. The Care Plan focus area with an initiation date of [DATE] documented Resident #4 was low risk for falls related to confusion. Staff were encouraged to anticipate and meet the resident's needs, ensure she is wearing the appropriate foot wear and her call light is within reach, encourage her to use it for assistance as needed. She needs prompt response to all requests for assistance. Record review revealed the following Progress Note: a) On [DATE] at 9:21 PM nursing staff alerted the nurse to resident's room where Resident #4 was observed to be lying on the floor with two pairs of pants around her ankles. Her head was pointed to the head of the bed and her feet were pointed toward the exit door in her room. The resident stated she was trying to roll over and get a drink of water and fell out of bed. The facility provided the following staff statements: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a) Staff F Certified Nursing Assistant (CNA) wrote: On the night of [DATE] I was walking down hall one and as I passed Resident #4's room (around 9:00 PM-9:15 PM) I heard a crash. When I opened the door, I found Resident #4 on the floor. Upon seeing her on the floor, I leaned out the door to call for Staff D Licensed Practical Nurse (LPN), and he activated the call light. Staff D came in about 2 minutes later and started making belittling comments to Resident #4 like: aww, did you fall out of bed, that was kind of a dumb idea. We then noticed she had on two pairs of pants. Staff D stated to Resident #4, well that's probably why you fell. Maybe you should start using your call light. Then Staff D turned to me and said by the way you don't need to scream my name, this happens all the time, it's inappropriate and not that urgent. Then Staff D started asking the resident if she can straighten her leg out and she said no, from my hip to my knee hurts really bad. Staff D again made belittling comments. We got her vital signs, Staff D told me to grab her under the arm and as we lifted her Staff D made the comment of they need to stop feeding you so much, your trunk is 4 times the size of the rest of you and it's getting gross. After Resident #4 was in bed, I told Staff D that when I found her in her room, the back of her head was across the supporter bar of her overbed table. I mentioned there was a bruise forming on the outside of her left thigh. Again, Staff D asked her to straighten her leg then stated or else you'll have to go to the hospital and I don't think you want that. Eventually Resident #4 said she would be fine and just wanted to go back to sleep. We put her quilt over her, told her to use her call light, and left her to sleep. Then, later on that night, Staff D was harassing Resident #5 telling her that her cats and dogs were not here, either at home alone or gone. Then he turned to me and said sometimes you gotta piss them off to make the night more fun. b) An email statement was provided to the facility by Staff D. The following statement was made: while on my shift on [DATE] at approximately 8:50 PM, I was documenting when I heard the male CNA scream my name from hall 1. As I made my way down there, another resident passed by and said there was a resident on the floor. I observed the resident sitting on the floor next to her bed. I went to grab the equipment needed to take vitals. The resident required me to be direct with my questioning since she requires redirection and she can be impulsive at times. I was asking her questions regarding her pain and if she could move her leg. As she sat on her bed, after being transferred from the floor, I again asked her to see if she could flex her leg, which she could. I did have to tell the male CNA not to scream for me since it can confuse and cause the resident to become anxious. After the initial assessment, I left the resident with both the female and male CNAs in the room as I went to go contact the resident's daughter. At no time was I verbally abusive during my assessment toward Resident #4. Any other interaction I had with that resident that shift was minimal. Review of Staff D's employee file revealed a Notice of Employment Termination effective [DATE] for the following concern: a verbal abuse allegation reported by a staff member, which was substantiated through internal investigation and escalated to the appropriate authorities. Staff D completed Dependent Adult Abuse Mandatory Reporter Training on [DATE]. On [DATE] at 11:21 AM Staff G CNA stated Staff D was the main reason she left the overnight shift. She stated he had a hard time talking with residents, he was just rude and had a tone to his voice and was not approachable with residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:19 PM Staff F stated Staff D could be hard on the residents; he's cold and abrasive with them. Resident #5 had a lot of behaviors and he was very short with her. She would ask him where her cats were and he would say they are gone, I don't know what happened to them and I don't care. She would ask him if her kids were coming to see her and he would say they know you are here. Staff F stated those things are not what you want to be saying to residents that have behaviors and dementia; just agitates them more. One night Staff F found Resident #4 on the floor in her room around 9:00 PM-9:45 PM as he walked down her hall, he heard a crash come from her room. When he opened the door, he saw Resident #4 on the floor, her neck rested on the foot base of her over bed table and her feet were towards the door. She had two pairs of pants on that were down around her ankles and a t-shirt on. When he asked her what happened she stated she was reaching for her water and fell. Staff F yelled for Staff D, he walked in 2-3 minutes later. After he asked what happened, he started to say weird stuff: oh wow you fell, good job that was really dumb, don't reach for your f***ing water, use the call light, oh wait you don't use it, how about we start making smart decisions. Resident #4 would scream in pain when she would move that leg. Staff D told him to grab under her arm and they both lifted her back to bed. As they did this Staff D stated to Resident #4 jesus they need to stop feeding you so much, your trunk is 4 times bigger than the rest of you and that's gross. He also said I need to know if you can move your hip. If you don't I will be sending you to the hospital. Resident #4 stated she wanted to go to bed. When asked what Staff D's tone was like when speaking to Resident #4 he stated in between joking and mean, he was so nonchalant about it. An interview with Staff D was not able to be conducted, he was deceased at the time of the survey. On [DATE] at 10:40 AM an attempt was made to interview Resident #4 but she had a short attention span and was unable to remain on topic. The resident had continuous non-sensical conversations and was not able to discuss any staff concerns On [DATE] at 12:50 PM the Director of Nursing (DON) was asked what ended Staff D's employment. She indicated they did a Self-Reported Incident that involved him. After they completed their investigation they did not feel like he should be in the facility anymore with their residents. Staff F was concerned about the things Staff D said to the resident after she fell. From what they could see how he spoke was not an appropriate way to speak with residents. The risk of this happening again was too much so they terminated Staff D's employment. The facility provided a document titled Abuse, Prevention, and Prohibition Policy with an approved date of 3/2025. The policy stated each resident has the right to be free from abuse by anyone including but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility prohibits mistreatment, neglect or abuse of residents. The policy defined verbal abuse as: the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within the hearing distance, regardless of their age, ability to comprehend, or disability.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility investigative file review, employee file review, staff interviews, and facility policy review the facility failed to timely report an allegation of abuse to the appropriate management staff member. The facility reported a census of 24 residents. Findings include: According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of [DATE], Resident #4 had a Brief Interview of Mental Status (BIMS) score of 6. A BIMS score of 6 suggested mild cognitive impairment. The MDS documented she was independent with mobility but required supervision or touching assistance to walk 10 feet, 50 feet with two turns, and 150 feet. Resident #4 was always continent of urine and frequently incontinent of bowel. The following diagnoses were listed for Resident #4: dementia, anxiety, depression, bipolar, post-traumatic stress disorder (PTSD), atrial fibrillation, irritability and anger, and cognitive communication deficit. The Care Plan focus area with an initiation date of [DATE] documented Resident #4 had Activities of Daily Living (ADLs) self-care performance deficit related to confusion and dementia. Resident #4 was able to transfer herself independently. Staff were to encourage her to use the call light for assistance. The Care Plan focus area with an initiation date of [DATE] documented Resident #4 had a behavior problem that included yelling at staff and residents. Staff were encouraged to assist the resident in the development of more appropriate methods of coping and interacting, assist her to express her feelings appropriately. The Care Plan focus area with an initiation date of [DATE] documented Resident #4 had impaired cognitive function/dementia or impaired though processes related to dementia. The care plan indicated she liked to sit herself on the floor and observe what's going on around her. Staff were encouraged to present just one thought, idea, question or command at a time. The Care Plan focus area with an initiation date of [DATE] documented Resident #4 was low risk for falls related to confusion. Staff were encouraged to anticipate and meet the resident's needs, ensure she is wearing the appropriate foot wear and her call light is within reach, encourage her to use it for assistance as needed. She needs prompt response to all requests for assistance. Record review revealed the following Progress Note: a) On [DATE] at 9:21 PM nursing staff alerted the nurse to resident's room where Resident #4 was observed to be lying on the floor with two pairs of pants around her ankles. Her head was pointed to the head of the bed and her feet were pointed toward the exit door in her room. The resident stated she was trying to roll over and get a drink of water and fell out of bed. The facility provided the following staff statements: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a) Staff F Certified Nursing Assistant (CNA) wrote: on the night of [DATE] I was walking down hall one and as I passed Resident #4's room (around 9:00 PM-9:15 PM) I heard a crash. When I opened the door, I found Resident #4 on the floor. Upon seeing her on the floor, I leaned out the door to call for Staff D Licensed Practical Nurse (LPN), and he activated the call light. Staff D came in about 2 minutes later and started making belittling comments to Resident #4 like: aww, did you fall out of bed, that was kind of a dumb idea. We then noticed she had on two pairs of pants. Staff D stated to Resident #4, well that's probably why you fell. Maybe you should start using your call light. Then Staff D turned to me and said by the way you don't need to scream my name, this happens all the time, it's inappropriate and not that urgent. Then Staff D started asking the resident if she can straighten her leg out and she said no, from my hip to my knee hurts really bad. Staff D again made belittling comments. We got her vital signs, Staff D told me to grab her under the arm and as we lifted her Staff D made the comment they need to stop feeding you so much, your trunk is 4 times the size of the rest of you and it's getting gross. After Resident #4 was in bed, I told Staff D that when I found her in her room, the back of her head was across the supporter bar of her overbed table. I mentioned there was a bruise forming on the outside of her left thigh. Again, Staff D asked her to straighten her leg then stated or else you'll have to go to the hospital and I don't think you want that. Eventually Resident #4 said she would be fine and just wanted to go back to sleep. We put her quilt on over her, told her to use her call light, and left her to sleep. Then, later on that night, Staff D was harassing Resident #5 telling her that her cats and dogs were not here, either at home alone or gone. Then he turned to me and said sometimes you gotta piss them off to make the night more fun. b) An email statement was provided to the facility by Staff D. The following statement was made: while on my shift on [DATE] at approximately 8:50 PM, I was documenting when I heard the male CNA scream my name from hall 1. As I made my way down there, another resident passed by and said there was a resident on the floor. I observed the resident sitting on the floor next to her bed. I went to grab the equipment needed to take vitals. The resident required me to be direct with my questioning since she requires redirection and she can be impulsive at times. I was asking her questions regarding her pain and if she could move her leg. As she sat on her bed, after being transferred from the floor, I again asked her to see if she could flex her leg, which she could. I did have to tell the male CNA not to scream for me since it can confuse and cause the resident to become anxious. After the initial assessment, I left the resident with both the female and male CNAs in the room as I went to go contact the resident's daughter. At no time was I verbally abusive during my assessment toward Resident #4. Any other interaction I had with that resident that shift was minimal. Review of Staff D's employee file revealed a Notice of Employment Termination effective [DATE] for the following concern: a verbal abuse allegation reported by a staff member, which was substantiated through internal investigation and escalated to the appropriate authorities. Staff D completed Dependent Adult Abuse Mandatory Reporter Training on [DATE]. On [DATE] at 11:21 AM Staff G CNA stated Staff D was the main reason she left the overnight shift. She stated he had a hard time talking with residents, he was just rude and had a tone to his voice and was not approachable with residents. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:19 PM Staff F stated Staff D could be hard on the resident's; he's cold and abrasive with them. Resident #5 had a lot of behaviors and he was very short with her. She would ask him where her cats were and he would say they were gone, I don't know what happened to them and I don't care. She would ask him if her kids were coming to see her and he would say they know you are here. Staff F stated those things are not what you want to be saying to residents that have behaviors and dementia; just agitates them more. One night Staff F found Resident #4 on the floor in her room around 9:00 PM-9:45 PM as he walked down her hall, he heard a crash come from her room. When he opened the door, he saw Resident #4 on the floor, her neck rested on the foot base of her over bed table and her feet were towards the door. She had two pairs of pants on that were down around her ankles and a t-shirt on. When he asked her what happened she stated she was reaching for her water and fell. Staff F yelled for Staff D, he walked in 2-3 minutes later. After he asked what happened, he started to say weird stuff: oh wow you fell, good job that was really dumb, don't reach for your f***ing water, use the call light, oh wait you don't use it, how about we start making smart decision. Resident #4 would scream in pain when she would move that leg. Staff D told him to grab under her arm and they both lifted her back to bed. As they did this Staff D stated to Resident #4 jesus they need to stop feeding you so much, your trunk is 4 times bigger than the rest of you and that's gross. He also said I need to know if you can move your hip. If you don't I will be sending you to the hospital. Resident #4 stated she wanted to go to bed. When asked what Staff D's tone was like when speaking to Resident #4 he stated in between joking and mean, he was so nonchalant about it. Staff F stated at the time he did not know who to call to make a report, so he waited until the next day. He has since been educated that if this happens again, he can call the Director of Nursing (DON). He was also educated that they have a 2 hour window to report allegations to the State Agency. An interview with Staff D was not able to be conducted, he was deceased at the time of the survey. On [DATE] at 12:50 PM the DON was asked what ended Staff D's employment. She indicated they did a Self-Reported Incident that involved him. After they completed their investigation they did not feel like he should be in the facility anymore with their residents. Staff F was concerned about the things Staff D said to the resident after she fell. From what they could see, how he spoke was not an appropriate way to speak with residents. The risk of this happening again was too much so they terminated Staff D's employment. She indicated the alleged incident was not reported when it should have been reported. All staff were educated on the abuse protocol to include reporting timeframes. On [DATE] at 10:40 AM an attempt was made to interview Resident #4 but she had a short attention span and was unable to remain on topic. The resident had continuous non-sensical conversations and was not able to discuss any staff concerns. The facility provided a document titled Abuse, Prevention, and Prohibition Policy with an approved date of 3/2025. The policy stated each resident has the right to be free from abuse by anyone including but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility prohibits mistreatment, neglect or abuse of residents. The policy defined verbal abuse as: the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within the hearing distance, regardless of their age, ability to comprehend, or disability. (continued on next page)

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	165217	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring Acres Nursing and Rehab Center	1000 Hillcrest Drive Anita, IA 50020

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided a document titled Abuse, Prevention, and Prohibition Policy with an approved date of 3/2025. The policy stated each resident has the right to be free from abuse by anyone including but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility prohibits mistreatment, neglect or abuse of residents. The policy defined verbal abuse as: the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within the hearing distance, regardless of their age, ability to comprehend, or disability. Reporting/Response: a) The facility employee or agent, who becomes aware of abuse or neglect, including injuries of unknown origin or alleged misappropriation of resident property, shall immediately report the matter to the facility Administrator of his/her designated representative in the Administrator's absence. b) All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property will be reported immediately to the Administrator. The person made aware of allegations of abuse or neglect OR the Administrator will report the allegations of abuse and neglect to the mandated state agency and law enforcement. The allegation will be reported no later than 2 hours, or per state regulations, after the allegation is made. 2. The MDS for Resident #6, dated [DATE] identified a BIMS score of 15/15 indicating normal cognition. The resident had diagnoses of neurogenic bladder, cerebral palsy, anxiety disorder, depression, bipolar disorder, PTSD, borderline personality disorder, and adjustment disorder with mixed anxiety and depressed mood. Resident #6 depended on staff for all bed mobility, transfers, and self care. The resident's Care Plan dated [DATE] revealed an ADL Focus Area with interventions including dependent on 2 staff for dressing, repositioning, transfers, and toileting. A focus area related to potential to have manipulative behaviors identified an intervention of having 2 staff present at all times in her room. On [DATE] at 1:35 PM Resident #6 stated Staff E, Agency CNA, had been rude to her and would use discriminatory words. The resident also stated Staff E refused to assist other staff when attending to her care giving various excuses. Resident #6 stated she felt bad when she heard these things. Resident #6 stated she did report the concerns to the previous DON and Administrator. On [DATE] at 2:50 PM Staff C, CNA, stated she had heard Resident #6 complain about Staff E and the way Staff E treated her. The staff stated Resident #6 did not like Staff E, but also the resident did not really like anyone. The staff stated since she had not witnessed any mistreatment she could not recall if she brought these comments to the administration. On [DATE] at 4:05 PM Staff L, CNA, stated Resident #6 had made complaints about Staff E, but that Resident #6 complained about everyone and everything. The staff did not recall if they told anyone since the resident always complained about something or someone. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:21 PM the Director of Nursing (DON) stated she began working at the facility a couple of weeks prior to the end of Staff E's contract. The staff stated there was 1 staff member who had made a complaint about Staff E and the way she treated other staff members. The DON stated there was no mention of instances of Staff E using unprofessional tones around or to other residents in the complaint. The DON stated there had not been any other complaints about staff mistreatment since that time. The DON expected staff to report any instances of reported or observed behavior to residents that could be construed as abusive. The DON stated the facility had recently had abuse training with staff. On [DATE] at 12:25 PM the Administrator stated she began her position after Staff E had completed her contract. The Administrator expected all suspected abuse to be turned in for investigation. The staff stated she did not care if a resident had a history of allegations/complaints as for every 1 false statement there could be one that is factual. The Administrator confirmed abuse training for the facility had been done electronically by the department heads, and will be addressed again at the next all staff meeting.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on clinical record review, staff interviews and facility policy review the facility failed to sign out an as needed (PRN) medication when given and follow up to ensure the PRN was effective for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 24 residents. Findings include: According to the annual Minimum Data Set (MDS) assessment tool with a reference date of 3/7/2025 documented Resident #1 had a Brief Interview of Mental Status (BIMS) score of 14. A BIMS score of 14 suggested no cognitive impairment. The MDS documented he was frequently incontinent of urine and bowel. The MDS indicated he required partial/moderate assistance with toileting hygiene and transfers. The following diagnoses were listed for Resident #1: Parkinson's Disease, coronary artery disease and diabetes mellitus. The Care Plan focus area with an initiation date of 2/4/2025 documented Resident #1 had Activities of Daily Living (ADL's) performance deficit related to activity intolerance. The Care Plan indicated Resident #1 required the assistance of one staff to move between surfaces for every transfer. Review of Resident #1 May 2025 Medication Administration Record (MAR) revealed the following order: milk of magnesia give 30 milliliters (mL) every 24 hours as needed (PRN) for constipation with a start dated of 5/1/2025 and end date of 5/22/2025. The order was not signed out as being given while it was an active order. On 6/12/2025 at 12:29 PM Staff H Certified Nursing Assistant (CNA) stated on Saturday (May 17th) Resident #1 was fine and had normal bowels. Sunday (May 18th) she stated Resident #1 would always have a bowel movement in the morning or before lying him down after lunch. She worked 6:00 AM-2:30 PM that day and he had not had a bowel movement at all, not once. She told Staff I Registered Nurse (RN) multiple times to check on him because he did not seem right and his color was off, but he never went in there. On 6/12/2025 at 2:19 PM Staff F CNA stated he worked 2:00 PM-10:00 PM on the weekend of May 17th and 18th. He took care of Resident #1 on Sunday (May 18th) and when he went to check on him later in the evening, he immediately noticed a foul smell. When he checked the resident, he had soiled himself. Resident #1 had a large bowel movement. On 6/13/2025 at 9:44 AM Staff I worked 6:00 AM-6:00 PM on May 17th and May 18th. He stated he gave Resident #1 his PRN of milk of magnesia later in the shift but was unsure what day and could not remember if he charted it or not. When asked if the PRN was effective he indicated he was not sure because it was later in the day, he could not remember if it was Saturday (May 17th) or Sunday (May 18th). On 6/19/2025 at 1:27 PM the Director of Nursing (DON) stated when giving a PRN medication, the nurses need to ensure the medication was given, then sign out the medication as given. When asked what follow-up should be completed, she stated she has not given a PRN since she has started at the facility but she would go back in to see if the medication was effective or not, then document it. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided an undated document titled Bowel Policy. The policy stated the nurse will check alerts on dashboard of the Electronic Health Record (EHR) upon starting shift. A list of residents who have not had a bowel movement need to be given to the CNA so they can follow up on it. The nurse must do an assessment-including bowel sounds, tenderness, destination, assess any symptoms that have to do with anything bowel related (nausea/vomiting, abdominal pain, etc. Ask about bowel movement details-what it looked like, feel constipated). This is to be put in a progress note.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on clinical record review, facility investigative file review, employee file review, staff interview and facility policy review the facility failed to provide proper assessments and interventions after 2 of 3 residents (Resident #1 and #4) had a change in condition. Resident #1 experienced a change in condition on May 18, 2025 during the day and on the evening shifts. The nurse that worked failed to assess the resident after staff reported concerns to him. The resident developed a fever at approximately 7:00 PM and staff applied a cold rag to his head. A PRN medication was not given to assist with lowering his fever nor was the physician notified until the resident's vital signs significantly changed at approximately 3:00 AM and was sent to the hospital. The resident was admitted to the hospital and expired 5 hours later. Resident #4 had an unwitnessed fall and complained of left hip pain. Staff failed to call the provider to obtain a PRN order for pain or an order to be evaluated. The resident was sent to the hospital 12 hours later and found to have a left hip fracture. The facility reported a census for 24 residents. Findings include: 1. According to the annual Minimum Data Set (MDS) assessment tool with a reference date of 3/7/2025 documented Resident #1 had a Brief Interview of Mental Status (BIMS) score of 14. A BIMS score of 14 suggested no cognitive impairment. The MDS documented he was frequently incontinent of urine and bowel. The MDS indicated he required partial/moderate assistance with toileting hygiene and transfers. The following diagnoses were listed for Resident #1: Parkinson's Disease, coronary artery disease and diabetes mellitus. The Care Plan focus area with an initiation date of 2/4/2025 documented Resident #1 had Activities of Daily Living (ADLs) preference deficit related to activity intolerance. The Care Plan indicated Resident #1 required the assistance of one staff to move between surfaces for every transfer. Review of Resident #1's meal intake revealed the following: a) On 5/16/2025 he ate 76-100% of his breakfast and lunch and 26-50% of his dinner. b) On 5/17/2025 he ate 76-100% of his breakfast and lunch and 51-75% of his dinner. c) On 5/18/2025 he ate 76-100% of his breakfast and lunch and refused his dinner. Review of Resident #1's bowel movement record revealed the following: a) On 5/16/2025 he had no bowel movement documented at 12:41 AM and 10:20 AM, was continent of a small formed bowel movement at 8:57 PM. b) On 5/17/2025 he had no bowel movement documented at 1:39 AM, 12:40 PM, and 11:28 PM and was incontinent at 9:59 PM (no other information documented about the bowel movement was noted). c) On 5/18/2025 he had no bowel movement documented at 1:09 PM and was incontinent of a large soft bowel movement at 9:59 PM. d) On 5/19/2025 at 1:11 AM he was incontinent of a large soft bowel movement. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review revealed Staff D Licensed Practical Nurse (LPN) documented the following Progress Notes: a) On 5/19/2025 at 3:08 AM change in condition: abnormal vital signs, fever, nausea/vomiting, shortness of breath. Resident #1's vital signs were: at 3:09 AM his blood pressure was 116/56 and his pulse was 124, at 3:11 AM his fever was 101.1 and his oxygen saturation was 75% oxygen via nasal cannula was applied. b) On 5/19/2025 at 4:13 AM Resident #1 had audible rhonchi throughout lung fields. Noted emesis to resident's left side of bed, oxygen saturation was 75% on room air, initiated oxygen supplement via nasal cannula a 4 liters (L). Resident was lethargic, skin clammy, unable to verbalize needs. Resident's wife was notified of his status, called the on-call physician and given orders to transport to the emergency room (ER). The Progress Notes for Resident #1 lacked any documentation on 5/18/25. Record review revealed Staff D documented the following change in condition evaluation on 5/19/2025 at 3:08 AM: a) The change in condition, symptoms or signs I am calling about are: abnormal vitals, fever, nausea/vomiting, shortness of breath, that started on the morning of 5/19/2025. b) Vital signs documented as: on 5/19/2025 at 3:09 AM blood pressure was 116/56 with a pulse of 124 and apical heart rate of 121. On 5/19/2025 at 3:11 AM respiratory rate of 28, a temperature of 101.1 and oxygen saturation of 75%, applied supplemental oxygen via nasal cannula c) Additional information as required: signs of aspiration d) Altered mental status with a sudden change in level of consciousness or responsiveness, swallowing difficulties, associated with new onset or progressive aspiration, audible rhonchi noted, resident having difficulty coughing. e) Respiratory assessment was relevant to the change in condition being reported due to the resident experiencing shortness of breath, with an abrupt onset of shortness of breath, fever. f) A cardiovascular assessment was relevant to the change in condition being reported due to the resident experiencing a resting pulse greater than 100 or less than 50. g) An abdominal assessment was relevant to the change in condition being reported due to the resident experiencing nausea and/or vomiting associated with intermittent recurrent nausea and vomiting. h) Things that make the condition or symptom worse are oxygen saturations not improving. i) Other relevant information: visible emesis noted near resident on bedsheet. j) Summarize your observations, evaluation and recommendations: resident likely aspirated. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	k) Primary care physician was notified on 5/19/2025 at 3:20 AM with recommendations to send to the ER. l) Resident #1's representative (wife) was notified on 5/19/2025 at 3:24 AM. The family provided Resident #1 death certificate that documented a date/time of death of 5/19/2025 at 8:03 PM with an immediate cause of death listed as sepsis due to or as a consequence of aspiration pneumonia. Review of Resident #1 May 2025 Medication Administration Record (MAR) revealed the following as needed (PRN) orders): a) acetaminophen oral tablet 325 milligrams (mg), give 2 tablets by mouth every 4 hours PRN for pain/fever, with a start date of 4/26/2025. The order was not signed out as being given in the month of May, b) milk of magnesia give 30 milliliters (mL) every 24 hours, PRN for constipation with a start dated of 5/1/2025 and end date of 5/22/2025. The order was not signed out as being given while it was an active order, c) gentle laxative rectal suppository 10 mg, insert 1 suppository rectally every 24 hours PRN for constipation with a start date of 5/1/2025. The order was not signed out as being given in the month of May. On 6/12/2025 at 12:29 PM Staff H Certified Nursing Assistant (CNA) stated she took care of Resident #1 on May 17th and 18th during her 6:00 AM-2:00 PM shift. He was fine on Saturday, a normal day for him. The 18th she came in to work and he would always have a bowel movement in the morning and after lunch or right before they laid him down for the day. During her shift on the 18th he did not have a bowel movement during her shift that day. It was not normal for him to not have a bowel movement. Staff H stated Resident #1 did not vomit during her shift but he looked like he wanted to. When asked about any confusion, she stated Resident #1 stated he seemed like he forgot to eat. He would take a spoon of food and put it by his eye or ears, which was not like him. His appetite was not great that day; he did not snack like usually would. She offered him a jell-o cup but he did not eat it at all. Resident #1 was really not himself. As CNA's we look out for our residents, we notice the changes. She was catching the changes but the nurse was not paying attention to her as the resident's caregiver and that was frustrating. She told Staff I Registered Nurse (RN) that he needed to go check on him because he was not right and his color was off. Staff H stated Staff I would not go in the resident's room after he said he would. She would find him outside or doing other things instead. She would confront Staff I about going in to check on Resident #1 and he would tell her yea I will be there in a minute. Staff H added this irritated her. When the 2:00 PM-10:00 PM CNA's came on for this shift, she told them to have the night nurse check in on the resident. She was not sure what was going on, but something was going on with him. When asked which staff member she told this to, she stated Staff F CNA. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 6/12/2025 at 2:07 PM Staff A CNA stated she took care of Resident #1 on May 17th and 18th during her 6:00 AM-2:00 PM shift. Resident #1 seemed fine on Saturday, nothing out of the ordinary. Staff A stated on Sunday after she laid him in bed after lunch, he sounded wheezy. She told the nurse about this and was told to keep an eye on it. The resident did not mention anything about not feeling well. She could not remember which nurse she told about the resident being wheezy. On 6/12/2025 at 2:19 PM Staff F CNA stated he worked 2:00 PM-10:00 PM on the weekend of May 17th and 18th. He took care of Resident #1 on Sunday (May 18th) and when he went to check on him later in the evening, he immediately noticed a foul smell. When he checked the resident, he had soiled himself. Resident #1 had a large bowel movement. When asked to describe the smell he stated it smelled like a rotten brush pile (rotten grass smell), it was somewhere in between soft and pudding consistency. It was a deep dark brown color, it had a green mucous cover. He told Staff D and assumed he went in to look at the resident. When asked if the resident ran a fever over the weekend, he stated he remembered feeling the resident's forehead and it was really hot. Staff F could not recall which day it was. He did remember telling Staff D, in which he went in and confirmed he had a fever. Staff F stated the resident did not eat dinner on Sunday. On 6/12/2025 at 3:12 PM Staff I stated he worked with Resident #1 on May 16th, 17th and 18th during his 6:00 PM-6:00 AM shift. He added that was a bad weekend, different residents had a lot of behaviors. Staff told him Resident #1 was in bed all day, early Saturday morning he got him up with a snack and on Sunday he aspirated. When asked how he knew that he stated when he went to assess him he noted rhonchi lung sounds. When he looked in his mouth he did not see anything; no emesis, loose food. He did note a little bit of emesis on his bed. Staff I denied that Resident #1 had a foul smelling bowel movement that weekend. When asked if Resident #1 had a fever, Staff I stated he thought at one point he did. He then stated when he assessed the resident he was having some difficulty breathing while he had abnormal lung sounds and did have a fever. He denied hearing Resident #1 cough or any cognitive changes during the weekend. He noted Resident #1's oxygen saturations to be low so he applied supplemental oxygen, increased respirations and blood pressure. Staff I denied being informed of the resident complaining of being cold and tired. He stated there was nothing reported to him during the nurse to nurse report at shift change. He denied family reporting concerns about Resident #1 being lethargic or not himself. On 6/13/2025 at 9:10 AM Staff I stated he worked with Resident #1 on May 17th and 18th during his 6:00 AM-6:00 PM shift. Staff I stated when he was leaving the facility on the 18th, Resident #1 was fine. He caught him in the hall from the dining room after dinner. Staff I denied staff reporting concerns to him about Resident #1 over the weekend. When he was informed of the concerns Staff H had about Resident #1, he denied being notified by Staff H. Staff I stated he assisted the resident to the bathroom on Saturday and he was weak while standing. Staff I stated he was a little confused with taking his pills on the 17th and 18th, he needed more assistance in taking them. When asked if there was anything out of the ordinary for Resident #1 he stated there was nothing out of the norm for him. He did appear more tired on the 18th but he was up that day. At 9:44 AM Staff I stated he gave Resident #1 his PRN milk of magnesia later in the shift but could not remember which date it was and whether or not he charted it. He also stated he was unsure if the medication was effective or not because it was later in the day; the 17th or 18th, he could not recall. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 6/13/2025 at 12:50 PM the Director of Nursing (DON) stated she had no reports about his health prior to him going to the hospital. When she came in to the facility on the 16th she saw him and he had the biggest smile on his face. She told him he looked nice and he smiled so big. She indicated he had reoccurring urinary tract infections (UTI) but knew of no other major health issues since she started in March. He had recently had a UTI and finished his antibiotic on the 9th. He was in the process of seeing infectious disease for his UTI's. She indicated the only thing staff should have done that weekend, was to contact her when they sent Resident #1 out to the hospital. During a follow up interview on 6/18/2025 at 1:00 PM, the DON was informed of the information obtained from staff interviews from the weekend of May 16th, 17th and 18th. She indicated she did not know a lot of that information. When asked what should have been done, she stated staff should have reached out to her to get more direction on what to do but at the same time they should have used their nursing knowledge. If he had a fever at 7:00 PM the nurse should have reached out to his provider, give Tylenol, and not waited. When asked what the CNA's should do if they feel like the nurses are not responding to their requests, she stated they can also call her if the charge nurse is not being helpful. On 6/17/2025 at 12:39 PM Staff J CNA stated she took care of Resident #1 during her 2:00 PM-10:00 PM shift on May 17th and 18th. She was working with Staff F, he was new to the facility. As she was changing the resident something was wrong with him but when she asked if he was ok, he said yes but something was off. She told Staff D that something was off. He told Staff J Resident #1 had a fever of 101. When asked what day this was she stated Sunday the 18th about 7:00 PM. Staff J told her he placed a cold rag on his head. Staff J was unsure if he gave the resident a PRN to help with his fever or did any other interventions. When she looked back in on Resident #1 he did have a rag on his forehead. When asked if the resident had a bowel movement that day, she stated yes and Staff F had assisted the resident with getting cleaned up. She noted the bowel movement to be large, green and mushy. She added this was a lot for him and that kind of bothered her. He did not get out of bed for them that weekend, but he did report being cold at one point so she got him a blanket. He already had three blankets so she thought that was odd. He also seemed more tired on Sunday, refused his dinners that weekend and stayed in bed all weekend on their evening shift which was not normal for him. The resident's wife did visit on the 16th during her shift. When Staff J went in to the resident's room to speak with him and he woke up. The wife stated that was the first time he had woken up since she had been there to visit him that day. When asked if he had vomited during her shift, she stated she heard he had. She noticed some green stuff around his mouth but thought he had ate something because he liked to snack throughout the day, so she cleaned his mouth up. No concerns about Resident #1 were reported during shift report with the day shift staff. She felt Staff D could have done more than just put a cold rag on the resident's head when he noted he had a fever. On 6/17/2025 at 12:55 PM Staff B CNA stated she only worked with Resident #1 on the 10:00 PM-6:00 AM shift before he went out. When she got report from the prior shift they reported to her he was not doing very well and she could tell. He had some chest congestion and it was a little worse than normal. Later in the shift Staff D took the crash cart to Resident #1's room and put supplemental oxygen on him and later sent him to the hospital. When asked how long between the oxygen being applied and the resident being sent to the hospital, she stated it was about an hour or so. When asked if Resident #1 had a fever during her shift, she stated she believed so because she remembered seeing a rag on his forehead. When asked if the resident had a bowel movement during her shift she stated she remembered someone had a bowel movement that was a weird color but not sure if it was Resident #1 or not. He was breathing heavily which was not normal for him. She told Staff D about her findings and questioned if the resident was transitioning even though he was not on hospice. She could not recall if Staff D said anything when she informed him of her concerns. (continued on next page)

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	165217	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring Acres Nursing and Rehab Center	1000 Hillcrest Drive Anita, IA 50020

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2. According to the quarterly MDS assessment tool with a reference date of 4/16/2025, Resident #4 had a Brief Interview of Mental Status BIMS score of 6. A BIMS score of 6 suggested mild cognitive impairment. The MDS documented she was independent with mobility but required supervision or touching assistance to walk 10 feet, 50 feet with two turns, and 150 feet. Resident #4 was always continent of urine and frequently incontinent of bowel. The following diagnoses were listed for Resident #4: dementia, anxiety, depression, bipolar, post-traumatic stress disorder (PTSD), atrial fibrillation, irritability and anger, and cognitive communication deficit. The Care Plan focus area with an initiation date of 1/8/2025 documented Resident #4 was low risk for falls related to confusion. Staff were encouraged to anticipate and meet the resident's needs, ensure she is wearing the appropriate foot wear and her call light is within reach, encourage her to use it for assistance as needed. She needs prompt response to all requests for assistance. Record review revealed the following Progress Note: a) On 5/18/2025 at 9:21 PM nursing staff alerted the nurse to resident's room where Resident #4 was observed to be lying on the floor with two pairs of pants around her ankles. Her head was pointed to the head of the bed and her feet were pointed toward the exit door in her room. The resident stated she was trying to roll over and get a drink of water and fell out of bed. Note was documented by Staff D. b) On 5/19/2025 at 8:41 AM staff went in to resident's room approximately 30 minutes ago to assist resident with cares. Resident #4 was screaming out in pain with the slightest touch or when staff slide resident in her bed. She was holding her left hip but extending and bending her leg to ease the pain. Resident #4's medical provider was called in regards to her pain. Note was documented by Staff H LPN. c) On 5/19/2025 at 9:53 AM the ambulance arrived to the facility after this nurse called for orders to have resident sent to the hospital for evaluation and treatment. Resident alert and talking with ambulance staff with nonsensical talk about moving her sister this weekend. Resident pleasantly confused and yells out in pain during transfer from bed to gurney. No bruising noted to left hip or leg, no other skin concerns noted at this time. d) On 5/19/2025 at 12:00 PM received a telephone call from the hospital. Resident has a left femur sub capital fracture with mild angulation. Record review revealed the follow facsimile (fax): a) was sent to Resident #4's medical provider dated 5/18/2025 labeled as a routine fax. Staff D documented on the fax: resident observed on the floor in her room. Resident stated I rolled off the bed. She complained of mild discomfort to her left hip. No bruising or obvious injuries noted, she is able to flex left leg and bear weight. Will continue to monitor. The fax had a printed date of 5/18/2025 at 9:45 PM. The medical provider returned the fax on 5/20/2025 at 4:55 PM with no new orders, b) was sent to Resident #4's medical provider dated 5/19/2025. Staff M documented on the fax: ok to send to the ER for evaluation and treatment due to previous fall and uncontrolled pain to left hip/leg. The medical provider returned the fax on 5/20/2025 at 4:55 PM with ok for above. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #4's MAR revealed it did not contain a PRN medication for pain until after she returned from the hospital on 5/23/2025. The facility provided the following staff statements: a) Staff F Certified Nursing Assistant (CNA) wrote: on the night of 5/18/2025 I was walking down hall one and as I passed Resident #4's room (around 9:00 PM-9:15 PM) I heard a crash. When I opened the door, I found Resident #4 on the floor. Upon seeing her on the floor, I leaned out the door to call for Staff D Licensed Practical Nurse (LPN), and he activated the call light. Staff D came in about 2 minutes later. We then noticed she had on two pairs of pants. Then Staff D started asking the resident if she can straighten her leg out and she said no, from my hip to my knee hurts really bad. We got her vital signs, Staff D told me to grab her under the arm and assisted the resident back to her bed. After Resident #4 was in bed, I told Staff D that when I found her in her room, the back of her head was across the supporter bar of her overbed table. I mentioned there was a bruise forming on the outside of her left thigh. Again, Staff D asked her to straighten her leg and Resident #4 said she would be fine and just wanted to go back to sleep. We put her quilt on over her, told her to use her call light, and left her to sleep. b) An email statement was provided to the facility by Staff D. The following statement was made: while on my shift on 5/18/2025 at approximately 8:50 PM, I was documenting when I heard the male CNA scream my name from hall 1. As I made my way down there, another resident passed by and said there was a resident on the floor. I observed the resident sitting on the floor next to her bed. I went to grab the equipment needed to take vitals. I was asking her questions regarding her pain and if she could move her leg. As she sat on her bed, after being transferred from the floor, I again asked her to see if she could flex her leg, which she could. Review of Staff D's employee file revealed a document dated 5/22/25 and titled: Notice of Employment Termination. The document indicated the termination of his employment, this decision follows internal review and documentation of multiple serious concerns related to your performance and conduct, including: -improper handling of a resident fall, including transferring a resident in a manner inconsistent with facility protocols, -failure to arrange timely medical evaluation and failure to notify the DON and Administrator. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 6/12/2025 at 2:19 PM Staff F stated one night he found Resident #4 on the floor in her room around 9:00 PM-9:45 PM as he walked down her hall, he heard a crash come from her room. When he opened the door, he saw Resident #4 on the floor, her neck rested on the foot base of her over bed table and her feet were towards the door. She had two pairs of pants on that were down around her ankles and a t-shirt on. When he asked her, what happened she stated she was reaching for her water and fell. Staff F yelled for Staff D, he walked in 2-3 minutes later. Resident #4 would scream in pain when she would move that leg. Staff D told him to grab under her arm and they both lifted her back to bed. During a follow up interview on 6/18/2025 at 11:43 AM Staff F stated D was trying to get Resident #4 to put her leg down because it was in a position as if she was sitting in a chair, but she was sitting on the floor. When he asked her to lay it down, she kept saying I can't I can't, it hurts. Staff D told Resident #4 if you are not able to put your leg down, you will have to go to the hospital. Staff D added if you go to the hospital you probably will not come back. Staff F stated it was obvious something was wrong with Resident #1 because when they transferred her from the floor to the bed she winced and yelled out in pain. He later learned they should have used a mechanical lift to assist Resident #1 from the floor to her bed. They should not have lifted her off the floor by putting their arms under Resident #1's arms and lifted her back to bed. Staff F stated he noticed what looked like a blood blister starting to form on the left, it was in the shape of a L. It looked like her blood vessels had broken and blood was pooling. When asked where this was located he stated her upper leg where her leg meets her hip, on the outer part of her leg. He reported this to Staff D but he blew it off. On 6/18/2025 at 1:00 PM the DON was asked to elaborate on the following statement found on Staff D's termination paperwork: 1. Improper handling of resident fall, including transferring a resident in manner that is inconsistent with facility protocols. She stated if a resident falls staff are to transfer them with a Hoyer (full body lift) and he did not do that. Him and Staff F lifted her up and put her on the bed. 2. Failure to arrange timely medical evaluation and failure to notify the DON and Admin. She stated Resident #4 was complaining about pain, did not provide any pain interventions and ended up having a broken hip. The DON was informed of Resident #4 not having a PRN at time, she stated he should have called to get an order. An interview with Staff D was not able to be conducted, he was deceased at the time of the survey. The facility provided a document titled Significant Condition Change and Notification with approved date of 12/2024. The purpose of the document is to ensure that the resident's family and/or representative and medical provider are notified of changes such as: -an accident or incident with or without injury that has the potential for needed medical intervention, -a significant change in the resident's physical, mental or psychosocial status such as: a) sudden onset of shortness of breath b) onset of a temperature of 101 degrees higher with or with symptoms c) significant chant in/or unstable vital signs d) emesis/diarrhea (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	e) mobility changes f) change in level of consciousness such as lethargy, sudden lack of responsiveness When any of the above situations exits, the licensed nurse will contact the resident's representative and their medical practitioners. Prior to calling the medical practitioner the nurse will complete the SBAR (subject, background, assessment, recommendation) assessment. Calls will be made to the resident's representative until they are reached. The medical provider will be contacted immediately for any emergencies regardless of the time of day. If the medical provider cannot immediately be reached in any emergency, the medical director will be called. If that medical provider is cannot be reached, the DON of the charge nurse can make arrangements for transportation to the emergency department. All significant changes will be recorded in the resident record. Charting will include an assessment of the resident's current status as it related to the change in condition.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 properly transfer Resident #1 from the floor to her bed after she sustained a fall with complaints of hip pain. The facility reported a census of 24 residents. Findings include: According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of [DATE], Resident #4 had a Brief Interview of Mental Status (BIMS) score of 6. A BIMS score of 6 suggested mild cognitive impairment. The MDS documented she was independent with mobility but required supervision or touching assistance to walk 10 feet, 50 feet with two turns, and 150 feet. Resident #4 was always continent of urine and frequently incontinent of bowel. The following diagnoses were listed for Resident #4: dementia, anxiety, depression, bipolar, post-traumatic stress disorder (PTSD), atrial fibrillation, irritability and anger, and cognitive communication deficit. The Care Plan focus area with an initiation date of [DATE] documented Resident #4 was low risk for falls related to confusion. Staff were encouraged to anticipate and meet the resident's needs, ensure she is wearing the appropriate foot wear and her call light is within reach, encourage her to use it for assistance as needed. She needs prompt response to all requests for assistance. Record review revealed the following progress note: a) On [DATE] at 9:21 PM nursing staff alerted the nurse to resident's room where Resident #4 was observed to be lying on the floor with two pairs of pains around her ankles. Her heard was pointed to the head of the bed and her feet were pointed toward the exit door in her room. The resident stated she was trying to roll over and get a drink of water and fell out of bed. The facility provided the following staff statements: a) Staff F Certified Nursing Assistant (CNA) wrote: on the night of [DATE] I was walking down hall one and as I was passed Resident #4's room (around 9:00 PM-9:15 PM) I heard a crash. When I opened the door, I found Resident #4 on the floor. Upon seeing her on the floor, I leaned out the door to call for Staff D Licensed Practical Nurse (LPN), and he activated the call light. Staff D came in about 2 minutes later. We then noticed she had on two pairs of pants. Then Staff D started asking the resident if she can straighten her leg out and she said no, from my hip to my knee hurts really bad. We got her vital signs, Staff D told me to grab her under the arm and assisted the resident back to her bed. After Resident #4 was in bed, I told Staff D that when I found her in her room, the back of her head was across the supporter bar of her overbed table. I mentioned there was a bruise forming on the outside of her left thigh. Again, Staff D asked her to straighten her leg and Resident #4 said she would be fine and just wanted to go back to sleep. We put her quilt on over her, told her to use her call light, and left her to sleep. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b) An email statement was provided to the facility by Staff D. The following was statement was made: while on my shift on [DATE] at approximately 8:50 PM, I was documenting when I heard the male CNA scream my name from hall 1. As I made my way down there, another resident passed by and said there was a resident on the floor. I observed the resident sitting on the floor next to her bed. I went to grab the equipment needed to take vitals. I was asking her questions regarding her pain and if she could move her leg. As she sat on her bed, after being transferred from the floor, I again asked her to see if she could flex her leg, which she could. On [DATE] at 2:19 PM Staff F stated one night he found Resident #4 on the floor in her room around 9:00 PM-9:45 PM as he walked down her hall, he heard a crash come from her room. When he opened the door, he saw Resident #4 on the floor, her neck rested on the foot base of her over bed table and her feet were towards the door. She had two pairs of pants on that were down around her ankles and a t-shirt on. When he asked her, what happened she stated she was reaching for her water and fell. Staff F yelled for Staff D, he walked in 2-3 minutes later. Resident #4 would scream in pain when she would move that leg. Staff D told him to grab under her arm and they both lifted her back to bed. During a follow up interview on [DATE] at 11:43 AM Staff F stated D was trying to get Resident #1 to put her leg down because it was in a position as if she was sitting in a chair, but she was sitting on the floor. When he asked her to lay it down, she kept saying I can't I can't, it hurts. He stated it was obvious something was wrong with Resident #1 because when they transferred her from the floor to the bed she winced and yelled out in pain. He later learned they should have used a mechanical lift to assist Resident #1 from the floor to her bed. They should not have lifted her off the floor by putting their arms under Resident #1's arms and lifted her back to bed. An interview with Staff D was not able to be conducted, he was deceased at the time of the survey. On [DATE] at 1:00 PM the Director of Nursing (DON) stated Staff D and Staff F should have used a mechanical lift to assist the resident off the floor and back in to bed. Instead they lifted her up and put her on her bed without the lift. The facility provided a document titled Floor Nurse Fall Instructions: What to do if a fall occurs during your shift, dated 10/2023. The documented instructed staff to assess the resident head to toe, check for range of motion (ROM), perform skin assessment. Staff then are to safely transfer them into their chair, bed, etc.