STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165251	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ravenwood Specialty Care	2651 St Francis Drive Waterloo, IA 50702

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on clinical review, staff interview, family interview, facility investigation, incident report, hospital record review, and facility policy the facility failed to ensure safe handling of equipment during resident assistance which resulted with a hematoma, laceration, unnecessary pain, 3 units of blood, prolonged hospitalization, wound assessments, and wound care for 1 out of 3 residents reviewed (Resident #2). The facility reported a census of 137. Findings include:Resident #2's Clinical Census printed 6/15/26 listed an admission date of 6/6/26 and a discharge date of 6/9/26. The Care Plan Focus dated 6/8/26 related to Resident #2's activities of daily living. The Interventions listed Resident #2 as independent with bed mobility, ambulation, transfers, upper body dressing, and lower body dressing. The Incident, Accident, Unusual Occurrence Note dated 6/8/26 at 7:30 AM written by Staff B, Agency Registered Nurse (ARN), documented Staff C, Certified Nurse Aide (CNA), told alerted them to Resident #2's complaint of severe right lower leg pain. Upon assessment, they found Resident #2 seated in a recliner with a pale, grayish, tender hematoma on the lateral anterior aspect of the right lower leg. During the assessment, the hematoma began actively bleeding with an estimated blood loss of 300 milliliters (mL). Staff B applied direct pressure with a bandage, but the bleeding persisted. Staff B elevated Resident #2's right limb and contacted 911 for Emergency Medical Services (EMS). Resident #2 indicated Staff A, CNA, hit her twice while lowering the footrest of the recliner. Staff A present in the room, acknowledged lowering the footrest but denied striking Resident #2, stating any contact they made was unintentional. Upon arrival, EMS prepared Resident #2 for transport. During the transfer to the stretcher, the skin over the hematoma split open, requiring the application of additional dressings. Resident #2 was safely moved to the stretcher using a sheet lift and transported to the hospital for evaluation and management of the bleeding hematoma and skin tear. The Incident Report dated 6/8/26 documented Resident #2 reported after using her call light and asking to get up for the day, she asked the CNA to lower the recliner leg rest because she felt weak. Resident #2 stated the CNA attempted to lower the leg rest manually and then used her foot to push it down, at which time the CNA's leg struck the resident's right lower leg. Resident #2 immediately reported pain and requested a nurse. The nursing assessment identified a grayish hematoma on the right lower leg that subsequently opened and bled, prompting emergency transport to the hospital for further evaluation and treatment. Staff B reported Resident #2 stated Staff A struck her while attempting to lower the recliner. The Hospital Discharge Summary documented diagnoses of lymphedema and venous stasis of the lower legs, class 3 severe obesity due to excess calories, and a body mass index (BMI) of 40.0-44.9. It also documented edema in both lower legs, a pulmonary embolism, and a large soft tissue hematoma of the right lower leg. The resident had a history of pulmonary embolisms (PE) and took Eliquis (an anticoagulant that thins the blood). Her hemoglobin dropped to 6.6, and she required a total of 3 units of packed red blood cell transfusions. On 6/16/26 at 7:20 AM, the hospital Case Manager indicated Resident #2 discharged from the hospital and had been there for quite a while. She added the facility that she would send the hospital discharge summary. On 6/16/26 at 11:27 AM, Staff B provided an account of an interaction between Resident #2 and Staff A while she assessed Resident #2. Staff A told Resident #2 she was doing what she asked her to do, she did not (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	have contact with the resident, and if she did, it was not intentional. Resident #2 told Staff A, Yes, it wasn't intentional but yes you hit me twice. Staff B indicated upon her arrival; Resident #2 didn't have her legs elevated. Staff B attempted to ask the CNA how they manipulated the footrest, but she stated this question went unanswered due to Resident #2's bleeding and the urgent need to transfer them to the Emergency Department (ED). Staff B described the CNA as experienced and reported no prior history of rough handling or boundary issues with residents. Following the incident, the Director of Nursing (DON), called Staff B and Staff A their office. Staff A subsequently went home. On 6/16/26 at 1:29 PM, Staff A indicated she couldn't lower the footrest on Resident #2's recliner. She pushed the footrest with her hands, but the footrest did not lock into place. Resident #2 told Staff A that she couldn't lift her legs. Staff A indicated she pushed the footrest down with her foot. She added she removed the first layer of blankets, but the resident still had a blanket wrapped around her legs and tucked under her limbs. Staff A indicated this was the first time she had worked with Resident #2. She also indicated she has always had a difficult time getting the recliner footrest down. Staff A indicated the facility put her on suspension ever since the incident. On 6/16/26 at 3:00 PM, the Administrator indicated she expected the recliner footrest to function properly. She stated she expected staff to remove blankets, ask for help, and alert maintenance that they had a footrest not working. On 6/16/26 at 4:00 PM, Resident #2 indicated an incident occurred on her first morning at the facility (at approximately 5:00-6:00 AM). Resident #2 indicated she had requested assistance from Staff A to lower the recliner footrest because she felt weak. Staff A turned to the right side, picked up her right foot, and attempted to kick the recliner's footrest mechanism. During this action, Staff A struck Resident #2's right leg. Resident #2 reported screaming in pain and telling Staff A that really hurt. Resident #2 indicated the footrest did not go down. On 6/17/26 at 11:28 AM, Staff C, Certified Nurse Aide (CNA), indicated when she went to answer Resident #2's call light, she saw Staff A in Resident #2's room standing to the left side of Resident #2. Staff A indicated Resident #2 needed to use the bathroom but told Staff C to look at the hematoma on Resident #2's right lower leg. Staff C indicated she saw a large, gray-colored hematoma. Resident #2 sat in the recliner with her feet on the ground. Staff C alerted Staff B. Staff C indicated didn't know if Resident #2 took an anticoagulant medication. She also indicated that Resident #2 requested to seek medical attention immediately and grabbed her leg. When Staff B started to apply a dressing to her right lower leg, it started bleeding. Then Resident #2 told her Staff A kicked her and it busted, adding they already had the footrest down and she was not bleeding at that time. The facility's Safe Lifting and Movement of Residents Policy, revised July 2017, instructed staff on the following: Resident safety, dignity, comfort, and medical conditions will be incorporated into goals and decisions regarding the safe lifting and moving of residents.Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices.Staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding the use of equipment and safe lifting techniques.Maintenance staff shall perform routine checks and maintenance of equipment used for lifting to ensure that it remains in good working order.All equipment design and use will meet or exceed guidelines and regulations concerning resident safety and the use of restraints.Safe lifting and movement of residents is part of an overall facility employee health and safety program that involves employees in identifying problem areas and implementing workplace safety and injury prevention strategies, addressing reports of workplace injuries, providing training on safety, ergonomics, and the proper use of equipment, and continually evaluating the effectiveness of workplace safety and injury-prevention strategies.