STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165278	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Living Center West	1050 4th Avenue SE Cedar Rapids, IA 52403

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interview, and facility policy review the facility failed to provide a call light within reach of a resident, which resulted in a fall with a bruise to the hip for 1 of 1 resident reviewed with a fall (Resident #1). The facility identified a census of 74 residents. Findings include: Review of Resident #1's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated moderate cognitive impairment. Diagnoses per the resident's MDS assessment included stroke, arthritis, hemiplegia or hemiparesis, and anxiety disorder. The MDS indicated Resident #1 required partial to moderate assistance with toilet transfer, sit to stand transfer, and ambulation. The MDS assessment further revealed the resident had impairment on one side to the resident's upper extremity. Review of Resident #1's Care Plan, date initiated 2/12/25, revealed the resident was at risk for falling related to weakness, impaired mobility, and transient ischemic attack (TIA). The intervention initiated on 2/12/25 revealed, Keep personal items and frequently used items within reach. The intervention initiated 3/6/26 directed staff to ensure call lights are within reach of the non affected extremity. An Incident Report for Resident #1 dated 3/5/26 at 11:15 AM prepared by Staff B, Licensed Practical Nurse (LPN) revealed resident was found sitting on the floor with her back against the toilet seat. Resident #1 stated she was trying to reach for the call light cord when she slid from the toilet seat and sat on the floor. The Resident Description section revealed, I was trying to reach for the call light cord. The Immediate Action Taken section revealed, in part, We make sure the that the call light cord should always be within reach. The incident report failed to document where the call light was located at the time of the fall. A Progress Note from 3/5/26 at 4:20 PM revealed Resident #1 was found sitting on the floor with her back against the toilet seat. Resident stated to staff she was trying to reach for the call light cord when she slid from the toilet seat and sat on the floor. On 6/4/26 at 9:45 AM an interview with Resident #1, she revealed she was on the toilet and asked for the cord for the call light. Resident #1 stated Staff A tossed it to me (resident) in a [NAME]. Resident #1 reported Staff A was irritated with [Resident #1], and [Resident #1] could not catch it. [Resident #1] called to her to wait and she did not wait. Resident #1 reported they fell trying to reach the cord, yelled for help, and she came back to the room and told [Resident #1] to get up, get up, get up. Review of Resident #1's statement included as part of the facility investigation, dated 3/9/26 at 5:30 PM revealed the following: Resident #1 explained Staff A had assisted the resident to the toilet. Resident #1 asked her for the call cord, and she (Staff A) tossed it at [Resident #1] in a [NAME] like she didn't want to be bothered. [Resident #1] didn't catch it. Before she left the room [Resident #1] yelled, wait but she didn't come back. [Resident #1] tried to reach it herself and slipped off the toilet. [Resident #1] started to yell, help, help, [Resident #1] had to yell it multiple times before she came back into the room. A written statement from the facility investigation revealed, in part, the following from Staff B, LPN (statement dated 3/6/26 at 11:36 AM): He was called to Resident #1's room by Staff A, CNA on 3/5/26 approximately 11:25am, upon arrival resident was found sitting in front of the toilet on the floor. Head to toe assessment completed with no issues found, vital signs stable, (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	resident denied pain. Resident #1 stated she was reaching for her call light when she slipped off the toilet. Per the statement, Staff B completed another skin assessment on resident on 3/6/26 as the CNA stated the resident had a bruise on her right hip. Per the statement, the bruise measured 12 centimeters (cm) x10 cm, and the resident continued to deny pain. On 6/4/26 at 10:43 AM during an interview with Staff B, Licensed Practical Nurse (LPN), he revealed did the assessment after Resident #1's fall on 3/5/26. Staff B explained the resident had a routine and couldn't move her right hand which was closer to the call light, so had to hand her the call light and place it in her left hand. Staff B stated Resident #1 reported Staff A just kind of tossed Resident #1 the call light. He reported Resident #1 could not move her right hand so staff had to place the call light in her left hand. A Progress Note dated 3/6/26 at 12:29 PM revealed Resident #1 had a 12 cm by 9 cm bruise noted to the right hip. Power of attorney and medical provider were notified. A Non-Pressure Skin Condition Report dated 3/6/26 revealed right hip bruise area measured 12 cm by 9 cm. The assessment of the area on 3/10/26 revealed tenderness with palpation, and dissolves quickly per self. A Progress Note dated 3/7/26 at 12:44 PM noted bruise to right hip reported previously. Resident #1 denied pain of right hip with passive or active range of motion, and still reported mild discomfort to touch the bruise. A Progress Note dated 3/8/26 at 1:06 PM noted Resident reported mild discomfort to touch the bruise to right hip. During an observation on 6/8/26 at 11:09 AM Staff C, CNA transferred Resident #1 from wheelchair to toilet without difficulty with gait belt and a stand pivot transfer. Once Staff C had Resident #1 on the toilet, she placed the call cord in her left hand and allowed privacy for Resident #1. On 6/8/26 at 12:04 PM Staff C revealed Resident #1 normally transferred with a cane outside of her room, and inside of her room she feels more comfortable with a gait belt and doing a pivot transfer. Per Staff C, normally the resident did transfer pretty well, explained the resident was very routine based, and she will explain her routine to you. Staff C explained if staff move too quick she can become anxious. Staff C further explained if take time with Resident #1 ,she will transfer pretty easily. Staff C explained they would put the call light to her left hand and she would ask for you to put it in her hand. Staff C further explained Resident #1 was pretty alert and oriented. On 6/8/26 at 12:15 PM Staff D, CNA explained when she put Resident #1 on the toilet, would hand her the call light. If you forgot it, she would repeat herself. Staff D explained it was very well known she wants her call light. She would repeat it until you did it for her. Staff D further explained would put it in her left hand because the right hand was restricted, she can't do anything with it. Staff D explained Resident #1 was alert and oriented; she knew what was going on and was able to let her needs be known.On 6/8/26 at 2:01 PM, Staff E, LPN, Assistant Director of Nursing (ADON) confirmed there was a bruise on Resident #1's left hip the next day after the fall on 3/5/26. She explained Resident #1 fell to the left and the bruise was related to the fall. After the fall the intervention we put in place was staff education. In this instance it was to make sure the call light was in reach of the non affected side. On 6/8/26 2:20 PM, the Director of Nursing (DON) stated they didn't know much about Resident #1's fall on 3/5/26 related to it was before they became DON. She was transferred on the toilet by Staff A, she made it onto the toilet but was reaching for call light when she lost her balance and fell off the toilet and landed on her hip. The DON stated staff should place the call light in the resident's hand. The DON confirmed the bruise on Resident #1 left hip was related to the fall on 3/5/26. On 6/8/26 at 2:45 PM the Administrator explained for the fall with Resident #1, the resident reported Staff A threw the call light and shoved it at Resident #1. The resident tried to get it into her left hand when she fell. She revealed the facility terminated Staff A related to her being disrespectful to residents. The facility provided a policy titled Fall Reduction and Response revised 2/17/25. The policy directed interventions to reduce the risk of falls will be implemented based on assessed risk. The procedure addressed to identify any factors that may predispose the resident for falls and/or activities that have helped prevent falls in the home environment. The policy directed staff to put call light within reach.