STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165307	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pillar of Cedar Valley	1410 West Dunkerton Road Waterloo, IA 50703

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and Resident Assessment Instrument (RAI) Manual the facility failed to transmit Minimum Data Set (MDS) assessments timely for 2 of 3 residents reviewed (Residents #29 and #139). The facility reported a census of 136 residents. Findings include:1. Resident #29's MDS Quarterly assessment listed a completed date of [DATE]. The record lacked a transmitted status.On [DATE] at 11:12 AM Staff M, MDS Coordinator, reported their electronic health record (EHR) program directed to not submit the MDS, so she didn't submit the assessment. She reported she didn't know why the MDS got coded like that.On [DATE] at 11:20 AM the Administrator reported the facility didn't have a policy, they used the RAI manual.The RAI manual dated [DATE] on page 2-18 directed to transmit the Quarterly MDS no later than 14 days after the completion of the assessment.2. Resident #139's MDS Death assessment with assessment reference date [DATE] was completed on [DATE]. The record identified the facility transmitted the assessment on [DATE].Resident #139's Progress Note dated [DATE] at 10:35 AM documented they died in the facility.On [DATE] at 11:15 AM Staff M reported she didn't know the MDS needed transmitted within a certain timeframe.The RAI manual dated [DATE] on page 2-20 documented the Death MDS needed transmitted no later than 14 days after the resident's date of death .

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, clinical record review, policy review, and staff interviews, the facility failed to follow a resident's Care Plan for 1 of 2 residents reviewed (Resident 5). The facility reports a census of 136.Findings include: On 9/9/25 at 1:49 PM observed Resident #5's wheelchair without anti-tippers on front of the wheelchair, no pressure relieving cushion, or non-slip material (Dycem) in the wheelchair.The Care Plan Focus dated 9/25/19 reflected Resident #5 had a risk of falls. The Care Plan directed the following Interventions:a. 9/25/19: Front anti-tippersb. 9/15/22: Dycem for the wheelchair.The Care Plan Focus dated indicated Resident #5 had a potential for pressure ulcers. The Intervention dated 9/3/20 directed to place a pressure reduction cushion in the wheelchair. On 9/10/25 at 7:33 AM observed Resident #5 sitting in a wheelchair in the hallway. Her wheelchair lacked the cushion, anti-tippers, and Dycem.On 9/10/25 at 9:24 AM Staff A, Registered Nurse (RN), verbalized she said she didn't know anything what Resident #5 needed for her wheelchair. On 9/10/25 at 9:26 AM Staff K, Certified Nurse Aide (CNA), reported she never saw a cushion or Dycem for Resident #5's wheelchair. On 9/10/25 at 1:15 PM, the Director of Nursing (DON) reported she expected the staff to follow the Care Plan Interventions. The Interim and Comprehensive Care Plans policy revised September 2011 directed staff to review and update the Care Plan every quarter at minimum.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, policy review and staff interview the facility failed to provide a palm splint to the left hand to reduce/prevent contracture for 1 of 1 resident's sampled (Resident #15). The facility identified a census of 136 residents.Findings include:Resident #15's Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 13/15 indicating intact cognition. The MDS documented Resident #15 had a functional limitation in range of motion to one upper extremity (shoulder, elbow, wrist, hand) and depended on staff for eating, oral hygiene, toileting, upper/lower body dressing and personal hygiene. The MDS listed diagnoses of non-traumatic brain dysfunction, stroke and hemiplegia/hemiparesis (paralysis or loss of muscle function on one side of the body).An Occupational Therapy (OT) Home Therapy Program dated 1/17/25 signed by Staff I, Assistant Director of Nursing (ADON), directed the staff to apply a soft carrot splint with larger end toward the 5th digit (pinky finger) to prevent the fingers from digging into the palm and contracture. Staff to apply in the morning (AM) and wear all day as patient tolerated. The staff could take the splint off at night. Resident #15's Care Plan revised 3/13/25 documented a potential for development of pressure ulcers or other skin injuries related to impaired mobility due to left hemiplegia. The Care Plan Intervention initiated 1/20/25 directed staff to apply a carrot splint to the left hand with the large end toward the 5th digit go prevent contracture and pressure to the palm from fingers. The staff could remove at night. The Activities of Daily Living Self Care Performance Deficit Care Plan revised 3/13/25 included an Intervention dated 3/27/24 that directed Resident #15 to wear a wrist splint on his left hand/wrist. He needed assistance with putting on/taking off the splint. The Order Review History Report acknowledged by the Provider on 8/27/25 at 1:38 PM documented a physician order initiated 1/29/25 per therapy apply a soft carrot splint with the larger end toward the 5th digit to prevent fingers from digging into the palms and contracture. Staff to place in the morning and take off at night as Resident #15 allowed. Observation on 9/8/25 at 11:49 AM Resident #15 sat in the wheelchair at the dining room table. Resident #15 had their left wrist/hand flexed inward at the wrist with the fore, middle, ring and pinky fingers curved inward toward the palm. Resident #15 did not have a carrot splint in their left palm/hand.Observation on 9/9/25 at 12:55 PM revealed Resident #15 sitting in the high back wheelchair at the dining room table. No carrot splint observed in the left hand with the fore, middle, ring and pinky finger all curved inward toward the palm/hand.Observation on 9/9/25 at 2:16 PM Resident #15 sat in the high back wheelchair in the dining room. Resident #15's left hand laid in his lap curved inward with the fore, middle, ring and pinky fingers curled inward toward the palm and the wrist flexed inward at the wrist with no carrot present in the left palm/hand.Observation on 9/9/25 at 2:18 PM revealed Resident #15 sitting in the wheelchair with his left wrist flexed inward with the fore, middle, ring and pinky fingers folded inward toward the palm. Resident #15 did not have a palm carrot in the left palm/hand. At 2:19 PM Staff C, Certified Nursing Assistant (CNA), assisted Resident #15 back to his room. Staff C and Staff D, CNA, transferred Resident #15 from the wheelchair to the bed, performed incontinence care and repositioned him. Staff C and D exited Resident #15's room without offering to place the palm carrot in Resident #15's left palm/hand. Resident #15's left wrist was flexed inward at the wrist with the fore, middle, ring and pinky fingers flexed inward toward his palm positioned along his left side. During an interview on 9/9/25 at 2:35 PM Resident #15 reported he would wear the palm carrot to his left hand if the staff offered it to him, but that didn't happen often. During an interview on 9/10/2025 at 10:21 AM Staff F, CNA, reported Resident #15 should be asked everyday if he wanted to wear the carrot splint, but she only goes in to help him as needed. If he refused the carrot splint, the staff should document it in the behavior charting and let the nurse know Resident #15 refused the carrot splint.Observation on 9/10/25 at 10:23 AM Resident #15 sat in the wheelchair with his left wrist (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	flexed inward with the fore, middle, ring and pinky fingers folded inward toward the palm. Resident #15 did not have a palm carrot in his left palm/hand.Interview completed on 9/10/2025 at 10:25 AM Staff G, CNA, reported Resident #15 has a small, padded glove that staff put on him at night to keep his hand open. He does not have anything that he wears or uses in the left hand during the daytime. Staff G added sometimes they offer him a rolled-up wash cloth for his left hand when they lay him down in bed during the day. Observation on 9/10/25 at 1:31 PM revealed Resident #15 sitting in the wheelchair with a rolled washcloth in his left palm/hand.Interview on 9/10/25 at 1:32 PM Staff E, Licensed Practical Nurse (LPN), reported he signs in the Electronic Treatment Administration Record (ETAR) that staff place Resident #15 carrot splint in his hand every morning. Staff E voiced he thought the resident works it out of his hand but didn't know for sure. He didn't usually go visually check to ensure the staff placed the carrot splint in Resident #15's left hand, he just goes on the fact that the carrot splint is listed under Resident #15's name on the Resident Care Sheet. The carrot splint is listed for Resident #15 to wear every day on the Resident Care Sheet which Staff I updated every day. Staff E provided a copy of the current Resident Care Sheet. Staff E voiced he didn't know where the CNA staff signed or documented regarding Resident #15's carrot splint. He had plenty to do every day and he just made sure he marked the boxes in the resident ETAR, so they turned green to show completion of the orders/tasks. Staff E verified the ETAR contained an order to utilize a carrot splint to Resident #15's left palm/hand. A 9/10/25 review of the Resident Care Sheet updated 8/21/25 provided by Staff E lacked documentation or direction to the staff that Resident #15 needed a carrot splint placed in the left hand to prevent/minimize contracture.A 9/10/25 review of the September 2025 ETAR showed Staff E signed Resident #15 wore the carrot splint to the left palm/hand on September 8, 9, and 10. Interview on 9/10/25 at 1:38 PM Staff J, CNA, explained they document the application of Resident #15's carrot splint in the Point of Care (POC) Electronic Healthcare Record. If Resident #15 refused the carrot splint, the program had an option to document the refusal.During an interview on 9/10/25 at 1:54 PM the Director of Nursing (DON) voiced she expected if the Care Plan included a splint, the staff should attempt to place the splint as a measure to prevent contractures. If a resident refused the splint, the staff should document the refusal. If the resident continued to refuse, they should have a referral to therapy services.On 9/11/25 at 12:17 PM the Administrator corresponded the facility didn't have documentation to support Resident #15 recently refused his left carrot splint.

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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. Based on observations, staff interviews and policy review, the facility failed to lock up hazardous tools when they didn't have staff present in resident areas. The facility reported a census of 136 residents.Findings include: During a continuous observation on 9/8/25 at 1:38 PM of the 3rd floor west side hallway noted the housekeeping closet open and unattended with a wheeled cart in front of the doorway. The unattended wheeled cart had a box cutter, pipe wrench, fire fighter eliminator 1330 (non-toxic antifreeze solution for fire sprinklers), and an impact drill. Observed 3 residents go by the area with no staff present. At 1:42 PM the contracted sprinkler company staff came to the housekeeping closet and worked with the cart items, shut the housekeeping closest, and left shortly after arriving with the cart of tools and antifreeze.During a continuous observation on 9/9/25 at 8:54 AM of the 3rd floor west side hallway noted the housekeeping closet open and unattended with a wheeled cart in front of the doorway. The wheeled cart noted a box cutter, pipe wrench, fire fighter eliminator 1330, and an impact drill. Observed a resident continuously walking around the area and several residents in their rooms not far from the area. At 9:07 AM the contracted sprinkler company staff came to the housekeeping door and began working with the fire fighter eliminator. They then took the cart and shut the door when done. During a continuous observation on 9/9/25 at 8:54 AM the 3rd floor west side hallway oxygen room noted the key hanging in the keyhole of the door. The key connected to a metal piece with 6 heavy chain links then a long wooden stick attached to the chain links. The wooden stick looked about a foot long. The continuous observation noted the key remained in the door with several staff and residents walking by. Staff O, Certified Nurses' Aide (CNA), removed the key at 9:44 AM. On 9/11/25 at 10:49 AM Staff L, Assistant Maintenance, reported Monday and Tuesday, the facility had a contracted sprinkler company there. He reported maintenance gets them all ready to do the stuff they needed to do. They educate them to keep them behind the locked doors, but they do not stay with them while at the facility. He reported he didn't know the company left hazardous tools out without staff nor the contracted company to keep an eye on them. He reported they shouldn't leave tools around. On 9/11/25 11:01 AM Staff B, Assistant Director of Nursing (ADON), verbalized the key for the oxygen is located in the nurses' station. She reported staff are to return the key when done and not leave it in the door or sitting out anywhere. On 9/11/25 at 11:25 AM the Administrator reported she expected maintenance to be with the sprinkler company when they worked on things. She added she expected staff to put back the oxygen key and not leave it in the door as those are hazardous things that wouldn't be good if a resident got a hold of them. The facility policy titled Physical Environment -Maintenance Repair Request revised 7/15/25 directed to ensure all tools, equipment, and furnishings are in good repair and working order, including security measures.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, policy review and staff interview, the facility failed to implement current physician orders for oxygen therapy for 1 of 1 resident's sample (Resident #15). The facility identified a census of 136 residents.Findings include:Resident #15's Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 13/15 indicating intact cognition. The MDS documented Resident #15 exhibited shortness of breath (SOB) trouble breathing with exertion, at rest and while lying flat. The MDS documented diagnoses of chronic obstructive pulmonary disease (COPD, a group of lung diseases that cause ongoing breathing problems characterized by narrow airways which make it difficult to breath, irritation and mucus of the airways that worsen breathing over time) and respiratory failure with use of oxygen therapy. Resident #15 Care Plan revised 3/13/25 documented a diagnosis of COPD and the resident utilized oxygen as needed. The Care Plan directed the staff to give oxygen therapy as ordered by the physician and to check the flow rate routinely for accuracy, as the resident chooses to change settings without consulting the nurse.An Electronic Healthcare Record (EHR) Census documented Resident #15 discharged to the hospital on 8/19/25 and returned to the facility on 8/26/25.A Summary of Hospitalization dated 8/26/25 documented a Principal Problem of acute on chronic respiratory failure with hypoxia (a condition where the body's tissues do not receive enough oxygen) and hypercapnia (a condition where there is excessive amount of carbon dioxide in the blood stream and the body is unable to eliminate it efficiently through breathing) and Active Problems of shortness of breath, pulmonary emphysema (a chronic lung condition that causes permanent damage to the lung air sacs) and respiratory failure (a condition where the lungs cannot adequately provide oxygen to the body or remove carbon dioxide). The Summary under Hospital Course documented Resident #15 arrived at the emergency department (ED) with shortness of breath and difficulty breathing with a history of COPD and aspiration pneumonia (a particle not part of the lungs enters the lungs and causes an infection). The Summary listed a physician order for oxygen 3 liters per minute (LPM) continuous. Observation on 9/8/25 at 11:49 AM Resident #15 sat in the wheelchair with oxygen running at 2 liters per minute (LPM) via nasal cannula. Resident #15 leaned to the right with his right arm hanging off by the lower part of the right wheel of his chair. He made no attempts to change his oxygen setting.Resident #15 observed 9/9/25 at 11:13 AM sitting up in bed with oxygen running at 2 LPM via nasal cannula. Resident #15 had the oxygen concentrator positioned on the left side of the bed where he couldn't touch the concentrator.An observation on 9/9/25 at 12:48 PM revealed Resident #15 sat in the high back wheelchair in the dining room with an oxygen concentrator running at 2 LPM via nasal cannula. Resident #15 had the oxygen concentrator positioned to the right side of his wheelchair. Resident #15 made no attempts to adjust his oxygen concentrator.Observation on 9/10/25 at 10:17 AM Resident #15 sat in the wheelchair in the dining room with his oxygen on 2 LPM on via nasal cannula. Observation on 9/9/25 at 2:18 PM revealed Resident #15 sitting in the wheelchair in the dining room with his oxygen concentrator set at 2 LPM. He had the oxygen concentrator positioned approximately 2 feet from Resident #15's right side out of his reach. At 2:19 PM Staff C, Certified Nursing Assistant (CNA), unplugged Resident #15's oxygen concentrator, took off his nasal cannula, and proceeded to wheel him approximately 60 feet from the dining area to his room. Staff D, CNA, took Resident #15's oxygen concentrator back to his room. Staff C and Staff D donned (put on) an isolation gown, gloves, and masks, then assisted him via the full mechanical lift from his wheelchair to the bed. Staff C and D provided incontinence care and then positioned Resident #15 in the bed. At 2:32 PM Staff C placed the oxygen cannula on Resident #15 and turned on his oxygen concentrator. Resident #15 asked Staff C to put his head of the bed up. Resident #15 went without continuous oxygen for 13 minutes.A review of the August and September 2025 Electronic Treatment Administration Records (ETARs) reflected the staff signed Resident #15 used oxygen at 3 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPM to keep oxygen saturations above 89 % from 8/26/25 to 9/10/25. The September 2025 ETAR showed Staff E, Licensed Practical Nurse (LPN) documented Resident #15 received oxygen at 3 LPM to keep saturations above 89% from 9/8/25 to 9/11/25. The ETAR didn't document the oxygen as continuous per the physician order.Interview on 9/10/2025 at 10:18 AM Staff F, Certified Medication Aide (CMA), stated Resident #15 used 2 liters of oxygen. She didn't see him try to change his oxygen rate since he returned from the hospital.Interview completed on 9/10/2025 at 10:25 AM Staff G, CNA, voiced they tried to place the concentrator where Resident #15 couldn't change it. The concentrator is to be set at 2 LPM. She tries to check his concentrator is set to 2 liters whenever she walked by him. He only used the oxygen concentrator and didn't use any portable oxygen. Interview on 9/10/25 at 10:26 PM Staff H, CNA, explained they check Resident #15 oxygen concentrator often to be sure it is set to 2 liters.Interview on 9/10/25 at 10:42 AM Staff I, Assistant Director of Nursing (ADON), stated Resident #15 received oxygen at 2 LPM as he blows himself out and gives himself exacerbations of COPD. The nurses are to check the oxygen concentrator liter flow every shift and document it on the ETAR. The aides check the concentrator liter flow with cares. All the staff know he is to be on oxygen at 2 LPM. At 10:44 AM Staff I checked Resident #15 Summary of Hospitalization to confirm the oxygen order at 2 LPM. Staff I reported she made a mistake and confirmed Resident #15's oxygen order as 3 liters continuous. She hadn't placed the current oxygen order in the EHR. During an interview on 9/10/25 at 11:57 AM the Director of Nursing (DON) voiced she expected the staff to follow the physician's order. She didn't know for sure if the facility had a policy for following physician orders, but they had an oxygen policy, and they should follow the physician's order.The Respiratory Care and Oxygen Administration Policy, revised April 2025, provided by the facility, directed the facility to provide guidelines for safe oxygen administration. The Policy Guidelines directed the nurse to verify the physician's order for oxygen use and oxygen administration.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, policy review, manufactures instructions for use, and staff interviews, the facility failed to ensure residents didn't receive expired insulin to diabetic residents for 2 of2 residents sampled (Residents #401 and #9). The facility reported a census of 136 residents.Finding include:1. Resident #401 Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating intact cognition. The MDS listed a diagnosis of diabetes mellitus. In addition, the MDS identified Resident #401 utilized insulin seven days a week.The Order Review History Report acknowledged by the provider on [DATE] at 13:38 PM listed the following physician orders:a. Humalog Injection solution 100 units (U) per milliliter (ML) injection 2 U subcutaneously twice a day for diabetes.b. Humalog Injection solution 100 U/ML inject 2 units per sliding scale for a blood sugar of 151-200.Observation on [DATE] at 8:23 AM Staff A, Registered Nurse (RN), reviewed Resident #401's [DATE] Electronic Medication Administration Record (EMAR). The EMAR listed the following orders:a. Humalog Injection solution 100 units (U) per milliliter (/ML) injection 2 U subcutaneously twice a day for diabetesb. Humalog Injection solution 100 U/ML inject 2 Units per sliding scale if blood sugar 151-200 give 2 units.Staff A performed hand hygiene, applied gloves, removed a bottle containing a vial of Humalog insulin, drew up 4 units of Humalog insulin into a syringe, and proceeded to administer the insulin to Resident #401 without verifying the expiration date of the insulin. Further observation revealed the insulin vial contained an open date of [DATE] and an expiration date of [DATE].Interview completed on [DATE] at 8:25 AM Staff A, voiced she should have checked the expiration date on the bottle of insulin, and shouldn't gave it to Resident #401.Interview completed on [DATE] at [DATE] at 8:30 AM Staff B, Assistant Director of Nursing (ADON), explained insulin is good for 28 days after opening. She expected the nurses to check the expiration date prior to administering insulin.A [DATE] review of Resident #401's [DATE] EMAR revealed they received Humalog insulin several times a day by several different nurses from [DATE] to [DATE].During an interview on [DATE] at 11:57 AM the Director of Nursing (DON) voiced the facility didn't have an insulin policy but with the facility medication administration policy medication rights, she expected a nurse to check the medication expiration date and not administer expired medication. She stated it wasn't the first time she found expired insulin in the medication cart.The Medication Administration Policy revised on [DATE], provided by the facility, directed the individual administering medication should verify the medication, dose, time, and method ofadministration. The policy lacked direction within the rights of medication administration to verify the expiration date of the medication prior to administration.The Novolog Highlights of Prescribing Information (manufacturer's instructions for use) revised [DATE] under Summary of Storage Conditions listed Humalog insulin vials as good for 28 days once opened.2. Resident #9's MDS assessment dated [DATE] showed a BIMS score of 12/15 indicating intact cognition. The MDS listed a diagnosis of diabetes mellitus and documented Resident #9 utilized insulinseven days a week.The Order Review History Report acknowledged by the provider on [DATE] at 13:38 PM listed the following physician orders:a. Novolog Injection solution 100 U/ML inject 3 U subcutaneously twice a day for diabetes.b. Novolog Injection solution 100 U/ML inject 2 U per sliding scale, for blood sugars of 350-399, give 4 units of insulin.Observation on [DATE] at 8:24 AM revealed Resident #9's vial of Novolog insulin had an open date of [DATE] and an expiration date of [DATE].Interview completed on [DATE] at 8:25 AM Staff A confirmed she gave Resident #9 her scheduled AM dose of Novolog insulin [DATE] from the expired insulin vial. Staff A voiced she shouldhave checked the expiration date on the bottle of insulin and not administered the insulin from that expired vial.A [DATE] review of Resident #9's September EMAR revealed they received Novolog insulin several times a day by several different nurses from [DATE] to [DATE].

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, policy review, and staff interviews the facility failed to have patient care equipment in good repair for 1 of 1 resident reviewed (Resident 37). The facility reported a census of 136 residents.Findings include: On 9/8/25 at 11:20 AM observed Resident 37's bed frame had plastic protective edging loose and sticking up at the foot of bed.On 9/9/25 at 9:53 AM observed Resident 37's bed frame plastic edging remained loose and sticking up at the foot of bed.On 9/10/25 at 7:15 AM observed Resident 37's bed frame plastic edging remained loose and sticking up at the foot of bed.On 9/11/25 at 11:10AM Staff N, Assistant Maintenance, reported the staff email or verbally call them if something needed fixed. In addition, Residents also let them know verbally.On 9/11/25 at 11:30 AM Administrator described the process of repairing things as an email sent to maintenance. They print the email out to know what needs fixed. The facility policy titled Physical Environment - Maintenance Repair Request revised 7/15/25 documented per regulations, inspections are completed on a routine basis, ensuring equipment and furnishing are free from safety hazards.