STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165316	A. Building B. Wing	06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eldora Specialty Care	1510 22nd Street Eldora, IA 50627

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to notify the Physician and family of an allegation of abuse for 2 of 2 resident reviewed (Resident #1 and #5). The facility reported a census of 36 residents.Findings include:1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 3, indicating severely cognitively impaired. The MDS identified Resident #1 required substantial or maximal assistance with showering and bathing and depended on staff for tub or shower transfers. The MDS included diagnoses of hypertension (high blood pressure), non-Alzheimer's dementia (mental decline), unspecified dementia with other behavioral disturbance (confusion with behaviors), and senile degeneration of the brain (brain tissue wasting). The MDS documented Resident #1 received hospice care (end-of-life care) during the stay. A handwritten Internal Investigation Witness Statement completed by Certified Nursing Assistant (CNA) Staff B dated 6/4/26 at 1:30 PM documented that Staff B and CNA Staff C assisted Staff A, CNA/CMA (Certified Medication Aide) with showering Resident #1. The statement indicated Resident #1 became combative due to a dislike of showers. Staff A bent down to wash Resident #1 when Resident #1 grabbed Staff A in the chest. Staff A yelled at Resident #1, stating, you will not do this to me, and then grabbed her right wrist and aggressively pushed it into Resident #1's chest. Resident #1 yelled that it hurt and that Staff A contracted her arm or broke her arm. Later during the shower, when Staff A bent down to apply Resident #1's Tubi grips (elastic support bandages), Resident #1 grabbed the hair bun on top of Staff A's head. Staff B tried to release Resident #1's hand from Staff A's hair when Staff A slapped her hands, yelled again, then held her hands against her chest until the shower finished. When getting out of the shower chair, Staff A told Resident #1, if you want to get out of here, then you better stand up on your own. Staff A then proceeded to tell Resident #1 that she tried to be nice and she'd act mean by lifting her out of the chair instead. Staff A reported to Staff B that she acted mean because she engaged in a fight with her mother and children. The statement documented that Staff B reported the incident to the Administration on 6/4/26 at 3:00 PM. A review of the Clinical Record lacked documentation showing that staff reported the allegation of abuse to Resident #1's Attending Physician or family on 6/4/26. On 6/11/26 at 9:49 AM, the Administrator reported that he expected staff to notify the doctor and family in relation to an abuse report. On 6/11/26 at 10:30 AM, the Director of Nursing (DON) reported that Resident #1's family and hospice knew about her behaviors and medication changes on 6/4/26. She stated that staff notified Resident #1's physician and family of the allegations on 6/8/26. The Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating policy dated April 2021 directed facility management to thoroughly investigate and report all claims of resident abuse, neglect, exploitation, or theft of resident property to local, state, and federal agencies. The policy instructed the Administrator or the individual making the allegation to immediately report suspicions to:The state licensing or certification agency responsible for surveying the facilityThe local or state ombudsmanThe resident's representativeAdult protective servicesLaw enforcement officials,The resident's attending physicianThe facility medical director. 2. Resident #5's Minimum Data Set (MDS) (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 3, indicating severely cognitively impaired. The MDS identified Resident #5 maintained independence with bed mobility, transfers, and ambulation up to 150 feet. The MDS included diagnoses of hypertension (high blood pressure), hyperlipidemia (high cholesterol), and non-Alzheimer's dementia (progressive brain decline). A handwritten Internal Investigation Witness Statement completed by Certified Nursing Assistant (CNA)/Certified Medication Aide (CMA) Staff F dated 5/18/26 at 10:45 AM documented that Staff F went back to the Chronic Confusion or Dementing Illness (CCDI) unit to assist Staff A, CNA/CMA. While Staff F stood in the unit, Staff A stated to Staff F, Resident #5 punched them in the back and they turned around and grabbed her right arm and told her they're not going to touch them. Staff F documented that when she left the unit, she reported the incident to the charge nurse, Director of Nursing (DON), and Administrator. A review of the Clinical Record lacked documentation showing that staff reported the allegation of abuse to Resident #5's Attending Physician or family on 5/18/26. On 6/11/26 at 10:30 AM, the DON reported she didn't recall staff reporting anything on 5/18/26 to Resident #5's family or Attending Physician.

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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 0600 Level of Harm - 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, facility investigation review, staff interviews and policy review, the facility failed to protect residents from verbal and physical abuse by a staff member for 3 of 3 residents reviewed for abuse (Residents #1, #5, #6). The facility reported a census of 36 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 3, indicating severely impaired cognition. The MDS identified Resident #1 required substantial or maximal assistance with showering and bathing and depended on staff for tub or shower transfers. The MDS included diagnoses of hypertension (high blood pressure), non-Alzheimer's dementia (mental decline), unspecified dementia with other behavioral disturbance (confusion with behaviors), and senile degeneration of the brain (brain tissue wasting). The MDS documented Resident #1 received hospice care (end-of-life care) during the stay. Resident #1's Care Plan with a target date of [DATE] revealed Resident #1 exhibited aggressive behavior with Activities of Daily Living (ADLs) which included combativeness with staff during care or repositioning. The Care Plan documented Resident #1 would hit the staff, yell out, and use foul language. The Care Plan directed the following interventions: Allow Resident #1 opportunities to make choices and participate in cares- [DATE]Approach Resident #1 with a calm and quiet demeanor- [DATE]Staff to talk to Resident #1 in a calm voice when behavior occurred as disruptive- [DATE]Staff to reapproach with a different staff person- [DATE]Encourage Resident #1 to reposition to a recliner after the lunch meal - [DATE]Staff to offer shower prior to the lunch meal because Resident #1 can get anxious as the day proceeds- [DATE]Staff to complete shower quickly because Resident #1 does not like to stay in the shower or have peri care completed. Resident #1 can get combative with showers and staff may need an extra person in the bathing area to use distraction while the other staff member completes the bathing tasks quickly and timely- [DATE] A handwritten Internal Investigation Witness Statement completed by Staff B, Certified Nursing Assistant (CNA), dated [DATE] at 1:30 PM documented that Staff B and Staff C, CNA, assisted Staff A, CNA/Certified Medication Aide (CMA), with showering Resident #1. The statement indicated Resident #1 resisted the shower due to a dislike of showers. Staff A bent down to wash Resident #1 when Resident #1 grabbed Staff A's chest. Staff A yelled at Resident #1, stating, you will not do this to me, grabbed Resident #1's right wrist, and aggressively pushed it into Resident #1's chest. Resident #1 yelled that it hurt and screamed that Staff A broke her arm. Later during the shower, Staff A bent down to apply Resident #1's Tubi grips (elastic support bandages), and Resident #1 grabbed the hair bun on top of Staff A's head. Staff B tried to release Resident #1's hand from Staff A's hair. Staff A slapped Resident #1's hands, yelled again, and held Resident #1's hands against Resident #1's chest until the shower finished. When getting out of the shower chair, Staff A told Resident #1, if you want to get out of here, then you better stand up on your own. Staff A then proceeded to tell Resident #1 that she tried to act nice but she'd choose to act mean by lifting Resident #1 out of the chair instead. Staff A told Staff B that she acted mean because she engaged in a fight with her mother and children. The statement documented that staff reported the incident to the Administration on [DATE] at 3:00 PM. Review of the Clinical Record lacked documentation showing that staff reported the allegation of abuse to Resident #1's Attending Physician or family on [DATE]. A review of the facility document titled Self Reports revealed the facility did not file an abuse allegation with the Iowa Department of Inspections and Appeals (DIAL) on [DATE] or notify law enforcement officials of the allegations. On [DATE] at 12:54 PM Staff A reported Resident #1 didn't like her baths and called staff names. Staff A stated Resident #1 called them every name in the book. Staff A stated she, Staff B, and Staff C got Resident #1 onto the shower chair. Staff A stated Staff B intended to leave, but staff kept two aides in the shower room with Resident #1 when things appeared iffy. Staff A stated they started showering (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #1. Staff A stated Staff B washed Resident #1's body and Staff A washed her hair. Staff A stated Resident #1 started swinging right after Staff A finished washing her hair. Staff A stated she initially took the hits. Staff A stated Resident #1 grabbed her shirt and bra, pulled them down, and also grabbed her pants and pulled them down. Staff A stated she maneuvered her thumbs up, placed her fingers around Resident #1's wrists, and pushed Resident #1's hands up onto Resident #1's chest. Staff A stated Staff B had to finish washing the front, so Staff A held Resident #1's hands to let Staff B finish without getting hit. Staff A stated she previously worked at a group home where a child acted out severely. Staff A stated she learned a safe maneuver to keep herself and the other person safe. Staff A stated she didn't clench down or provide any force, and used the maneuver as a last resort. When asked to demonstrate the maneuver, Staff A wrapped her middle finger and thumb around both of the interviewer's wrists and brought the arms up to the chest. Staff A stated she previously used this maneuver when Resident #1 experienced behavioral issues. Staff A stated she didn't press hard, squeeze, or use force, but acted to keep herself and the other person safe. On [DATE] at 2:10 PM the Director of Nursing (DON) and the acting Administrator received notification of an abuse allegation involving Resident #1 during a shower on [DATE]. The DON reported Staff B brought the issue to her attention because Staff B thought Resident #1's bath could've gone differently. The DON stated Staff C also witnessed the care. The DON stated that after speaking with Staff C, the facility management felt Staff A defended herself. The DON stated Resident #1 acted very combatively and pulled at Staff A's shirt and bra. The DON stated the facility provided education on how to work with aggressive residents. The DON stated the previous Administrator talked to the Corporate Office, and they didn't complete a self-report to DIAL. On [DATE] at 2:30 PM the acting Administrator reported that staff didn't report an abuse allegation to the facility. The acting Administrator stated the reported concerns related to a combative resident and a staff member defending herself during a shower. The acting Administrator stated [DATE] marked the first time an abuse allegation came to their attention. The acting Administrator stated the facility would complete a self-report, conduct an investigation, and suspend Staff A according to facility policy. On [DATE] at 4:03 PM Staff B reported she trained Staff C, and the day marked Staff C's first day at the facility. Staff B stated she went to assist Staff A with giving a shower to Resident #1. Staff B stated Resident #1 routinely combated staff and didn't like showers. Staff B stated the experience didn't seem too bad if staff talked Resident #1 through it and stayed calm. Staff B stated Staff A and she assisted Resident #1 to the shower chair, and Staff C grabbed the wheelchair and placed the shower chair underneath Resident #1. Staff B stated Staff A bent down in front of Resident #1 while washing her, and Resident #1 hit and grabbed Staff A in the chest. Staff B stated Staff A screamed at Resident #1, stating, you are not going to be doing this to me, this is unacceptable and you are going to stop. Staff B stated Staff A's tone didn't seem okay. Staff B stated Staff A grabbed Resident #1's wrists and pushed them to her chest. Staff B stated Resident #1 said, you are hurting me, you are breaking my arm. Staff B stated that for the remainder of the shower, Resident #1 commented that her arm felt broken and that she felt hurt. Staff B stated later, when applying Resident #1's Tubi grips, Resident #1 grabbed Staff A's hair bun on top of her head. Staff B stated that action set Staff A off again. Staff B stated Staff A grabbed Resident #1's forearms and pushed them very aggressively against her chest, which caused the shower chair to move backward. Staff B reported she intervened and suggested that either Staff A or she hold Resident #1's hands, or Staff A could step back from providing care. Staff B reported she finished getting Resident #1 dressed. Staff B stated Staff A told Resident #1, you are going to have to stand up or you're not gonna get out of the chair. Staff B stated Staff A and she helped Resident #1 get out of the chair. Staff B stated the shower ended around 2:00 PM, and the charge nurse appeared busy, so Staff B went to the DON. Staff B stated the DON got upset and told her she interpreted things wrong because she possessed a calmer personality. Staff B stated they called the Administrator, and she filled out a witness form. Staff B stated the Administrator and the DON stated they had too much occurring in their personal lives and refused to move forward with the report, noting they couldn't (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	keep finding people to cover Staff A's shifts. Staff B stated that day, Staff A said she acted mean to the residents and didn't want to be at work because she engaged in a fight with her mother and children. Staff B stated she believed Staff A knew what she did and felt like Staff A took her anger out. On [DATE] at 6:10 PM Staff C reported she felt uncomfortable during the shower with Resident #1. Staff C stated Resident #1 acted aggressively, didn't want a shower, and punched and hit staff. Staff C stated Staff A aggressively held Resident #1's arms down and screamed in her face. Staff C stated Staff A held Resident #1's wrists up against her chest. Staff C stated Resident #1 cursed and said, I am going to kill you. Staff C stated Resident #1 tried to break loose. Staff C stated she didn't think any resident deserved treatment in that manner. Staff C stated staff should step away if a resident acted combatively. Staff C stated the transfer seemed rough initially, and Resident #1 clearly didn't want a bath from the start. Staff C stated residents hold a right to refuse a bath. Staff C stated she felt uncomfortable and just stood there because she didn't know the resident or the staff. On [DATE] at 9:43 PM Staff D, Licensed Practical Nurse (LPN), reported she heard about the incident with Resident #1 in the shower room after it occurred. Staff D stated Staff B came out of the DON's office sobbing. Staff D stated she asked Staff B what happened, and Staff B reported she faced trouble for reporting the incident as required. Staff D stated Staff B told her the DON had personal things to complete outside of work, and now the DON had to stay. The Complaint/Incident Investigation Report documented the facility filed a self-report on [DATE] at 4:25 PM. The incident summary documented the interviewer reported an abuse allegation to the interdisciplinary team. The corrective actions documented on the report included the staff member suspended, allegation reported, and investigation to follow, along with the primary care physician, family, and hospice made aware of the allegations. On [DATE] at 2:40 PM Staff E, previous Administrator, reported Staff B came to the DON's office while Staff E walked inside. Staff E stated Staff B reported she didn't like the way Staff A performed Resident #1's shower. Staff E stated Staff B reported Staff A briefly held Resident #1's wrists to prevent getting struck by Resident #1. Staff E stated Staff A reported Resident #1 acted combatively and left her with no alternatives. Staff E stated Staff A implemented a protective intervention to prevent getting hit. Staff E stated leadership decided to provide additional training on how to react to combative residents. Staff E stated they didn't complete a self-report because they held no suspicion of abuse, neglect, or misappropriation. Staff E stated Staff A put an intervention in place to prevent Resident #1 from hitting her. On [DATE] at 10:25 AM Resident #1 rested in bed. Resident #1 stated she didn't like baths and then uttered multiple unintelligible words. Resident #1 commented that she felt tired. On [DATE] at 12:45 PM Staff B stated she reported an allegation of physical abuse regarding Staff A and Resident #1 to Staff E and the DON. Staff B stated that when she went to the office to report her concerns, the DON explicitly called the incident abuse. Staff B stated the DON appeared ready to take immediate action. Staff B stated the situation changed after leadership spoke with the other staff. Staff B reported the DON stated she had too many personal issues and couldn't find coverage for Staff A. Staff B stated the DON claimed they didn't think anything happened and refused to move forward with the report. On [DATE] at 3:15 PM Staff B reported that when Resident #1 held her hand in Staff A's hair bun, Staff B tried to remove Resident #1's hand, but the process took a minute. Staff B stated Staff A became frustrated and yelled at Resident #1. When asked about the slap to the hand, Staff B stated Staff A used a slap motion to grab Resident #1's hand. Staff B stated Staff A ripped Resident #1's hand out of her hair. Staff B stated Staff A then grabbed Resident #1's hands and pushed them to her chest. Staff B stated Resident #1 screamed and said something similar to the first time, you're hurting me. Staff B stated a difference existed between sternness and acting mean. Staff B stated Staff A moved far past the point of sternness and acted mean. Staff B stated she witnessed a stern voice with other residents, but this situation differed and appeared more aggressive. A review of Resident #1's tasks revealed Staff A documented a completed shower or bath on [DATE] and [DATE]. Resident #5's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 3, (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	indicating severely impaired cognition. The MDS identified Resident #5 maintained independence with bed mobility, transfers, and ambulation up to 150 feet. The MDS included diagnoses of hypertension (high blood pressure), hyperlipidemia (high cholesterol), and non-Alzheimer's dementia (mental decline). Resident #5's Care Plan with a target date of [DATE] revealed Resident #5 experienced behavioral problems. The Care Plan documented Resident #5 would often hit the doors to try to get them to open, yelling that she wanted out. In addition, she would hit and scratch the staff. The Care Plan directed the following interventions: Activity staff to visit with Resident #5 and provide diversional activities- [DATE]Staff to anticipate and meet Resident #5's needs- [DATE]Staff not to argue with Resident #5- [DATE] The Progress Note dated [DATE] at 10:34 AM documented Staff A reported Resident #5 hit Staff A in the back. An Internal Investigation Witness Statement completed by Staff F, CNA/CMA, dated [DATE] at 10:45 AM documented Staff F went back to the Chronic Confusion or Dementing Illness (CCDI) (severe memory loss) unit to assist Staff A. While Staff F stood in the unit, Staff A told Staff F, Resident #5 punched me in the back and I turned around and grabbed her right arm and told her you are not going to touch me'. Staff F documented that when she left the unit, she reported the incident to the charge nurse, the DON, and the Administrator. An Internal Investigation Witness Statement completed by Staff G, Registered Nurse (RN), dated [DATE] at 11:00 AM documented Staff F notified Staff G that Staff A told her Resident #5 punched her in the back, and she turned around, grabbed Resident #5, and said, Do not hit me. In addition, the statement included documentation that at 10:30 AM, Staff A told Staff G and another nurse that Resident #5 punched her, but didn't state she grabbed Resident #5. Ten minutes later, Staff A used a radio to ask the nurse if she could give Resident #5 Tylenol (pain reliever) for a hurt shoulder. On [DATE] at 9:08 PM Staff F stated she reported a concern regarding Staff A a couple of weeks ago. Staff F stated she didn't know the exact date, but the incident occurred on a Monday during the first shift around mid-morning. Staff F stated she went back to the dementia unit, and Staff A told her Resident #5 hit her in the back. Staff F stated Staff A explained that she turned around, grabbed Resident #5's arm, and said you are not going to touch me. Staff F stated she went and reported the incident to Staff G. Staff F stated Staff G stated they needed to report it to the DON and the Administrator. Staff F stated the DON and Staff E stood in the office together. Staff F stated that when they reported the concern, leadership didn't perceive it well. Staff F stated the DON appeared very upset that they reported it. Staff F reported she intended to leave early around 11:00 AM, but the DON told her she could no longer leave and had to stay to cover the remainder of Staff A's shift. Staff F reported she stayed and finished Staff A's shift. Staff F stated Staff A remained in the office for a short time and then went home. Staff F stated Staff A held a scheduled day off the next day and returned to work on Wednesday. On [DATE] at 1:55 PM the DON stated she received a report from Staff F and Staff G. The DON stated Staff A left for the day, and Staff F worked in the unit because someone needed to cover the area. The DON stated Staff E and she notified the Regional Consultant and the Human Resources director and obtained written statements. The DON stated she directed a staff member to assess Resident #5. The DON stated Staff A faced separation from the unit instead of suspension and held an original schedule to remain off until [DATE]. The DON stated that after speaking with Human Resources and the consultant, she assigned dementia training to Staff A, who completed the training on [DATE]. The DON stated that after reviewing staff statements, they didn't report the incident to DIAL. On [DATE] at 2:40 PM Staff E reported that a few weeks ago, staff reported Resident #5 became combative with Staff A when no one else stood around. Staff E stated Staff A reported Resident #5 punched her in the back when she stood next to the medication cart. Staff E stated she didn't exactly remember what occurred or what staff said. Staff E stated Staff A said something like please don't do that. Staff E stated she didn't recall Staff A touching or grabbing Resident #5. Staff E stated they held no concerns regarding how Staff A responded to Resident #5. Staff E stated Staff A appeared more shaken up about getting hit in the back. Staff E stated they decided to give Staff A tools on how to deal with difficult behaviors and handle the situation. Staff E stated Staff A worked (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	fairly often in the CCDI unit and frequently took a beating from the residents, noting it happened to her a good amount of the time. On [DATE] at 3:00 PM Staff A reported she worked in the unit, and report notes indicated Resident #5 would try to use her shoulder to get out the door. Staff A stated that after breakfast, Resident #5 tried to leave through the main doors. Staff A stated Resident #5 seemed pretty easily redirected. Staff A stated she stood at the medication cart trying to document when Resident #5 walked back from the main door. Staff A stated she saw Resident #5 walk up behind her out of the corner of her eye and hit her in the middle of the back. Staff A stated she turned and told Resident #5 not to hit her, noting she hadn't acted mean or rude to her. Staff A stated Resident #5 did or said something that made her think Resident #5 needed to use the bathroom. Staff A stated she held out her hand, Resident #5 grabbed it, and they walked down to her room to use the bathroom. Staff A stated that when Resident #5 stood in the bathroom, Staff A radioed for a nurse to come back to the unit. Staff A stated that after Resident #5 finished in the bathroom, she asked Resident #5 if she liked to read books. Staff A stated Resident #5 took her hand again, and they walked down to the closet to look at the books. Staff A stated Staff G and another nurse both came back to the unit. Staff A stated she reported to Staff G that Resident #5 hit her. Staff A stated she reported it so it could get documented. Staff A stated Resident #5 complained of right shoulder pain, so she notified the nurse and received permission to give her Tylenol. Staff A stated the only time she touched Resident #5 occurred when she held out her hand to walk with her. Staff A stated she didn't grab Resident #5's arm after Resident #5 hit her, and she didn't tell anyone that. Review of the facility document titled Self Reports revealed the facility did not file an allegation of abuse to DIAL on [DATE] and/or notify law enforcement of the allegations. Resident #6's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS identified Resident #6 required partial or moderate assistance with bed mobility, all transfers, and ambulation up to 150 feet. The MDS included diagnoses of hypertension (high blood pressure), diabetes mellitus (high blood sugar), hip fracture (broken hip), non-Alzheimer's dementia (mental decline), anxiety disorder (severe worry), and depression (severe sadness). Resident #6's Care Plan with a target date of [DATE] revealed Resident #6 experienced a history of emotional trauma because her daughter died this past January. The Care Plan documented Resident #6 had a recliner in her room that she would sit in as an alternate positioning device. On [DATE] at 9:27 PM Staff F reported that another incident involving Staff A and Resident #6 occurred on the same day as the incident with Resident #5. Staff F stated Resident #6 reported to Staff E that Staff A acted very rude and mean to the point of making her cry twice. Staff F stated she believed the issue involved a recliner. Staff F stated she watched Resident #6 go into Staff E's office to report it. On [DATE] at 9:43 PM Staff D reported that about a week and a half ago, Resident #6 told her at supper that Staff A left her in tears over her recliner. Staff D stated Staff A told Resident #6 to quit moving the chair. Staff D stated staff inspected the chair and found an electrical issue. Staff D stated she told Resident #6 to go and talk to Staff E about the issue with Staff A. Staff D stated Resident #6 appeared alert and oriented to person, place, time, and situation, and her BIMS score showed a 15. On [DATE] at 10:15 AM Resident #6 reported Staff A flew off the handle when she got stuck in her recliner chair. Resident #6 stated her chair didn't work right. Resident #6 stated the night before, Staff A got under the chair and fixed a loose wire. Resident #6 stated the next morning, the chair kept moving up. Resident #6 stated she held onto the tray table to prevent herself from sliding out. Resident #6 stated she pushed the button for help. Resident #6 reported Staff A came in and scolded her over and over. Resident #6 reported Staff A stated she told her not to use the recliner and they wouldn't find themselves in the situation if she had listened. Resident #6 stated she felt like staff treated her like a little kid. Resident #6 reported she had been crying a lot since her daughter's passing in January. Resident #6 stated Staff A triggered the crying. Resident #6 stated that at breakfast, she told some tablemates and a couple of nurses, and they suggested talking to Staff E. Resident #6 stated she went and spoke to Staff E, and Staff E appeared apologetic. Resident #6 stated Staff E asked her if (continued on next page)

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	165316	A. Building B. Wing	06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eldora Specialty Care	1510 22nd Street Eldora, IA 50627

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Staff A used foul language. Resident #6 stated Staff A didn't use foul language that day, but she previously heard her use foul language around others. When asked if she felt abused, Resident #6 stated she didn't experience physical abuse but felt verbally abused by Staff A's words. Resident #6 stated Staff A scolded her hard. Resident #6 stated she didn't see Staff A for a couple of days after. Resident #6 stated when she saw her in the hall, they wouldn't speak. Resident #6 stated eventually leadership assigned Staff A to her area, and they had to try to trust each other again. Resident #6 stated she proceeded with caution. Resident #6 stated everything had gone okay since then, noting leadership hadn't assigned Staff A to her area very much. On [DATE] at 11:35 AM Staff H reported Resident #6 and Staff A do not get along very well. Staff H stated she stood in the room when the recliner didn't work. Staff H stated Staff A told Resident #6 that the wires were all messed up and that Resident #6 pulled on them, which upset Resident #6. Staff H stated she felt it was a normal thing to say because chairs experience wear and tear. Staff H stated she believed Resident #6 took the comment wrong. Staff H stated Staff A's wording can seem very strong, but she didn't think she meant it maliciously. On [DATE] at 2:40 PM Staff E stated the only concern Resident #6 brought to her attention involved Resident #6 moving to Wisconsin. Staff E stated Resident #6 didn't come to her office or speak to her about any concerns regarding her recliner or Staff A, noting she would've recalled that conversation. On [DATE] at 3:00 PM Staff A reported she hadn't been aware of any concerns with Resident #6 until today. Staff A stated the new Administrator called her and asked about the recliner. Staff A reported she assisted Resident #6 to the recliner after lunch. Staff A stated the control didn't work. Staff A stated she checked the plug and cable and saw tape around the cord. Staff A stated she wiggled it, and the remote started working. Staff A stated Resident #6 took a nap, and later before supper, the call light stood on. Staff A stated Staff H and she answered the call light. Staff A stated that when they walked into the room, the chair moved all the way up and Resident #6 looked like she stood up. Staff A stated she walked around the chair to turn the call light off. Staff A stated she asked Resident #6 if she could put the chair down a little bit because it scared her, and Resident #6 responded she would if she could. Staff A reported the bedside table got caught underneath the recliner. Staff A stated she mentioned the bedside table to Resident #6, and Resident #6 stated the table had nothing to do with it. Staff A stated Resident #6 used a loud tone, appeared upset, and displayed sharpness in her voice, though she didn't yell. Staff A stated she remembered the cord and tried to wiggle it. Staff A stated one could tell the cord got pulled because the stickiness from the tape showed. Staff A stated she made a comment to Staff H about the cord getting pulled, and Resident #6 got upset, stating you're always accusing me. Staff A stated she stayed quiet and completed the care. Staff A stated as soon as Resident #6 sat safely in her wheelchair, she left Staff H with Resident #6. Staff A stated Resident #6 didn't forget things easily. Staff A stated she avoided Resident #6 for the next couple of days and asked the other aides to answer her call light to let her cool down. Staff A stated she assisted Resident #6 with rehab and placed her on the bike, and they chatted the entire time, so she believed things had blown over. When asked if any crying occurred, Staff A replied no, stating Resident #6 tore her up with her tongue. On [DATE] at 9:38 AM the Acting Administrator reported he expected the following actions when staff reported an abuse allegation: Staff must report allegations or suspicions of abuse to the DON or Administrator immediately.Separate, suspend, and investigate.Witnesses or recipients of allegations must provide clear, factual, and detailed descriptions of what they observed or heard.Facility leadership obtains statements from other parties.Staff completes a skin audit on the victim.The Administrator or DON reports the incident to DIAL as regulations require. On [DATE] at 9:49 AM the Acting Administrator reported he expected law enforcement to be notified in relation to an abuse report. The Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating policy dated [DATE] directed facility management to report all accounts of resident abuse, neglect, exploitation, or theft or misappropriation of resident property to local, state, and federal agencies, and thoroughly investigate the claims.

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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. Based on staff interviews, facility investigation review, clinical record review and policy review the facility failed to notify DIAL (Department of inspection, appeals and licensing) and Law Enforcement of an alleged verbal and physical abuse for Resident #1 that occurred on 6/4/26 at approximately 1:30 PM in a timely manner. The CNA (Certified Nursing Assistant) reported she told the DON (Director of Nursing) and Administrator of the allegations of abuse at 3 PM on 6/4/26. The facility reported the incident to DIAL on 6/8/26 at 4:25 PM after DIAL entered the building and reported an allegation of abuse. In addition, the facility failed to report an allegation of physical abuse for Resident #5 that occurred on 5/18/26 at approximately 10:30 AM. The facility reported a census of 36 residents. Findings include:1. A handwritten Internal Investigation Witness Statement completed by Staff B, Certified Nursing Assistant (CNA), dated 6/4/26 at 1:30 PM, documented Staff B and Staff C, Certified Nursing Assistant (CNA), assisted Staff A, Certified Nursing Assistant/Certified Medication Aide (CNA/CMA), give Resident #1 a shower. The statement indicated Resident #1 resisted the shower and exhibited combative behavior because she didn't like showers. Staff A bent down to wash Resident #1, and Resident #1 grabbed Staff A's chest. Staff A yelled at Resident #1, stating, you will not do this to me, grabbed Resident #1's right wrist, and aggressively pushed it into Resident #1's chest. Resident #1 yelled that it hurt and that Staff A broke her arm. Later during the shower, Staff A bent down to apply Resident #1's Tubi grips (elastic support bandages), and Resident #1 grabbed the hair bun on top of Staff A's head. Staff B tried to release Resident #1's hand from Staff A's hair. Staff A slapped Resident #1's hands, yelled again, and held Resident #1's hands against Resident #1's chest until the shower ended. When Resident #1 moved out of the shower chair, Staff A told Resident #1, if you want to get out of here, then you better stand up on your own. Staff A then told Resident #1 that she tried to act nice but she'd choose to act mean by lifting Resident #1 out of the chair instead. Staff A told Staff B that she acted mean because she engaged in a fight with her mother and children that day. The statement documented that staff reported the incident to the Administration on 6/4/26 at 3:00 PM. A review of the facility document titled Self Reports revealed the facility didn't file an abuse allegation with the Department of Inspections and Appeals (DIAL) on 6/4/26 or notify law enforcement officials of the allegations. On 6/8/26 at 2:10 PM, the Director of Nursing (DON) and the acting Administrator received notification of an abuse allegation involving Resident #1 during a shower on 6/4/26. The DON reported that Staff B brought the issue to her attention, stating she thought Resident #1's bath could've gone differently. She stated that Staff C also witnessed the shower. The DON said that after speaking with Staff C, the facility management felt Staff A defended herself. She noted that Resident #1 exhibited combative behaviors and pulled at Staff A's shirt and bra. She stated the facility provided education on how to handle aggressive residents. The DON explained that the previous Administrator talked to the Corporate Office, and they didn't complete a self-report to DIAL. On 6/8/26 at 2:30 PM, the acting Administrator reported that staff didn't report an abuse allegation to the facility. He stated that the reported concerns only related to a combative resident and Staff A defending herself during a shower. He stated that 6/8/26 marked the first time an abuse allegation came to his attention. He stated the facility would complete a self-report, conduct an investigation, and suspend Staff A according to facility policy. The Complaint/Incident Investigation Report documented that the facility filed a self-report on 6/8/26 at 4:25 PM. The incident summary documented an abuse allegation received by the interdisciplinary team. The corrective actions listed on the report included suspending the staff member, reporting the allegation, initiating an investigation, and notifying the primary care physician, family, and hospice provider of the allegations. On 6/9/26 at 2:40 PM, Staff E, the previous Administrator, reported that Staff B entered the DON's office while Staff E walked inside. She stated Staff B expressed dissatisfaction with how Staff A performed Resident #1's shower. She said Staff B reported that Staff A briefly held (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's wrists to avoid a strike from Resident #1. She stated Staff A reported that Resident #1 acted combatively and that she couldn't do anything else. Staff E stated Staff A implemented a protective intervention to avoid getting hit. Staff E noted that facility leadership decided to provide additional training on how to handle aggressive residents. Staff E stated they didn't complete a self-report because they held no suspicion of abuse, neglect, or misappropriation. She reiterated that Staff A used an intervention to prevent Resident #1 from hitting her. On 6/11/26 at 12:45 PM, Staff B stated she reported an allegation of physician abuse regarding Staff A and Resident #1 to Staff E and the DON. Staff B stated that when she reported her concerns in the office, the DON explicitly called it abuse. She said the DON appeared ready to take immediate action. She stated that the situation changed after leadership spoke with other staff. Staff B reported that the DON cited too many personal issues and an inability to find coverage for Staff A. She said the DON claimed they didn't think anything happened and refused to move forward with the report. On 6/11/26 at 9:38 AM, the acting Administrator reported that he expected the following actions when staff reported an abuse allegation:Staff must report allegations or suspicions of abuse to the DON or Administrator immediately.Separate, suspend, and investigate.Witnesses or recipients of allegations must provide clear, factual, and detailed descriptions of what they observed or heard.Facility leadership obtains statements from other parties.Staff completes a skin audit on the victim.The Administrator or DON reports the incident to DIAL as regulations require. On 6/11/26 at 9:49 AM, the acting Administrator reported that he expected staff to notify law enforcement in relation to an abuse report. The Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating policy revised April 2021 instructed staff to report all accounts of resident abuse, neglect, exploitation, or theft of resident property to local, state, and federal agencies. It required facility management to thoroughly investigate and report the findings of all investigations. The policy directed the administrator or the individual making the allegation to immediately report suspicions to the following individuals or agencies:The state licensing or certification agency responsible for surveying and licensing the facility;The local or state ombudsman;The resident's representative;Adult protective services;Law enforcement officials;Resident's attending physician;The facility medical director. 2. A handwritten Internal Investigation Witness Statement completed by Staff F, Certified Nursing Assistant/Certified Medication Aide (CNA/CMA), dated 5/18/26 at 10:45 AM, documented that Staff F went back to the Chronic Confusion or Dementing Illness (CCDI) (severe memory loss) unit to assist Staff A. While Staff F stood in the unit, Staff A told Staff F, Resident #5 punched me in the back and I turned around and grabbed her right arm and told her ?You are not going to touch me'. Staff F documented that upon leaving the unit, she reported the incident to the charge nurse, DON, and Administrator. A review of the facility document titled Self Reports revealed that the facility didn't file an abuse allegation with DIAL on 5/18/26 or notify law enforcement of the allegations. On 6/9/26 at 1:55 PM, the DON stated she received a report from Staff F and Staff G, Registered Nurse (RN). She noted that Staff A left for the day and Staff F worked in the unit because someone needed to cover the area. She said that Staff E and she notified the Regional Consultant and the Human Resources director and obtained written statements. The DON stated she directed a staff member to assess Resident #5. She stated the facility separated Staff A instead of suspending her, and Staff A held an original schedule to remain off until 5/20/26. She said that after consulting with Human Resources and the consultant, she assigned dementia training to Staff A, who completed the training on 5/19/26. She stated that after reviewing staff statements, they didn't report the incident to DIAL.