STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165333	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmark Care Center	215 Highway 30 SW Mount Vernon, IA 52314

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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 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on staff interview, clinical record review, and facility policy review, the facility failed to provide bed hold notice to resident or resident representative prior to transferring 2 of 3 residents to the hospital (Resident #35 and Resident #27). The facility reported a census of 38 residents. Findings include: 1. Resident #35: The Minimum Data Set (MDS), dated [DATE], revealed the most recent reentry to facility dated 1/26/25 from acute/short-term general hospital. The Electronic Health Records (EHR) census tab informed that on 1/22/25 Resident #35 had a hospital paid leave and on 1/26/25 Resident #35 readmitted to facility. Review of the Nursing Notes revealed the following entries: On 1/22/25 at 3:11 AM, Resident #35 had unwitnessed fall with head injury and vital signs out of normal range. Resident #35 transferred to the hospital via ambulance. Family, physician, and Director of Nursing notified of transfer. On 1/22/25 at 3:57 AM, Nursing Note included reason for transfer and personal belongings sent but lacked documentation for the questions: -Does resident and/or resident representative want to hold the bed? -Was the Bed Hold notice sent with resident representative or to the hospital? In a Hospital History and Physical, dated 1/22/25, revealed Resident #35 presented to the hospital with a mechanical, unwitnessed, fall from her Nursing Home with head trauma, unknown if loss of consciousness. In Emergency Department Resident #35 found to be hypertensive with blood pressure 180/70 and unable to provide any history regarding fall. (continued on next page)

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

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	In a Hospital Discharge Summary, dated 1/26/25, revealed Resident #35 admitted to the hospital for unwitnessed fall, found to have fever due to pneumonia human metapneumovirus positive, required oxygen and antibiotics. Resident #35 improved and stable, discharged back to facility. Facility provided document, titled Private Pay Reserved Bed Form, dated 1/25/25, identified an amount to be charged rate per day to reserve the bed for Resident #35. Resident #35 signed and dated form on 1/27/25 in request for bed to be reserved during absence from facility and agreed to pay the rate identified per day. 2. Resident #27: The Minimum Data Set (MDS), dated [DATE], revealed the most recent reentry to facility on 1/18/25 from acute/short-term general hospital. The Electronic Health Records (EHR) census tab revealed on 1/12/25, Resident #27 had a hospital paid leave and on 1/18/25, Resident #27 returned to the facility. Review of Nursing Notes revealed the following entries: 1. On 1/12/25, Resident #27 experienced change of condition when nursing documented assessment of adventitious lung sounds, bilateral lower extremity edema, wet sounding non-productive cough, and decrease in appetite. Family and physician notified of condition with order received from physician to send Resident #27 to the hospital for evaluation and treatment. 2. On 1/18/25, Resident #27 returned to the facility following acute hospitalization for viral pneumonia. In a hospital History and Physical Note, dated 1/13/25, Resident #27 diagnosed with acute hypoxemia secondary to human metapneumovirus infection with shortness of breath and cough for 1 week. In a hospital Discharge Summary, dated 1/12/25 through 1/18/25 for meta-pneumovirus infection. The facility lacked documentation of a Bed Hold notice provided to Resident #27 or resident representative prior to hospitalization [DATE]. On 3/19/25 at 10:30 AM, Facility Administrator confirmed that facility lacked documentation of notice of Bed Hold for Resident #35 or Resident #27 provided prior to transfer, or within 24 hours of transfer to hospital. The facility policy, titled Bed Hold and Return Policy, dated 10/2023, revealed the purpose of policy is to ensure that residents are made aware of facility's bed hold and return policy before and upon transfer or when taking a therapeutic leave of absence from the facility. The policy instructed staff to provide bed hold notice to residents and/or resident representative upon admission and at the time of transfer or within 24 hours of transfer if the transfer is emergent/urgent. The policy additionally instructed the facility to inform the resident and/or resident representative in writing in a language and manner they understand prior to transferring a resident to a hospital or the resident going on therapeutic leave of the bed hold and return policy.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. 48452 Based on MDS (Minimum Data Set) review, resident census data, the Resident Assessment Instrument (RAI) manual, staff interview, and policy review the facility failed to submit a discharge MDS for 1 of 1 residents reviewed (Resident #25). The facility reported a census of 38 residents. Findings include: The MDS for resident #25 dated 01/02/25 documented the resident admitted to the facility 11/01/24, discharged from the facility on 01/02/25 to the community, and return was not anticipated. The census tab of the electronic health record indicated the facility stopped billing on 01/02/25. The MDS Summary screen documented the facility completed the MDS with a note that read 'Do not submit to CMS (Centers for Medicare and Medicaid Services)'. During and interview on 03/19/25 at 12:57 PM the Director of Nursing (DON) stated the MDS should have been submitted. She was not sure what happened to trigger the do not submit indicator or how this had been missed. The DON reported that based on the resident's insurance and discharge status they had to submit the discharge MDS and confirmed it would be late. On 03/18/25 at 1:39 PM the Administrator reported the facility did not have a policy for MDS or Care Plan assessments. She stated they followed the RAI manual. The RAI manual dated October 2024, page 2-45 with a section titled Tracking Records and Discharge Assessments Reporting, indicated tracking records and discharge assessment reporting was required for all residents in skilled nursing facilities. The section further documented the discharge assessment must be submitted within 14 days after the completion date.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 48452 Based on electronic health record review, Pre-Admission Screening and Resident Review (PASRR) review, resident interview, staff interview, and policy review the facility failed to ensure a resident's mental health diagnoses and medications were accurately reported to the designated state agency for 1 of 3 residents diagnosed with PTSD (Post Traumatic Stress Disorder) (Resident #17). The facility reported a census of 38 residents. Findings include: The Minimum Data Set (MDS) for Resident #17 dated March 3, 2025 included diagnoses of depression, anxiety disorder, and PTSD. The Brief Interview for Mental Status (BIMS) indicated the resident scored 15/15 which indicated intact cognition. The resident's Electronic Health Record (EHR) confirmed they had diagnoses of anxiety disorder, unspecified dated 9/20/24; post-traumatic stress disorder, unspecified dated 9/20/24; and depression, unspecified dated 9/20/24 which indicated they were present at admission. On 9/23/24 the resident signed medication consent forms for Alprazolam aka (also known as) Xanax (anxiety), Duloxetine aka Cymbalta (PTSD), Lamotrigine aka Lamictal (depression), and Aripiprazole aka Abilify (anxiety). Resident #17's EHR included a document titled Notice of PASRR Level I Screen Outcome, based on information submitted by the hospital, dated 9/20/24. Mental health diagnoses included Anxiety Disorder and Depression/Depressive Disorder. It did not include PTSD. The PASRR included medications Abilify and Cymbalta for depression and anxiety. It did not include Alprazolam or Lamictal, or behaviors associated with the resident's mental health medications. During an interview on 3/19/25 at 10:21 AM Resident #17 reported talking to social services during her admission regarding her mental health including PTSD. Further discussion revealed staff had spoken to the resident about some of her actions and behaviors since she moved in. She felt her medications were stable, but also revealed she continued to experience anxiety and stress related to her diagnoses. During an interview on 03/19/25 at 09:21 AM Staff A, Licensed Practical Nurse (LPN) stated she did not know a lot about Resident #17's mental health diagnoses. She reported behaviors of being manipulative, saying things that were untrue, yelling at staff, needing to be right no matter what, and scratching herself. She thought the PASRR would be reviewed and/or completed by social services or the Director of Nursing (DON). On 03/19/25 at 09:52 AM the DON indicated the facility would complete a new PASRR if a resident had a new diagnosis and maybe for new medications. She reported that social services would complete a PASRR form review on admission. The DON acknowledged they missed that there was not a PTSD diagnosis and some of the medications on the initial form, and stated they needed to start a new PASRR for this resident. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/20/25 at 01:09 PM the facility Administrator stated the facility had gotten better with PASRRs but didn't see PTSD wasn't addressed on the PASRR the hospital submitted for this resident. She acknowledged they didn't catch it and stated they try to look at the PASRRs during the referrals process. During a follow up on 03/20/25 at 01:34 PM the Administrator stated the facility did not have a PASRR policy and just followed the regulations.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 48888 Based on resident and staff interviews, clinical record review, and facility policy review, the facility failed to ensure interventions for pain management provided resident with effective pain relief following a fall with injury to right wrist for 1 of 3 resident reviewed for pain management (Resident #8). The facility reported a census of 38 residents. Findings include: The Care Plan revealed Resident #8 had been at risk for falling related to decreased safety awareness and impulsiveness with an intervention initiated on 2/13/25 for pain evaluation to be completed with Primary Care Provider, elastic bandage wrap (ACE wrap), and ice to be applied to right wrist for swelling and pain control. The Care Plan revealed Resident #8 had impaired cognition related to a traumatic brain injury that affected short term and long term memory. The Care Plan lacked a focused area for pain management, goals for pain, or identification of ongoing pain symptoms following the fall on 2/11/25 with injury to the right wrist. Review of Nursing Notes revealed the following entries: 1. On 2/11/25 at 6:10 AM, Resident #8 had fallen after self transferring in room and was found sitting on floor against the wall underneath television with blood observed coming from Resident #8's nose. Resident #8 rated pain a 9 on a scale of 1 to 10 (from least pain to worst pain) in right wrist. Resident was transported via ambulance to Emergency Department for possible nasal fracture and a possible right wrist fracture. 2. On 2/11/25 at 9:44 AM, Hospital notified facility that Resident #8 had fractured nose and a soft tissue injury to right wrist. Resident #8 transferred back to facility. 3. On 2/12/25 at 3:32 PM, Resident #8 rated pain 9 out of 10 to right wrist, Nursing Note lacked interventions attempted or follow up assessment. 4. On 2/13/25 at 9:30 AM, Resident #8's right wrist documented as painful and swollen from fall, nursing to review with Primary Care Provider on rounds this day and therapy to evaluate for wrist splint and ice as needed for pain. 5. On 2/14/25 at 2:03 PM, Resident #8's right hand had swelling from previous fall and resident reported pain at 8 out of 10. 6. On 3/05/25 at 8:44 PM, a recommendation received from therapy for ace wrap to the left upper extremity, starting at resident's fingers and up to elbow, on in morning and off at bed time and instructed that once swelling is down, therapy would evaluate a use of cock up wrist splint. Note lacked recommendation for injured right wrist. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Hospital note, dated 2/11/25, revealed an x-ray had been completed on right wrist, indicated for right wrist pain and deformity after fall, findings revealed old fracture deformity in distal right radius without an acute fracture and soft tissues swollen throughout the wrist. A Computed Tomography (CT) scan also completed on Resident #8's face and jaw, revealed a small, comminuted, mildly displaced fracture of the right nasal bone. The Medication Administration Record (MAR), dated February 2025, revealed Resident #8 had the following orders in place for pain: -Gabapentin 300 milligrams (mg) with instructions to give 300 mg by mouth one time per day for pain, order initiated on 1/24/2022. -Acetaminophen (Tylenol) 650 mg with instructions to give 650 mg every 6 hours as needed for pain, order initiated on 1/24/2022. The February MAR revealed Resident #8 had not utilized as needed (PRN) Tylenol 650 mg between 2/01/25 and 2/11/25. Resident #8 required a dose of PRN Tylenol 650 mg for pain on the following dates: 2/11/25 at 7:53 PM, pain rated 8 out of 10, noted with an E, or effective, for pain. 2/12/25 at 2:00 AM, pain rated 9, noted as effective. At 2:29 PM pain rated 8, noted with I, or ineffective, for pain relief. At 8:29 PM, rated 8, noted to be effective. 2/13/25 at 8:14 AM, pain rated 9, noted as ineffective. At 4:53 PM, pain rated 9, noted as effective. 2/14/25 at 9:04 AM, pain rated 9, noted as effective. 2/15/25 at 1:16 PM, pain rated 9, noted as effective. 2/16/25 at 1:00 AM, pain rated 8, noted as effective. At 10:19 AM, pain rated 5, noted effective. At 5:19 PM, pain rated 9, with ineffective relief. 2/17/25 at 6:04 AM, pain rated 3, noted to be ineffective. At 7:10 PM, pain rated 9, noted effective. 2/21/25 at 7:46 PM, pain rated 9, noted to be effective. 2/22/25 at 12:38 PM, pain rated 5, noted as effective. At 6:39 PM, pain rated 9, noted effective. 2/23/25 at 5:21 PM, pain rated 8, noted effective. 2/24/25 at 6:47 PM, pain rated 9, noted effective. 2/25/25 at 12:35 PM, pain rated 7, noted effective. 2/28/25 at 12:43 PM, pain rated 7, noted effective. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MAR lacked a follow up pain number rating following doses noted to be effective or ineffective. The Treatment Administration Record (TAR), dated February 2025, revealed Resident #8 had the following orders in place for wrist pain: -Apply ice to right wrist/hand with instructions to apply for 20 minutes and remove for 20 minutes, every one hour as needed for pain. The February TAR indicated as needed ice order utilized 8 times, each noted to provide effective pain relief. The MAR, dated March 2025, revealed no changes made to Resident #8's pain medication regimen. The March 2025 MAR revealed Resident #8 required a dose of as needed Tylenol 650 mg for pain on the following dates: 3/01/25 at 6:41 PM, pain rated 9 out of 10, Tylenol noted with a U or unknown pain relief. 3/02/25 at 7:52 AM, pain rated 8, noted to be effective. At 5:06 PM, pain rated 9 with unknown effectiveness. 3/03/25 at 9:10 AM, pain rated 9, noted effective. At 5:10 PM, pain rated 6 with unknown effectiveness. 3/04/25 at 12:27 PM, pain rated 8, noted effective. 3/06/25 at 2:36 PM, pain rated 7, noted effective. 3/07/25 at 12:20 PM, pain rated 7, noted effective. 3/14/25 at 6:25 PM, pain rated 9 with unknown effectiveness. 3/15/25 at 6:56 PM, pain rated 9, noted effective. 3/17/25 at 6:32 PM, pain rated 9, noted effective. 3/18/25 at 2:34 PM, pain rated 9, no documentation of effectiveness charted. Resident #8's Electronic Health Records (EHR) lacked documentation of physician notification related to pain rated 9 out of 10 or ineffective pain relief following pharmacological intervention. On 3/18/25 at 2:33 PM, Resident #8 sat in recliner in their room, noted to have cloth sleeve (tubigrip) covering right wrist and forearm. Resident #8 reported right wrist still painful after fall and requested pain medicine from surveyor. Staff A, Licensed Practical Nurse (LPN) gave Resident #8 dose of as needed pain medicine. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/25 9:18 AM, Staff B, Certified Nursing Assistant (CNA), reported Resident #8 wears a right wrist splint at night and cloth sleeve during the day. Staff B stated Resident #8 had not recently complained of wrist pain and informed that resident had been improving with transfers using the walker since fall. Staff B reported that Resident #8 would request pain medicine if she needed and stated the Tylenol or ice had been effective in providing resident with pain relief. Staff B claimed Resident #8's sleep and day to day activities had not been affected by wrist pain. On 3/19/25 at 9:25 AM, Staff A, Licensed Practical Nurse (LPN), confirmed as needed Tylenol 650 mg had been given to Resident #8 on 3/18/25 at 2:33 PM upon request of pain medicine for pain rated 9 out of 10. Staff A stated Resident #8 would always ask for pain medicine when needed and informed that resident's pain typically was related to right wrist. Staff A reported she would follow up with Resident #8 about 45 minutes after giving Tylenol by verbally asking if pain had improved, Staff A denied documentation of verbal follow up assessment for Resident #8's pain but stated the MAR would reflect if Tylenol had been effective. On 3/20/25 at 1:30 PM, Facility Administrator stated Resident #8 had shown symptoms of pain such as guarding of right wrist with swelling and tenderness following fall with injury to the area which has since improved. Administrator acknowledged that nursing documentation was needed to take credit for the work they do, but did feel they were adequately managing Resident #8's pain. The facility policy, titled Pain Policy, dated 9/2023, revealed the purpose of the policy is to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. The policy instructed staff to assess the resident for effectiveness of pain medication following as needed (PRN) pain medication and if pain is unrelieved despite pharmacologic and nursing measures, the resident's physician will be notified.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on observation, record review, resident interview, staff interview, and policy review the facility failed to account for a resident's experiences, preferences, and potential triggers that might cause re-traumatization for 1 of 3 residents diagnosed with PTSD (Post Traumatic Stress Disorder) (Resident #17). The facility reported a census of 38 residents. Findings include: Resident #17's Social History, dated 09/23/24 at 12:34 PM for an admission on 09/20/25, documented the resident suffered a lot of abuse as a child. She indicated she didn't like to sleep with her door closed, was nervous around people, had difficulty trusting others, felt sadness, lost family connection, and had a lot of traumatic experiences as an adult. The document included recognition of her PTSD diagnosis. The Minimum Data Set (MDS) for Resident #17 dated March 3, 2025 included diagnoses of depression, anxiety disorder, and PTSD. The Brief Interview for Mental Status indicated the resident scored 15/15 which indicated intact cognition. The Care Plan for Resident #17, admitted [DATE], did not address her mental health diagnoses, mental health medications, triggers, goals, focus areas, or interventions. During an observation on 03/17/25 at 02:01 PM the resident was sitting in her recliner next to her roommate. She was scratching at her right shoulder, put her hand down, and started scratching her calf. She answered a few questions and asked for a return visit for her interview. During the follow up interview on 3/19/25 at 10:21 AM observed the resident lounging in her recliner, scratching at the top of her leg. She reported talking to Social Services during her admission regarding past trauma and some of her mental health triggers. Further discussion regarding her mental health revealed staff had spoken to her about some of her actions and behaviors since she moved in. She recalled a couple of times she yelled at staff if she thought they were rushed or in a bad mood. She reported she felt more down and frustrated, and needed more attention, when her health changed including when staff 'made me use' the sit to stand lift to get up. The resident stated staff didn't really talk to her about health changes affecting her mental health, and she thought she needed more support at those times. An interview with Staff B, Certified Nurses Aide (CNA) on 03/19/25 at 09:05 AM revealed she was not aware of the resident's diagnoses or triggers. She stated she knew the resident didn't like male caregivers but didn't know if that was written anywhere. She didn't know if her scratching was medical or behavioral. Her primary non-pharmacological intervention was talking to the resident, and she reported she would tell the nurse if Resident #17 needed more support. During an interview with Staff B, Licensed Practical Nurse (LPN) at 09:21 AM on 03/19/25 she stated she did not know a lot about the resident's mental health diagnoses. She stated the resident could be manipulative and had said things that were not true, and reported the staff just knew that, said okay, and moved on. She reported the resident had a lot of behaviors including scratching herself, yelling at staff, and had to be right no matter what. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/18/25 at 1:52 PM Staff C, Social Services, stated she started trauma informed care discussions with residents at admission as part of the resident's social history. They would discuss triggers and non-pharmacological interventions. Sometimes the DON would assist with this as well. One of them would make sure new information would get into the Care Plan. During an interview on 03/19/25 at 09:52 AM with the Director of Nursing (DON) she reported Staff C would assess trauma triggers as part of admission and usually put mental health information into resident Care Plans. She was not sure why the diagnoses, triggers, medications, and non-pharmacological interventions were not in the Care Plan. She stated adding triggers was a 'new one' they were working on and needed to be added to the Care Plan. The DON expected non-pharmacological interventions in Care Plans to include things such as repositioning, pain management, toileting, addressing hunger, walking, activities, hydration, addressing potential overstimulation. She reported some behaviors for Resident #17 were related to declines in functional status and acknowledged that could impact mental health. On 03/20/25 at 01:09 the Administrator reported there was not a policy for trauma informed care and stated the facility followed regulations.