STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165336	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center of Allison	900 7th Street West Allison, IA 50602

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. On 6/24/25 at 9:28 AM Resident #143 was noted to have multiple days' worth of facial hair growth. At that time, he explained he preferred to be clean shaven. Further explained he had a shower scheduled later that morning and would like to be shaven at that time. On 6/24/25 at 4:01 PM Resident #143 explained he did have his shower but the CNA failed to shave him. The Care Plan for interventions for Resident #143 included the information that historically he likes to be clean shaven. During an interview on 6/25/25 at 11:05 AM, Staff C explained men should be shaven daily. During observations on 6/25/25 at 10:22 AM and 6/26/25 at 8:51 AM the resident remained unshaven. During an interview on 6/26/25 at 10:24 AM Staff A explained men should be asked if they want to shave daily. On 6/26/25 at 10:26 AM, Staff A and the surveyor went to Resident #143's room. Staff A acknowledged the facial hair growth. She asked the Resident if he prefers to be clean shaven. He explained he asked to be shaved a couple days ago, but it didn't get done. He further explained he has his own razor but was told the facility had a razor they would use to shave him. Based on clinical record review, observation, resident and staff interviews, the facility failed to ensure residents are treated with dignity and respect for 2 of 2 residents reviewed (Residents #31 and #143). The facility reported a census of 39 residents. Findings include: (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident #31's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score 14 out of 15 indicating intact cognition. The MDS documented Resident #31 as independent (Resident completes the activity by themselves with no assistance from a helper for self-care.) for eating, oral hygiene, upper and lower body dressing, and mobility. The MDS documented Resident #31 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and /or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for shower/bathe self and tub/shower transfers. The MDS included diagnoses of coronary artery disease, diabetes mellitus, and leukemia. The Care Plan Focus identified Resident #31 has behavior problems related to becoming verbally aggressive towards staff and other residents. The following interventions directed staff to: a. Approach/speak in a calm manner. b. Assure the resident that concerns are validated and the staff is willing to address legitimate concerns. c. Communicate clearly and assertively what behaviors are unacceptable and inappropriate. d. Document behaviors and response to interventions. e. Intervene as necessary to protect the rights and safety of others. f. Monitor behavior episodes and attempt to determine underlying cause. A Progress Note dated 6/21/25 at 6:11 PM described an incident that occurred around lunch time between Staff M, Housekeeper and Resident #31. Resident #31 reported to Staff A, Licensed Practical Nurse (LPN) that Staff M would not leave her room. Staff M reported Resident #31 did not want the light on and stated she needed the light on to clean. Staff A directed Staff M to leave the room. Staff M failed to leave the room and continued dusting. When she finished, she left the room. Staff M failed to respect Resident #31's preferences to leave the light off and to leave the room when requested. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/24/25 at 9:31 AM Resident #31 reported she had been watching a movie and wanted to see the end of the movie when the incident with Staff M occurred. Resident #31 verbalized she asked Staff M to turn off the light when she was finished cleaning. She reported Staff M stepped out of the room and failed to turn the light off so she rose and turned off the light. Resident #31 reported Staff M re-entered the room to continue cleaning and turned the light back on. Resident #31 reported she did ask Staff M to come back later. In an interview on 6/24/25 at 11:40 AM, Staff M verbalized she recalled Resident #31 said it was okay to clean the room. Staff M revealed she had stepped out of the room to get a rag off of her cart. When she re-entered the room, the light had been turned off. Staff M reported she had turned the light back on. Resident #31 reacted by hollering at her that she did not want the light on. Staff M revealed if Resident would have asked, she would have come back at a later time to clean. Staff M acknowledged she had been trained on dependent adult abuse and resident rights. In an interview on 6/24/25 at 12:17 PM Staff A, LPN reported she had been called down to the resident's room on 6/21/25 at approximately 12:20 PM. Staff M and Resident #31 had not been heard talking when she entered the room. When Staff A informed Resident #31 that she had been called down to the room, Staff M and Resident #31 began bickering about the light being on/off. Staff A revealed to Staff M that she should have come back at a later time and directed Staff M to leave the room. In an interview on 6/24/25 at 12:51 PM with Staff N, Housekeeping Supervisor verbalized resident rooms are cleaned once per week unless the room needs it more often. On weekends resident rooms are vacuumed or mopped, check the garbage, restock bathroom and mop the bathroom floor. Staff N acknowledged the light should be on when cleaning. Staff N acknowledged if a resident did not want the room light on, the housekeeper should return at a later time. On 6/24/25 at 3:10 PM the Administrator acknowledged training videos had been assigned to review resident rights and abuse. Review of the Iowa Time Card report revealed Staff M had not punched out until 3:05 PM on 6/21/25. Review of the facility Patient Protection Guidelines, Abuse Prevention, Reporting and Investigation policy revised in May 2025 documented employees are educated upon hire and annually on the abuse prevention program including the immediate reporting of any suspicion of abuse, neglect, exploitation, mistreatment, misappropriation, patient rights, reporting reasonable suspicion of crime, and use of computers/phone/electronic devices specific to audio/video recordings.

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F 0600 Level of Harm - Minimal harm or potential for 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 record review, policy review, personnel files review, resident and staff interviews the facility failed to prevent a staff member alleged of potential abuse of a resident (Resident #31) from contact with other residents. The facility reported a census of 39 residents. Findings include: Resident #31's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score 14 out of 15 indicating intact cognition. The MDS documented Resident #31 as independent (Resident completes the activity by themselves with no assistance from a helper for self-care.) for eating, oral hygiene, upper and lower body dressing, and mobility. The MDS documented Resident #31 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and /or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for shower/bathe self and tub/shower transfers. The MDS included diagnoses of coronary artery disease, diabetes mellitus, and leukemia. The Care Plan Focus identified Resident #31 has behavior problems related to becoming verbally aggressive towards staff and other residents. The following interventions directed staff to: a. Approach/speak in a calm manner. b. Assure the resident that concerns are validated and the staff is willing to address legitimate concerns. c. Communicate clearly and assertively what behaviors are unacceptable and inappropriate. d. Document behaviors and response to interventions. e. Intervene as necessary to protect the rights and safety of others. f. Monitor behavior episodes and attempt to determine underlying cause. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/21/25 at 2:26 PM the Administrator contacted Iowa Department of Inspections, Appeals and Licensing to submit and initial report for potential dependent adult abuse. A review of the Progress Noted dated 6/21/25 at 6:11 PM documented an incident had occurred between Staff M, Housekeeper and Resident #31. The Progress Note revealed the nurse was paged by the housekeeper to the resident room. I got there, Resident #31 was pushing her lunch tray away and looked frazzled with flushed cheeks. I asked her if she was ok, she said yes I said I was asked to come down here she said yes, because she won't leave my room then the housekeeper said I paged because she put her hands on me I asked Resident #31 what happened as the housekeeper was dusting and said she didn't want the light on but I need the lights on to clean (Lights are off at this time) I said so she put her hands on you? The housekeeper said yes as Resident #31 yelled yes, because she pushed me! Then the housekeeper said because you grabbed me! I stopped them and asked the housekeeper to leave the room and told her when the resident says not right now then they need to come back at a later time. She continued dusting, finished, then left the room. I stayed and asked Resident #31 if she was ok, she stated no I said tell me what happened. She said the housekeeper came in and wanted to clean and I didn't want her to turn the light on to do the cleaning but she kept insisting that she had to have the lights on to clean and she couldn't see without the lights! She said I grabbed her to get her away from the light then the housekeeper pushed me I asked if I could see her skin, she said for what? I stated to see if it left any marks she said no, she didn't push me that hard she stated I just think when I ask if they can wait to do something than it can wait until later. I am in my room today because my teeth, bottom plate, is bothering me and it hurts to chew. I asked if she wanted something for the pain and she stated no, I don't like to take any more medications then what I have to I told her I could tell people to stay out of her room this weekend so she could rest if she would like and she said no, I don't mind if they come to do what they need to do just not when I don't want them in here. They can come back. I told her she is right, asked if she was ok again, she said she will be. Assessment of Resident including range of motion & Pain: within normal limits Vital Signs - If FALL include Ortho B/P: 130/79,80, 95%, 98.8, 18, no pain Describe Any Injury Noted: none noted at this time List Any Treatment Provided: emotional support List Relevant Interventions That Were In Place At The Time of The Incident: Removed the housekeeper from the situation Preliminary Recommendations, if any, for consideration as further preventative measures:: respect resident wishes List Responsible Party Notified: daughter Which Physician Was Notified - Include Date & Time of Notification: Primary Physician notified at 1822 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/24/25 at 9:31 AM Resident #31 recalled the incident from 6/21/25. Resident #31 revealed she had wanted to finish watching a movie and had the lights off in her room. Staff M, Housekeeper had wanted to clean the room. Resident #31 allowed Staff M to enter the room. Staff M left the room and had not shut the light off so Resident 31 shut the light off. Staff M re-entered the room and turned the light on. Resident #31 revealed she rose from her chair to go shut the light off. Staff M had been near the light switch. Resident stated she had reached over Staff M's right shoulder as she was reaching for the light. Resident #31 revealed Staff M had raised her hand up with fingers open, her elbows along her side. Resident #31 acknowledged staff did not extend her arms nor was any force or pressure felt as Resident #31 continued to move forward. Resident did not appear fearful, agitated or anxious as she recalled the incident. Resident acknowledged she had no injuries. During an interview on 6/24/25 at 11:40, Staff M recalled the incident. Staff M revealed as Resident #31 reached for the light the resident had grabbed her arm. Staff M acknowledged there had been no marks left on her arm. Staff M acknowledged she had raised her hands up as the resident was coming towards her. Staff M could not recall if her hands actually touched the resident. Staff M revealed when her hands were up the resident was less than 6 inches away from her. Staff M acknowledged when she left the residents room she continued cleaning other resident rooms. Staff M acknowledged she went in to approximately 18 (all of east hall way and approximately half of the south hallway rooms) rooms. Staff M revealed residents had been in all rooms but 2. Staff M acknowledged no other staff members had accompanied while she continued to clean resident rooms. During an interview on 6/24/25 at 12:17 PM, Staff A revealed she had directed Staff M to leave Resident #31's room. Staff A acknowledged she separated Staff M from the resident but failed to separate Staff M from all other residents. During an interview on 6/24/25 at 1:50 PM, Staff D, LPN acknowledged she had been the nurse on call on 6/21/25 and had received a call from Staff A. Staff D directed Staff A to get statements and to call the Administrator. Staff D acknowledged she failed to provide direction to remove Staff M from potential contact with all residents. During an interview on 6/24/25 at 3:10 PM, the Administrator acknowledged she had been notified around 1:00 PM on 6/21/25. When the Administrator returned the call to the facility, Staff A thought Staff M had already left the facility. Review of the Personnel File for Staff M revealed a Dependent Adult Abuse training certificate dated 12/30/22. Review of the Personnel File for Staff A revealed a Dependent Adult Abuse training certificate dated 4/6/25. Review of the facility policy Patient Protection Guidelines, Abuse Prevention, Reporting and Investigation with a revision date of May 2025 directed the following: Employees are educated upon hire and annually on the abuse prevention program including the immediate reporting of any suspicion of abuse, neglect, exploitation, mistreatment, misappropriation, patient rights, reporting reasonable suspicion of crime, and use of computers/phone/electronic devices specific to audio/video recordings. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protection Upon receiving a report of an allegation of resident abuse, neglect, exploitation, injuries of unknown origin or misappropriation, the facility shall immediately implement measures to prevent further potential abuse of resident from occurring while the facility investigation is in process. If this involves an allegation of abuse by an employee, this will be accomplished by separating the employee accused of abuse from all residents through the following or a combination of the following, if practicable: (1) suspending the employee; (2) segregating the employee by moving the employee to an area of the facility where there will be no contact with any residents of the facility; and in rare instances (3) separating the employee accused of abuse from the resident alleged to have been abused, but allowing the employee to care for and have contact with other residents, only if there is a second employee who remains with and accompanies the employee accused of abuse at all times to supervise all contacts and interactions with residents.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff interview the facility failed to thoroughly investigate an allegation of abuse. The facility failed to conduct resident and staff interviews for the date of the incident to determine the extent of the allegation or determine if other residents had been affected. The facility reported a census of 39 residents. Findings include: Resident #31's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score 14, indicating intact cognition. The MDS documented Resident #31 as independent (Resident completes the activity by themselves with no assistance from a helper for self-care.) for eating, oral hygiene, upper and lower body dressing, and mobility. The MDS documented Resident #31 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and /or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for shower/bathe self and tub/shower transfers. The MDS included diagnoses of coronary artery disease, diabetes mellitus, and leukemia. The Care Plan Focus identified Resident #31 has behavior problems related to becoming verbally aggressive towards staff and other residents. The following interventions directed staff to: a. Approach/speak in a calm manner. b. Assure the resident that concerns are validated and the staff is willing to address legitimate concerns. c. Communicate clearly and assertively what behaviors are unacceptable and inappropriate. d. Document behaviors and response to interventions. e. Intervene as necessary to protect the rights and safety of others. f. Monitor behavior episodes and attempt to determine underlying cause. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note Incident Report for 6/21/25 6:11 PM documented by Staff A, LPN revealed Resident #31 stated Staff M, Housekeeper had pushed her while in the residents' room. Staff A completed an assessment of Resident #31 including range of motion and pain and documented to be within normal limits. Vital signs - blood pressure: 130/79, pulse 80, O2 saturation 95%, temperature 98.8, and respirations 18, Resident had no pain. Describe any injury noted: none noted at this time List any treatment provided: emotional support List relevant interventions that were in place at the time of the incident: removed the housekeeper from the situation. Preliminary recommendations, if any, for consideration as further preventative measures: respect resident wishes. Staff A notified the resident representative and primary physician. The Investigation Report submitted by the facility had been received on 6/23/25. The facility investigation lacked documentation of interviews with other residents and staff. It further lacked documentation of investigation if Staff M had contact with other residents following the incident. Recommendations in the Investigation Report listed re-education for housekeeping and dietary employees but lacked training or re-education for other department employees. In an interview on 6/24/25 at 12:17 PM, Staff A reported she had notified the nurse manager on call for 6/21/25 at approximately 12:38 PM. Staff A had been directed to obtain written statements and to call the Administrator. Staff A revealed the Administrator had called back at approximately 2:30 PM and reported to the Administrator that Staff M had finished her shift and left the facility. Staff A acknowledged she failed to keep a potential abuser from contact with other residents. In an interview on 6/24/25 at 1:50 PM, Staff D, LPN acknowledged she had been the nurse manager on call for 6/21/25. Staff D verbalized she had directed Staff A to obtain written statements from everyone and disclosed it was a possible allegation of abuse that would need to be reported. Staff D sent a text message to the Administrator to inform her of the nurse calling in regards to the incident. In an interview on 6/24/25 at 3:00 PM, the Director of Nursing (DON) acknowledged she had been notified by the Administrator about the incident on 6/21/25 at approximately 2:30 PM. The DON reported she had been out of town and the Administrator did not direct her to do anything. The DON verbalized the Administrator had reported the incident to the Iowa Department of Inspections, Appeals and Licensing. In an interview on 6/24/25 at 3:10 PM, the Administrator reported she had called the Iowa Department of Inspections, Appeals and Licensing on 6/21/25 at 2:26 PM. The Administrator provided 2 hand written statements from Staff A and Staff M. The Administrator reported she had no other statements on file for the investigation of the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/25/25 at 9:55 AM, the Administrator reported she had not interviewed any other residents as part of her investigation. The Administrator acknowledged she had spoken with Staff A, Staff M, Staff O, Laundry and Staff P, Dietary Manager and no other staff members that had worked on 6/21/25. The Administrator verbalized she had been continuing her investigation and reiterated she had 5 days to submit a summary. On 6/26/25 at 1:37 PM the Iowa Department of Inspections, Appeals and Licensing had received additional information to the facilities Investigation Report. The Investigation Reported included 1 additional staff statement and re-education of all staff on residents' rights, including the right to refuse care can control of their environment.