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	05/05/2026

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** Based on resident and staff interviews, policy review, the facility failed to treat residents with respect and dignity in a manner that promotes maintenance or enhancement of his or her quality of life for 2 of 4 resident reviewed. (Resident #6 and Resident #7). The facility identified a census of 40 residents.Findings include:1. Resident #6's Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. She understood others, made herself understood, and didn't show behaviors. Resident #6 depended on staff for toileting hygiene, upper and lower body dressing, and transfers. She required supervision for personal hygiene and used a wheelchair independently. Her diagnoses included cancer, heart failure (the heart doesn't pump blood as well as it should), hypertension (high blood pressure), diabetes mellitus (high blood sugar), and depression.The Care Plan with a target date of 6/30/26, documented Resident #6 preferred to self-administer medications with meals due to gastric (stomach) issues. She'd voice concerns if she didn't have them at specific times. She could see pills and notice if one dropped. Interventions directed staff not to keep medication at the bedside. Staff brought medications with applesauce to Resident #6 so she'd take them during her meal. Staff provided education on proper administration and storage.The Provider Visit Progress Note dated 4/21/26 at 9:15 PM, documented Resident #6 felt upset with the Certified Nursing Assistant (CNA) and Registered Nurse (RN) because she didn't receive medications at supper. Staff told her she couldn't have Tylenol (pain reliever) because she'd taken it too recently. The RN found medications, including Tums (antacid) and Tylenol, in cups on the bedside table. Resident #6 hadn't taken them. She stated she's legally blind and only sees shades and outlines, so she didn't know they're there. The RN reviewed her complaints about cancer medications. All medications for the 4/21/26 time periods appeared punched out of the packs. The RN told her staff gave her the medications properly. She appeared to settle down slightly.On 4/29/26 at 11:08 AM, observed Resident #6 lay in bed with two pillows on each side. A round blue pressure device circled her right ankle to keep it off the mattress, and a dressing covered the outside of her right ankle.On 4/29/26 at 11:30 AM, Resident #6 stated Staff A, RN, who only worked weekends, didn't give her the medications she needed one hour before meals. She claimed she once went all day without eating but couldn't recall the weekend. Resident #6 felt Staff A didn't treat her with the dignity and respect she deserves and felt like a nobody when Staff A worked. Resident #6 informed administration, but they didn't take action.2. Resident #7's Minimum Data Set (MDS) assessment dated [DATE], documented a BIMS score of 15, indicating intact cognition. She understood others and made herself understood without behaviors. She had a limited range of motion (ROM) in her arms and legs. She depended on staff for toileting hygiene, dressing, personal hygiene, and transfers. She used a wheelchair independently. Her diagnoses included neurogenic bladder (bladder dysfunction), cerebrovascular accident (stroke), paraplegia (lower body paralysis), and moisture associated skin damage (skin irritation).The Care Plan with a target date of 6/14/26, documented Resident #7 had behavior problems related to derogatory (insulting) and racist comments toward African American staff. Interventions directed staff to approach and speak in a calm manner (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	and communicate clearly what behaviors aren't acceptable. Resident #7 stated she doesn't want Black men performing personal care, though they could bring medications.The Interdisciplinary Team (IDT) meeting notes dated 3/18/26 at 6:18 AM labeled Late Entry, documented Resident #7 and her daughter complained about agency staff. They claimed staff didn't listen, acted rude, and walked out before meeting her needs. The daughter stated she witnessed this. The facility initiated a grievance (formal complaint).On 4/29/26 at 11:40 AM, witnessed Resident #7 sitting in a motorized wheelchair in her room while dressed appropriately.On 4/29/26 at 11:40 AM, Resident #7 stated Staff A didn't treat her with the dignity and the respect she deserved. She felt she's a person and wanted treatment as such.On 4/29/26 at 4:33 PM, the Director of Nursing (DON) acknowledged staff should treat all residents with dignity and respect.On 5/5/26 at 10:30 AM, the Administrator acknowledged staff should treat residents with dignity and respect.The Resident Rights-Dignity and Respect policy dated April 2024, directed each resident has the right to considerate and respectful care and to treatment with honesty, dignity, and respect.

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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, resident and staff interviews, the facility didn't ensure timely notification of incidents to the legal representative or the Hospice provider for 2 of 4 residents (Resident #2 and Resident #4). The facility reported a census of 40 residents.Findings include:1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE], documented she had a Brief Interview for Mental Status (BIMS) score of 4, indicating severely cognitively impaired. She understood others and made herself understood. She didn't show behaviors. Resident #2 required partial to moderate assistance from staff for toileting hygiene, upper and lower body dressing, and personal hygiene. She performed transfers and ambulation (walking) independently. She had two falls without injury and one fall with a minor injury. Diagnoses included heart failure (heart pumping problem), hypertension (high blood pressure), Alzheimer's Disease (progressive brain disorder), and non-alzheimer's dementia (cognitive decline).The Communication with Hospice dated 3/10/26 at 10:00 AM, documented a Registered Nurse (RN) informed the Hospice Nurse that Resident #2 had a fall the previous night at 6:50 PM. The Hospice Nurse asked why no one called to report the incident so a representative could examine Resident #2. The RN stated they didn't know why staff didn't call.The Communication with Hospice dated 3/10/26 at 1:00 PM, documented the Hospice Nurse called to confirm Resident #2 fell again the previous night. Staff confirmed reports of a fall two nights in a row. The Hospice Nurse stated Resident #2's wife didn't receive a call regarding the incidents and felt upset. Staff added a note to remind nurses to call families and providers when incidents happen.2. Resident #4's Minimum Data Set (MDS) assessment dated [DATE], documented she had a BIMS score of 12, indicating moderately impaired cognition. She understood others, didn't show behaviors, and didn't resist care. Resident #4 required substantial to maximal assistance with activities of daily living (ADL) (everyday tasks). She needed assistance with transfers and ambulation. She had falls prior to admission. Diagnoses included heart failure, hypertension, non-Alzheimer's dementia, history of falling, and abnormalities of gait (walking style) and mobility.The Incident Report dated 4/22/26 at 11:09 PM, documented a Certified Nursing Assistant (CNA) assisted Resident #4 to bed when she lost her balance and fell backward onto her bottom. Resident #4 wore appropriate footwear, a gait belt (safety strap), and used a wheeled walker while staff assisted her. Staff didn't notify the family at that time.The Communication with Hospice dated 4/23/26 at 11:08 AM, documented an RN informed Hospice that Resident #4 had a witnessed fall the previous night at 8:15 PM. Hospice staff didn't know about the fall and stated they'd call Resident #4 Representative (son) to provide an update.The Incident Report dated 4/27/26 at 11:35 PM, documented staff found Resident #4 sitting on the floor in front of the bathroom door with one leg bent inward and the other fully extended. No injuries appeared at that time. The record didn't show documentation of family notification for this fall.The Shift Follow up to Incident Note dated 4/28/26 at 1:16 AM, documented staff found Resident #4 on the floor. She also fell on 4/25/26 while attempting to transfer herself. Staff called Hospice at this time. Resident #4's left elbow appeared swollen, and she reported pain.The Communication with Hospice dated 4/28/26 at 1:25 AM, documented staff called the on-call Hospice regarding bruises on Resident #4's left elbow and older bruises on her right upper arm and elbow. Staff hadn't called the family regarding the fall that evening.Observation on 4/30/26 at 12:00 PM, showed staff pushing Resident #4 to the dining room in a wheelchair. She had her left arm elevated on a pillow, and her right pinky finger had buddy tape (taping fingers together for support) to the adjacent finger.On 4/30/26 at 1:44 PM, Resident #4 Representative stated he received a phone call from the Hospice Nurse on 4/26/26 at 1:50 AM. The nurse told him Resident #4 had a fall on 4/25/26. He stated he'd like notification of falls when they happen instead of hours later or the following day.On 5/5/26 at 3:01 PM, the facility Director of Nursing (DON) confirmed nurses should notify families immediately after an incident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and facility policy, the facility didn't ensure 2 of 4 residents (Resident #6 and Resident #7) received showers in accordance with their Plan of Care (POC). The facility identified a census of 40 residents.Findings include:1. Resident #6's Minimum Data Set (MDS) assessment dated [DATE], documented she had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. She understood others and made herself understood without behaviors. She depended on staff for shower/bathing. Her diagnoses included cancer, heart failure (pumping problem), hypertension (high blood pressure), diabetes mellitus (high blood sugar), and depression.On 4/29/26 at 11:30 AM, Resident #6 stated she only gets 1 shower a week and wanted 2 showers a week.The Plan of Care (POC) with a target date of 6/30/26, documented Resident #6 required assistance with activities of daily living (ADL) (everyday tasks) related to poor eyesight, impaired mobility, and incontinence (loss of bladder or bowel control). Interventions directed staff to assist Resident #6 with a shower or bath per the schedule two times per week.Review of the electronic health record (EHR) titled POC Response History, documented staff scheduled Resident #6 for showers on 3/11/26 and 3/29/26. She didn't receive a shower on those dates.Review of the EHR for April 2026, documented staff scheduled a shower for Resident #6 on 4/5/26. She didn't receive a shower on 4/5/26.2. Resident #7's Minimum Data Set (MDS) assessment dated [DATE], documented she had a BIMS score of 15, indicating intact cognition. She understood others and made herself understood without behaviors. She had functional limitations in her range of motion (joint movement) in her arms and legs. She depended on staff for showers, toileting hygiene, dressing, and personal hygiene. Her diagnoses included neurogenic bladder (bladder dysfunction), cerebrovascular accident (stroke), paraplegia (lower body paralysis), and moisture associated skin damage (skin irritation).The Plan of Care (POC) with a target date of 6/14/26, documented Resident #7 required assistance with ADLs related to a stroke and impaired mobility. Interventions directed staff to assist Resident #7 with a shower or bath per the schedule.On 4/29/26 at 11:40 AM, Resident #7 stated she hadn't received a shower twice a week. She stated she'd refuse a bed bath and wanted 2 showers a week.Review of the EHR for March 2026, documented staff scheduled Resident #7 for a shower on 3/16/26. She didn't receive a shower on 3/16/26.Review of the EHR for April 2026, documented staff scheduled showers for Resident #7 on 4/2/26, 4/6/26, and 4/9/26. She didn't receive showers on those dates.On 5/5/26 at 10:30 AM, the Administrator stated the facility expected staff to provide 2 showers or baths per week for all residents.The Hygiene-Bathing/Shower policy dated March 2024, directed staff to cleanse skin to promote cleanliness and prevent infection. Staff may complete hygiene by bed bath, tub bath, or shower.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy, resident, and staff interviews, the facility didn't provide necessary treatment and services for a skin tear for 1 of 4 residents (Resident #5). Staff failed to implement physician treatment orders for 10 days, which resulted in the wound bed deteriorating and the surrounding skin becoming soft and broken down. The facility reported a census of 40 residents. Findings include:Resident #5's Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. She understood others and made herself understood. She didn't show behaviors or resist care. The MDS documented she required partial to moderate assistance from staff for activities of daily living (ADLs) and showed no skin issues. Resident #5 had falls without injury and falls with non-major injuries. Her diagnoses included cerebrovascular accident (CVA) (stroke) and chronic kidney disease (gradual loss of kidney function).The Plan of Care (POC) Focus with a target date of 7/12/26, documented Resident #5 had a risk for alteration in skin integrity related to limited mobility, anemia (low red blood cell count), and fragile skin. Interventions directed staff to administer treatment per physician's orders, follow facility policies for the prevention and treatment of skin breakdown, and observe skin condition during activities of daily living care.The Incident Report Progress Note dated 4/6/26 at 12:40 PM, documented Resident #5 walked back from physical therapy (PT) when her knee gave out. She sat in front of her recliner. Staff lowered her safely to the floor. Staff noted a 2 centimeter (cm) by 2 cm skin tear on the front of her right shin. Staff cleansed the area with wound cleanser and applied a bandage.The Incident Report dated 4/6/26 at 12:40 PM, revealed an order to change the bandage daily until the wound healed.The Non-Pressure Skin Condition Record dated 4/6/26, documented a skin tear to the right shin. Staff cleansed the area and applied a dressing. The area measured 2.0 cm by 2.0 cm.The Non-Pressure Skin Condition Record dated 4/13/26, revealed a dark pink/red tissue wound bed (the surface of the wound) with a reddened area surrounding the skin. The area measured 3.0 cm by 1.0 cm. The record documented a macerated (softened and broken-down skin from moisture) area measuring 2.6 cm by 0.7 cm around the skin tear.The Interdisciplinary Team (IDT) note dated 4/15/26 at 9:22 AM, documented Resident #5 Representative (son) wanted information about a fall. He talked about the wound on her leg. A Registered Nurse (RN) looked at the wound and assessed it. The Representative wanted the primary care provider (PCP) to look at the wound during the next visit.The April 2026 Treatment Administration Record (TAR) didn't contain the order from 4/6/26 to change the bandage daily until healed. The April 2026 TAR documented the dressing started on 4/16/26, with orders to cleanse the right shin and apply a bandage to the skin tear until healed, once a day on the day shift.The facility didn't have documentation of a treatment initiated earlier than 4/16/26.The Office Visit record dated 4/23/26, revealed Resident #5 had a skin tear to the right shin that healed appropriately. She used a Mepilex (absorbent foam dressing). The assessment noted a skin tear of the lower leg without complication.The Non-Pressure Skin Condition Record dated 4/30/26, revealed a partial thickness area with serous exudate (clear, watery drainage). The wound showed dark pink/red tissue and maceration measuring 3.0 cm by 0.5 cm and 2.0 cm by 0.5 cm around the skin tear.On 4/30/26 at 8:30 AM, Resident #5 sat in her recliner with a dressing on the right lower shin.On 5/5/26 at 11:00 AM, Resident #5 stated the area on her right shin hurt when she fell, but it didn't hurt anymore since it almost healed.On 5/5/26 at 11:11 AM, Staff C, Licensed Practical Nurse (LPN), stated she completed the dressing change earlier that morning. She stated the area almost resolved and staff could leave the dressing off. Staff C confirmed the skin tear hurt during dressing changes when staff first observed it.On 5/5/26 at 2:11 PM, Staff D, RN, acknowledged the April 2026 TAR didn't have the treatment orders for the skin tear on 4/6/26 and staff didn't put them on the record until 4/16/26. Staff D confirmed that according to the skin sheets, the area on the right shin deteriorated (got worse). She stated nurses should follow physician orders and perform daily dressing (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	changes. She confirmed the clinical record didn't have documentation of daily treatments.The Skin Management Guide dated November 2023, instructed staff on identifying residents at risk for skin alterations and prevention techniques. The policy directed staff to complete a skin evaluation, notify the physician, and obtain treatment orders when a resident experienced a new injury.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and facility policy review the facility failed to ensure one 2 of 5 residents received adequate supervision to protect against hazards in the environment. (Resident #1 and Resident #4). Record review and staff interviews revealed Resident #1 room door required to be open and on 4/19/26, Resident #1 had his room door closed, was yelling for help and was found by staff sitting on the floor with complaints of right knee pain and sustained a right hip fracture. Record review and staff interviews revealed Resident #4 required assistance of two staff for transfer. On 4/22/26, one nursing staff person assisted Resident #4 to transfer. The resident lost balance and fell backwards onto the floor. The facility reported a census of 40 residents.Findings include:1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 3, indicating severely cognitively impaired. He understood others sometimes and staff understood him sometimes. He didn't show behaviors or resist care. Resident #1 showed functional limitation in range of motion (joint movement) to his lower extremity. He depended on staff for toileting hygiene and required substantial to maximal assistance with transfers. He used a wheelchair for mobility. He frequently showed incontinence (loss of control) of bladder and always showed incontinence of bowel. The MDS documented he had no falls and reported no pain. His diagnoses included anemia (low red blood cells), heart failure (pumping problem), hypertension (high blood pressure), renal insufficiency (kidney underperformance), diabetes mellitus (high blood sugar), aphasia (communication disorder), cerebrovascular accident (stroke), reduced mobility, and weakness.The Care Plan Focus with a target date of 6/18/26, documented Resident #1 had a risk for falls related to impaired cognition, weakness, impaired mobility, and history of falls. Interventions directed staff to perform frequent visualization (visual checks), keep the door open, check him frequently, and place a mattress next to the bed when he's in bed.The Behavior Note dated 4/16/26 at 4:34 AM, documented Resident #1 attempted to get his legs off the bed or roll close to the edge of the bed. Staff should leave the door open at night.The Incident Report Note dated 4/19/26 at 6:40 PM, documented a Registered Nurse (RN) responded to Resident #1's room and found him sitting on the floor. Staff told the RN that Resident #1's door remained closed while he yelled for help.The 5-day Investigation Report dated 4/24/26, documented camera footage showed staff entering Resident #1's room when he sat on the floor and called for help. Staff E, Certified Nursing Assistant (CNA), stated during an interview she performed hourly checks and heard yelling. She followed the voice and when she opened the door, she saw Resident #1 on the floor.On 4/28/26 at 8:30 AM, Resident #1 sat in a wheelchair in his room wearing a baseball cap. He told staff he wanted to lie down.On 4/28/26 at 8:30 AM, when the staff attempted to interview Resident #1, his speech sounded non-coherent and mumbling.On 4/28/26 at 10:40 AM, Staff F, Licensed Practical Nurse (LPN), confirmed Resident #1's room door needed to stay open at all times.On 4/28/26 at 2:05 PM, Staff E confirmed Resident #1's room door remained closed when she heard yelling. She confirmed the door should stay open at all times.On 4/28/26 at 11:50 AM, Staff G, CNA, confirmed Resident #1's room door needed to stay open at all times per the POC due to Resident #1 attempting to get up on his own.On 4/28/26 at 3:33 PM, Staff D, RN, and the Director of Nursing (DON) both confirmed the incident report showed the room door remained closed. They confirmed the POC required the door to stay open at all times due to Resident #1 attempting to transfer by himself.2. Resident #4's Minimum Data Set (MDS) assessment dated [DATE], documented a BIMS score of 12, indicating moderately impaired cognition. Staff understood her, and she didn't show behaviors or resist care. Resident #4 required substantial to maximal assistance with activities of daily living (ADLs) (everyday tasks). She needed assistance with transfers and ambulation (walking). She had falls documented prior to admission. Her diagnoses included heart failure, hypertension, non-Alzheimer's dementia (brain (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	function decline), history of falling, and abnormalities of gait (walking pattern) and mobility.The Care Plan documented Resident #4 required assistance with ADLs and had a risk for falls. Interventions directed staff to use 2 staff members to assist with a walker and gait belt (safety belt) for transfers and ambulation.The Fall, Staff Assist Report dated 4/22/26 at 10:15 PM, documented an RN received a report that while staff assisted Resident #4 to bed, they lowered her to the floor. She wore appropriate footwear, a gait belt, and used a wheeled walker. She didn't hit her head. Resident #4 stated she just lost her balance and fell backwards.The Incident Report in the progress notes dated 4/22/26 at 11:09 PM, documented an aide assisted Resident #4 to bed when she lost her balance and fell onto her bottom.On 5/5/26 at 3:01 PM, Staff D confirmed staff should use 2 people for transfers if the POC directed it.On 5/5/26 at 3:01 PM, the DON acknowledged staff should transfer Resident #4 with 2 staff members at all times.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interview, and facility policy/procedure, the facility failed to ensure Resident #1 received a timely medical evaluation and assessment following a fall, for 1 of 4 residents reviewed (Resident #1). The failure resulted in harm to Resident #1, who sustained a right hip fracture and experienced severe, prolonged pain for two days before receiving surgical treatment. The facility identified a census of 40 residents. Findings include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 3, indicating severely cognitively impaired. Resident #1 sometimes understood others and others sometimes understood Resident #1. No behaviors existed and Resident #1 didn't resist cares. Resident #1 had a joint movement (range of motion) limitation to the lower leg. Resident #1 depended on staff for bathroom cleaning (toileting hygiene) and needed substantial to maximal help to move from one surface to another (transfers). Resident #1 used a wheelchair for mobility. Resident #1 frequently had bladder leakage (incontinence) and always had bowel leakage. The MDS showed no falls, no pain, and the use of a blood thinner (anticoagulant) in the last 7 days. Diagnoses included anemia (low red blood count), heart failure (weak heart), hypertension (high blood pressure), renal insufficiency (reduced kidney function), diabetes mellitus (high blood sugar), aphasia (communication disorder), cerebrovascular accident (CVA) (stroke), reduced mobility, and weakness.The Care Plan with a target date of June 2026, identified acute pain as a focus area. Interventions included giving pain medication per physician (doctor) orders, evaluating the efficiency (how well it worked) of pain management, and evaluating pain levels as ordered. Staff had instructions to offer to lay the resident down to rest and notify the doctor if pain relief appeared inadequate or if pain interventions didn't work. The plan directed staff to notify the physician if current pain represented a significant change from past experiences. Staff also watched for non-verbal signs of pain and any behavior changes in usual routines, sleep patterns, functional abilities, joint movement, and any withdrawal or resistance to cares.The Fall, Suspected/Actual form dated 4/18/26 at 2:15 PM, documented a Certified Nursing Assistant (CNA) called a Nurse to Resident #1's room because they found Resident #1 sitting on the floor. The Nurse found Resident #1 sitting on the floor and assessed the surrounding area for potential triggers. The Nurse finished an initial assessment and noted no injury, and staff helped Resident #1 into a recliner.The Incident Report Note dated 4/19/26 at 6:40 PM, documented a Nurse went to Resident #1's room because Resident #1 was on the floor. According to a CNA, Resident #1's room door stayed closed and Resident #1 yelled for help. Resident #1 showed signs of pain when staff touched his right leg. Staff gave Acetaminophen (Tylenol) and Ativan (anti-anxiety medicine) for pain and anxiety.The Shift Follow up to Incident note dated 4/19/26 at 1:36 AM, labeled late entry, documented Resident #1 appeared restless and agitated. Staff noted facial grimacing (pained look) and Resident #1 complained of pain in the right knee and leg area. Resident #1 rated the pain at an ?8' on a 1-10 pain scale (1 low to no pain, with 10 extreme pain).The General Progress Note dated 4/19/26 at 7:11 PM, documented Resident #1 fell on 4/18/26 at 2:15 PM. Staff finished an assessment and noted no visible injury, except for facial expressions of pain when staff touched Resident #1's right leg. A fall follow-up finished on 4/19/26 noted Resident #1's right knee appeared swollen and Resident #1 expressed pain when staff touched the area.The Health Status Note dated 4/20/26 at 7:48 AM, labeled late entry, documented a Nurse approached another Nurse with concerns for Resident #1 and asked for an assessment. After the assessment, a Nurse reported to the Charge Nurse (lead nurse) that Resident #1 needed transported to the hospital for further evaluation.The Communication with physician dated 4/20/26 at 8:05 AM, documented Resident #1 continued to have pain in his right knee and hip following the fall on 4/18/26, and yellow bruising (skin discoloration) appeared on the right knee. Staff used a full-body mechanical lift for transfers. A Nurse asked if an X-ray (bone image) to the right hip and knee appeared appropriate and received a call from a physician (continued on next page)

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	05/05/2026

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

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F 0697 Level of Harm - Actual harm Residents Affected - Few	at 8:46 AM, for Resident #1 to go to the emergency room (ER) for evaluation.The Communication-with outside vendor dated 4/20/26 at 11:29 AM, labeled late entry, documented a call from a hospital ER nurse. The hospital nurse stated Resident #1 entered the hospital with a fractured (broken) hip and needed surgery the next evening.Resident #1's April 2026 Medication Administration Record (MAR) documented an order for Acetaminophen 500 milligrams (mg), 2 tablets by mouth every 6 hours as needed for pain. Staff gave Acetaminophen on 4/18/26 and 4/19/26 for a pain level of 3 out of a 1-10 scale.The Pain Level Summary with a look back period of 90 days revealed Resident #1 had pain scores of 3 on 4/18/26 at 3:43 PM and on 4/19/26 at 6:00 PM, 6:34 PM, and 8:16 PM. On 4/20/26 at 6:40 AM, Resident #1 had a pain score of 5.The ED to Hosp-admission (Current) report printed 4/21/26 included the following:a. The X-ray report dated 4/20/26, documented an indication of trauma (injury) with an impression of an acute intertrochanteric fracture (hip break) of the right proximal femur (upper thigh bone).b. The X-ray report dated 4/21/26, indicated Resident #1 had status Open Reduction Internal Fixation (ORIF) (surgical bone repair) of a right hip fracture. Skin staples appeared and Resident #1 had no other fractures.c. The Occupational Therapy (OT) Notes dated 4/24/26, documented Resident #1 admitted on [DATE] for an initial fall which resulted in a closed right hip fracture.Observation on 4/28/26 at 8:30 AM, revealed Resident #1 sat in a wheelchair in his room wearing a baseball cap. Resident #1 told his daughter he wanted to lie down. He had both feet on the foot pedals of the wheelchair.On 4/28/26 at 8:30 AM, an attempted interview with Resident #1 revealed mumbled speech and he didn't understand.On 4/28/26 at 10:40 AM, Staff F, Licensed Practical Nurse (LPN), stated Resident #1 complained of his right leg hurting after the fall on 4/18/26. Staff F didn't feel it represented an emergency situation at the time but acknowledged Resident #1 should've gone to the ER due to leg pain complaints. On 4/19/26 at approximately 4:30 PM, Resident #1 started to yell and scream that his right leg hurt and his right knee appeared swollen. Staff F called the Resident #1's Representative who told her to place ice on the knee.On 4/28/26 at 11:50 AM, Staff G, CNA, stated on 4/18/26 after Resident #1 fell, Resident #1 couldn't cross his legs without a lot of pain. Resident #1 cried and whimpered. Staff G stated Resident #1 needed to go to the ER due to the increase in pain and a change in transfers, as Resident #1 needed a mechanical lift with 3 staff members. On 4/19/26, Resident #1 still had a lot of pain and cried during transfers and cares.On 4/28/26 at 12:10 PM, Staff I, CNA, stated on 4/19/26, after the supper meal, Resident #1 sat in a wheelchair across from the nurse station, took his right leg off the foot pedals, rubbed his leg, crying and whimpering in pain. Staff I explained to Staff F that Resident #1 had a lot of pain. Staff F explained that Staff A, Registered Nurse (RN), stated, it is the weekend, what is the hospital going to do anyway, nothing is going to happen.On 4/28/26 at 12:20 PM, Staff C, LPN, explained on 4/20/26, the night aides cried and felt upset because the nurses working the weekend didn't take them seriously when they reported Resident #1 cried in pain when staff touched or moved his right leg.On 4/28/26 at 12:46 PM, Staff J, CNA, stated on 4/19/26, Resident #1 cried out in pain and whimpered during morning cares, saying ow, ow, ow. Staff J told Staff F that Resident #1 had pain and didn't eat, but Staff F stated they completed an assessment and didn't find changes since the fall on 4/18/26.On 4/28/26 at 1:01 PM, Staff K, LPN, reported they worked the overnight shift on 4/18/26 and learned Resident #1 fell around 2:15 PM. The staff told them Resident #1 grimaced in pain and attempted to hold his right leg. Staff K gave Resident #1 anti-anxiety medication and Tylenol. After learning Resident #1 complained of pain, on 4/19/26, Staff K pulled up his pant leg and saw a yellowish color on top of Resident #1's right knee. They attempted to do joint movement, but Resident #1 screamed in pain and fought the movement. Staff K instructed staff to use a mechanical lift for transfers but acknowledged they didn't complete joint movement or an assessment on Resident #1.On 4/28/26 at 3:33 PM, Staff D, RN, and the Director of Nursing (DON) both acknowledged Resident #1 should've gone to the ER after the fall on 4/18/26 due to his pain complaints. They expected if the nursing staff had doubt, they sent the resident out.On 4/29/26 at 12:30 PM, Staff H, LPN, stated the facility expected the staff to send residents out if they had pain or obtain an x-ray at the facility to rule out a (continued on next page)

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	165336	A. Building B. Wing	05/05/2026

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

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F 0697 Level of Harm - Actual harm Residents Affected - Few	fracture.On 4/29/26 at 1:40 PM, the Primary Care Provider (PCP), confirmed Resident #1 needed to go to the ER for an x-ray because of his right leg and knee pain complaints.The Pain Policy dated September 2023, instructed the facility to provide pain management to residents who required it, consistent with professional standards, the Care Plan, and resident goals. If pain medication appeared needed, staff gave it per order, and staff assessed the resident for effectiveness after administration. If pain remained unrelieved despite nursing measures, staff must notify the resident's physician.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, call light logs and the facility policy/procedure, the facility staff failed to answer resident call lights in a timely manner (no longer than 15 minutes) for 3 of 4 residents reviewed (Resident #4, #6 and Resident #7). The facility identified a census of 40 residents.Findings include:1. Resident #4's Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. She understood others and made herself understood. She didn't show behaviors or resist care. Resident #4 required substantial to maximal assistance with activities of daily living (ADLS) (everyday tasks). She showed frequent incontinence (loss of control) of urine and occasional incontinence of bowel. Her diagnoses included heart failure (pumping problem), hypertension (high blood pressure), non-Alzheimer's dementia (brain function decline), history of falling, and abnormalities of gait (walking pattern) and mobility.On 4/30/26 at 2:22 PM, Resident #4 stated staff took over 15 minutes to answer her call light.Review of the Past Calls report from 4/25/26 through 4/26/26, for all shifts, documented Resident #4's call light stayed on for 32 minutes on 4/25/26.2. Resident #6's Minimum Data Set (MDS) assessment dated [DATE], documented a BIMS score of 15, indicating intact cognition. She understood others, made herself understood, and didn't show behaviors or resist care. Resident #6 depended on staff for ADLS. Her diagnoses included cancer, heart failure, hypertension, diabetes mellitus (high blood sugar), and depression.On 4/29/26 at 11:30 AM, Resident #6 stated staff took over 15 minutes to answer her call light.Review of the Past Calls report from 4/25/26 through 4/26/26, for all shifts, documented Resident #6 had call light wait times over 15 minutes on 4/25/26 at 11:44 PM for 16.11 minutes, on 4/26/26 at 8:59 AM for 27.28 minutes, and on 4/26/26 at 1:52 PM for 22.33 minutes.3. Resident #7's Minimum Data Set (MDS) assessment dated [DATE], documented a BIMS score of 15, indicating intact cognition. She understood others, made herself understood, and didn't show behaviors or resist care. She showed functional limitation in her range of motion (joint movement) in her arms and legs. She depended on staff for showers, toileting hygiene, dressing, and personal hygiene. Her diagnoses included neurogenic bladder (bladder dysfunction), cerebrovascular accident (stroke), paraplegia (lower body paralysis), and moisture associated skin damage (skin irritation).On 4/29/26 at 11:40 AM, Resident #7 stated staff took over 15 minutes to answer her call light. She stated she'd holler and yell until someone came to assist.Review of the Past Calls report from 4/25/26 through 4/26/26, for all shifts, documented Resident #7 had call light wait times over 15 minutes on 4/25/26 at 11:27 AM for 16.18 minutes and on 4/26/26 at 9:18 AM for 21.31 minutes.On 4/29/26 at 4:33 PM, the Director of Nursing (DON) acknowledged staff should answer resident call lights within 15 minutes.On 4/30/26 at 11:00 AM, Staff B, Certified Nursing Assistant (CNA), confirmed staff should answer call lights within 15 minutes. She stated staff shortages prevented this from happening consistently.On 5/5/26 at 10:30 AM, the Administrator acknowledged staff should answer call lights within 15 minutes. He verified the call light log showed residents waiting over the 15-minute expectation.The Call Light policy dated September 2023, directed staff to provide a prompt response to residents' calls for assistance. The facility ensured the call system stayed in proper working order. The policy instructed staff to answer call lights in a timely manner.