STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165358	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thomas Rest Haven	217 Main Street Coon Rapids, IA 50058

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. (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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(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	Based on clinical record review, staff interviews and policy review the facility failed to ensure that staff contacted the physician when a resident had a change in status for 1 of 2 residents reviewed. Resident #31 had many falls during his stay and the chart lacked documentation of physician notification. The resident was found to have a bruised, swollen hand and staff failed to contact the doctor for direction or orders. The facility reported a census of 31 residents. Findings include:According to the Minimum Data Set (MDS) date 8/11/25, Resident #31 had a Brief Interview for Mental Status (BIMS) score of 1 (severe cognitive deficits). The resident was independent with eating, transferring and walking 50 feet. Resident #31 had wandering behaviors that occurred 1 to 3 days a week. He had diagnoses that included cancer, anemia, deep venous thrombosis, benign prostatic hyperplasia and dementia. The Care Plan updated on 8/18/25, showed that Resident #31 was at risk for impaired skin integrity related to fragile and thin skin, friction and sheering potential. Staff were to complete weekly treatment documentation to include measurement of each area of skin breakdown. Resident #31 was admitted to the facility for respite care with the intention of returning to community upon discharge. On 8/7/25, the resident was accepted to a facility with a locked unit.The following documentation was included in the Nursing Progress Notes:a. On 8/2/25 at 3:59 PM, the resident was on the floor in front of the television. Nurse did vitals within normal limits (WNL). Did full skin assessment and neuro assessment. Chart lacked skin assessment and notification to family and/or physician. b. On 8/7/25 at 2:40 AM, resident on the floor on his side by the door. Nurse did full assessment and noted skin tear to left wrist and left elbow and on the back ribs. The chart lacked notifications to the doctor or to the family c. On 8/9/25 at 2:02 AM resident had bruising across the top of his left hand and swelling.d. On 8/9/25 at 4:33 AM left iliac crest 7 centimeter (cm) x 4 cm purple bruise on left rear flank, the medical doctor was not notified regarding wound condition.e. On 8/9/25 at 9:56 AM, an abrasion to top of scalp, top of left hand bruised and swollen. The chart lacked documentation of doctor notification of swollen hand.On 9/15/25 at 2:36 PM, Staff H, Licensed Practical Nurse (LPN) said that he worked the overnight shift and many of the falls for Resident #31 were after 10:00 PM. He said that if it was an emergency, the day shift would do the notifications the next day.On 9/16/25 at 7:52 AM, the Administrator said that she came in at 4:00 AM the morning of 8/9/25, she and the overnight nurse looked at the swollen hand together and she had directed the nurse to call the doctor and to document. She said that she found out later that the doctor had not been contacted. She acknowledged that the doctor and family should have been contacted with falls and injuries. According to a document used to educate nursing staff, titled: Nursing Standards of Practice dated 2024, page 11, When documenting a change in condition or resident issue in the progress notes, it must be followed up with an appropriate solution or plan and order follow up assessment if needed. Notify the physician as needed with changes for further direction. Assess and notify the physician of concerns and follow orders as directed. Page 14 indicated that staff should set up follow up per-shift assessments with any incident on hot chart form to support evaluating for changes and documenting regarding effectiveness of interventions and resident status.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record review, family interview, staff interview and policy review, the facility failed to provide timely and accurate assessment and interventions for 1 of 2 residents reviewed (Resident #31.) Resident #31 had many falls and the staff failed to complete skin assessments with measurements and failed to document and monitor injuries. The facility reported a census of 31 residents. Findings include:According to the Minimum Data Set (MDS) date 8/11/25, Resident #31 had a Brief Interview for Mental Status (BIMS) score of 1 (severe cognitive deficits). The resident was independent with eating, transferring and walking 50 feet. Resident #31 had wandering behaviors that occurred 1 to 3 days a week. He had diagnoses that included cancer, anemia, deep venous thrombosis, benign prostatic hyperplasia and dementia. The Care Plan updated on 8/18/25, showed that Resident #31 was at risk for impaired skin integrity related to fragile and thin skin, friction and sheering potential. Staff were to complete weekly treatment documentation to include measurement of each area of skin breakdown, including; width, length, depth type of tissue and exudate and any other notable changes or observations. Resident #31 was admitted to the facility for respite care with the intention of returning to community upon discharge. On 8/7/25, the resident was accepted to a facility with a locked unit.The following was found in the Nursing Progress Notes:a. On 7/29/25 at 10:40 AM, Resident #31 was admitted to the facility for respite care. He had a history of falls, was disoriented, ambulatory and continent of bowel and bladder.b. On 8/2/25 at 3:59 PM the resident was on the floor in front of television. Vitals were taken and a full skin assessment completed (The chart lacked a skin assessment and lacked documentation of notification to family and/or physician).c. On 8/3/25 at 3:15 PM, the resident was found on the floor in his room. He had an abrasion on right lower leg and one on left lower leg. (The chart lacked a skin assessment or note related to measurements or descriptions of injuries).d. On 8/7/25 at 2:40 AM, the resident was found on the floor on his side by the door, the nurse did a full assessment and noted a skin tear to the left wrist and left elbow and on the left back ribs. (The chart lacked a skin assessment with measurements and lacked documentation that the physician had been notified).e. On 8/8/25 at 1:40 PM, dining room, resident was lying on left side on the floor, abrasion with bump noted on left side of forehead, injury type abrasion top of scalp. (The chart lacked a skin assessment with wound measurements and descriptions).f. On 8/9/25 at 2:02 AM, the resident was found to have bruising across the top of his left hand and swelling. (The chart lacked documentation of description and measurements).On 9/15/25 at 2:45 PM, a Family Member (FM) for Resident #31 said that he had so many falls she couldn't remember if they had been contacted for each one. FM said that she saw the residents swollen hand after 8/8/25 on more than one occasion, and the family was concerned about it. It was bruised, and huge. She said that another family member had asked staff if they would do a, X-ray and the response they got from a nurse was that it was not broken. FM said that they didn't know that they could have taken him to the clinic themselves, and they wished they would have done that. When he was transferred to a different facility, they took him right in for an X-Ray and found he had a couple of fractured bones. On 9/15/25 at 12:30 PM, Staff C, Licensed Practical Nurse (LPN) said that on the morning of 8/9, he assessed the resident's swollen hand after the night nurse pointed it out to him. He had the resident move his fingers and grip and he didn't seem to have any pain or any trouble moving it so they just monitored it from there. Staff C said that the resident's wife was visiting that day and she did not voice any concerns to him about wanting to get an X-Ray or further assessment. Staff C said that he was the nurse on duty when the resident fell on 8/8 and he did not have any pain, swelling, bruising at the time. He said that the overnight nurse would have started a skin assessment related to the bruising and swelling. On 9/16/25 at 11:21 AM, Staff B, CNA said that she saw the residents swollen hand and helped the wife get his ring off. Staff B reported the swelling to the nurse, Staff C, and his response was that it was okay and not broken. Staff B said that the wife had voiced concerns about getting further assessment. On 9/15/25 at 1:33 PM, a staff member from the receiving facility reported that when the resident was delivered to the facility on 8/12/25, a staff member met the family and the wife immediately asked them what they were going do about his hand. The nurse saw that it was bruised and swollen so they took him for an X-Ray and found fractures. According to the Imaging Report dated 8/12/25, an exam of left wrist showed fractures of the fourth and fifth metacarpals. On 9/16/25 at 7:52 AM, the Administrator said that she came into the facility at 4 AM on 8/9/25 when the nurse said that the morning it was discovered the swollen hand. She looked at it with the nurse and told him to call the doctor and to document. She said that she found out later he hadn't contacted the doctor. In the process of investigating the residents falls she