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	01/15/2026

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 0689 Level of Harm - 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 observation, staff interviews, clinical record review and nursing standard of practice, the facility failed to ensure that staff used safe transfer techniques and fall preventions for 1 of 3 residents reviewed. Resident #1 had frequent falls and a history of self-transferring, the staff failed to use a gait belt while transferring, and failed to ensure the intervention of slip proof strips on the floor was implemented. The facility reported a census of 33 residents. The facility corrected the deficiency practice per past non-compliance on 1/7/26 through the following actions:*Nursing staff re-education on fall prevention, proper transfer techniques, mandatory use of gait belts and accountability for care plan compliance. *Audits of transfers and ambulation to ensure gait belt use when required. *Supervisory observations by nursing leadership. *Any non-compliance will result in immediate re-education and progressive discipline if indicated. *Ongoing review of fall incidents through QAPI to identify trends and implement further interventions if needed. Findings include:According to the Minimum Data Set (MDS) dated [DATE], Resident #1 had a Brief Interview for Mental Status (BIMS) score of 11 (moderate cognitive deficit). The resident required partial assistance with transfers and sit to stand, was always incontinent of urine, and was on supplemental oxygen therapy. Her diagnoses included: hypertension (high blood pressure), diabetes mellitus, chronic obstructive pulmonary disease and morbid obesity.The Care Plan for Resident #1, revised on 5/14/25, showed that she had self-care deficits and impaired balance during transitions, required assistance and or walking. The Care Plan documented she was at risk for falls related to impaired balance, and poor safety awareness. It directed staff that she had a fall on 11/2/25 and non-skid strips put in place to the floor in the bathroom on 11/4/25. On 5/23/25 therapy evaluated and resident now a transfer of 2 staff with front wheeled walker (FWW). It directed that on 8/14/25 employee education on falls and staff to toilet resident approximately every 2 hours using toilet in shower room or resident room. Fall intervention on 12/7/25 for a Hoyer (full-body mechanical lift) for all transfers, and staff education to use gait belt when transferring.Morse Fall Scale (risk assessment to help prevent falls) assessment dated [DATE] at 12:00 PM overestimates or forgets limits. Scoring high risk 45 or higher she scored 70.The following was documented in the Nursing Progress Notes:a. On 10/2/25 at 3:46 PM, Resident #1 continues to self-transferb. On 10/2525 at 9:57 PM, the resident was in the bathroom with staff and being transferred to the toilet. Staff could not hold the resident up and slowly put her to the ground. c. On 10/29/25 at 2:48 PM, Resident #1 was found to be self-transferring, reminded to get assistance. d. On 10/30/25 at 9:00 AM, Physical Therapy and Occupational Therapy (PT/OT) orders for strengthening and mobility e. On 11/2/25 at 11:49 AM, resident had a witnessed fall during transfer to the toilet, the resident lost her footing and went down. Non skid strips being put in the bathroom. f. On 12/7/25 at 3:52 PM, the resident was being ambulated by staff to the bathroom in her room, resident stated it felt like her legs were giving out and she was lowered to the floor. g. On 12/7/25 at 7:08 (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 0689 Level of Harm - Actual harm Residents Affected - Few	PM, Resident #1 had left distal fracture to the tibia, a splint was placed and she was non weight bearing. She was also found to have a urinary tract infection and was being transferred back to the facility.A Post Fall Evaluation dated 12/7/25 at 3:54 PM, showed that Resident #1 was ambulated by staff to the bathroom in her room and resident stated it felt like her leg was giving out. She leaned on the bathroom door then was lowered to the floor, stated left leg ankle pain with swelling to left ankle noted. The resident was sent to the emergency room.The emergency room Xray report dated 12/7/25, showed that Resident #1 had a fracture of the distal end of fibula and fracture of distal end of right tibia (bones in the lower leg.) A posterior splint was applied and the resident was sent back to the nursing home.A Major Injury Determination Form date of injury 12/7/25, showed the injury to be at the left distal fracture to tibia. The physician response concluded that after reviewing the circumstances, injury and prognosis of the patient, the injury sustained was a major injury. The document was signed on 12/10/25 at 11:54 AM.On 1/14/26 at 10:50 AM, Staff A Licensed Practical Nurse (LPN) said that she was the nurse on duty when Resident #1 had the fall on 12/7/25. When she came into the room, the resident was on the floor in the doorway of the bathroom, she was not wearing a gait belt, and her walker was in the bathroom. Staff A said that the resident was a one-assist, but she thought that most of the time, the aides would use two to transfer her.On 1/14/26 at 11:00 AM, the Administrator said they did not have a policy on gait belt use, but they go by the standards of care.In an observation on 1/14/26 at 12:20 PM, Staff C, Certified Nurse Aide (CNA) and Staff B transferred Resident #1 with the Hoyer mechanical list. Staff C and Staff B said that they had transferred the resident before her fall in December, and at that time, they used two people with a gait belt (GB), because the resident was large and they felt that it was safer with two.The floor in the bathroom of the resident's room did not have gripper strips applied.On 1/14/26 at 12:39 PM, Staff D, CNA said that she was working on 12/7/25 when Resident #1 had a fall in the bathroom. She said that when she came into the room, the resident was on the floor, and she did not have a gait belt applied. Staff D said that at times the resident would be weak and she would ask another staff member to assist her with the transfers. On 1/14/26 at 3:30 PM Staff E, Certified Nurse Aide (CAN) said that she was assisting Resident #1 into the bathroom on 12/7/25 and as she was entering the bathroom, the resident was holding onto a support bar but her legs gave out. She stated she didn't know if her feet gave out. Staff E said that she was behind the resident and when she started to go down, she tried to hold the resident by putting her arms around her, under her arm-pits. She was unable to keep her up, then lowered her to the floor. Staff E said that she hadn't transferred Resident #1 before and was told that the resident did pretty well with just one person assisting. Staff E was not familiar with the resident's care plan or how to access it for reference. Staff E acknowledged that she hadn't applied a gait belt on the resident before transferring her. She said that she had been educated on the use of gait belts and she knew she should have used one with Resident #1.On 1/15/26 at 11:00 AM, the Director of Nursing (DON) and Administrator said that Resident #1 changed rooms on 12/3/25 and when she did, they failed to implement the fall precaution of anti-slip strips in her new room. They were establishing a new process to ensure this step did not get missed again. The DON said that she had a one-on-one meeting with Staff E and provided a special meeting with all care staff regarding gait belt use.According to the Nursing Standard of Practice (provided by the Administrator), if a resident required care other than that established in the minimum standards, that care would be described in the resident's care plan. It would be the responsibility of each staff member to be knowledgeable of each resident care plan and to meet each resident individual needs. All residents requiring assistance with stand/pivot transfers and or ambulation would have a gait belt on for safety.