STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165366	A. Building B. Wing	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Mills Care Center	406 South Tenth Avenue East Lake Mills, IA 50450

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (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 0697 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review and staff interviews, the facility failed to promptly identify, intervene and notify the provider of an acute change in a resident's uncontrolled pain following a fall on 7/21/25 for 1 of 3 residents reviewed (Resident #1). On 7/21/25 at 4:00 AM, Resident #1 had a witnessed fall. When the nurse assessed her, she reported pain to her leg but had range of motion to her legs. After transferring the resident to the bed, the resident reported an increase in pain reporting it was the worst pain ever. The nurse faxed the physician instead of sending her for evaluation. The resident continued to put her call light on seven times between 4:50 AM to 5:15 AM reporting to staff severe pain. The nurse said she just needed to wait for the Tylenol to kick in, because it isn't quick acting. At 7:15 AM the next shift nurse sent the resident to the hospital Emergency Department (ED) due to yelling out in pain. The hospital ED records noted the resident had a comminuted left acetabular fracture with protrusion of femoral head in the pelvis. The facility reported a census of 48 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview of Mental Status (BIMS) score of 5 indicating severe cognitive impairment. The MDS include diagnoses of hypertension (high blood pressure), anxiety and monoplegia (paralysis of a single limb) of the upper limb affecting the left nondominant side. Resident #1's Care Plan with a focus area for pain documented an intervention dated 5/29/25 directed staff to notify the physician if interventions are unsuccessful or if current complaint is a significant change from my past experience of pain. Resident #1's Incident Report for the fall on 7/21/25 at 4:15 AM documented she complained of hip pain but kept switching left or right side. Resident #1's Pain Score in the Electronic Health Record at 4:32 AM documented a score of 10 on a scale of 1 to 10, 10 being the worst pain. On 10/14/25 at 4:25 PM Staff B, Licensed Practical Nurse (LPN) verbalized on the early morning of the fall she was working as an aide. Staff B reported Staff A, LPN came over the walkie and said she would need help getting Resident #1 up due to having to lower her to the floor. Staff B reported when she got to the room, Resident #1 was by the bathroom door on the floor. Staff B reported the resident was complaining of lots of pain at the time. Staff B reported when Staff A and her got Resident #1 up she was in pain but did take steps. She verbalized they got her in bed and she still was in pain. Staff B reported she asked Staff A if she was going to send her out and Staff A said she could not due to it being a different provider (meaning doctor) for the Resident #1. On 10/15/25 at 10:38 AM Staff D, LPN stated prior to Resident #1's fall, Staff D could not recall her ever complaining of pain. On 10/15/24 at 1:33 PM Staff C, Certified Nurses Aide (CNA) reported Resident #1 kept hitting her call light every 5 minutes or so because she was in so much pain. Staff C verbalized she reported it to Staff A. Staff C reported roughly 45 minutes after Resident #1 got into bed she finally settled down. Review of Resident #1's call light log documented she put her call light on seven times between 4:50 AM and 5:15 AM. On 10/15/24 at 2:40 PM Staff A, LPN reported the bed alarm was going off for Resident #1 and she heard it from the nurses station. Staff A reported Resident #1 was 3 feet away from the bed and the walker and wheelchair were next to the bed. Staff A verbalized she tried to get Resident #1 to wait but she wouldn't wait. Staff A reported Resident #1 was unsteady walking so she went right to her. Staff A reported she was walking behind Resident #1 on the left side and Resident#1 turned quickly toward the bathroom. Staff A reported she couldn't get behind Resident #1 and Resident #1 slipped and fell back against the door and facing Staff A. Staff A verbalized as Resident #1 was sliding to the floor she was supporting Resident #1's head. Staff A reported a little ways off the floor Resident #1 lost her footing and dropped to the floor about 2 feet from the floor. Staff A verbalized Resident #1 dropped to her left side with legs facing toward the bathroom. Staff A reported she can't remember for sure if Resident #1's legs were bent or not. Staff A reported Resident #1 sat herself up and leaned her back against the door. Staff A reported Staff B came in and Staff A talked about the machine to get Resident #1 up and Resident #1 started to try and get herself up. Staff A verbalized prior to Staff B coming in Staff A assessed range of motion on Resident #1. Staff A reported Resident #1 complained of pain to her legs. Resident #1 could lift and rotate her legs. Staff A reported she asked Resident #1 to point to where it hurt and Resident #1 pointed to the leg. Staff A reported Resident #1 could not rate the pain. Staff A reported no shortening noted at the time. Staff A reported she knew Resident #1 hit her leg. Staff A reported the pain was not a lot when moving Resident #1 and once in bed she rated it worse. Staff A reported Resident #1 verbalized it as the worst pain ever. Staff A reported that is why she documented the pain score at a 10. Staff A reported at the time of the fall the facility did not call the doctor with every fall. Staff A