STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165386	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Manor of Elma	407 9th Street Elma, IA 50628

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review the facility failed to implement a Care Plan chair alarm intervention for 1 of 3 residents reviewed for falls (Resident #3). The facility reported a census of 31 residents. Findings Include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 documented a Brief Interview for Mental Status (BIMS) of 2 out of 15, which indicated severe cognitive impairment. The MDS documented the need for substantial/maximal assistance (staff did more than half the effort) for transfers and walking up to 50 feet. The MDS also documented diagnoses of non-Alzheimer's dementia, anxiety, respiratory failure, and adult failure to thrive.The Care Plan created 2/18/25 revealed, Resident is at risk for falls. The Intervention initiated 2/24/25 and created on 3/6/25 revealed, Chair alarm placed to alert staff when I am self transferring. Review of the Witness Statement for Staff A License Practical Nurse (LPN) dated 4/30/25 at 11:45 AM documented on 4/25/25 she watched Resident #3 stand up impulsively from the wheelchair and immediately fall over. The statement lacked if the chair alarm was in place. During an interview on 8/26/25 at 3:12 PM with Staff C, Staffing Coordinator and Activities Director revealed she helped with Resident #3 fall on 4/25/25 and did not recall seeing the chair alarm in his wheelchair. During an interview on 8/26/25 and 4:14 PM with Staff D, Social Services Designee revealed she did not recall a wheelchair in alarm in place during Resident #3 fall on 4/25/25. During an interview on 8/28/25 at 12:59 PM with the Director of Nursing (DON) revealed if he had a chair alarm on his Care Plan that should of been in place at the time of the fall. She revealed she was not the Director of Nursing at the facility when the fall occurred. During an interview on 8/28/25 at 2:44 PM the Administrator revealed she would of expected the chair alarm to be used when Resident #3 fell, however it would of not of changed the outcome because it was an observed fall. Review of the facilities policy and procedure for Alarms, Voice Activated Devices, Monitoring Devices, last revised 4/25/25 instructed: The use of any type of alarming device, including audio devices (such as personal alarms, monitors and voice activated chair commands), used to alert staff of a change in position, will be assessed for appropriateness and continued effectiveness. (Alarming devices do not generally prevent a resident from falling but may alter staff of position changes with residents who have diminished cognition related to self-safety.)

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