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	04/09/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, resident and staff interviews, and facility policy review, the facility failed to ensure one of six residents reviewed remained free from a resident to resident physical altercation when a resident with severe cognitive impairment and a known history of aggressive behaviors (Resident #6) hit another resident (Resident #2). Three of six residents reviewed experienced fear from the Resident #6's aggressive behavior (Resident #2, Resident #4, and Resident #5). Resident #2 experienced increased anxiety, social isolation, a decline in nutritional intake, and fear following the incident. Resident #4 and Resident #5 expressed fear of Resident #6 and reported decreased activity participation due to Resident #6's behaviors. The facility reported a census of 32 residents.Findings include:1.Resident #6's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 2 out of 15, which indicated severe cognitive impairment. Per the MDS, the resident made herself understood and understood others. The MDS addressed the resident was independent for toileting, hygiene, dressing, ambulation and transfers. Per the MDS, the Resident #6 had no behaviors, did not wander, or reject care. The MDS included diagnoses of hypertension (when the pressure in your blood vessels is too high) Non-Alzheimer's Dementia, and osteoarthritis of the right knee, and the resident received antidepressant medication in the last 7 days.Resident #6's Significant Change MDS assessment dated [DATE] documented the resident had a BIMS score of 1 out of 15, which indicated severe cognitive impairment. Per the MDS, Resident #6 made herself understood and usually understood others. The MDS further revealed the resident had inattention which fluctuated (difficulty focusing attention, being easily distracted or keeping track of what was being said), disorganized thinking which fluctuated (rambling or irrelevant conversation, unclear or illogical flow of ideas or switching from subject to subject), hallucinations (experiences in the absence of real external sensory stimuli), and delusions (misconceptions or beliefs that are firmly held, contrary to reality). Per the MDS, Resident #6 had physical behavioral symptoms directed toward others (hitting, kicking, pushing, scratching, grabbing), verbal behaviors directed towards others (threatening others, screaming at others, and cursing at others,) and other behavioral symptoms not directed towards others (physical symptoms such as hitting, scratching self, pacing, rummaging, screaming, disruptive sounds). Per the MDS, Resident #6's behaviors significantly intruded on the privacy or activity of others, the resident rejected care 1 to 3 days, and the resident wandered 1 to 3 days. The MDS documented that the resident required partial to moderate assistance with dressing, transfers and ambulation. The MDS further revealed the resident required set up assistance with eating and personal hygiene. The MDS included diagnoses of hypertension, Non-Alzheimer's Dementia, and arthritis, and revealed Resident #6 received antidepressant medication in the last 7 days.Resident #6's Plan of Care with target dated 6/22/26 had a focus area for impaired cognitive function related to moderate dementia. An additional focus area with target date 6/22/26 revealed the resident was at risk for elopement/wandering related to memory/disorientation/decision making. Resident #6's Care Plan also included a focus area for psychotropic medication use for dementia diagnosis.The Plan of Care lacked interventions (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 0600 Level of Harm - Actual harm Residents Affected - Few	pertaining to the behaviors that were documented on the 3/17/26 MDS.The March 2026 Point of Care (POC) Response History documented behaviors on these dates and times:a. 3/13/26 at 9:59 PM: behavior observed, grabbing others, hitting others, physically aggressive towards others, accusing and cursing at others, frustration, and threatening to others.b. 3/15/26 at 1:09 PM: behavior observed included, in part, expressed frustration/anger at others.c. 3/20/26 at 9:59 PM: behavior observed included, in part, expressed frustration/anger at others.d. 3/23/26 at 9:57 PM: behaviors observed included grabbing others, hitting others, pushing others, grabbing others, scratching others, physically aggressive towards others, accusing of others, cursing at others, and expressed frustration/anger at others, and threatening others.e. 3/24/26 at 1:02 PM: behaviors observed included physical aggression, verbal behaviors, socially inappropriate behavior.The March 2026 Documentation Survey Report documented on 3/20, 3/23, 3/24, 3/25, 3/26, and 3/30, specific instances of behaviors including accusing others, cursing at others, expressing frustration/anger, screaming at others, threatening others, grabbing others, hitting others, physically aggressive, scratching others, pushing others, entering other residents rooms/space, agitation, anxious, restlessness, experiencing hallucinations/delusions, wandering, and verbalizing persistent false beliefs.The Health Status Note dated 3/23/26 at 2:15 PM revealed the resident was being disruptive to other residents while out in the living room and lobby, bossing them around. Other residents do not want her near them due to her confusion and her non-stop talking and her physical closeness to them. Resident has been redirected several times throughout the day by several staff without much success.Non-stop talking continues about changes needed to be made with this place, farm, [redacted], people and what is wrong with them, setting up committees, etc.The Health Status Note dated 3/23/26 at 4:40 PM revealed, .Non-stop talking and worrying about random things in the community: nursing home, staffing, police station, committees, etc.She was not able to stay on topic very long and would get lost in thought.The Incident Report Note dated 3/26/26 at 6:47 PM described, resident was in the hallway and misunderstood what 2 other residents were talking about and confronted them. Staff attempted to keep them apart. Res (Resident #6) slapped the other resident (Resident #2) in the arm and was yelling at her and combative with staff and very difficult to redirect. Res (Resident #6) was becoming more and more violent with staff and residents and verbally abusive towards both. The staff will attempt to keep these 2 residents (Resident #6 and Resident #2) apart.The Alert Note dated 3/27/26 at 4:21 AM stated that Resident #6 attempted to enter another resident's room, and was redirected to her own room.The Behavior Follow-up note dated 3/28/26 at 3:39 PM documented the resident was very difficult to redirect. Has been getting in staff and resident faces, and talking about getting a 2 by 4 and woopping <sic> people who don't shape up. She feels she owns this place. Very violent verbally and threatening .Attempted to elope (leave the facility) X3 (three times) before 2:00 PM.The Behavior Notes for Resident #6 documented the following:a. 3/29/26 at 12:16 AM: Resident out in lobby accusing staff of taking her belongings. CNA (Certified Nursing Assistant) had assisted her previously with finding her shoes. Staff attempted to redirect the resident back to her room. The resident refused and entered nurse's station. Writer attempted to reassure resident that all her belongings are in her room. Resident then started grabbing items and papers off of desk. Writer tried to redirect, but resident grabbed writers wrists and started to squeeze. CNAs got resident attention and she returned to lobby and sat quietly. Now resident again started grabbing items off of CNA's cart. Allowed until resident struck staff on buttocks by whipping chair pad. Resident then ambulated to front door. Writer approached and stood at door way. Resident walked away. Stopped and took out the residents sign out book which is a heavier book. Resident then turned an walker directly to writer, striking writer. When tried to remove book, resident then struck writer's face with closed fist. Staff then walked resident back to her room and assisted into bed.b. 3/30/26 at 2:30 AM: Resident was in the dining room trying to get into the kitchen. Doors were locked but she was aggressively pushing and trying to turn handle. This staff tried to redirect her and she picked up a fork and aggressively waved it at me saying that she was going to get a ball bat and hit me in the head. In addition to this she was also (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	trying to go out the fire door and pull the fire alarm. Eventually she was redirected to the living room and had ice cream, coffee and a cookie. This nurse sat 1:1 with her because she was trying to go back into the dining room and other residents are getting upset with her. She continued to talk about hurting others and that we need to watch out because we are next and she is going to hurt us.c. 3/30/26 at 3:10 PM: Swiping at staff unable to redirect. Picking up objects and hitting staff garbage can and cups. Unable to redirect. Active hallucinations of bank robbery, [NAME] and mayhem. Delusions that she owns everything, that she is the only one that can make choices and that everyone is her [NAME].The Alert Noted dated 3/31/26 at 4:38 AM documented the resident had a few moments of wandering into other rooms and was redirected by staff.The General Progress Note dated 4/1/26 at 2:58 PM documented, Resident currently in the office sitting at her desk with this writer for the last 30 minutes. Prior to this resident was in lobby verbalizing to staff walking by, visitors walking by and residents that we are all in danger, we all need to have guns to take care of those that are a danger to us because they are here to kill us, we should have the power to change things and make better. She thinks that we have law enforcement here and that we also need to include the FBI and that this is not a joke, and in the same breath thinking we are in the school and the kids have taken over because nothing was done. Been reminiscing with resident about previous career and family.The New Order Follow Up Note dated 4/1/26 at 6:13 PM revealed, Resident very difficult to redirect this afternoon. going in other resident rooms, verbally aggressive towards staff. in a very bad mood.During an interview on 4/3/26 at 12:50 PM with Staff A, Housekeeper, Staff A acknowledged that Resident #6 was able to ambulate independently throughout the facility and showed behaviors such as hitting, kicking, and throwing things at staff. Staff A explained the resident had verbal outbursts during meals and activities.Observation on 4/3/26 at 1:05 PM revealed Resident #6 ambulated in front of the nurses' station, and attempted to go into the activity that was going on in the main dining area. A staff member offered a cup of coffee and the resident sat down in a chair in front of the nurses' station. An interview was attempted with Resident #6. Resident #6 was upset that the cows were not being milked, and was not able to recall an incident on 3/26/26.Observation on 4/3/26 at 3:05 PM revealed Resident #6 sat at a desk in the Director of Nursing office, voiced the facility was hers, and that she would make sure that all staff and residents did what she said.On 4/7/26 at 2:00 PM, Staff B, Licensed Practical Nurse (LPN), stated that she worked on the night of the 3/26/26 incident between Resident #6 and Resident #2. Staff B explained that she heard some commotion in the west hallway and came out of the nurses station to investigate. By the time she got to the incident, other staff removed Resident #6 away from Resident #2. Staff B proceeded to do an assessment on Resident #2 and found a red mark on the left shoulder/upper arm area, and after a few minutes the red mark disappeared. On 4/7/26 at 2:42 PM, Staff D, CNA stated that Resident #6's behaviors had gotten a lot worse in the past couple of months and that other residents were fearful and scared of Resident #6.On 4/8/26 at 1:30 PM, Staff G, Registered Nurse (RN) acknowledged that the facility failed to put interventions in place after the 3/26/26 incident, and that the plan of care lacked interventions of behaviors that were identified on the 3/17/26 MDS.2. Resident #2's MDS assessment dated [DATE] documented the resident had a BIMS score of 15 out of 15, which indicated intact cognition. Per the MDS, the resident was able to be understood and understood others. The MDS addressed the resident was independent for personal hygiene, upper extremity dressing, and eating, and once in a motorized wheelchair was independent for mobility. The MDS assessment further revealed the resident had no behaviors, did not wander, and did not exhibit rejection of care. The MDS included diagnosis of Cerebral Palsy, anxiety, depression, and adjustment disorder.Resident #2's Plan of Care, target date 5/13/26, had a focus area that the resident enjoyed activities such as watching movies, listening to music, playing on tablet and going outside when weather permitted. Also enjoys some group activities such as BINGO, paddle wheel, arts and craft/coloring, and social hours and games. The resident's care plan also included a focus area for a history of trauma that may impact psychosocial functioning. The goal target date 5/13/26 revealed, (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Will seek assistance if feeling symptoms of traumatization and/or anxiety related to trauma.The Progress Note dated 3/26/26 at 10:10 AM documented that the patient shared discomfort with individuals who exhibit loud and aggressive behaviors, which has prompted her preference to spend most of her time alone in her room or outdoors. The patient's mental status during the session included a tearful affect and a depressed mood, with irritable interview behavior. The patient demonstrated openness and engagement in sharing her emotional experiences during the session, including discomfort around loud and aggressive individuals.Continued therapy sessions remain necessary to support her emotional processing to promote growth and autonomy.Encouraging participation in group activities and physical therapy will persist as integral to her holistic treatment.The Incident Report Note dated 3/26/26 at 6:34 PM present in Resident #2's Progress Notes revealed, Resident had an altercation with another resident and the other resident slapped her with an open hand on the left upper arm. Staff witnessed and had been attempting to separate them when it happened. Pain at the time of the incident. Possible injury/bruising in the future. Will attempt to keep the two residents separated.The Long Term Care (LTC) Progress Note dated 3/27/26 at 7:44 AM documented the resident had quite a bit of anxiety and lower mood. She stated she had situational/social anxiety and got stressed out and had to take her meals in her room. She didn't like crowds or large groups of people, which made her nervous. Feels mood has been better in the past. New orders were received to reduce her Wellbutrin (a prescribed antidepressant) and increase Vraylar (a medication to treat bipolar depression or as an add on for major depressive disorder) and add Klonopin (a medication used for panic attacks) 0.5 mg (milligram) every day as needed for anxiety.The Physician Visit Note dated 3/27/26 at 2:52 PM, resident seen by Dr. [Name Redacted] on rounds.assessed resident, reviewed progress notes and recent vitals. New orders to reduce bupropion (Wellbutrin), increase vraylar and Klonopin prn (as needed).The Social Service Note dated 4/7/26 at 1:31 PM, for follow up from incident on 3/26/26, revealed the following: [Resident #2] is voicing increased anxiety being around [Resident #6]. She is stating worry about going to activities during the day. [Resident #2] is still attending but stated [Resident #6] is disruptive during activities. [Resident #2] states she just doesn't want to get hit again. This writer will bring this back to the team and further discuss safety intervention options.The Progress Note dated 4/7/26 at 10:05 AM documented Resident #2 described ongoing anxiety about a resident at the home who exhibited unpredictable outbursts.The patient openly expressed thoughts and emotions about these issues.Observed that the patient's affect was tearful, with an anxious mood noted during the session.Her expressions as well as anxiety related to a certain resident behavior, signal the need for ongoing focus on emotional regulation and interpersonal strategies. On-going sessions are medically necessary to continue addressing the patient's anxiety and depression.Review of Resident #2's Point of Care Response History for activity participation record for March 2026 documented the resident attended group activities on 3/17, 3/19, 3/23, 3/24, 3/27, 3/30, and 3/31. Review of the Documentation Survey Report for March 2026 revealed from 3/1/26-3/25/26, Resident #2 participated in BINGO, arts/crafts, snacks, social hour, trivia, and games. From 3/26-3/31/26, Resident #2 participated in BINGO, games, music, and physical activity.Review of the Point of Care Response History for Nutrition for 3/1/26-3/31/26 revealed the following:a. 3/1/26-3/25/26: Documentation revealed Resident #2 ate 75 %-100% of meals for breakfast, lunch and dinner on 3/1/26, 3/3/26, 3/4/26, 3/6/26, 3/7/26, 3/12/26, 3/14/26, and 3/23/26.b. 3/26/26-3/31/26: Documentation revealed Resident #2 did not eat 75% of meals for breakfast, lunch, and dinner on 3/26/26, 3/27/26, lacked documentation of amount eaten for breakfast and lunch on 3/28/26 and 3/29/26. The resident also did not eat 75% of meals for breakfast, lunch, and dinner on both 3/30/26 and 3/31/26.Observation on 4/3/26 at 10:00 AM revealed Resident #2 in her room. The resident watched television, and sat in a motorized wheelchair.On 4/3/26 at 10:00 AM, Resident #2 explained the following about an incident that happened involving Resident #6 hitting Resident #2 on the left upper shoulder/arm leaving a red mark and it hurt. Resident #2 explained that she was afraid of Resident #6, (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	and stayed in her room due to not wanting to get hit again. Resident #2 stated that if she did come out for meals, she wore headphones and listened to music to drown out Resident #6's verbal outbursts during meals. Resident #2 stated that the facility Administrator indicated that the facility would attempt to keep Resident #6 away but couldn't promise anything. The resident felt like she was isolated to her room due to Resident #6's ability to independently ambulate around the facility. Resident #2 stated that she kept her door to the room closed all the time.Observation on 4/3/26 at 11:30 AM revealed Resident #2 came out of the dining room, wore a pair of white headphones with cellphone on her lap, and went straight to her room making no eye contact with anyone.On 4/3/26 at 12:50 PM, Staff A stated that when she cleaned Resident #2 room, she (resident) would start to cry because she felt she was not able to leave her room because she was afraid of Resident #6. Staff A explained that Resident #2 was very interactive with all staff and other residents and would socialize with them, but since the 3/26/26 incident Resident #2 stayed in her room more.Observation on these dates and times, revealed Resident #2 with her room door closed/shut: 4/3/26 at 1:15 PM, 2:20 PM, and 3:00 PM.On 4/7/26 at 11:15 AM, Resident #2 stated she was still scared of Resident #6, was afraid of getting hit again, and stayed in her room. Resident #2 stated that the primary care physician started a PRN (as needed) medication to help with the panic attacks and anxiety due to being hit by Resident #6.On 4/7/26 at 2:00 PM, Staff B, LPN acknowledged that Resident #2 only came out of her room for meals and wore a white pair of headphones with a cellphone in her lap. Staff B confirmed that Resident #2 would cry due to being scared of Resident #6 and would not make eye contact due to being afraid.On 4/7/26 at 2:30 PM, Staff C, CNA stated that Resident #2 was afraid of Resident #6 and would only come out for meals. Per Staff C, the resident would cry in the mornings not knowing what was going to happen and did not want to get hit again by Resident #6.On 4/7/26 at 2:42 PM, Staff D, CNA stated that Resident #2 was scared of Resident #6 and would cry in her room due to being afraid of getting hit by Resident #6 again. Staff D confirmed and verified that Resident #2 would only come out of her room now for meals. Staff D explained Resident #2 had panic attacks when saw Resident #6.On 4/7/26 at 3:03 PM, Staff E, CNA stated that Resident #2 would cry in her room due to being scared and fearful of getting hit again by Resident #6. Resident #2 would come out of her room wearing a white pair of headphones and a cellphone in her lap and will not make eye contact with anyone.On 4/7/26 at 3:38 PM, Staff F, CNA stated that Resident #2 was fearful and scared of Resident #6 and would come out for some small group activities and meals. Staff F explained the resident wore a white pair of headphones and a cell phone in her lap and would not make eye contact with anyone. Per Staff F, Resident #2 had declined a lot of activities which was a decline, and would sit in her room and cry due to not wanting to get hit again by Resident #6.On 4/7/26 at 4:50 PM, the facility Administrator confirmed that Resident #2 got hit by Resident #6 on 3/26/26 and that Resident #2 still came out for meals and some activities, but participation in activities had declined due to being hit by Resident #6. The Administrator stated that the primary care physician reviewed Resident #2 medications and a new medication was started as a PRN for panic attacks and anxiety.On 4/8/26 at 2:20 PM, Resident #2 Primary Care Physician (PCP) confirmed Resident #6 was seen on 3/27/26 after the incident that occurred on 3/26/26. Resident #2 stated that they were having some anxiety with going out to the dining room for meals and being around large groups. The PCP explained the following: Not until after doing round table discussions did they become aware of the incident between Resident #6 and Resident #2 on 3/26/26, and by adding a PRN medication for Resident #2 would assist in getting through this incident.Observation on 4/8/26 at 5:10 PM revealed Resident #2 sat in the dining room facing east with a white pair of headphones on.3. Resident #4's MDS assessment dated [DATE] documented the resident had a BIMS score of 15 out of 15, which indicated intact cognition. The resident was able to be understood and understood others. The MDS revealed the resident used a walker/wheelchair for mobility, had no behaviors, did not wander, and did not reject care. The MDS included diagnosis of Cerebral Palsy, depression, hypertension, and diabetes mellitus.The Plan of Care for Resident #4, target date 6/10/26, revealed the resident enjoyed (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	independent activities such as word searches, coloring in adult coloring books, and watching movies/listening to music in [Resident #4's] room or friends room. Resident also enjoys group activities such as BINGO, arts and crafts, listening to live on site music, playing card games, and facility outings when offered.On 4/7/26 at 1:00 PM, Resident #4 stated that she was scared and afraid of Resident #6. Resident #4 explained the incident on 3/26/26 happened right outside of her room door. Resident #2 was visiting with another resident across the hall. Resident #6 came up beside Resident #2 and hit Resident #2 on the left shoulder/upper arm area and said I will hit you harder if needed because you are not working hard enough. Resident #4 stated that Resident #2 started to cry, yell, and scream. Staff came running out of rooms, assisted Resident #6 away from Resident #2, and took Resident #2 to her room. Resident #4 said that she would only come out for meals and does not attend activities like she used to due to Resident #6's verbal outburst and behaviors. Resident #4 kept her room door open to see if Resident #6 would come into her room, and would chase out if needed.On 4/7/26 at 2:00 PM, Staff B, LPN, explained Resident #4 was scared of Resident #6. On 4/7/26 at 2:30 PM, Staff C, CNA explained Resident #4 was scared of Resident #6 and would only come out of her room for meals. Staff C explained Resident #4 would leave the door to her room open to make sure if Resident #6 attempts to come in then Resident #4 could chase her out.4. Resident #5's MDS assessment dated [DATE] revealed the resident scored 13 out of 15 on a BIMS exam, which indicated intact cognition. The MDS revealed the resident was able to be understood and understood others. The MDS revealed Resident #5 was independent with a walker for mobility, the resident had no behaviors, did not wander, and did not reject care. The MDS included diagnosis of anemia, heart failure, hypertension, anxiety, and depression.The Plan of Care for Resident #5, target dated 6/7/26, stated that resident enjoyed most group activities such as BINGO, social hours, some games, and independent activities such as word puzzles, reading, watching television, and some arts/crafts.On 4/7/26 at 12:00 PM, Resident #5 stated she was scared of Resident #6 and did not want to come out of her room due to Resident #6 becoming irate and upset. The resident explained Resident #6 would yell and scream during activities and the meal service and would hit anyone. Resident #5 explained that due to this behavior from Resident #6, Resident #5 did not come out for activities.The Abuse, Prevention, Reporting and Investigation Policy with a revision dated 9/25 revealed the following purpose: To provide professional care and services in an environment that is free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subjected to abuse by anyone, including, but not limited to.other residents.or other individuals. The policy included the following definition of physical abuse: Includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment.