STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165389	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Luke's Helen G Nassif Transitional Care Center	1420 Unitypoint Way Cedar Rapids, IA 52402

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interviews, clinical record review, and facility policy review, the facility failed to ensure a resident was treated in a dignified manner for 1 of 5 residents reviewed (Residents #3). The facility reported a census of 41 residents.Findings include: The Minimum Data Set (MDS) dated [DATE] identified Resident #3 was cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 out of 15, and had the following diagnoses: Chronic diastolic (congestive) heart failure, diabetes mellitus and morbid obesity. The MDS also identified the resident required substantial staff assistance for chair/bed to chair transfer and to walk ten feet.The Care Plan dated 2/23/2026 identified the resident at risk for falling related to impaired mobility, weakness, debility, GI (gastrointestinal) infection, obesity, and pain. The Care Plan goal reflected Resident #3 would transfer and ambulate with assistance while minimizing the risk of falls. The intervention initiated 3/4/26 revealed, Ambulate resident with assist of 1 with wheelchair, walker in room and to nurses station and to dining room. During an interview on 3/2/2026 at approximately 3:45 PM, Resident #3 advised she had one Certified Medication Assistant (CMA) identified as Staff A, that had made very rude comments to her. Resident #3 shared on 2/16/26 she felt weak and asked Staff A to assist and push their wheelchair to the dining room and the staff member responded you need to do it yourself. When the resident told the worker they couldn't they were too weak right now Staff A responded can't push [resident], [resident] are too heavy for me to push. Resident #3 advised she felt humiliated. Resident #3 described another incident in which a different staff member was assisting her and Staff A walked by and said, you know she can do that herself, and the resident responded, No that is not in [resident's] plan. Staff A reportedly responded back, you need to mind your own business [Staff A] wasn't talking to [Resident], [Staff A] was talking to staff. Resident #3 shared she felt very disrespected by Staff A. Review of a typed document provided by facility revealed the Director of Nursing and Assistant Director of Nursing (ADON) had spoken with the resident on 2/23/26. The document revealed the resident had stated that a staff member had spit in the garbage can in the dining room and it was beside her while she was eating. She lost her appetite and pushed her food away. On 3/04/2026 at 12:26 PM, Staff C, Certified Nursing Assistant (CNA) reported during a shift change meeting she heard Staff A tell one of the nurses she had told Resident #3 they were too heavy for her to push and that she probably should not have said that and she wanted to apologize to the resident. Review disciplinary action taken by the facility with Staff A revealed, in part, the following: A 2/23/26 Disciplinary Report Form revealed, in part, Tone when speaking to a resident and felt it was clashing, demanding .Spit in a garbage can.On 03/05/26 at 1:50 PM, Staff A was queried, and acknowledged did say the resident was too heavy to push, acknowledged shouldn't have said that, explained tried to apologize, and the resident didn't want to hear it. Staff A explained she tried to push the residents to do what they could to help themselves. That is why most of them are here. To get better and return home. It's not a personal thing but Staff A explained thought this resident and [Staff A] just rubbed each other the wrong way. Per Staff A, the resident thought [Staff A] was being rude or mean and in their own way, Staff A explained tried to be assertive and push her to get better. Staff (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165389	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Luke's Helen G Nassif Transitional Care Center	1420 Unitypoint Way Cedar Rapids, IA 52402

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A explained the incident when they spit in the garbage, that was unfortunate. Staff A explained just went to the nearest garbage to expel it and didn't really pay that much attention, put their face down to the garbage and covered it with their hand as it spit. Per Staff A, was not a disrespectful thing and was not something could control. Staff A advised she did not ever remember telling the resident that something was none of her business. On 3/05/2026 at 2:14 PM, an interview was held with the Director of Nursing (DON). She advised was aware of a clash of personalities between Resident #3 and Staff A. The DON advised being aware of several incidents between the resident and staff member. The DON advised, in part, Staff A had now been told she had to make it to somewhere private or to the staff bathroom before spitting. The DON advised the way Staff A can come across can be misconstrued as being harsh or demanding. Staff A had been talked to and advised to work on her tone and presentation. The DON advised it was her expectation that staff are professional, kind and upbeat and that they follow the facility policies and procedures.Review of the undated facility document titled, [Facility Name] admission Agreement : Resident [NAME] of Rights revealed, A. Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. 1. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment, that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165389	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Luke's Helen G Nassif Transitional Care Center	1420 Unitypoint Way Cedar Rapids, IA 52402

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on clinical record review, policy review, and resident and staff interviews the facility failed to follow physician orders by not giving medications within 1 hour before to 1 hour after the ordered time for 3 of 3 residents reviewed (Residents #6, #21, and #27). The facility reported a census of 41 residents.Findings include:1.Resident #6's admission record documented an admission date of 1/29/26 and a discharge date of 2/27/26. The Order Recap Report included medications to be given up to 2 times per day. The Medication Admin Audit Report for February revealed medications not given within the 2 hour time frame it was to be given (1 hour before to 1 hour after the ordered time) on 4 separate days. The clinical record lacked documentation of provider notification.2. Resident #21's admission record documented an admission date of 2/19/26 and a discharge date of 3/4/26. The Order Recap Report included medications to be given up to 4 times per day. The Medication Admin Audit Report for February and March revealed medications not given within the 2 hour time frame it was to be given (1 hour before to 1 hour after) on 10 separate days. The clinical record lacked documentation of provider notification.3. Resident #27's admission record documented an admission date of 2/20/26. The resident had not been discharged . The Order Recap Summary Report included medications to be given up to 3 times per day. The Medication Admin Report for February and March revealed medications not given within the 2 hour time frame it was to be given (1 hour before and 1 hour after) on 7 separate days. The clinical record lacked documentation of provider notification. During an interview on 3/5/26 at 9:57 AM, the resident reported his medications could be late. He reported his insulin was given around the time he ate, but his pills could be more variable.During an interview on 3/5/26 at 1:16 PM, the Director of Nursing (DON) explained staff have 1 hour before and 1 hour after the time the medications are ordered to give the medications. If the medications are early or late for any reason, the provider should be notified. She would expect staff to follow the policy.The facility policy titled Medication Administration last revised on 6/30/23 directed staff to give the medications one hour prior to one hour after the scheduled administration time. If the administration occurs outside of these time frames, physician notification is required.