STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165449	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spencer Post Acute Rehabilitation Center	711 West 11th Street Spencer, IA 51301

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 - Minimal harm or potential for 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 clinical record reviews, staff interviews and policy review, the facility failed to put effective interventions in place and provide adequate nursing supervision to prevent accident and injuries from falls for 1 of 1 residents reviewed (Resident #2). Resident #2 had a risk for falls with a history of repeated falls. Resident #2 had his thirteenth fall on 3/15/25 in a three-month period of time. Findings include: Resident #2's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 2, indicating severe impaired cognition. The MDS listed Resident #2 as substantial/maximal assistance with rolling left and right, sit to lie, toilet transfer, supervision for toileting and chair/bed to chair transfer. The MDS described Resident #2 as frequently incontinent of urine. Resident #2's MDS included diagnoses of Parkinson's disease, cerebrovascular accident, diabetes mellitus, and renal insufficiency. The Facility Incident Reports (IR) documented revealed Resident #2 fell on [DATE], 12/27/25, 12/2925, 12/31/25, 1/2/26, 1/6/26, 1/7/26, 2/4/26, 2/25/26, 3/8/26, 3/12/26, 3/13/26 and 3/15/26. The Care Plan with a target date of 10/2/2025 revealed Resident #2 was at risk for falls related to history of falls and decreased safety awareness. The interventions directed the following:12/23/25 Room free from clutter,12/27/25 No current intervention listed,12/29/25 Resident placement closer to nurses station to monitor when resident is ready to get up, so staff is able to assist before resident attempts to self-transfer,12/31/25 Hospice consult,1/2/26 Continue to be out by nurses station for increased supervision,1/6/26 Resident to be seen on facility rounds by provider on 1/7/26, 2/4/26 Transferred to his wheelchair and brought to the recliner near the nurses station for close monitoring,2/25/26 Resident was trying to help another resident and fell. Staff to be mindful when Resident #2 is sitting in the common area with other residents who need assistance.3/9/26 Resident #2 to be toileted before lunch,3/12/26 Will reach out to hospice and see if they can provide more activity throughout the day to help with supervision.3/13/26 Resident #2 to be toileted prior to supper,3/15/26 Urinalysis obtained and started on antibiotic. An Incident Report (IR) dated 1/2/26 at 5:00 p.m. identified an unwitnessed fall in his room. The IR indicated Resident #2 was found in his room on the floor. The IR stated the staff heard yelling coming from Resident #2's room and saw him picking himself up off the bathroom floor. The IR indicated Resident #2 had self transferred to the toilet without a walker or assistance. Resident #2 was trying to go to the bathroom without assistance or utilizing the call light. Immediate action taken to reeducated Resident #2 on the use of the call light and asking for assistance. Resident #2 is oriented to self only. Continue to encourage staff to keep Resident #2 near the nurses station for increased supervision. The notes on the IR indicated Resident #2 was oriented to self only, dementia progression, short recall and impulsiveness. An IR dated 1/7/26 at 7:50 pm identified an unwitnessed fall in the common area. The IR indicated the nurse heard someone yelling and went up to the lounge area to see what happened. Resident #2 was found lying on his left side on the floor, Resident #2 was unable to give a description of what happened. Resident #2 received two abrasions to the left elbow. This nurse and certified nurses assistant (CNA) assisted Resident #2 back to his feet and then put him in the recliner. Staff kept Resident #2 within a visual view after this incident. The IR indicated (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 - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 was seen on nursing home rounds and started on antibiotics, lasix (water pill) and a 2 liter fluid restriction. An IR dated 2/25/26 at 8:05 pm identified an unwitnessed fall in the common area. The IR indicated Resident #2 was sitting in recliner in the common area and another resident asked for help, Resident #2 stood up to help the other resident and he lost his balance and fell landing on his right side. Resident #2 received a skin tear to the right elbow. Intervention for staff to be mindful when Resident #2 is sitting in the common area with other residents who need assistance. Interview on 3/26/26 at 12:58 pm with Staff D, LPN, Staff D stated we had Resident #2 out in the living room a lot for increased supervision. Staff D stated the expectations for Resident #2 was to have visual supervision. Staff D stated she doesn't remember where the other staff were at during this time. An IR dated 3/8/26 at 12:15 pm identified an unwitnessed fall in the common area. The IR indicated this nurse was sitting at the nurse's station on the phone when she turned her head and saw Resident #2 was in mid-fall out of the left side of his recliner. Intervention Resident #2 to be toileted prior to lunch. Interview on 3/26/26 at 1:11 pm with Staff E, LPN stated that she was on the phone talking to another family member and she turned her head and that is when she saw him in mid fall out of his recliner. Staff E stated he self transfers constantly, he wants to go home, bathroom or to bed. Staff E stated we put him in the wheelchair and he will propel himself around, sometimes he is okay with that. The expectation now is to keep at least one staff member out there, before it was just to make sure he was out in the living room area. Staff E stated he wouldn't be out there very long without someone. We would have other staff out there and if he tried to get up, they would call us for help. An IR dated 3/15/26 at 7:45 am identified an unwitnessed fall in the rehab gym. The IR indicated this nurse returned from administering medications to another resident down the hall to find Resident #2 was not in the dining area but his wheelchair was. Resident #2 was found in the therapy room on his knees and leaning on the therapy bed with his arms. (like in a praying position). The therapy gym is connected to the dining room by 3 short hallways. Interview on 3/26/26 at 1:29 pm with Staff C, Licensed Practical Nurse (LPN), revealed Resident #2 was at the dining room table in his wheelchair. She stated when she returned from another resident's room he wasn't in the wheelchair. She stated they found him in the therapy gym. Review of the facility's policy named Fall Management System revised 10/2020 revealed the facility is committed to promoting resident autonomy by providing an environment that remains as free of accident hazards as possible. Each resident is assisted in attaining or maintaining their highest practicable level of function through providing the resident adequate supervision, assistive devices and functional programs as appropriate to prevent accidents. It is the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. On admission / re-admission to the facility each resident is assessed using the Fall Risk Evaluation to determine his/her risk for sustaining a fall.Residents with a Fall Risk Evaluation score of 10 or above are considered high risk and will have an individualized care plan developed that includes measurable objectives and timeframes. The care plan interventions will be developed to prevent falls and will consider the particular elements of the assessment that put the resident at risk.When a resident sustains a fall, a physical assessment will be completed by a licensed nurse, with results documented in the Nursing Progress Notes. The Attending Physician and family/ responsible party shall be notified of the fall and the resident status. The Interdisciplinary Team (IDT) will review the circumstances surrounding the fall and implement actions to reduce the incidence of additional falls and minimize potential injury. IDT review of the fall incident will include but not limited to determining probable causal factors, environmental factors, resident medical condition, resident behavioral manifestations, and medical or assistive devices that may contribute to the fall. The IDT will also review fall patterns for residents with multiple/repeat falls. Results of the IDT review will be documented in the resident's Clinical Record.Resident's existing care plan will be updated. The care plan interventions will address those elements determined by investigation as probable causal factors that contributed to the fall. Residents will be reassessed for fall risk with any significant change in resident's condition or the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	development of behavioral symptoms that increases the resident's risk for falls; as well as with a comprehensive MDS and quarterly thereafter. Interview on 3/26/26 at 10:30 am with the DON stated the expectation is that staff were to have visual supervision on Resident #2, and they are to read the resident's kardex's and careplan for updated interventions/communication when they are on shift.