STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165460	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Karen Acres Care Center	3605 Elm Drive Urbandale, IA 50322

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. Based on observations, clinical record review, staff interview, and facility policy review, the facility failed to follow the Care Plan for proper and safe transfer for 1 of 1 residents reviewed, resulting in a fall (Resident #27). The facility reported a census of 28 residents. Findings include: The Minimum Data Set (MDS) Assessment of Resident #27 dated 3/5/25 identified a Brief Interview for Mental Status score of 15, which indicated intact cognition. The MDS documented the resident had suffered no falls since the last assessment. The Care Plan, last reviewed 6/9/25, identified a Focus Area of Activities of Daily Living (ADL) Self Care Performance. The Care Plan directed staff that Resident #27 required assistance with transfers, and ambulation with a gait belt (a belt worn around the resident's waist to assist the caregiver to provide support and stability) and a walker. The Care Plan identified an additional Focus Area of high risk for falls related to history of frequent falls. Resident #27 score 75 on the Morse Fall Scale (a clinical tool used to assess a resident's risk of falling) dated 2/26/25, classifying her as a very high risk of falls. Scoring for Morse is as follows: Low Risk 0-24 Moderate Risk 25-44 High Risk, 45 or higher The Incident Note dated 5/28/25 authored by the Staff B, Licensed Practical Nurse documented Resident #27 was being assisted to the dining room when the resident indicated she needed to use the restroom. Staff A, Certified Nurse Aide (CNA) stopped at the shower room on the way to the dining room. The note documented the CNA stopped to move an object from the entrance and the resident followed her and lost her balance and fell. The fall was witnessed and she hit her left hand resulting in a skin tear. No other injuries. (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
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/25 at 2:31 pm, Staff A, CNA stated she was assisting Resident #27 to the shower room. She stated when she got to the shower room, she stopped to unlock the door and the shower chair was blocking access to the toilet. Staff A verified she let go of the gait belt around Resident #27's waist to move the shower chair out of the way. The resident then attempted to follow the CNA and lost her balance and fell. On 6/10/25 at 2:35 pm, an observation of the shower room revealed a closed curtain to the left immediately upon entering the room. Behind the curtain the shower chair was observed perpendicular to the toilet, blocking access as described. On 6/10/25 at 3:55 Staff B, LPN stated the fall was witnessed. She stated the CNA told her she had moved away only for a moment and the resident attempted to follow her and that is how she fell. On 6/10/25 at 4:14 pm, Staff C, CNA was observed walking Resident #27 from the restroom back to her recliner. Staff C was not using a gait belt during the ambulation/transfer. At 4:17 pm, Staff C stated Resident #27 required the assistance of one staff member for transferring and walking. She stated she should have used a gait belt and failed to do so. On 6/11/25 at 9:05 am, the Director of Nursing stated staff should always use gait belts for transfers and ambulation. The undated facility document titled Gait Belt Use identified the following: Point 1: Each nursing staff member will have a gait belt readily available for use when on duty. Point 2: Gait belts are to be used to transfer unsteady, heavier, poor weight bearing residents, or who require assistance to ambulate.