

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165462	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/21/2025
NAME OF PROVIDER OR SUPPLIER  Sunny Hill Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1708 Harding Street Tama, IA 52339	

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 - Actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (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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(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 - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, resident interview, family interview, staff interviews and policy review, the facility failed to ensure a safe transfer for 1 of 3 residents reviewed (Resident #5) . Staff attempted to transfer from the recliner to wheel chair and did not utilize a gait belt (Resident #5). The resident fell and sustained a non-displaced humeral fracture (left arm). The facility reported a census of 48 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #5 revealed diagnosis of heart disease, stroke, hemiplegia or hemiparesis referring to left side paralysis. The MDS coding reflected dependence on transfer from a bed or chair. The Brief Interview of Mental Status (BIMS) assessment scored 12 out of 15 indicated moderately cognitive impairment. The MDS documented that the resident was last admitted from a stay at a general hospital on 7/5/25. The Care Plan for Resident #5 documented focus area with initiated date of 12/13/24 for Resident #5 revealed potential for falls secondary to generalized weakness, decreased mobility, and poor safety related to history of stroke, noted left side is flaccid. The goal, not to sustain major injury should a fall occur. The Care Plan also included Resident #5 had impaired function, use of a wheel chair, able to use a hemi walker (provides stability of one hand) with transfer and with assistance as needed. A mechanical lift can be used, if the resident is weak, lift required to and from bed. A Witness Statement dated 6/27/25 at 2:35 PM by CNA Staff C, documented went in Residents #5 room with Staff D, to transfer resident from recliner to wheelchair , resident sat before wheel chair was placed behind him, resident was having trouble pivoting his weak side, fell to the floor on his weak side, nurse called and other aids to assist helping resident up. Resident #5 seemed to be ok after being assessed by the nurse. A Witness Statement dated 6/27/25 at 2:45 PM by CNA Staff C, documented, additional information, included, Resident #5 in recliner chair, went to get him up and both (CNA Staff C &amp; D) got on each side of the resident, went to lift under arm, resident stood, asked resident to turn and sit, he couldn't move his foot and bad side and sat too soon, was still holding under left side and he fell with me landing on top of him on his left side, other staff rolled him to his back, left arm was stuck under him until rolled over. A Witness Statement dated 6/27/25 at 2:35 PM by CNA, Staff D, documented was working with new CNA, Staff C and were transferring Resident #5 from recliner to the wheel chair, the resident had trouble pivoting his weak side and resident sat too soon before the wheel chair was in place. Resident #5 fell to the floor on his weak side, summoned a nurse and another aide to assist helping resident up. Relayed, Resident #5 seemed okay after being assessed by the nurse. A Witness Statement dated 6/27/25 at 2:15-2:45 PM by CNA, Staff E, documented was summoned for help, walked in and Resident #5 was on the floor leaning on CNA, Staff C, said needed help getting Resident #5 off the floor. Called for the nurses, RN, Staff A responded, came in and CNA, Staff D said Resident sat before the wheel chair was behind him and fell to the ground. RN, Staff A asked if he was lowered and both said no, the resident was too heavy. RN, Staff A did the exam, CNA's used a mechanical lift to assist residents up. The Incident report dated 6/27/25 at 2:35 PM documented by Registered Nurse (RN) Staff A relayed Resident #5 was being assisted out of his recliner to get into his wheel chair, all assistive devices in place, two staff assisting, resident pivoting to get into the wheel chair, resident was trying to sit down, the wheel chair was not quite in place. The aids were able to ease the resident to the floor onto his left, weak side. Resident #5 complained of left shoulder pain, is stroke side and is normal. Range of Motion (ROM) to lower extremities and right arm also were Within Normal Limits (WNL), did not hit head when eased to the floor. Staff assisted him up with the use of mechanical lift into wheel chair, ROM assessed again and all WNL, no complaints of any increase in pain, said it was his fault, he didn't wait, reassurance given and discussed possibly trying therapy again, replied would try anything, vital signs assessed and noted. Resident voiced, did not stand good for the girls. A Progress Note dated 6/27/25 at 5:16 PM written by RN, Staff A relayed resident #5 was being assisted out of his recliner to wheelchair, all assistive devices in place, two staff assisting when Resident #5 pivoting to sit, wheel chair was not quite in place. CNA's able to ease to the floor onto left side, weak side, did complain of pain to left shoulder area but, is the stroke side and is normal, ROM was WNL, did not hit head when eased to the floor, assisted up with mechanical lift in wheel chair, ROM again WNL, no complaints increase in pain. Resident #5 said felt at fault, didn't wait, reassurance given and discussed trying therapy again, Vital signs assessed, provider notified, emergency contact notified included therapy discussion and therapy notification. A Progress Note dated 6/27/25 at 8:30 PM written by RN, Staff B documented, called to room at 7:50 PM, resident in severe pain with any touch or movement to</p>		