STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165481	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayflower Home	616 Broad Street Grinnell, IA 50112

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. Based on clinical record review, written resident statement, resident interviews, staff interviews and policy review, the facility failed to ensure residents were treated with respect and dignity for 2 of 6 residents reviewed for dignity (Residents #1 and Resident #9). The facility reported a census of 27 residents. Findings include: 1. The Minimum Data Set (MDS) assessment, dated 1/9/26, documented Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS reflected the resident had diagnoses to include progressive neurological conditions, Parkinson's disease and anxiety disorder. The Care Plan, initiated 1/19/26, included a focus area the resident had Parkinson's affecting functional ability and mental thought process as evidenced by visual hallucinations and resident is at risk for impact on other functions such as constipation, urinary retention, vision, etc. The goal was the resident will remain free of further complications related to Parkinson's disease through the review date. The Interventions included: Adaptive devices as recommended by therapy, monitor for safe use. Administer psychotropic medications as ordered by the physician. Monitor/document side effects and effectiveness. Follow up with neurology as indicated. Continue discussing changes and medication management with facility provider/medical director to determine effective use and need.Monitor/document ability to perform activities of daily living (ADLs). Report any improvement or decline to medical director. Provide emotional support, encouragement. Encourage resident to vent feelings about disease. The Care Plan further included a focus area the resident had impaired functional ability with impaired range of motion to bilateral lower extremities and contributing diagnosis of Parkinson's disease. Resident needs assistance with self care and mobility tasks. The goal was for resident to improve current level of functional ability with participation in therapy services and activities of daily living (ADL's) through review period. The interventions included: Ambulation/transfers: Assist of 1, supervision with front wheeled walker. Bed mobility: Assist of 1 with completing tasks.Dressing: Assist of 1 with completing tasks. Allow the resident to attempt to complete independently prior to assisting. Personal hygiene: Assist of 1 with completing tasks. Toilet use/hygiene: Assist of 1 with completing tasks. During an interview 4/7/26 at 9:50 AM, Resident #1 reported Staff A, Certified Nursing Aide (CNA), had appeared frustrated with him while performing care for the resident. Resident #1 stated Staff A would appear frustrated when the resident told Staff A the resident was unable to perform a task on his own. Resident #1 stated Staff A worked the overnight shift and on several occasions Staff A would tell the resident to do tasks on his own, telling the resident Staff A had observed the resident do it before. Resident #1 stated he can do more during the day, but at night he cannot do as many things on his own given his diagnosis of Parkinson's disease. Resident #1 stated he tried to explain this to Staff A, the disease process, and Staff A would just tell the resident he observed him do it before. Resident #1 stated Staff A would help him, but would act like he didn't want to, and would ask the resident why he couldn't do the task on his own. Resident #1 stated when he would push his call light and if Staff A was working, Staff A would tell the resident he couldn't come in every 5 minutes and would ask the resident why he was using his call light. Staff A responded to the resident's call light one night and told the resident when he came into the room he was not dealing with this today. Staff A would have (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a frustrated tone of voice with the resident. Resident #1 stated he did not feel he should be treated that way. Resident #1 recalled an incident in January, on the night of the 22nd, when the resident pushed his call light, Staff A came into the resident's room and the resident told Staff A he needed changed, and Staff A said I am not dealing with you today. Resident #1 stated Staff A tossed the resident's blankets onto the resident and told the resident to straighten them out himself. The resident stated he felt like Staff A was frustrated with him every time he came in to respond to the resident's call light. Resident #1 stated he had stress and anxiety about Staff A working and coming in to help him, he had anxiety when Staff A worked. The resident stated he couldn't sleep well when Staff A worked. The resident stated he would have anxiety every time he pushed his call light and would hope it was not Staff A who responded. The resident advised he filed a grievance and reported these concerns with Administration, Staff A had not provided care to the resident since January 22nd of 2026. Resident #1 stated when Staff A provided care for him, Staff A would look at the resident with disdain. Resident #1 stated Staff A saw the resident in the hallway recently and looked at the resident with the same disdain and walked away. Resident #1 stated he reported his concerns to the Administrator on the 23rd of January, 2026. Review of the facility resident grievance form revealed Resident #1 completed a written grievance on 1/23/26. Resident #1 documented the reason for the grievance was disrespect of him or more residents by Staff A. When Staff A assisted him into bed, Staff A just threw the covers on him and said you cover yourself. If the resident has to use the bathroom in the middle of the night, Staff A begrudgingly gets up to help him. Staff A has answered the call light and when he sees it is Resident #1 he says he is not dealing with the resident tonight. Resident #1 wrote Staff A treats him with very little compassion. 2. The MDS assessment for Resident #9, dated 2/27/26, documented a BIMS score of 15, indicating intact cognition. The resident had diagnoses to include progressive neurological conditions, Multiple Sclerosis (MS), anxiety disorder and depression. The Care Plan for Resident #9, initiated 2/28/24, included a focus area the resident is at risk for psychosocial well-being problem and not meeting emotional, intellectual, physical and social needs due to requires assistance with self-care and mobility secondary to diagnosis of MS. The goal was the resident will identify coping mechanisms and increase out of room participation and prevent self-isolation problems through the review date. The interventions included: Allow the resident time to answer questions and to verbalize feelings, perceptions and fears.Encourage participation from resident who depends on others to make own decisions. Consult with: Social services, psych services; resident continues to decline. During an interview 4/6/26 at 2:35 PM, Resident #9 stated there is one staff member who is not kind to her and does not treat her well, this is Staff A, CNA. Resident #9 stated Staff A is rude to her. Staff A works the overnight shift usually. Resident #9 stated Staff A talks to her in a rude and obnoxious way. Staff A will make a face at her sometimes and say Yes (her name), or what do you want (her name). Resident #9 stated Staff A acts like he does not want to work here or be here. Resident #9 stated Staff A makes her feel he does not want to help her. Resident #9 stated Staff A has a bad attitude, he is rude and has rolled his eyes at her. During an interview 4/7/26 at 1:05 PM, Staff B, CNA, stated she had worked with staff who were not as respectful as they should be with residents, this is specifically one staff person, Staff A. Staff B stated she is aware of residents who do not want Staff A to provide care for them, Resident #1 and Resident #9 are two of these residents. Resident #9 advised Staff B that Staff A is rude to her, had made sarcastic comments to her and had tone in his voice. On the night of 1/22/26, Staff B worked with Staff A on the overnight shift, from 10 pm to 6 am. Staff B recalled during the shift she provided care to Resident #1 and then Staff A just came into the resident's room without being asked, Resident #1 was a 1 person assist. Staff A tossed Resident #1's blankets on his legs. Staff B stated she had not asked Staff A for assistance prior to Staff A coming into the resident's room. Staff B had helped Resident #1 back to bed and was getting him into his bed from the bathroom when Staff A walked into the room. When Staff A came in, Resident #1 looked upset, like he did not want Staff A in the room. When the resident saw Staff A, his face totally changed, he seemed upset. (continued on next page)

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Staff A would tell Resident #1 something and the resident would say something back, it felt like it was children back and forth bickering. Staff C stated Staff A had a sarcastic tone with Resident #1. Staff C felt Staff A's tone was sarcastic and inappropriate with Resident #1. During an interview 4/8/26 at 8:40 AM, Staff D, RN, stated she recalled working the overnight shift on 1/22/26 and recalled working with Staff A and Staff B. Staff D stated when she first went in to meet Resident #1 and responded to a call light, he was very appreciative of her and told her thank you for being so nice to him. Resident #1 told Staff D there was a staff member, a CNA, Staff A, who was not nice to him. The resident said he thought Staff A did not like him. She recalled helping the resident to the bathroom with the other CNA working that night, Staff B. The resident was very kind, he was not combative or upset and did not display any behavioral concerns. He was kind and easy to redirect. She recalled helping the resident another time that night when he pushed his call light, she went in and then Staff A came in after her. When Staff A came into the room, there seemed to be tension between Staff A and the resident. Staff D could tell there was something between them or that something had happened between them. The resident was very kind to Staff A and thanked him for taking care of him, but Staff A did not respond and was quiet with the resident. Staff A did not really respond to the resident. The other CNA came in and Staff D left the room. During an interview 4/8/26 at 3:05, Staff E, Social Services, stated she did talk to other residents after Resident #1 filed his grievance. Staff E stated Resident #9 has said previously she did not like Staff A and said he is too sarcastic. Resident #9 is a two staff person assist with her care and stated although she would rather Staff A not provide care for her, she is okay with this taking place. Resident #9 did not give specific examples of Staff A being sarcastic. Staff E stated Staff A had not provided care to Resident #1 since 1/22/26, after Resident #1 filed the grievance with his concern regarding Staff A. During an interview 4/9/26 at 8:30 AM, Staff A, CNA, stated he began employment at the facility in July of 2025. Staff A stated he currently works the overnight shift and had for several months. Staff A stated he rarely had issues with the residents, other than three residents who have issue with him, including Resident #1 and Resident #9. Staff A stated Resident #9 does not like him. Staff A stated with Resident #1, he does not provide care to him anymore. Staff A stated Resident #1 was a resident with behaviors and with behavioral residents he can be stern and to the point. Staff A stated Resident #1 screamed loudly at night in January, and screamed loudly the first night Staff A worked with him. Staff A stated he did ask the resident at times what do you need, when the resident pushed the call light. Staff A stated he liked to have another staff in the room with him when he did care for Resident #1, even though Resident #1 was a one staff assist for care, this was due to what he felt was behavioral issues with the resident and he was not comfortable being in the room alone with him. Staff A stated Resident #1 would have some delusions and would use his call light often, sometimes 5-10 times in 20 minutes. Staff A stated he kept it strictly business with Resident #1. He would ask the resident to do things first, ask him to try, if he said no, would then help him. Staff A stated Resident #1 started getting rude with him and then told Staff A he was rude to the resident. Staff A stated the week of the incident of January 22nd, Resident #1 had behaviors during the night and did not sleep well and would be up most of the night. He would push his call light all the time. Staff A stated he would tell Resident #1 to give him a minute, that he had other residents to help. That week of the incident the resident lunged toward him, but not that night. The night of the 22nd, Staff A worked with Staff B, CNA. Staff A noted (continued on next page)

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