STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165484	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Luke Lutheran Nursing Home	1301 Saint Luke Drive Spencer, IA 51301

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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 - Immediate jeopardy to resident health or safety 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 observations, clinical record review, facility policy review and staff interviews the facility failed to ensure residents needing a mechanical lift were provided safe and appropriate transfers to prevent injuries for 1 of 1 residents reviewed (Resident #54). This failure resulted in the resident falling out of the mechanical lift during a transfer and obtaining injuries and therefore causing an Immediate Jeopardy to the health, safety, and security of the residents. The facility failed to prevent further falls by following the care plan and implemented interventions for 1 of 1 residents reviewed (Resident #70). The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of August 16, 2025 on August 28, 2025 at 10:32 a.m The Facility Staff removed the Immediate Jeopardy on August 28, 2025 through the following actions:Notification to Nursing Staff on private Facebook page. Reminder to staff that if a sling needs readjustment that they need to place the resident back into bed or the chair while making adjustments before proceeding with transfer. Completed on 8/16/2025Education: All nursing staff educated on Smart Lift Operating Instructions. Furnished instructions for review and acknowledgment of understanding by staff. Completed on 8/18/2025. Assessments: All residents utilizing a mechanical lift were re-sized to ensure properly sized slings are being used for each resident. All residents were correctly sized. Notice of correct sling sizing placed by each resident room via a magnet for staff notification. Sizing of slings completed by Unit Managers on 8/27/2025.EZ Lift Slings1.The EZ Lift Slings stay with the resident, and in the resident's room.2.The EZ Lift Slings will be labeled with the resident's name.3. Residents will be sized for correct sling usage according to the sizing guide.4. Re-sizing will occur when needed by the charge nurse/unit managers according to the sizing guide.5. Magnets with matching colors to the sizing guide will be placed outside the resident rooms to identify what size lift sheet to use. EZ Way Sling Sizing Charts placed at each nurses' station. 8/27/2025.Education: Assigned all staff to watch video via CE Solutions (EZ Way Smart Lift Training Video). Assigned on 8/27/2025.Notification to Nursing Staff on a private Facebook page to educate staff on not locking the brakes when lifting or transferring a resident. Those employees that don't have Facebook access education provided with in-person or one-one education. Completed on 8/28/2025 User/Operating Manuals attached to each lift for staff reference if needed along with a reminder to not lock the brakes during transfers. Completed on 8/28/2025Nursing management will randomly monitor staff competency for safe transfers.All PRN nursing staff will be required to watch Training Video before being allowed to work the next scheduled shift. The scope lowered from a J to G at the time of the survey after ensuring the facilityimplemented education and their policy and procedures. The facility identified a census of 68 residents. Findings Include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #54 documented diagnoses of Alzheimer's Disease, heart failure and anemia. The MDS showed a Brief Interview for Mental (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Status (BIMS) score was not completed as resident is rarely or never understood. Review of Progress Notes revealed the following: On 8/16/25 at 9:32 a.m., facility requesting patient to be seen in Emergency Department (ED) for evaluation due to fall from mechanical lift that was above that height. On 8/16/25 at 9:38 a.m., Certified Nursing Assistant (CNA) getting the resident out of bed with mechanical lift, they stated there was a kink in the sling that they tried to fix and she fell to the side onto the floor. She did not hit her head, but did hit her left shoulder. On 8/16/25 at 1:11 p.m., new orders received and noted 8/16/25 new diagnosis bilateral sacral body fractures. On 8/16/25 at 1:12 p.m., resident leaves facility via ambulance at 7:45 a.m., to go to the ED. Returns to the facility at 12:10 p.m., via facility van. Review of the medical chart revealed Resident #54's weight on 8/15/25 was 141 pounds. Review of the facility investigation dated 8/18/25 revealed the following information: Resident is dependent on the facility staff for all Activities of Daily Living (ADL's) and require the use of mechanical lift for transfers. On 8/16/25 two CNA's were getting ready to transfer Resident #54. Upon interview with both staff members, they had placed the sling under Resident #54. Attached the appropriate loop device to the hanger bar with the leg portion of the sling crossed and double looped (using the bigger loop as a safety net) in case the first loop failed. After beginning the transfer, they noticed that the hanger bar was not level and that the loop on the right side had moved and folded upon itself. The nurse aide stated that she fell before they could even do anything. The 2nd loop was also unattached. In review of the lift sheet itself it was in good condition with loops not fraying or thinned. The resident was using the appropriate size lift sheet (large) at the time. Resident was sent to the emergency room for evaluation out of precaution. She was not exhibiting any signs of pain or injury at the time of the fall. She did wince with the left arm movement. A CT scan was performed and found to have severe osteopenic disease and closed fracture of sacrum. Review of facility provided report dated 8/16/25 at 7:10 a.m., revealed the following information: Injuries rule out left shoulder sent to hospital for evaluation following fall Under notes witness statement on 8/19/25 at 10:02 a.m., Staff G, CNA and Staff H, CNA revealed the following: We noticed the hoyer was slanted weird at the top, Staff H reached up to fix it and it slipped off the machine. As a result Resident #54 slid out of the hoyer lift and fell to the floor on her left side. We called for the nurse immediately. Review of hospital Discharge Plan dated 8/16/25 at 11:24 a.m., revealed resident had a fall from a mechanical lift at the facility and fell approximately four feet. Following CT imaging revealed bilateral sacral body fractures as suspected. Recommendations based on orthopedic consultation revealed (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	conservative management as the patient is not a surgical candidate. Pain management with existing morphine regimen from nursing home. Review of Major Injury Form dated and signed by the physician 8/18/25 revealed the following information: Resident up in hoyer, kink in sling causing loop to slide off, staff attempted to fix sling. Resident fell out of the side onto the floor. X was marked in front of after reviewing the circumstances, injury, and prognosis of the patient, I believe the injury sustained is a major injury. Interview on 8/26/2025 at 10:15 a.m., with Resident #54's family member revealed the resident had a fall from the mechanical lift. Resident #54's family revealed they had spoken to the CNA that was in the room when the fall happened. Resident #54's family member revealed the CNA was transferring resident with mechanical lift and the other staff was supposed to use a clip for safety before transferring her to her bed and the staff didn't use it and that is what caused the resident to fall from the lift. Resident #54's family revealed the resident went to the ED and the resident had fractures in her lower region but was unsure of exactly where. Interview on 8/26/2025 at 10:56 a.m., with Staff H revealed her and Staff G were assisting resident #54 with the mechanical lift transfer. Staff H explained that they were getting resident up and when they hooked up the hooks to the mechanical lift they hooked up all four hooks onto the lift. Staff H stated the one strap on the front did not get hooked all the way and when noticed that she was going to put the lift back down and it went the opposite way and came unhooked and the resident fell to the floor. Staff H revealed she should have lowered her right back down onto the bed and fixed the hook and re-lifted her up. Staff H revealed the staff do not use a particular size lift sheet size and it was our fault. Staff H explained she had learned her lesson and didn't want this to ever happen again. Interview on 8/26/2025 at 1:08 p.m., with Staff G revealed her and Staff H were assisting Resident #54 with a mechanical lift. Staff G stated she lifted the resident in the mechanical and noticed there was a kink in the sheet. Staff H went to straighten it out and it fell off and the resident fell to the floor. She further revealed the resident was sent to the hospital for an evaluation. Staff G explained she used a large lift sheet underneath her but was unsure of what was under her when they lifted her that day. Staff G explained if a large was not available then she would use a medium lift sheet. She explained the sheets go by dimensions and weight of the person. Observation on 8/27/2025 at 9:57 a.m., of Staff A, CNA and Staff B, CNA assisting resident #54 with transfer from wheelchair to bed. Staff A and Staff B assisted the resident to place the sling underneath her in the wheelchair. Staff locked the wheels on the mechanical lift and hooked up the sling to the mechanical lift. With the mechanical lift wheels still locked, staff lifted resident out of the wheelchair and moved over to the bed and lowered down until comfortable onto the bed. Interview with Staff A and Staff B revealed the staff just picks a sling that fits the resident. Staff A explained the staff just pick a sling that fits the resident and they use a size medium or a size large for Resident #54. Staff B explained the aides usually just try and pick a sling that fits around the resident's shoulder and that's not too big. There isn't a size assigned to the resident that she is aware of. Staff A confirmed there is no book that she is aware of that has a chart to help the staff pick a lift sheet for the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 8/27/2025 at 12:43 p.m., with Staff C, CNA and Staff D, CNA transfer Resident #11 into bed. Staff D told Staff C to lock the wheels on the mechanical lift. Staff C locked the wheels on the mechanical lift and hooked the resident's lift sheet to the mechanical lift. Staff D with mechanical lift wheels still locked raised Resident #11 up and unlocked the wheels and placed him onto this bed. Staff D explained they use a medium lift for this resident as he is not a giant man and it goes around his shoulders nice. Interview on 8/27/2025 at 1:54 p.m., with the Director of Nursing (DON) revealed she understood the situation to have happened as Staff G and Staff H were transferring Resident #54 and the lift sheet came loose and was coming off the mechanical lift and they wanted to push it back down and the sheet came off and the resident fell to the floor. The DON revealed the lift sheets stay with the residents in the facility. The DON confirmed she felt the resident was in the right lift sheet size during the transfer. The DON explained after the fall the facility changed the sling size for Resident #54 to a medium sling as that was a better fit for her. The DON revealed the Business Office Manager (BOM) does the sling sizing for the residents. The DON explained the BOM was a CNA for twenty plus years and she did the sizing but has not had any education regarding how to size the lift sheets. When asking the DON how do the CNA's and other staff members know the appropriate size lift sheet to use for the mechanical list she replied I don't know as there was nothing in writing for them to refer to. Review of the mechanical lift instruction manual with a revision date of 5/5/25 revealed the following information: The wheels of the mechanical lift should never be locked when lifting or lowering a patient. Sling sizing chart within the manual revealed the sling size large weight of the patient range is 190-320 pounds. Review of facility provided policy titled Safe Lifting and Movement of Residents with a revised date of February 2014 revealed the following information: Staff responsible for direct resident care will be trained in the use of manual and mechanical lifting devices. Staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques. Enough slings, in the sizes required by residents in need, will be available at all times. Interview on 8/27/2025 at 1:54 p.m., with the DON revealed she felt the facility did everything they could to prevent the fall and she has been doing education since the fall occurred. 2. Resident #70's MDS assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 3, indicating severely impaired cognition. The MDS documented Resident #70 required supervision or touching assistance with toileting (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity). The MDS included diagnoses of dementia, Parkinson's disease and anxiety disorder. Resident #70's fall investigation dated 5/31/25 documented the staff left Resident #70 unattended by staff in the bathroom. When staff returned to Resident #70's room, she was ambulating unattended (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and fell. The intervention put in place at the time of the fall documented staff to not leave Resident #70 unattended in the bathroom. Resident #70's Care Plan under safety date 5/31/25 directed staff to not leave her unattended and alone in my bathroom. Resident #70's fall investigation dated 7/31/25 documented the resident fell in the bathroom when washing her hands. The Fall Scene Investigation Report completed by Staff G, Certified Nurses Aide documented she left Resident #70 unattended at the bathroom sink to go into the room to get her wheelchair and the resident fell. It further documented the root cause was the resident was left unattended and staff not using a gait belt. On 8/28/2025 at 9:52 AM, the Director of Nursing reported staff are made aware of care plan changes with a care plan alert and it is at the nurses station to follow. Staff should not have left Resident #70 unattended in the bathroom. The facility policy titled Falls-Clinical Protocol dated 8/10/2008 documented staff and physicians will identify pertinent interventions to try to prevent subsequent falls. It lacked documentation of follow up to ensure interventions are being done.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, resident interviews, and staff interviews the facility failed to respect each resident's dignity throughout all care and services provided to 6 out of 22 residents reviewed (Resident #5, #44, #54, and #80). The facility reported a census of 68 residents.Findings include:1.The Minimum Data Set (MDS) assessment dated [DATE] for Resident #5 documented diagnoses of dementia, vision impairment and anxiety disorder. The MDS showed the Brief Interview for Mental Status (BIMS) score of 00, which indicated severe cognitive impairment. The MDS also showed Resident #5 required partial/moderate assistance for hygiene, bathing and toileting.In an interview on 8/27/25 at 11:29 AM Staff I, Certified Nursing Assistant (CNA) reported they witnessed Resident #5 attempting to exit the bed when Staff C, CNA entered the resident's room without knocking, flipped on the light, failed to introduce herself then flung the resident's feet in bed and told her to stay in bed. 2. The MDS assessment dated [DATE] for Resident #44 documented diagnoses of Alzheimer's Disease, anxiety disorder and pain unspecified. The MDS showed the BIMS score assessment unable to be completed. The MDS also showed Resident #44 dependent for toilet hygiene, bathing, and dressing. In an interview on 8/27/25 at 11:29 AM Staff I, CNA reported while transferring Resident #44, she became incontinent of bowel movement which Staff C, CNA commented, in the presence of the resident, Are you fucking kidding me? 3.The MDS assessment dated [DATE] for Resident #54 documented diagnoses of heart failure, dementia and seizure disorder. The MDS showed the BIMS score of 6, which indicated severe cognitive impairment. The MDS also showed Resident #52 dependent for toilet hygiene and lower body dressing. On 2/10/25 at 12:00 PM Staff I, CNA reported Resident #54 voiced she felt another CNA was upset at her because they didn't get her up for supper. While Staff I and Staff C, CNA worked to get the resident up for supper, in the presence of the resident, Staff C talked about why staff didn't like the resident.4. The MDS assessment dated [DATE] for Resident #80 documented diagnoses of heart failure, dementia and malnutrition. The MDS showed the BIMS score of 4, which indicated severe cognitive impairment. The MDS also showed Resident #80 required substantial/maximal assistance for hygiene and dressing. On 2/10/25 at 12:00 PM Staff I, CNA reported while in the presence of Resident #80, Staff C stated that she believed the resident would pass away soon. In an interview on 8/27/25 at 11:29 AM Staff I, CNA witnessed Staff C, CNA rapidly removed Resident #80's shirt which caused the resident to elevate her voice. Staff C informed Staff I the resident suffered from gout. Staff I reported Staff C, knowing the condition of the resident, failed to use a method that could have possibly avoided discomfort. Staff C then stated to the resident, you're fine. Staff I reported, Staff C didn't ask the resident if she was okay. Observation on 8/27/25 at 2:57 PM of Staff C's personnel file showed an untitled document dated February 21, 2025 recorded the following:We have received some complaints concerning the care you are providing to the residents. Careful on how you talk to residents or about them in front of the residents and your co-workers. It is my experience that all residents are treated in a kind and considerate manner, and that they are always treated with dignity and respect in all interactions. You need to explain what you are doing to the resident while providing cares so they know what you are doing and so you don't come across as being rude or rough. The document was signed by the Administrator and Assistant Director of Nursing. An untitled policy last revised November 2016 identified the resident has a right to be treated with respect and dignity including the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.In an interview on 9/2/25 at 3:06 PM, the Director of Nursing (DON) reported she expected staff to treat all residents with dignity and respect. The DON reported submitting all information regarding Staff C, had no further documentation regarding Staff C, and couldn't recall if other incidents were reported.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on personnel file review, facility policy review and staff interview the facility failed to meet requirements for Dependent Adult Abuse Mandatory Reporter Training for 1 of 5 employees reviewed (Staff H). The facility identified a census of 68 residents.Findings include:Review of Staff H, Certified Nursing Assistant (CNA) personal file revealed Dependent Adult Abuse Mandatory Reporter Training certificate dated [DATE]/22. The file also revealed Staff H repeated the training on [DATE]. Review of timecards showed Staff H worked the following dates without being certified in Adult Abuse Mandatory Reporter Training: [DATE]/[DATE]/25 The Nursing Facility Abuse prevention, Identification, Investigation and Reporting policy dated [DATE] identified training of employees upon initial employment, each employee shall be provided with a copy of the facility's policies and procedures relating to abuse identification and reporting requirements. Within 6 months of hire, each employee shall be required to complete an initial 2 hour training course provided by the Iowa Department of Human Services relating to the identification and reporting of dependent adult abuse. Each employee will take one hour recertification training within three years of the initial training and every three years thereafter. In an interview on [DATE] at 2:14 PM, Staff E, Licensed Practical Nurse (LPN) reported staff are required to be certified in Dependent Adult Abuse Mandatory Reporter Training. When asked about the facility's process to ensure all staff stay current in training, Staff E stated, I don't know if there's a process or how they handle that. In an interview on [DATE] at 6:03 AM, the Director of Nursing (DON) acknowledged that Staff E worked with residents while certification in Dependent Adult Abuse Mandatory Reporter Training had expired. The DON stated, Staff E should have taken the class sooner. She worked a couple of shifts but is now certified.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on clinical record review, observation, staff interview and facility policy review the facility failed to provide privacy of a body during personal cares (Resident #11 and #54). The facility reported a census of 27 residents.Findings include: 1. Observation on 8/27/2025 at 12:43 p.m., Staff C, Certified Nursing Assistant (CNA) and Staff D, CNA assisted Resident #11 into bed. During the transfer with the mechanical lift, staff failed to close the curtains to provide privacy during the transfer. 2. Observation on 8/27/2025 at 9:57 a.m., revealed Staff A, CNA and Staff B, CNA assisted Resident #54 into bed. During the transfer with the mechanical lift staff failed to close the curtains to provide privacy during the transfer. Review of the facility policy titled Resident Right Guidelines undated revealed close the door to the room when privacy is appropriate. Draw window curtains as well as the privacy curtain between beds. Provide privacy for the resident during cares. Interview on 8/27/2025 at 1:54 p.m., with the Director of Nursing (DON) revealed staff should have the curtains closed when performing transfers.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, facility policy review and staff interviews the facility failed to protect residents from the use of physical restraint that the resident could not remove on their own (Resident #54). The facility reported a census of 68 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #54 documented diagnoses of Alzheimer's Disease, heart failure and anemia. The MDS showed a Brief Interview for Mental Status (BIMS) score was not completed as resident is rarely or never understood. Observation on 8/25/2025 at 1:32 p.m., revealed a positioning device behind Resident #54's left side of her back under the fitted sheet. Observation on 8/27/2025 at 9:57 a.m., revealed Staff A, Certified Nursing Assistant (CNA) and Staff B, CNA assisted Resident #54 into bed. After Resident #54 was laying in bed. Staff B removed a positioning device from the closet and placed it under the fitted sheet and pressure relieving device behind her left side of her back. Staff finished assisting the resident and left the room. Review of Facility provided policy titled Use of Restraints dated 11/1/19 revealed the definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's condition and this restricts his or her typical ability to change position or place, that device is considered a restraint. Interview on 9/2/2025 at 2:44 p.m., with the Director of Nursing revealed the wedge should not have been under the sheet.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility record review, staff interviews and facility policy review the facility failed to report allegations of abuse to the Iowa Department of Inspections & Appeals and Licensing (DIAL) within 2 hours of an allegation of abuse for 4 of 4 residents reviewed for abuse (Resident #5, #44, #54, and #80). The facility reported a census of 68 residents. Findings include:1.The Minimum Data Set (MDS) assessment dated [DATE] for Resident #5 documented diagnoses of dementia, vision impairment and anxiety disorder. The MDS showed the Brief Interview for Mental Status (BIMS) score of 00, which indicated severe cognitive impairment. The MDS also showed Resident #5 required partial/moderate assistance for hygiene, bathing and toileting.In an interview on 8/27/25 at 11:29 AM Staff I, reported they witnessed Resident #5 attempting to exit the bed when Staff C, CNA entered the resident's room without knocking, flipped on the light, failed to introduce herself then flung the resident's feet in bed and told her to stay in bed. 2. The MDS assessment dated [DATE] for Resident #44 documented diagnoses of Alzheimer's Disease, anxiety disorder and pain unspecified. The MDS showed the BIMS score assessment unable to be completed. The MDS also showed Resident #44 dependent for toilet hygiene, bathing, and dressing. In an interview on 8/27/25 at 11:29 AM Staff I, CNA reported while transferring Resident #44, she became incontinent of bowel movement which Staff C, CNA commented, in the presence of the resident, Are you fucking kidding me? 3. The MDS assessment dated [DATE] for Resident #54 documented diagnoses of heart failure, dementia and seizure disorder. The MDS showed the BIMS score of 6, which indicated severe cognitive impairment. The MDS also showed Resident #52 dependent for toilet hygiene and lower body dressing. On 2/10/25 at 12:00 PM Staff I, CNA reported Resident #54 voiced she felt another CNA was upset at her because they didn't get her up for supper. While Staff I and Staff C, CNA worked to get the resident up for supper, in the presence of the resident, Staff C talked about why staff didn't like the resident.4. The MDS assessment dated [DATE] for Resident #80 documented diagnoses of heart failure, dementia and malnutrition. The MDS showed the BIMS score of 4, which indicated severe cognitive impairment. The MDS also showed Resident #80 required substantial/maximal assistance for hygiene and dressing. On 2/10/25 at 12:00 PM Staff I, CNA reported while in the presence of Resident #80, Staff C stated that she believed the resident would pass away soon. In an interview on 8/27/25 at 11:29 AM Staff I, CNA witnessed Staff C, CNA rapidly removed Resident #80's shirt which caused the resident to elevate her voice. Staff C informed Staff I the resident suffered from gout. Staff I reported Staff C, knowing the condition of the resident, failed to use a method that could have possibly avoided discomfort. Staff C then stated to the resident, you're fine. Staff I reported, Staff C didn't ask the resident if she was okay. In an interview on 8/27/25 at 11:29 AM, Staff I, CNA reported the same day she witnessed the allegations, and additional allegations, she typed a note and submitted the note under the office doors of the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON). When asked if allegations were reported to other staff, Staff I stated, I didn't report it. I was new. I didn't know what nurse to trust. I didn't want the story to go around differently than what happened. When asked what she would do if she witnessed possible abuse today, Staff I reported she didn't know because she reported to all three administration staff and no one did anything. Staff I reported no one followed up with her. Approximately a week later, I went to the Administrator's office. Staff I stated, the Administrator said he had six days to follow up. No one followed up.Observation on 8/27/25 at 2:57 PM of Staff C's, CNA personnel file showed an untitled document dated February 21, 2025 recorded the following:We have received some complaints concerning the care you are providing to the residents. Careful on how you talk to residents or about them in front of the residents and your co-workers. It is my experience that all residents are treated in a kind and considerate manner, and that they are always treated with dignity and respect in all (continued on next page)

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	165484	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interactions. You need to explain what you are doing to the resident while providing cares so they know what you are doing and so you don't come across as being rude or rough. The document was signed by the Administrator and ADON.In an interview on 8/28/25 at 9:50 AM, the ADON reported she didn't recall all the details of the meeting with the Administrator and Staff C, CNA. The ADON stated, it was all the way back in February, that's hard to remember. The ADON reported meeting with Staff C about her gruff voice, then made plans for Staff C's work assignments to be in the same hall as the ADON's office. When asked to provide documentation related to resident care incidents and the meeting with Staff C, the ADON reported she doesn't keep documentation of any incident. The ADON explained once she reported to the Administrator or DON, she destroys her documentation. In an interview on 8/28/25 at 10:28 AM, when asked if the Administrator received any typed letter in February regarding Staff C, CNA and concerns with resident care. The Administrator stated, I remember getting something but I don't know if it was one of the letters we already gave you, or something else, or I may have gotten rid of it. When asked if he is required to keep documentation, the Administrator stated, I don't know am I? When asked if the [DATE] documentation concerning Staff C occurred in reaction to receiving a concern, the Administrator stated, yes but I don't remember what was said. I looked through my notes and I didn't see anything. In an interview on 9/2/25 at 3:06 PM, the DON reported submitting all information regarding Staff C, had no further documentation regarding Staff C, and couldn't recall if other incidents were reported. The DON stated, I know we are supposed to report allegations of abuse within two hours, but I already gave you all the documentation I had. I don't remember anything else that was reported. The Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated October 2022 identified all allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting allegations of abuse to the Administrator, or designated representative. All allegations of Resident neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the Iowa Department of Inspections and Appeals, not later than two hours after the allegation is made, if the events that cause the allegation result in serious bodily injury, or not later than twenty-four hours if the events that cause the allegation involve neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation, but do not result in serious bodily injury.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and facility policy, the facility failed to ensure bed hold notices were signed by the residents and or the resident's responsible person when residents transferred out of the facility. The chart also lacked documentation regarding notification and residents or resident's responsible person's decision to enact a bed hold for 2 of 2 residents reviewed (Residents #3 and #23). The facility reported a census of 68 residents.Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 documented reentry to the facility on 8/19/25 for a short term hospital stay. Review of the Clinical Census report for Resident #3 revealed the following information:a. 4/28/25 - discharged to acute care hospital b. 4/29/25- readmission c. 8/15/25- discharged to acute care hospital d. 8/19/25- readmission Review of the Progress Notes for Resident #3 revealed the following:a. 4/25/25 at 12:19 PM- admitted to the hospital for dehydrationb. 8/19/25 at 2:18 PM- admitted to the hospital Review of Resident #3's chart on 9/2/25 at 9:14 AM showed the bed hold form for 4/28/25 lacked a signature of the residents or resident's responsible person. The facility also lacked a bed hold form for 8/15/25. The Nurse's Notes lacked documentation regarding bed hold communication of the resident or resident's responsible person for 4/28/25 and 8/19/25. 2. The MDS assessment dated [DATE] for Resident #23 documented diagnoses of coronary artery disease, hypertension and Non-Alzheimer's Dementia. The MDS showed the BIMS score of 5, indicating severe cognitive impairment. Review of Resident #23's Census listing revealed the following information: 8/25/25- transfer date 8/24/25 8/26/25- readmission date 8/26/25 Review of Progress Notes revealed the following: 8/24/25 at 11:17 p.m., Resident transferred to the emergency room (ER) for assessment. 8/25/25 at 2:26 a.m., admitting resident to local hospital for monitoring. 8/26/25 at 2:15 p.m., resident returns from the hospital. Review of the medical chart contained a bed hold but the bed hold lacked any decision on if the resident representative wanted the bed hold or not. The Progress Notes lacked information obtained from the family regarding if they contacted for a bed (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hold for the resident and lacked any signatures of receipt of notification. Review of facility provided policy titled Bed-Holds and Returns dated 4/21/25 revealed all residents or representatives are provided written information regardless of the facility and stated bed-hold policies which address holding or reserving a resident's bed during periods of absence including hospitalizations. Multiple attempts to provide the resident representative with notice should be documented in cases where staff were unable to reach and notify the representative timely. Interview on 9/2/2025 at 2:44 p.m., with the Director of Nursing (DON) revealed the facility sends a bed hold with the resident to the hospital with the paperwork the facility prints out. The next day the Business Office Manager prints off a bed hold and mails it to the family. The facility then scans the bed hold into the chart. The DON verifies the chart lacks notification of the family regarding the bed hold. The DON verifies if the bed hold is scanned in then the notification has been sent to the family but does not know if the bed hold was ever completed for this resident. The DON revealed it was her fault that nothing was charted on the day after the resident went to the hospital.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and the Resident Assessment Instrument (RAI) Manual, the facility failed to accurately document and submit an accurate resident Minimum Data Set (MDS) Assessment for 2 of 3 residents reviewed (Resident #6 and #10). The facility reported a census of 68 residents.Findings include: 1. Resident #6's MDS assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 13, indicating intact cognition. The MDS included diagnoses of anxiety disorder, depression, and schizophrenia (a serious mental illness that affects how a person thinks, feels and behaves). The MDS coded the resident as a no for a Preadmission and Resident Review (PASRR) Level II (a comprehensive evaluation that follows a positive Level I screening to determine if an individual has a mental Illness (MI) or intellectual/developmental disability (IDD) and whether they need a nursing facility (NF) placement and specialized services for their condition). Resident #6's current PASRR dated 4/21/23 documented Level II approved with specialized services. On 8/28/2025 at 8:45 AM Staff F, Unit Manager reported Resident #6 is a Level II PASSAR. She reported it should be coded on the MDS as a Level II and is an error if not. On 8/28/2025 at 9:54 AM the Director of Nursing (DON) reported it should be coded on the MDS for Resident #6's Level II PASSAR. She reported the facility does not have a policy for MDS assessments. She reported the facility follows the RAI Manual. The RAI manual dated October 2025 documented in Chapter 3 page A-32 to code yes if the PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition. 2. Resident #10's MDS assessment dated [DATE] documented a BIMS score of 15, indicating intact cognition. The MDS included diagnoses of seizure disorder or Epilepsy, bed confinement status and malnutrition. The MDS further documented the bed rails used as a physical restraint (any manual method, physical, or mechanical device, material or equipment attached or adjacent to the resident's body the individual cannot remove easily which restricts freedom of movement or normal access to one's body). Resident #10's Care Plan documented she could not complete her own cares due to right sided weakness. The intervention documented Resident #10 requested a transfer assist rail for the left side of the bed so she may use her right arm for transfer assistance, mobility, care and increase in independence.On 8/28/2025 at 8:46 AM Staff F , Unit Manager reported the bedrail for Resident #10 is not a restraint. Staff F reported it said bedrail on the MDS so she marked it. She further verbalized it does not restrict Resident #10's movement. Staff F reported it is not a restraint then it should not be coded on the MDS. The RAI manual dated October 2025 documented in Chapter 3 page P-6 that bed rails are used with residents who are immobile. If the resident is immobile and cannot voluntarily get out of bed because of a physical limitation or because proper assistive devices were not present, the bed rails do not meet the definition of a physical restraint.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, infection control policy and staff interview, the facility failed to wear Enhanced Barrier Precautions (EBP) with catheter care and failed to perform hand hygiene between glove changes with 1 of 1 residents (Resident #41). The facility reported a total census of 68 residents.Findings include: Observation on 8/27/2025 at 10:11 a.m., of Staff E, Licensed Practical Nurse assisted Resident #41 to empty her catheter bag. Staff E was in the residents room walking around in the room with gloves on and no other EBP and had a graduate in her left hand. Resident wheeled herself into her room and Staff E closed the door behind her. Staff E with the same gloves on opened the spout on Resident #41's leg bag. Staff E emptied the contents and set the graduate with urine in directly onto the floor and with soiled gloves on, took alcohol swabs out and cleaned the end of the catheter bag opening. Staff E then picked up the graduate off of the floor with the same soiled gloves on and emptied the graduate into the toilet. With the same soiled gloves on got soap out of the soap dispenser and added it into the graduate and rinsed it out with water and dumped contents into the toilet. Staff E then removed the soiled gloves and without performing hand hygiene applied clean gloves and applied the leg strap to her leg, pulled resident pant leg back down, applied her boots and then removed the gloves and performed hand hygiene prior to opening the room door. Review of the facility provided policy titled Enhanced Barrier Precautions dated 3/27/24 revealed Enhanced Barrier Precautions can be applied to residents with any of the following, chronic wounds or indwelling medical devices, regardless of MDRO colonization status. Examples of indwelling medical devices include urinary catheters and suprapubic catheters. Review of facility provided policy titled Handwashing Hand Hygiene with a reviewed date of 3/10/2020 revealed perform hand hygiene before applying non-sterile gloves and perform hand hygiene after removing soiled gloves. Interview on 9/2/2025 at 2:44 p.m., with the Director of Nursing (DON) revealed when staff are working with a resident with a catheter they are to be using EBP in the room especially when emptying a catheter bag.