STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165494	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tripoli Nursing & Rehab	604 Third Street SW Tripoli, IA 50676

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. 25858 Based on Resident rights policy/procedure review, resident and staff interview the facility failed to treat a resident with respect and dignity in a manner that promotes maintenance or enhancement of his or her quality of life for 2 out of 4 resident reviewed. (Resident #1 and Resident #3). The facility identified a census of 26 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #1, with an assessment reference dated 3/19/25, documented diagnoses which included heart failure, hypertension, diabetes mellitus, and anxiety. The MDS revealed the resident with a Brief Interview for Mental Status (BIMS) score of 9 which indicated moderate memory impairments, is usually understood and understand by others and substantial to maximal assistance with toileting hygiene, and supervision to set up with personal hygiene and partial to moderate assistance with mobility. The MDS documented no behaviors. The Plan of Care with an initiated date 9/3/24, had a focus area, the resident is independent for meeting emotional, intellectual, physical and social needs, and resident has an activity of daily living self-care performance deficit related to weakness, reduced mobility and history of left arm and hip fracture. Interventions include: *PERSONAL HYGIENE/ORAL CARE: The resident is able to perform personal hygiene/oral cares with set-up assistance. *TOILET USE: The resident requires moderate assistance of 1 staff for toileting. *TRANSFER: The resident requires mod assistance by 1 staff to move between surfaces. *Encourage the resident to participate to the fullest extent possible with each interaction *All staff to converse with resident while providing care. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/15/25 at 9:30 a.m., Resident #1, stated that during an evening shift Staff A, Certified Nursing Assistant, (CNA) was assisting them to go to bed, Resident #1 was sitting on the edge of the bed and Staff A grabbed the upper part of Resident #1 arms and pushed resident into bed. Resident #1 did not tell anyone about the incident and was not able to remember the exact date of the incident. Resident #1 stated that they were not injured during the incident. 2. The MDS for Resident #3, with an assessment reference dated 1/31/25, documented diagnoses which included insomnia, anxiety, depression, and muscle weakness. The MDS revealed the resident with a BIMS score of 15 which indicated no memory impairments, is understood by others and understands others. The MDS documented the resident required substantial to maximal assistance with oral hygiene and dressing, and dependence on toilet hygiene. The MDS documented resistance to cares occurred 4-6 days in the look-back period. The Plan of Care with an initiated date 5/17/23, had a focus area, the resident is independent for meeting emotional, intellectual, physical and social needs. Interventions include: *Encourage ongoing family involvement. Invite the resident's family to attend special events, activities, meals. (Date Initiated: 05/17/2023) *Ensure that the activities the resident is attending are: Compatible with physical and mental capabilities; Compatible with known interests and preferences; Adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation), Compatible with individual needs and abilities; and Age appropriate.(Date Initiated: 05/17/23) *Invite the resident to scheduled activities. (Date Initiated: 05/17/23) *Modify daily schedule, treatment plan PRN to accommodate activity participation as requested by the resident. *Provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression and responsibility (Date Initiated: 10/11/2023) *Provide with activities calendar. Notify resident of any changes to the calendar of activities. *Resident enjoys spending time with the therapy pets here in the facility. *The resident is known to repeatedly sound call light after staff exits room to ask for bathroom, transfer to recliner/wheelchair, despite staff asking if she needed these prior to exiting room. Resident will also report it takes staff too long to answer her call light because they are sitting in the breakroom (charge nurse reports this to be untrue). (Date Initiated: 12/04/2023, Revision on: 01/31/2024) *The resident needs assistance with ADLs as required during the activity. (Date Initiated: 10/11/23) (continued on next page)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/16/25 at 11:00 a.m., Resident #3 stated that they over hear staff in the hallways talking about subjects that should not be talked about. Resident #3 stated that they had an issue with a staff member a while ago, but did not want to talk about it. The Facility Internal Interview Write-up dated 3/31/25, documented, Residents interviewed after concerns discussed during resident council of alleged roughness from staff and inappropriate conversations occurring between staff members. Residents interviewed. Resident #1 on 3/31/25 at 2:54 p.m., Interview was initiated by Director of Nursing (DON), who stated, Did an incident happen between you and a staff member that you want to talk about? Resident stated, There was no abuse happening. She didn't grab my arm. I was walking from the bathroom to bed and she just kind of threw me in bed or pushed me in bed. DON asked who she was referring to. Resident stated, Staff A, CNA, Resident stated, I do know that she was mad at a different worker and called him a name. Staff A had something against him and called him an asshole. DON asked, So were staff feuding? Resident stated, Yes, I could feel the tension between them. DON asked, Was she rough with you?. Resident stated, Yes she was. I just took it she was mad and I let it go. DON asked, Was this something that happened recently? Resident stated, No it was last Friday. Visual reenactment done between DON and Resident #1 to determine how she was transferred and positioned. After further discussion it appears staff member had transferred resident appropriately via 1 assist pivot transfer with a gait belt on, however, may have been done in a quick manor or a manor considered rough. Resident #3 on 3/31/25 at 3:03 p.m., I am in my room and I can hear them talking to other residents. I don't like the way there are being talked to. They have no compassion. They talk to them very demanding, DON asked, who are they? Resident stated, It is the girls on 3rd shift. They don't work well together. DON asked if she knows them by name. Resident stated, Yes, Staff A, CNA and Staff B, CNA, They always talk about life business. They aren't like the other CNA's. They work better when they are not together. DON asked, Was anything ever said to you directly? Resident stated, I have had some things said to me. I asked to be repositioned in my chair and they told me well your are going to have to wait. We are doing rounds. DON asked, who is they? Resident stated, Staff A, CNA, they need a little bit of teaching of how they talk to residents. It is not ethical. We are family here. Interview on 4/15/25 at 4:30 p.m., the facility administrator confirmed and verified that all residents are to be treated with respect and dignity and it is the expectation that all staff treat residents per the resident bill of rights. The Resident Rights dated 7/3/24, documented the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. a. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment, that promotes maintenance or enhancement of his or her quality of life, recognizing each resident individuality. The facility must protect and promote the rights of the resident.

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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. 25858 Based on staff and resident interviews, facility investigation, and review of policy and procedures, the facility failed to ensure all alleged violations involving mistreatment, neglect, or abuse of a resident and/or residents (Resident #1) were reported to the Department of Inspection and Appeals and Licensing (DIAL) within 2 hours. The facility reported a census of 26 residents. Findings include: The Minimum Data Set (MDS) for Resident #1, with an assessment reference dated 3/19/24, documented diagnoses which included heart failure, hypertension, diabetes mellitus, and anxiety. The MDS revealed the resident with a Brief Interview for Mental Status (BIMS) score of 9 which indicated moderate memory impairments, is usually understood and understood by others, and substantial to maximal assistance with toileting hygiene, and supervision to set up with personal hygiene and partial to moderate assistance with mobility. The MDS documented no behaviors. The Plan of Care with an initiated date 9/3/24, had a focus area, the resident is independent for meeting emotional, intellectual, physical and social needs, and resident has an activity of daily living self-care performance deficit related to weakness, reduced mobility and history of left arm and hip fracture. Interventions include: *PERSONAL HYGIENE/ORAL CARE: The resident is able to perform personal hygiene/oral cares with set-up assistance. *TOILET USE: The resident requires moderate assistance of 1 staff for toileting. *TRANSFER: The resident requires mod assistance by 1 staff to move between surfaces. *Encourage the resident to participate to the fullest extent possible with each interaction *All staff to converse with resident while providing care. Interview on 4/15/25 at 9:30 a.m., Resident #1, stated that during an evening shift Staff A, Certified Nursing Assistant, (CNA) was assisting resident to go to bed, Resident #1 was sitting on the edge of the bed and Staff A grabbed the upper part of Resident #1 arms and pushed resident into bed. Resident #1 did not tell anyone about the incident and was not able to remember the exact date of the incident. Resident #1 stated that they were not injured during the incident. The Facility Internal Interview Write-up dated 3/31/25, documented, Residents interviewed after concerns discussed during resident council of alleged roughness from staff and inappropriate conversations occurring between staff members. Residents interviewed. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 on 3/31/25 at 2:54 p.m., Interview was initiated by Director of Nursing (DON), who stated, Did an incident happen between you and a staff member that you want to talk about? Resident stated, There was no abuse happening. She didn't grab my arm. I was walking from the bathroom to bed and she just kind of threw me in bed or pushed me in bed. DON asked who she was referring to. Resident stated, Staff A, CNA, Resident stated, I do know that she was mad at a different worker and called him a name. Staff A had something against him and called him an asshole. DON asked, So were staff feuding? Resident stated, Yes, I could feel the tension between them. DON asked, Was she rough with you?. Resident stated, Yes she was. I just took it she was mad and I let it go. DON asked, Was this something that happened recently? Resident stated, No it was last Friday. Visual reenactment done between DON and Resident #1 to determine how she was transferred and positioned. After further discussion it appears staff member had transferred resident appropriately via 1 assist pivot transfer with a gait belt on, however, may have been done in a quick manor or a manor considered rough. Resident #2 on 3/31/25 at 3:20 p.m., Resident stated, When she put Resident #1 to bed, in my impression she threw her in bed. She was just nasty and rude. She didn't take Resident #1 to the bathroom or change her clothes or anything. We called her back in because her brief wasn't right and she didn't do anything, she just slammed things around. ADON asked, who is she? Resident stated, Staff A, Administrator asked, Did she do anything directly to you? Resident stated, One time I asked her to get me a box of Kleenex when doing my legs and she just sighed, threw the door open, and slammed it shut. I don't know if she was having a bad day or what. Administrator asked, Would it be reasonable enough to educate her and talk to her about her actions and that they weren't ok? Resident stated, Yes it's reasonable. They just don't see how other people see them. It was hard for me not to say something. Administrator stated, It is ok to say something if you don't feel what they are doing is right. Interview on 4/15/25 at 1:27 p.m., the facility Administrator confirmed and verified that the facility failed to notify DIAL of the incident between Resident #1 and Staff A within the 2 hour time frame. The Abuse Prevention and Prohibition Policy dated 7/3/24, documented the Policy Statement All residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident medical symptoms. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, or volunteers, staff of other agencies serving the resident, family members or legal guardians, friend, or other individuals. Reporting: 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 the allegation of abuse to the Administrator, or designated representative. All allegations of Resident abuse shall be reported to the Iowa Department of Inspections and Appeals not later than 2 hours after the allegation is made.

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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. 25858 Based on observation, resident and staff interview the facility failed to properly secure a resident in a wheelchair in the facility van which resulted in the resident tilting backwards in the van while going up a steep hill (Resident #2). The facility census was 26 residents. Finding include: The Minimum Data Set (MDS) for Resident #2, with an assessment reference dated 3/19/25, documented diagnoses which included heart failure, hypertension, diabetes mellitus, depression, and chronic pain. The MDS revealed the resident with a Brief Interview for Mental Status (BIMS) score of 15 which indicated no memory impairments, is able to be understood and understands others. The MDS documented the resident required supervision to touching assistance with activities of daily living and mobility. The Plan of Care with an initiated date 3/23/22 and revision dated 6/18/24, had a focus area, the resident has an activity of daily living self-care performance deficit related to history of right humerus fracture & chronic back pain. Interventions include: *Resident is a stand by assist with hallway ambulation, with 1 staff to follow in wheelchair in case of fatigue. (Date Initiated: 06/15/2022) *TRANSFER: The resident is able to transfer/ambulate independently in room. (Revision on: 11/19/2022) *TRANSFER: The resident is independent with ambulation in room, but requires stand by assist when ambulating for walk to dine, with 1 staff to follow in wheelchair. Interview on 4/15/25 at 9:00 a.m., Resident #2 recalled coming back from an eye appointment, the van that the resident was riding in was going up a steep hill and she felt the wheelchair starting to tip backwards so I yelled at Staff C, that I am tipping backwards. Staff C pulled over onto the side of the road and repositioned me in the van and tightened up straps around my wheelchair. Resident #2 stated that they were glad they had slacks on or the van driver would of seen a show and started to laugh. Resident #2 said that they were not hurt in any way. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/15/25 at 10:10 a.m., the facility administrator, Staff C, and surveyor, went out to the 12 passenger van, and proceeded to take Resident #2 wheelchair with us, the administrator let down the chair lift and pushed the wheelchair onto the lift and raised the lift. Staff C, positioned the wheelchair in the middle of the van, behind the driver seat and in front of a bench that was up against a window, Staff C, secured the back q-straint (a self locking retractable tie down system for wheelchair) to the right side of the wheelchair and then another q-straint to the left side of the wheelchair, then took a seat belt and positioned it around the administrator who was sitting in Resident #2 wheelchair, then Staff C went to the front of the wheelchair and took another q-straint and secured to the cross bar underneath the wheelchair. Staff C stated that when he was bringing the resident back from an appointment they went through a town, as they were going up a steep hill, Staff C heard Resident #2 say, hey, so Staff C looked in the rear view mirror and noticed that the residents was tipping back in her wheelchair. Staff C went back to the wheelchair and loosened up the back two q-straints to allow the wheelchair to set it self down on the floor, and then secured the straps tight again and made sure that the two back ones and the one in the front were tight and secured. Staff C stated that the van only had 3 q-straints, and that the van usually has 4 q-straints. Staff C, said that he was not able to find the 4th q-straint in the van when he took the resident to her appointment so he only used 3. Staff C, said that the front wheels were off the floor in the front but her back was not on the floor. Staff C, explained to the facility director of nursing what had happened and that a written statement was given to the director of nursing per her request. Interview on 4/15/25 at 10:33 a.m., Staff C, explained that he has transported resident from other facilities before, Resident #2 was his first at this facility. Staff C stated that he did not have any training or education on the facility van here at this facility, or check off lists to follow, normally in the other vans that he drove, there were 4 of the q-straints to use, this van only had 3, he did not look to see if there was another one around, he just secured the third one in the middle of the van and secured it to the cross bars underneath the wheelchair. Interview on 4/15/25 at 1:10 p.m., the facility administrator did not realize that there were only 3 q-straints in the facility van and that she had no knowledge of Resident #2 having a near fall in the van and that this was the first time she had heard about it. The administrator stated that she looked and did not see any education or competency check off list in Staff C employee file for securing a resident in the facility van. The administrator said that she looked in the van and in the facility for a users manual on how to secure the resident in the van while in a wheelchair and was not able to find anything. The administrator confirmed and verified that she did not know about this and that there is no documentation in the resident charts, no incident report and no follow up on any of this incident and that the only documentation is the written statement from Staff C. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility interview form dated 3/25/25 at 2:00 p.m., documented, in regards to Resident #2 transportation to/from eye clinic on 3/25/25. Transported via facility wheelchair van accompanied by Staff C, Maintenance Director, Certified Nursing Assistant (CNA). Around 2:00 p.m., on 3/25/25, Staff C was transporting Resident #2 back to the facility from her eye appointment. Resident #2 was secured in the van prior to departure. Seat belt in place and 3 tie downs were in place and noted to be secure to the wheelchair. Wheelchair brakes were on. As we went through a town we approached a steep hill. As we inclined residents wheelchair slightly tilted back to no more than a 70 degree angle. Resident made a squack sound. I asked her Are you alright? Resident stated, My chair tilted back. I immediately pulled over the vehicle to a safe location with my hazards on and assessed the wheelchair. All seatbelt and tie downs remain secure. It appears that the steep incline may have caused a slight adjustment to the strap lick. Resident did not at any tie fall back or tilt even far enough to touch anything. There is a two person passenger seat that lies directly behind where the wheelchair is secured making falling backwards or out of the chair not even a possibility. Once I returned to the building with the resident I went to the director of nursing and made aware that residents chair did tilt in the wheelchair van when we were on that steep incline, which did appear to scare the resident, however, I pulled over immediately and assessed the situation, she did not fall backwards or out of the chair in any way. Following this transport I went out to the wheelchair van to asses all of the tie downs and securement's. I verified that all are in place and in good working order at this time. Interview on 4/16/25 at 2:45 p.m., the administrator stated that the facility has no guidelines or policy/procedures on how to secure a resident in the facility van with the q-straints.