STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165523	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estherville Community Care Center	2001 First Avenue North Estherville, IA 51334

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to ensure resident's individualized interventions were in place to prevent falls for 4 of 4 resident's reviewed (Resident #1, #2, #3, and #4). Resident #1 had an alarm to alert staff if she got up so they could assist her. Resident #1 stood up, walked a few steps and fell fracturing her left hip. The resident's alarm did not sound. Resident's #2, #3, and #4 had alarms that failed to sound and alert staff to assist them.The facility reported a census of 36 residents.Findings include:1) According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 demonstrated long- and short-term memory problems and severely impaired skills for daily decision making. The resident required substantial/maximal assist to transfer and partial/moderate assist to ambulate. Resident #1's diagnoses included primary osteoarthrosis of the right knee, age related physical debility, and unspecified fall, subsequent encounter. The resident used a bed alarm and chair alarm daily.The Care Plan with a goal target date of 5/14/26 identified Resident #1 at risk for falling related to repeated falls, unsteadiness, and abnormality of gait and mobility. Interventions included Resident #1 had a bed and chair alarm, approved by a family member dated 1/22/25, staff re-educated on wearing gripper socks daily dated 10/27/25.The Progress Notes dated 10/24/25 at 8:23 p.m. documented staff heard Resident #1's alarm sound and found Resident #1 on the floor next to her bed with the wheelchair behind her. The resident said she tried to get herself into the recliner. The nurse assessed the resident. Range of motion (ROM) within normal limits for the resident, hip alignment normal. The resident denied pain, and no injuries noted.The Progress Notes dated 12/15/25 at 5:50 p.m. documented the nurse was on west hallway when heard a woman scream for help. The writer walked into this resident doorway and witnessed resident sliding out of the recliner chair. Resident #1 slid onto her bottom with her feet out in front of her. Resident did not have proper footwear on. No injuries or c/o pain at the time (per the care plan staff reeducated on wearing gripper socks daily, dated 10/27/25. The Progress Notes dated 3/25/26 at 4:04 p.m. documented the writer received notification by a staff member Resident #1 was on the floor. Resident #1 laid on the floor in the east hallway on her right hip, with her head facing east and her feet facing west. Her wheelchair was in the hallway against the north side of hall facing east. The alarm did not sound. Witness stated Resident #1 used the railing to walk and then tipped over. VS- 97.4, 125/78, 66 heart rate, 18 and 98%. Resident yelling out in pain, initially stating her back hurt. Resident #1 adjusted to evaluate and continued to yell out in pain. Resident #1 carefully placed in wheelchair by multiple staff. Resident #1 stated her hip caused her pain. Call placed to the physician for orders. Ice and Tylenol administered. Resident #1's alarm replaced.The Progress Notes dated 3/25/26 documented receiving a call from the physician stating the resident had a right intertrochanteric hip fracture. He had spoken with the resident's family and they were considering what route to take with resident. The physician told them surgery probably wasn't the best option with her health/age, and again, talked about hospice. The physician would admit the resident to the hospital for pain control until the family decided what they would like to do.A hospital History and Physical report dated 3/25/26 documented Resident #1's assessment included a fall with a closed intertrochanteric fracture of the right femur. (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 - Actual harm Residents Affected - Few	The resident had some steady decline over the past several months with poor oral intake, weight loss and frequent falls secondary to generalized weakness. Given the nature of fall and frailty, CT of the head along with x-rays of the hips/pelvis ordered. Mildly comminuted right intertrochanteric fracture noted. Resident would be given morphine 2 mg every 2 hours and Ofirmev 1 gm every 6 hours as needed.On 6/10/26 at 9:08 a.m. The Director of Nursing (DON) showed the different alarm boxes they had available. The alarm Resident #1 had could be turned off/on with a switch. She currently used a blue box that had to be squeezed after the resident no longer sat or laid on it to silence the alarm (then it would activate when the resident sat on it). The DON confirmed she wrote the statement about the 3/25/26 fall. She had taken the resident from the dining room to outside the room where the Podiatrist and his assistant were trimming resident's toenails. They saw Resident #1 get up, walk a couple steps and fall. The DON said the alarm did not sound. She did not know if the alarm was turned on, only that it didn't sound. She said the resident did restorative and could walk with assistance. She said the alarm alerted them if she was getting up so they could assist her.On 6/10/26 at 12:15 p.m. Staff A Certified Nursing Assistant (CNA) said she didn't work with Resident #1 that much except with transfers. She said it was a hectic day. She thought she and Staff B CNA got her up before lunch and then Staff A went to lunch. When she got back from lunch she went to talk to the DON and she said Resident #1 fell and the alarm was not turned on. Staff A said she thought Resident #1 had an alarm you could turn off and on. She said you turned it off when you transferred a resident and then you turned it back on so it was ready when the resident sat/laid on the pressure pad. She said then you would get a beep when they sat back down on it. She could have sworn it was on that day.On 6/10/26 at 2:03 p.m. Staff B stated she did work the day Resident #1 fell and fractured her hip. She said she thought it was just her and Staff A getting people up for lunch. She said she would normally shut the alarm off and then when she was off it, turn the alarm back on so it was ready the next time she was on it. She said she thought the alarm was on, but after Resident #1 fell she was told the alarm was off. She said it's really hard to be sure because there are so many alarms there. 2) According to the MDS assessment dated [DATE], Resident #2 scored 11 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident required substantial/maximal assistance with transfers and depended on staff for ambulating. Resident #2's diagnoses included diabetes, non-Alzheimer's dementia, and cellulitis of his right lower limb. The Care Plan identified Resident #2 at risk for falls/injuries with the goal Resident #2 would remain free from fall related injuries through nursing/therapy interventions by next review date of 7/21/26. Interventions included a personal alarm while up in the chair/bed dated 4/17/26.The Progress Notes dated 4/8/26 at 6:15 p.m. documented Resident #2's roommate alerted staff to the resident on the floor in the west hallway, between the dining room and his room, directly in front of his wheelchair. The resident laid on his right side with his feet under his foot pedals. His head to the west and his feet to the east. Resident #2 wore a gripper sock on the left foot and cast shoe to his right foot at the time of the incident. Resident #2 attempted to propel himself back to his room when noted leaning forward prior to the fall. Resident #2 denied pain, no injuries noted, denied hitting head but neuros initiated and within normal limits (WNL). An Unwitnessed Fall Report dated 4/8/26 at 6:15 p.m. documented a chair alarm would be in place when up in the wheelchair.The Progress Notes dated 4/11/26 at 5:57 p.m. documented Resident #2 was in the dining room in his wheelchair. The writer saw the resident tipping forward out of his wheelchair. The writer attempted to reach the resident. Resident #2 tipped forward out of the wheelchair and hit his head on the floor and landed on his head and knees. Resident #2 assessed no injuries or pain at the time. The left side of the wheelchair wheel got caught on a walker and the wheelchair was unable to move. Clutter removed from the dining room and aides educated. The Progress Notes dated 5/1/26 at 3:50 p.m. documented the writer was notified by a CNA that Resident #2 was on the floor. Upon entering room the resident was in the fetal position lying on his left side. Resident #2's wheelchair at the end of his feet. Resident #2 stated he bent over to pick something up off of the floor. Resident #2's alarm did not sound and the alarm box (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	changed to one that could not be turned off. No complaints of pain or discomfort at the time. The Progress Notes dated 5/15/26 at 6:05 p.m. documented a CNA came out to inform staff Resident #2 was on the floor. The writer found the resident on the floor with his head under the bed, back towards the wall and his legs beside the bed pointing towards the door. The resident verbalized he tried to reach his bedside table and fell out of bed. Did obtain a 1.7 x 1 cm skin tear to his left upper arm which was cleansed and Steri-strips applied. Scratch noted above the left eye measuring 4 x 0.1 cm.An Unwitnessed Fall Report dated 5/15/26 documented bed alarm applied. The Care Plan dated 4/17/26 documented chair/bed alarm.The Progress Notes dated 5/25/26 at 2 p.m. documented the nurse called to Resident #2's room as he fell out of his wheelchair. The resident was laid with his back against his bathroom door on his left side and his head right by his sink cupboard. Both boot and shoe were being worn at time of fall. Resident #2 stated he dropped his ring and was leaning over to grab it off the floor and fell, catching himself with his hands. Checked over for injuries with none noted. The alarm was not switched on after returning from dialysis. The alarm box was changed to one that sets itself to try to avoid this from happening again (the Progress Notes dated 5/1/26 documented the alarm box changed to one that could not be turned off). 3) According to the MDS assessment dated [DATE], Resident #3 scored 15 on the BIMS indicating no cognitive impairment. The resident was independent with transfer and ambulation. Diagnoses included heart failure, disorientation and repeated falls.The Care Plan identified Resident #3 at risk for falling related to difficulty in walking, history of falling, lack of coordination, abnormalities of gait and mobility, and unsteadiness on feet. Interventions included a new bed alarm box and pad was put onto her bed on 2/13/26. Resident #3 needed assistance with a.m. cares, assist with toilet use at 5:30 a.m. 2/25/26, staff and resident educated the resident must wear gripper socks when not wearing nonskid shoes 7/20/25.The Progress Notes dated 1/27/26 at 8 a.m. documented an aide called nurse to resident #3's room. Resident #3 sat on her suitcase at the end of her bed between the bed and a piled up tote and a box. Her legs were hanging off the suitcase pointing towards the west without any gripper socks on. Resident was hanging on to the foot board of her bed with her right arm and her left arm sitting on the suitcase. Resident's alarm was not sounding, as it was not working. Resident's walker was over by her closet facing the complete opposite way, so would assume she was not using it as she is supposed to. Resident assessed for injuries and none noted. Box and tote were moved to the basement and her suitcase was put into her closet. New bed alarm box and pad were put onto her bed.The Progress Notes dated 2/23/26 at 10:43 a.m. documented the writer called to Resident #3's room at 6:20 a.m. Resident #3 laid in the prone position with her head pointing west and her feet facing east in front of the bathroom door. Her walker was in front of the bed to the right hand side of the resident and several feet in front of her. Resident had bare feet. The bed alarm was not sounding. Resident stated that she went to the bathroom and when she finished she tried to pull her pants up and lost balance. Resident #3 rated pain 5/10. She had a bruise to left forehead, 5cm X 5cm with a small abrasion.An unwitnessed Fall report dated 2/23/26 identified the predisposing situation factors included bed alarm, transfer unassisted and improper foot wear. The immediate action taken to assist the resident to the toilet at 5:30 a.m. The report failed to address why the alarm didn't sound and why the resident did not wear gripper socks.The Progress Notes dated 3/30/26 at 7:30 a.m. documented Resident #3 noted laying on her left side, head against the bottom of the bed. Reported she was getting clothes out of the closet, stumbled backwards et fell. Alarm not sounding, on not working when checked. Alarm noted in reach of the resident. Alarm box moved out of the reach of this resident to avoid possible stopping the alarm. The Progress Notes dated 4/14/26 at 10 p.m. documented the resident found sitting on the floor with her legs out in front of her facing the bathroom door. Resident stated that she attempted to walk backward with her walker, her feet stuck to the floor, she lost her balance and fell hitting the other bed in the room. Resident #3 verbalized that the left side of her back hurt but able to ambulate without difficulty. An Unwitnessed Fall report dated 4/14/26 at 10 p.m. documented the above information and included the predisposing situational factors of bed alarm and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	during transfer (self/unassisted). The report failed to document if the alarm sounded at the time of the incident.On 6/9/26 at 8:50 a.m. Resident #3 in her room in her chair. She admitted having some falls. She said she walked around her room and in the hall with her walker. She said they had an alarm at night so if she got up it made a sound and they came running.On 6/10/26 at 9:08 a.m. the DON stated they put the bed alarm on the resident's bed because she would get up at 5:30 a.m. and fall while getting ready. 4) According to the MDS assessment dated [DATE] Resident #4 scored 11 on the BIMS indicating moderate cognitive impairment. The resident partial/moderate assistance with transfer and supervision/ touching assistance with ambulation. Diagnoses included arthritis, a stroke, and Parkinson's disease.The Care Plan identified Resident #4 at risk for falls/injuries related to a history of falling, with a goal the resident would remain free from fall related injuries through nursing/therapy interventions by the review target date of 7/8/26. Interventions included a bed alarm at night dated 5/9/26. The Progress Notes dated 5/9/26 at 11:05 p.m. documented finding Resident #4 on the floor beside his bed on his right side, feet towards the bathroom door and the top of his head towards his roommate. He verbalized he sat on the side of his bed and slid off onto the floor. An Unwitnessed Fall Report dated 5/9/26 at 11:05 p.m. documented the fall, and a new intervention for a bed alarm at night.The Progress Notes dated 5/16/26 at 3:20 a.m. documented finding Resident #4 on the floor face down in a pool of blood, feet towards the bathroom, top of his head pointing towards his roommates bed. Resident #4 obtained a 4.5 x 1 cm laceration above his right eye. Resident #4 sent to the Emergency Department (ED) for evaluation and sutures.An Unwitnessed Fall Report dated 5/16/26 at 3:20 a.m. documented the same fall information and predisposing situation factors included bed alarm and ambulating without assistance. The report failed to identify if the alarm sounded.The Progress Notes dated 5/31/26 at 10:50 p.m. documented called to the resident's room by the CNA. The resident was on the floor beside his bed, his head faced towards the door and partially under the bedside table, feet towards the bed. An Unwitnessed Fall Report dated 5/31/26 at 10:50 a.m. documented the fall and staff education on the bed alarm and ensuring it was in place and turned on.On 6/8/26 at 4:20 p.m. Resident #4 sat in his room in the wheelchair. He said he'd had some falls. He said he had to get stitches after 1 of them. He said they put something on the bed that made noise so they knew when he got up, so they could help him. He said he used his walker in his room, but someone had to be with him when he walked in the hall. He didn't know if the alarm sounded the night he fell and needed stitches.On 6/10/26 at 9:08 a.m. the DON stated they started documenting alarm checks on the treatment sheets after another resident's fall in March. She said she knew there were still issues with the alarms after they started the checks. The undated facility Accidents and Supervision policy documented the resident environment would remain as free of accident hazards as was possible. Each resident would receive adequate supervision and assistive devices to prevent accidents, including: a. Identifying hazards and risks, the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. All staff (e.g., professional, administrative, maintenance, etc.) are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident. The facility should make a reasonable effort to identify the hazards and risk factors for each resident. b. Evaluating and analyzing hazards and risks, the process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents. Interdisciplinary involvement is a critical component of this process. Analysis may include, for example, considering the severity of hazards, the immediacy of risk, and trends such as time of day, location, etc. Both the facility-centered and resident-directed approaches include evaluating hazard and accident risk data, which includes prior accidents/incidents, analyzing potential causes for each hazard and accident risk, and identifying or developing interventions based on the severity of the hazards and immediacy of risk. Evaluations also look at trends such as time of day, location, etc. c. Implementing interventions to reduce hazards and risks, using specific interventions to try to reduce a resident's risks from hazards in the environment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The process includes: 1. Communicating the interventions to all relevant staff, 2. Assigning responsibility, 3. Providing training as needed. 4. Documenting interventions, 5. Ensuring that the interventions are put into action, 6. Interventions are based on the results of the evaluation and analysis of information about hazards and risks and are consistent with relevant standards, including evidence-based practice. d. Monitoring for effectiveness and modifying interventions when necessary. Monitoring is the process of evaluating the effectiveness of care plan interventions. Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks. Monitoring and modification processes include: 1. Ensuring that interventions are implemented correctly and consistently, 2. Evaluating the effectiveness of interventions, 3. Modifying or replacing interventions as needed, 4. Evaluating the effectiveness of new interventions.