STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165537	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hiawatha Care Center	405 North 15th Avenue Hiawatha, IA 52233

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on observation, staff interviews, clinical record review, employee file review and facility policy review the facility failed to transfer one out of three residents reviewed according to their Care Plan resulting in one resident obtaining a laceration to her left leg that required sutures and a blood transfusion (Resident#1). The facility reported a census of 98 residents. Finding include:The Minimum Data Set (MDS) assessment for Resident#1 dated 9/2/25, listed diagnoses of Atrial Fibrillation (irregular heart beat), heart failure, and osteoporosis The Brief Interview for Mental Status (BIMS) score 4 out of 15 (severely cognitively impaired). The MDS reflected Resident#1 dependent on staff for chair to chair transfers. The Care Plan for Resident#1 dated 8/29/25, reflected interventions of Physical Therapy (PT), Speech Therapy (ST), and Occupational Therapy (OT) evaluation and treat, follow their recommendations Dated 8/29/25 and directed staff to transfers with assist of 1 staff with gait belt and a walker, date initiated 9/4/2025. The Medication Administration Record (MAR) dated 10/2015 directed the staff to administer Eliquis (blood thinning mediation) 2.5 milligrams (mg) two times a day for the pacemaker. The Progress Note dated 10/20/25 at 4:30 PM read a Certified Nurse Aid (CNA) called Staff D, Registered Nurse (RN) to the lounge area in the wing. Staff D found the Resident#1 in her wheelchair (w/c) with staff controlling the bleeding to her left lateral leg. The note reflected that Staff D applied a pressure dressing and wrapped it to control bleeding. Per Staff A, she was transferring Resident#1 and her left lateral leg caught the lever of the wheelchair causing the laceration. The Emergency Department (ED) Provider Note dated 10/20/25, identified staff transferred the resident into a wheelchair and accidentally cut the front aspect of her leg with significant bleeding per Emergency Medical Services (EMS). The ED note reflected a large left leg laceration with significant acute blood loss anemia requiring prolonged repair while in the ED (1.5 hours total), with patient required figure-of-eight sutures to tie off 2 different arteriolar bleeds (occurs when an artery is damaged, causing blood to flow rapidly and forcefully from the wound), multiple horizontal mattresses given that wound is under tension (stitch crosses under the wound horizontally), and wound approximated with otherwise standard simple suture. Bleeding completely resolved and was observed for over 2 hours with no development of a hematoma or any significant venous bleeding from the wound edges. No indication for anticoagulation reversal at this time. Hold Eliquis for at least 1 week. Admit to hospital, start 1 unit packed red blood cells (PRBC). Hemoglobin (Hgb) 5.9, baseline 9.1-10.6 grams per deciliter (g/dL) (a protein found in red blood cells that is responsible for transporting oxygen throughout the body). The Consult Note last updated 10/22/25, reflected Resident#1 presented to the ED on 10/20/25 with a leg laceration. The note reported staff transferred her into her w/c and accidently cut the front side of her leg with significant bleeding. The Note revealed Resident#1 required 4 figure-of-eight sutures to 2 arterial bleeders; 20 sutures total. The left anterior lateral lower leg laceration is approximated with sutures. The note included the wound painful for Resident#1 and included a photograph of the laceration post sutures. The wound approximately measured 7 centimeters (cm) long with another 2 cm curved around the top of the wound. On 10/27/25 at 2:51 PM Staff D reported as she passed medication on the wing when Staff A alerted her they needed help with a resident for a cut in the lounge. Staff D said she took her supplies, went to the lounge and when she saw the blood on the floor she knew she needed to send the resident to the hospital. She revealed Resident#1 took AC medication. Staff D reported Staff A told her, she just transferred Resident#1 from the recliner to the w/c and her upper left leg got a laceration. On 10/27/25 at 3:25 PM Resident #1 was in her room and sitting in her w/c. The w/c pedals were in place and able to move back freely. A pink bag sat in the seat of the w/c. The left w/c foot pedal metal above the release lever felt and looked sharp. On 10/28/25 at 2:01 pm Staff A reported on 10/20/25 around 4 PM Resident#1 needed to use the toilet. She said she placed the gait belt (G. B.) on Resident#1 and completed a stand pivot transfer (SPT) to the w/c that she placed right next to Resident#1. Staff A stated as she sat her in the chair Resident#1 said ouch. Staff A reported she saw Resident#1 left leg sat bent back at the knee under the w/c. Staff A revealed after she moved Resident#1's left leg she saw her knee high sock turned red from blood. Staff A reported she called for help, the Human Resource (HR) Director got to her first and applied pressure to the wound and Staff D got there next. Staff A reported the w/c pedal on the right side went back 180 degrees while the left foot pedal only went back 90 degrees. Staff A said a pink bag that held the phone hung on the left side of the w/c and prevented the foot rest from going back 180 degrees. On 10/28/25 at 12:52 PM the HR reported as she worked in her office on 10/20/25 she heard Staff A say Oh **** blood. HR said she immediately went to help. She said she saw a