STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165599	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Manor Nursing Home	1200 Mulberry Street Tipton, IA 52772

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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, facility policy review and staff interviews, the facility failed to provide a dignified eating experience for six of six resident's (Resident #21, 32, 38, 41, 43, 50) who ate their plated meals while they remained on a serving tray, The facility reported a census of 50 residents.Findings include:During an observation on 11/17/2025 at 12:16 PM, six residents in the Assisted Dining Room (ADR) ate their meal, while it sat on a tray. During an observation on 11/18/25 at 11:58 AM, all residents seated at the tables in the ADR were served their meal on trays. Their plate left on the tray while they ate. During an observation on 11/19/2025 at 12:15 PM, six out of the six residents in the ADR sat at a table while their plated meals sat on the tray. Staff C and Staff D, Certified Nursing Assistants (CNA's) sat and fed two of the six residents. On 11/20/2025 at 9:59 AM, Staff C, CNA reported Resident's #21, 32, 38, 41, 43, and 50 ate in the ADR on 11/17/25, 11/18/25 and 11/19/25. She confirmed all the residents in the ADR ate their meals off a plate which sat on a serving tray. Staff C confirmed the residents who ate in the main dining room did not have their plates on a tray while they ate. Staff C stated eating off trays seemed undignified. On 11/20/2025 at 10:02 AM, the Director of Nursing (DON) said four or five residents ate in the ADR area. She confirmed they ate their plated meals off of trays. She said it's more sanitary and they have different diet types. She confirmed the residents that ate in the main dining room did not keep their plate on trays while they ate. The DON reported it may not be dignified to eat a plated meal that remained on a serving tray. The facility provided the Resident [NAME] of Rights undated, directed the resident has a right to dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.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's individuality. The facility must protect and promote the right of the residents.b. The facility must provide equal access to quality care regardless of diagnosis severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the Ste plan for all residents regardless of payment source.

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, equipment manual review, resident and staff interviews, the facility failed to transport residents in the hallways in a safe manner for 2 of 2 residents (Resident #17 and Resident #53) reviewed for safety. The facility reported a census of 50 residents.Findings include:1. The Minimum Data Set (MDS) for Resident #17 dated 10/7/25 documented diagnoses of other idiopathic scoliosis in the lumbar region, atrial fibrillation, and Alzheimer's disease. The resident scored 3 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated severe cognitive impairment. Resident #17 assessed dependent on a wheelchair for mobility and dependent on staff for transfers.During an observation on 11/19/2025 at 1:44 PM, Staff A, Certified Nursing Assistant (CNA) pushed the Resident #17 in her wheelchair from a table in a common area to the dining room for an activity. During the transport, Resident #17's right foot rested on a foot pedal, while the left foot dropped down between the right pedal and the left pedal. She wore a non-skid sock. As Staff A pushed the chair around the corner, the resident's sock bumped along the ground. At 1:46 PM, Staff A brought the resident back to the common area, while the resident's left foot remained between the pedals.During an interview on 11/19/25 at 3:01 PM, Staff A, CNA reported she was trained on wheelchair and other equipment safety about once a year and that the trainers demonstrated how to use them. She stated the resident's feet should be on the pedals as soon as they put them in their wheelchair and acknowledged she did not check Resident #17's feet before moving her. The CNA stated the resident's leg was constricted and didn't stay on the pedal anyway. When asked who that should be reported to, she said the head nurse. She stated she said something in the past, the resident had therapy, and it got better for a while. She had not reported concerns about the resident keeping her feet on the pedals since then. When asked what would happen if the resident's leg caught on the floor while it was between the pedals, Staff A stated the resident would probably break her leg.2. Review of a progress note in Resident #53's Electronic Health Record (EHR) titled admission summary dated [DATE] at 10:15 AM indicated the resident admitted that day. The EHR diagnosis tab included diagnoses of Chronic Obstructive Pulmonary Disease (COPD), lumbago with sciatica (pain, numbness, or tingling that radiates down the right buttock and leg along the sciatic nerve), and spondylosis (age related wear and tear of the spine).Review of Resident #53's Baseline Care Plan directed staff to allow adequate rest periods during Activities of Daily Living (ADL) tasks due to shortness of breath. The Plan indicated Resident #53 required the assistance of one staff, a gait belt, and a 4-wheel walker for mobility.During an observation on 11/19/2025 at 1:26 PM, Staff E, CNA pushed Resident #53 from the shower room to her room seated on her walker, a distance of approximately 40-50 feet. The walker did not have pedals and the resident held her feet up, off of the floor. About half way to the room, the resident's right foot lowered and skipped 3 times along the tile floor. During an interview on 11/19/25 at 2:19 PM, Resident #53 she stated she did not feel safe being pushed on her walker. She stated the CNA was very nice and helpful but thought she should be in her wheelchair when she was in the hall.During an interview on 11/19/25 at 2:23 PM, Staff E, CNA confirmed she received training during orientation about equipment and safe transfers. She reported facility policy was for residents transported in the hallway to have pedals. Staff E stated the resident had only been there for two days, had some anxiety while she was in the shower and was short of breath, and just wanted to get back to her room. Staff E said she knew the resident should have been in her wheelchair instead of sitting on her walker.During an interview on 11/19/25 at 2:31 PM, the Director of Nursing (DON) stated she would like to see residents who used wheelchairs have foot pedals on, footwear on, and for staff to ensure feet were on the pedals before moving a resident. She expected staff to receive training from the CNA's they trained with during orientation and while they are reviewing competencies. When asked if staff should push a resident seated on a walker, she said absolutely not. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She stated she did not know if the facility had written policy, protocol, or training related to wheelchair or walker safety and none were provided.Review of the User Instructions for Resident #53's wheelchair, section Safety Instructions General Cautions included, in part: Rollators are intended for individual use only and are NOT TO BE USED AS A WHEELCHAIR. Serious injury to the user and/or damage to the rollator's frame or wheels may result from improper use.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of resident council minutes, facility policy review, resident and staff interviews, the facility failed to answer call lights within 15 minutes to meet resident needs for 2 of 2 residents (Resident #5 and Resident #49) reviewed for call lights. The facility reported a census of 50 residents.Findings include:1. Resident #5's Minimum Data Set (MDS) assessment dated [DATE] documented an admission date of 6/05/24. The list of diagnoses included heart failure, adjustment disorder with depressed mood, benign prostatic hyperplasia with lower urinary tract symptoms (enlarged prostate gland presses on the urethra), and pain. The MDS indicated Resident #5 utilized a wheelchair for mobility, dependent on staff for transfers and toileting hygiene. The Brief Interview for Mental Status (BIMS) assessment score of 11 out of 15 indicated a moderate cognitive impairment. Review of Resident #5's Care Plan, dated 9/17/25, revealed the following Focus area's:a. I have an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) weakness, impaired balance, and physical deconditioning. b. I am at risk for falls r/t poor safety awareness, impaired balance and deconditioning. During an interview on 11/17/25 at 10:32 AM Resident #5 reported he needed help with his care and had to push his call light to use the restroom. He stated he knew staff were busy and when they came they were helpful, but it was hard to wait to go to the bathroom. The resident reported evening call lights had taken a half hour or more and knew that because he had a clock on his wall. He reported it had happened most recently in the past two days and that he had talked to staff about the long waits. He further stated that it happened on other shifts too.2. Resident #49's MDS dated [DATE] documented an admission date of 2/12/24. The list of diagnoses included hypertension, Parkinson's disease, anxiety and depression, and malnutrition. A BIMS score of 15 out of 15 indicated intact cognition. The MDS indicated Resident #49 required a walker for mobility, and partial/moderate assistance (helper provided less than half of the effort) with transfers and toileting hygiene. Review of Resident #49's Care Plan, dated 9/26/25, revealed a Focus area to address I have an ADL self-care performance deficit r/t to impaired balance m/b (manifested by) Parkinson's disease. Interventions included, in part, to encourage the resident to use her light to call for assistance.During an interview with Resident #49 on 11/17/25 at 10:52 AM she stated she paid close attention to her medications and call lights. She reported the past month had seemed to be more difficult because of staffing changes and that it took 20 minutes to get her call light answered just that morning. She knew because she had to go to the bathroom and watched the clock on her wall while she waited. She stated it was 'kind of depressing' when she had to wait for help, and she didn't want to fall.Review of a document titled Resident Council, dated 9/25/25, revealed a resident reported she was still waiting for 30 minutes on the stool and that caused her legs to go numb. The resident stated CNA's (Certified Nursing Assistant) would shut her light off and forget to come back. There was a show of hands from other participants in Resident Council who agreed this happened to them too. The document further noted that with residents in the room staff talked about being shorthanded and overworked, and residents reported they felt the tension of the aides. Review of the 10/23/25 Resident Council Meeting Agenda notes revealed a resident reported waiting 45 minutes for someone to help her with her hearing aids. Attendees still felt they were short of help.The facility did not provide documentation regarding follow up on the concerns identified during Resident Council meetings. During an interview on 11/19/25 at 3:01 PM, Staff A, CNA reported staff were trained to do their best to answer call lights before their system indicated the resident had waited an 'extended time'. She was not able to explain how long that meant a resident was waiting. During an interview on 11/19/25 at 2:31 PM, the Director of Nursing (DON) stated staff were trained to try to answer call lights by the '3rd request' indicated by their call light system. She said it was her 3rd day in the role of DON but she had worked at this facility in other roles before that, and she thought people were (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aware of the 15-minute regulation. She did not know how many minutes it was between pushing a call light and the '3rd request'. She had not had any call light complaints yet, but thought the former DON had been working on something.During an interview on 11/19/25 at 10:48 AM, the Administrator stated he was not sure if there was a call light policy and thought they had just always followed the 15-minute regulation. He did not know how many minutes it took from pushing a call light to the 3rd request notification or the extended time notification. The Administrator later provided a document titled Call Alarm Times after a phone call to their system provider. It documented the following: 1st reminder, 90 seconds; 2nd reminder 3 minutes; 3rd reminder 4 minutes 30 seconds; Extended reminder, 7 minutes 30 seconds; repeated every 180 seconds thereafter. The documentation did not include notification language for calls over 15 minutes.