STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165607	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Cottages	1742 Main Street Pella, IA 50219

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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F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on clinical record review, policy review, and staff interviews, the facility failed to create and implement interventions to prevent a fall which resulted in an ER visit for 1 of 3 residents reviewed for falls(Resident #20). The facility reported a census of 95 residents. Findings include:The Minimum Data Set (MDS) assessment tool, dated 5/20/25, listed diagnoses for Resident #20 which included fracture, non-Alzheimer's dementia, and arthritis. The MDS stated the resident sustained a fracture related to a fall in the 6 months prior to admission and stated the resident required partial/moderate assistance for chair and toilet transfers. The MDS listed a Brief Interview for Mental Status (BIMS) score as 11 out of 15, indicating moderately impaired cognition. The facility Accident/Incident Investigation and Reporting Policy and Procedure, revised 4/2025, stated the facility provided an environment that was free from accident hazards over which the facility had control and provided supervision to prevent avoidable accidents. The policy directed staff to initiate new interventions after a fall to attempt to prevent recurrence and to add the interventions to the Communication Board for immediate availability to team members. A 5/12/25 Fall Risk Assessment, dated 5/12/25, stated the resident was at high risk for falls.Nurses Note on 5/18/25 at 2:09 a.m. documented staff found the resident on her left side and the resident stated she went to the bathroom and fell when she tried to get back to the recliner.Care Plan entries, dated 5/20/25, stated the resident was at risk for recurrent falls related to a history of falls, decreased cognition, and decreased safety awareness. The entries directed staff to determine causative factors, keep personal items close, encourage the resident to stay in common areas, and wear non-skid footwear. A 5/22/25 2:45 a.m., Unwitnessed Fall report stated the resident laid on the floor with her knees bent and stated she hit her head and her scalp was tender. The resident was confused and thought it was time to get up. The Care Plan lacked an intervention related to the resident's 5/22/25 fall. Social Services Note dated 5/22/25 at 9:03 a.m. documented the resident admitted to the facility from Assisted Living (AL) on 5/12/25. She had a fall in the AL which resulted in a trip to the ER and therefore was no longer qualified to be at that level of care. A 5/25/25 4:40 p.m. Unwitnessed Fall report stated the resident was wedged between folding chairs and stated she went to the bathroom. The resident had a goose egg on the back of her head. The Care Plan lacked an intervention related to the resident's 5/25/25 fall. A 6/4/25 Orthopedic Clinic report stated the resident had an ankle fracture from an injury 6 weeks ago.A 6/7/25 3:30 p. m. Unwitnessed Fall report stated the resident's call light came on the screen and a Certified Nursing Assistant (CNA) said she had to get to the resident's room right away or she would get up on her own. The CNA was almost to her room when she heard a loud crash. The resident was on the floor with blood everywhere and she stated her head hurt. A 6/7/25 3:50 p.m. Nurses Note stated the resident fell in her room and hit the back of her head and it bled profusely but then stopped. The resident's daughter declined to send the resident to the ER. A 6/7/25 7:45 p.m. Nurses Note stated the resident had a 3.6-centimeter(cm) laceration to the back of her head with a moderate amount of bright red blood. Staff called the resident's daughter and suggested an ER visit. The daughter picked up the resident at approximately 9:00 p.m. and called back at 11:15 p.m. to say the resident was admitted for observation for four brain bleeds. A hospital History and Physical Report, dated 6/7/25, stated the resident presented to the ER due to a fall. The resident sustained a 7 inch gash and the computerized tomography(CT) scan(a scan which used a series of X-ray images taken from different angles to create detailed cross-sectional images of the inside of the body, helping doctors diagnose conditions, plan treatments, and monitor disease progression) showed several areas of intraparenchymal hemorrhages(bleeding directly into the brain's tissue [parenchyma] and often caused by head trauma). A 6/28/25 4:48 p.m. Unwitnessed Fall report stated the resident laid on the floor and stated she was going to the bathroom. She had no injuries. A 6/30/25 Unwitnessed Fall report stated the resident was found on the floor on her back between the recliner and the other side of the chair. The resident stated she hit her head. A 7/1/25 Care Plan entry directed staff to offer the resident toileting assistance before and after meals. A 7/2/25 Unwitnessed Fall report stated staff found the resident on the floor between her chairs in her room. The resident said she had to go to the bathroom. A 7/5/25 Unwitnessed Fall report stated the resident was on the floor and her head hurt and was bleeding. The resident stated she tried to move the table to go to the bathroom. The Care Plan lacked documentation of further interventions related to the above falls using root cause analysis to create preventative measures.On 8/20/25 at 1:28 p.m., Staff A Registered Nurse (RN) stated after a resident fell they had to come up with a new intervention add it to the care plan. On 8/20/25 at 3:27 p.m., the Director of Nursing (DON) stated for each fall, they came up with an

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff interview, the facility failed to ensure the availability of routine medications for 1 of 4 newly admitted residents(Resident #99). The facility reported a census of 95 residents. Findings:The Minimum Data Set(MDS) assessment tool, dated 4/27/25, listed diagnoses for Resident #99 which included rheumatoid arthritis, weakness, and depression and listed the resident's Brief Interview for Mental Status(BIMS) score as 14 out of 15, indicating intact cognition. The MDS documented that the resident was admitted on [DATE] from a hospital.The undated facility policy Pharmacy-Initiated Order Workflow stated the nurse received a signed order from the prescriber and faxed it to the pharmacy. The pharmacy then processed the medication and delivered it to the facility. The procedure did not address what staff should do if a medication did not arrive from the pharmacy. A 4/25/2025 10:30 a.m. Clinical admission entry stated the resident admitted to the facility. The April Medication Administration Record(MAR) listed the following 4/25/25 orders: a. Alrex suspension 0.2%(an eye drop used to treat allergies of the eye), instill one drop in both eyes. The following doses lacked a checkmark to indicate staff administered the medication and had 9 for the entry which referred to the resident's Progress Notes: 5/25/25 4:00 p.m. and 8:00 p.m. doses, 5/26/25 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. doses, 5/27/25 12:00 p.m. and 4:00 p.m. doses.B. Pregabalin (a medication used to treat nerve pain) 100 milligrams(mg) three times per day. The following doses lacked a checkmark to indicate staff administered the medication and had 9 for the entry which referred to the resident's progress notes: 5/25/25 4:00 p.m. dose, 5/26/25 8:00 p.m. dose, 5/27/25 6:00 a.m. 12:00 p.m., and 8:00 p.m. dosesC. Duloxetine (an antidepressant) 30mgs 1 capsule twice daily. The 5/25/25 4:00 p.m. entry lacked staff initials to indicate staff administered the medication and had a 9 for the entry which referred to the progress notes. Progress Notes entered on the following dates and times stated that the resident's Alrex eye drop was not available: 4/25/25 5:53 p.m., 4/25/25 9:07 p.m., 4/26/25 9:33 a.m., 4/26/25 11:12 a.m., 4/26/25 6:02 p.m., 4/26/25 8:41 p.m., 4/27/25 10:45 a.m. Progress Notes entered on the following dates and times stated that the resident's Pregabalin was not available: 4/25/25 2:18 p.m., 4/26/25 9:11 a.m., 4/27/25 11:05 a.m.A 4/25/25 2:17 p.m Progress Note stated the resident's Duloxetine was not available. The Progress Notes did not contain documentation the facility staff contacted the pharmacy to follow up on the missing medications.A 4/27/25 7:00 p.m., Nurses Note stated the resident left the facility with her spouse Against Medical Advice(AMA). On 8/20/25 at 1:28 p.m., Staff A Registered Nurse(RN) stated when Resident #99 admitted they had trouble getting her Pregabalin. She stated she received education that she should call the provider to obtain the medication. She stated it wasn't appropriate to just wait for the pharmacy. On 8/20/25 at 3:27 p.m., the Director of Nursing(DON) stated if a medication did not arrive from the pharmacy, staff could call for a stat delivery. If the resident didn't come with an order, staff should reach out to the provider and obtain an order for the medication or an order to hold.