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	11/25/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility investigation file, staff interviews, and policy review, the facility staff failed to treat residents with dignity and respect and honor the resident's right when a resident refused to take a shower, and failed to protect residents from abuse by not conducting a thorough investigation of the incident for 1 of 2 residents reviewed for abuse (Residents #2) The facility reported a census of 86 residents. Findings include:A Complaint/Incident Investigation Report revealed the facility self-reported an allegation of abuse to the Department of Inspections, Appeals, and Licensing (DIAL) on 11/03/25 at 5:29 PM. The incident occurred on 10/31/25 at approximately 9:20 AM. Staff A, Certified Nursing Assistant (CNA) notified Staff E, Registered Nurse (RN) that Resident #2 refused to take a shower. Staff E was upset and said she did not have time for this shit and followed Staff A into the resident's bathroom. Staff E told Resident #2 she had to take a shower and the resident said no. Staff E then pried the resident's hand off of the chair and forcefully took off her shirt. Resident #2 was uptight and clenched her hand as Staff E removed the resident's hand and shirt and yelled no stop, stop right now, no, no. On 10/31/25 at approximately 9:45 AM, Staff A reported the incident. Staff E was removed from the unit. Staff B, CNA, reported she was told to tell Resident #2 they are going to take a shower and not to ask the resident, but the resident was very adamant about not taking a shower. Staff B reported she was not in the room when the (resident's) shirt was removed. Resident #2 was assessed from head-to-toe without any injuries noted. The physician was notified on 10/31/25 at 5:00 PM. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had diagnoses of anxiety disorder, depression, osteoarthritis, and muscle weakness. The MDS recorded the resident had a Brief Interview for Mental Status score of 11 out of 15, indicating moderately impaired cognition. The MDS indicated the resident required substantial to maximum assistance for upper body dressing and partial to moderate assistance for showering/bathing. The MDS revealed the resident had no behaviors during the seven day look-back period. The Care Plan revealed Resident #2 required assistance with ADL's (activities of daily living). The Care Plan directed staff to cue, reorient and supervise as needed (initiated 12/9/24), present one thought or command at a time (initiated 12/9/24), and leave the resident alone in a safe position and retry the task in a few minutes if the resident was resistive to care (initiated 8/26/24).A Progress Note dated 10/31/25 at 10:32 AM revealed the resident became very agitated during a shower and refused to get in the shower. The nurse assisted resident with removing her clothing. Resident alert and oriented x 3. Staff H documented the Safety Measures implemented at that time included to encourage the resident to take a shower and if refusing, try again at a later time.The facility's investigative file provided to DIAL during the survey revealed the timeline of the incident on 10/31/25: a. At 9:00 AM, Staff A, CNA, and Staff B, CNA, went into Resident #2's room to get her up and assist into the shower. Resident #2 was transferred into the shower chair after she was toileted and was not dressed below the waist. She still had her shirt on. Resident #2 refused to shower at this time stating It's too cold. b. At 9:20 AM, Staff A notified Staff E, RN, that the resident was refusing her shower. Resident #2 continued to refuse a shower at that time. Staff A reported Staff E was upset and said I don't have (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time for this shit. Staff E followed Staff A into the bathroom and started telling Resident #2 she had to take a shower. The resident said no. Staff E then pried the resident's hand off the chair and then forcefully took off her shirt. Resident #2 was uptight and clenching her hands and saying no, stop this, stop right now, no, no as Staff E removed the resident's hand and shirt. Staff B reported the resident was adamant about not taking a shower The resident said I'm not doing that involves water, this is bullshit. Staff B was not in the room when the shirt was removed. c. At 9:45 AM, Staff A reported the incident. Staff E was removed from the unit and interviewed. A head-to-toe assessment was done on Resident #2 and no injuries were found. d. At 5:00 PM, the physician was notified. An attempt was made to notify the POA (Power of Attorney). The Facility Investigation File also revealed that the facility provided staff education on the right of refusal, and the provision of kind and considerate care. The team member was immediately removed from resident care. Maintenance assessed the bathroom temperature on 10/31/25 at 1:00 PM and found it to be at 74 degrees Fahrenheit.The facility's investigation file revealed a timeline of the incident, separation of staff from the involved resident, and staff education related to resident rights of refusal and treating residents with kindness and consideration. The facility's investigation lacked documentation of follow up with other residents residing at the facility for potential abuse, police notification, and follow up with other staff members working. The Facility's Investigation File contained Investigation Questions for the following: a. On 10/31/25 at 10:30 AM, Staff E, RN, was interviewed by the Director of Nursing (DON) and the Clinical Quality Specialist (CQS). Staff E reported she encouraged the CNA's that morning to get Resident #2 in the shower. Resident #2 typically resisted her showers and that they can't always give a choice, but they could let it go if she really acted out. Staff A approached Staff E and told Staff E you need to come and talk to Resident #2 because she is absolutely refusing the shower and is grabbing onto her arm rests on her shower chair and saying no, no, no to a shower. Staff E said she came in and helped Resident #2 out of her shirt because she would need to be helped anyways. Resident #2 was not upset about Staff E taking her shirt off. The resident was not grabbing at Staff E or yelling or anything. She was just vocal about not wanting a shower. Staff E told her she needed to shower and the shower was running. The agency aide said this is inappropriate, she is absolutely refusing her shower. Staff E said she did get frustrated and said well, okay, do whatever you think is best, and then she left kind of upset. The aide approached Staff E later and said that she was very upset with Staff E and felt like her actions were inappropriate when dealing with Resident #2. Resident #2 ended up getting her shower. Staff E said she told the CNA that she did not have to give Resident #2 a shower. b. On 10/31/25 at 11:08 AM, Staff A, CNA, was interviewed by the CQS and DON and obtained statements to the questions asked. Staff A reported she witnessed the incident. She went to get the resident up for her shower. Resident #2 told her she did not want to take a shower because it was too cold right now. Staff A said she would go talk to the nurse. Staff A told Staff E the resident refused to shower right now because it was too cold. Staff A offered to help the resident later. Staff E said no you have to do it now. Staff B and Staff A went into Resident #2's room. The resident said no over and over again, she did not want a shower. Staff A and Staff B took her to the restroom, turned on the shower to get it warm for her. She still had her shirt on but was nude below the waist. She was gripping the shower chair and when Staff A went to remove the resident's shirt, the resident said you are not going to take my shirt off. Staff A said she was not going to pry her hands off the chair and would go get the nurse. Staff B stayed with Resident #2 while Staff A went and got the nurse. Staff B left the room to assist other residents when the nurse came in. Staff E was upset when Staff A went and spoke with her. Staff E said I don't have time for this shit. Staff E followed Staff B into the bathroom and started telling Resident #2 she had to take a shower. Resident #2 said no, then Staff E pried the resident's hand off the chair and then forcefully took off her shift. Resident #2 was uptight and clenching her hands and saying no stop this, stop right now, no, no, no as Staff E removed the resident's hand and shirt. Staff A told Staff E she could not do this to her, it was the resident's right to refuse the shower. Staff E said no we have to give her a shower. Staff A proceeded to tell the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse that the resident had the right to refuse. Staff E then got upset and said I'm so over this, dropped the shirt on the ground, and said she would give her a shower but to do whatever the hell she wanted and slammed the bathroom door as she left. Staff A apologized to the resident because she felt so bad. Resident #2 said what's her problem? She is crabby, she's mean. Then the resident said since we are here at the shower already you can just get me in, I'm cold. Staff A told Staff C, Restorative Aide (RA). Staff A inquired as to who she needed to talk to. Staff C told Staff A she would tell someone. Staff A relayed she just felt like Staff E was being forceful because of the way the resident appeared. Resident #2's face was grimacing and she looked scared. Staff A knew she would not want to be treated like that. Staff E cursed and stomped and seemed angry. Her behavior was inappropriate. Staff A spoke with Staff E after the event and told Staff E she did not appreciate how she treated Resident #2 and Staff A, or that Staff E had slammed the door. Staff E said she was so sorry she lost her temper and lost her cool. Staff E said she was very stressed out and overstimulated. c. On 10/31/25 at 11:30 AM, Resident #2 was interviewed by the CQS and DON. Resident #2 remembered taking a shower on the morning of 10/31/25. Resident #2 said the shower was terrible. It was too damn cold in there and they refused to turn up the thermostat. She did not like to take showers at the facility. Sometimes staff are kind to her but they are mouthy and bossy. She did not know if the nurse was kind to her because she did not meet her. Resident #2 responded no when she was asked if any staff had been physically aggressive with her. d. On 10/31/25 at 11:52 AM, Staff B, CNA, was interviewed by the CQS and DON. Staff B signed the document on 10/31/25 at 8:25 PM. Staff B reported she had heard that Staff E forcefully took off Resident #2's shirt for a shower even though the resident refused the shower. Staff B reported she was told that with this resident staff had to tell her she was going to take a shower and not ask but she was very adamant about not taking a shower. The resident said I'm not doing that, that involves water, this is bullshit. Staff B reported she was in the room when Resident #2 refused the shower. Staff B helped Staff A get Resident #2 into the shower chair and that is when the resident did not have her shirt off yet. She used the toilet and then they got her into the shower chair. Staff B said she heard that Staff E was being forceful from Staff A. Prior to this incident, Staff B reported she had an encounter with Staff E when she brought another resident out to the dining area. Resident #1 had a pajama shirt on and Staff E told the resident she could not wear the pajama shirt, she had to put on a shirt. Resident #1 said I don't understand why I cannot wear this. e. On 10/31/25 at 1:30 PM, Staff C, RA, was interviewed by the CQS and DON. Staff C signed the document on 10/31/25 at 1:43 PM. Staff C reported she was in the library with another resident. As she walked the resident, Staff A peeked her head out of Resident #2's room and asked if Staff C worked at the facility. Staff C said yes. Staff A finger motioned Staff C into the room and proceeded to ask what was going on with the nurse, and if the nurse was always like that. Staff C asked Staff A what do you mean? Staff A said she had been by herself for the first hour of the morning and she was told that she needed to make the beds and try to get the residents up first and then do the cleaning afterward. Staff A said when she was getting Resident #2 ready for the shower that Resident #2 grabbed onto the chair sides and did not want to take a shower and then Staff E grabbed Resident #2's hands off the chair and forcefully removed her hands from the chair. Staff A told Staff E not to do that to Resident #2. Staff E said do whatever you want and stormed off. Staff A said she was not sure who she should talk to about the event. Staff C said she would talk to someone about it and then notified Staff D, Social Services (SS). Staff C also shared concerns that Staff E got flustered very easily. Staff C had brought concerns to Staff E before and Staff E responded with I'm so done with this job and seemed very frustrated.f. On 10/31/25 at 1:43 PM, Staff D, SS, was interviewed by the CQS and DON. Staff D signed the document on 10/31/25 at 1:53 PM. Staff D reported Staff C came and told her that Staff A told Staff D that Staff E was very aggressive with Resident #2. Staff D said Staff A gave the example of ripping the resident's hands off the rails and forcefully removed her shirt to get her in the shower after the resident stated she did not want to shower multiple times. Staff A told Staff E that was not right and that Staff E needed to stop. Staff E (continued on next page)

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Staff E said no, I don't have time for this shit. Staff A could tell Staff E was frustrated by the tone in her voice and her throwing her hands above her head, saying I don't have time for this shit. Like she was over it. Staff E came back to the resident's room and told Resident #2 you have to take a shower. Resident #2 said no I don't want to take a shower. Staff E said you are going to take a shower. Resident #2 said no. Resident #2's hands were clenched down on the shower chair. Staff E forcefully pulled the resident's hands off and took her shirt off. Staff A told Staff E that she (Resident #2) doesn't want to take a shower. Staff A could not pull Staff E off of the resident. Staff A told Staff E you can't do this, just leave it alone. Staff A then told Staff E this is like abuse. Staff E finally got the shirt off of Resident #2 and the resident sat in the chair naked. Staff A stated she felt like Staff E violated the resident and she pushed it to the point where she forced the resident. Staff E acted like the resident does this all the time. Staff A told Staff E she did not feel right giving the resident a shower. Staff E yelled do whatever the hell you want, stormed out of the room, and slammed the door. Staff E said she apologized to Resident #2 and told her she did not know what that was all about. Resident #2 said she is just moody, and she's the crabby one. Staff A told Resident #2 she did not have to take a shower now. Resident #2 said now I'm naked, you might as well put me in the shower. Staff A asked Resident #2 what she wanted to do, and Resident #2 said put me in the shower. Staff A told Resident #2 she needed to go report this. Staff A did not have a walkie at that time and did not want to leave the resident alone. Staff A set the shower head by Resident #2 and let the water run. Staff A left the bathroom to get towels located in the room. At that time, another aide walked by the resident's room. Staff A had Staff C come into the room. Staff A told Staff C what happened and wanted to know who she should talk to. Staff C told Staff A she would find someone. Staff C helped Staff A give the resident's shower, then Staff C went to tell someone. The DON talked to Staff A and typed up a statement as Staff A talked about the incident. Staff A reported she believed the way a resident was approached made a difference as far as getting the resident to do things. Staff A felt Staff E took away Resident #2's right to say no. Staff A stated the look on the resident's face was like she wanted to be strong but she was being overpowered by someone who could overpower her. Staff A said she confronted Staff E afterward, and told Staff E she thought what she did was so disrespectful, she did not need to slam the door, and she did not need to cuss. Staff E responded, I lost my cool. I am frustrated, I have a lot of things going on. Staff A told Staff E to not bring things to work and that Staff E needed to give respect. Staff E started to cry. In an interview 11/24/25 at 12:25 PM, Staff B, agency CNA, reported Resident #2 was alert and oriented with what is going on and could let staff know whenever she needed to be changed or needed something. On the day of an incident, she remembered helping get the resident up. Resident #2 was supposed to get a shower but she did not want a shower. The other CNA she was working with (Staff A) went to tell the nurse and Staff B left the room to help another resident. Staff B stated she would let the nurse know when a resident refused something or was resistive to cares, then she waited for the nurse to tell her how to proceed. She would also let the nurse know if the resident had behaviors and document the behaviors in the 24-hour binder at the desk. In an interview on 11/25/25 at 10:55 AM, the CQS reported her impression of the incident that occurred with Resident #2. The CQS believed the agency CNA may not have known the things that the regular staff tried to get the resident to take a shower. The facility also expected the CNA to let the nurse know if a resident (continued on next page)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility investigation file review, staff interviews, and policy review, the facility failed to report and allegation of abuse to the Iowa Department of Inspections, Appeals and Licensing within the required time for 2 of 2 residents reviewed for abuse (Resident#1 and Resident#2). The facility reported a census of 86 residents. Findings include:A Complaint/Incident Investigation Report revealed the facility self-reported an allegation of abuse to DIAL on 11/14/25 at 1:42 PM. The incident occurred on 11/12/25 at approximately 9:40 PM. Resident #1 expressed to Staff F, Certified Nursing Assistant (CNA) anxiety and concerns about an interaction that took place overnight between 11/11/25 to 11/12/25 with Staff I, CNA. Resident #1 told Staff F that Staff I took her bed remote away when she had raised the foot of the bed too high, then Staff I threw the bed remote toward her and struck her wound vac. Staff I was placed on administrative leave on 11/13/25 at 4:30 PM pending the investigation. The Minimum Data Set (MDS) assessment form dated 8/15/25 revealed Resident #1 had diagnoses of Alzheimer's Disease, dementia, left femur fracture, and anxiety disorder. The resident admitted to the facility on [DATE] and readmitted to the facility on [DATE]. The MDS revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating cognition intact. The assessment revealed the resident had dependence on staff for transfers, dressing, and toileting. The MDS documented the resident had hallucinations but no behaviors. The Care Plan revised on 9/4/25 revealed the resident had impaired cognitive functioning related to Alzheimer's disease and hallucinations, and had a high risk for falls related to confusion. The care plan directed staff to cue, reorient, and supervise the resident as needed, chart any hallucinations in the progress notes, and anticipate the resident's needs. A Head-to-Toe assessment dated [DATE] at 4:34 PM revealed the resident reported to the evening CNA that the overnight CNA on 11/11/25 had yelled at the resident when the resident had raised her bed up high, then the CNA hid the remote to her bed so that the resident could not access it. Resident then pushed her call light so she could elevate the head of her bed and the resident reported that the CNA yelled at the resident and threw the bed remote and the remote hit her wound vac machine. Resident alert and oriented times four (person, place, time, and event). Resident verbally denied any pain or discomfort. The on-call nurse was contacted and notified of the report. A Grievance Report was completed and given to the DON (Director of Nursing). The facility's investigative file provided to DIAL during the survey revealed the timeline of the incident: a. On 11/12/25 at approximately 9:40 PM, Resident #1 told Staff F, CNA, that Staff I, CNA, took the remote away from her so she did not have access to the bed remote. Resident #1 reported the event occurred the night prior to the overnight of 11/11 to 11/12/25. Resident #1 reported that the CNA took the remote away because she had raised the foot of her bed up too high. Staff I then left the room. Resident #1 stated she put her call light on because she wanted her remote back. Resident #1 reported to Staff F that Staff I came back into her room yelling and threw the bed remote and the remote hit her wound vac. b. On 11/12/25 at 9:45 PM, Staff F notified Staff G, Licensed Practical Nurse (LPN) of the incident. Staff G notified Staff H, Nurse Leader, of the incident and completed a Grievance Form. c. On 11/13/25 at approximately 9:00 AM, the Director of Health Services (DOHS) was made aware via a Grievance Form. d. On 11/13/25 at approximately 11:00 AM, DOHS and Staff K, Assistant Director of Nursing (ADON) interviewed Resident #1. Resident #1 stated Staff I came into her room the night before and took away her bed remote control. Resident #1 put her call light on to get her bed remote control back and Staff I tossed the bed control towards her, hitting her wound vac machine. e. On 11/13/25 at approximately 11:30 AM, the DOHS and the Clinical Quality Specialist interviewed Staff I. Staff I stated I did take her remote away from her at the time but if I hadn't done that she would have fallen out of bed. She wasn't in her right mind. She was telling me her husband was in bed with her. I didn't mean that to be a permanent thing. I was just trying to keep (continued on next page)

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	11/25/2025

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her safe. I told my nurse that the resident was confused. I did go back to her room later to check on her. I wasn't doing it trying to be mean. I was doing it for her safety. I don't remember if I gave her the bed remote when I went back into her room.f. On 11/13/25 at 4:30 PM, a head-to-toe assessment was done. g. Physician was notified on 11/13/25 at 5:40 PM, and family was made aware of incident at 5:56 PM. h. Staff I was suspended pending the investigation. The timeline did not include when DIAL was notified. A Grievance Form dated 11/12/25 filled out by Staff G, LPN, revealed the incident reported on 11/12/25 at 9:40 PM but the actual incident occurred on 11/11/25. The Summary of Concern revealed while Staff F was assisting Resident #1 in the bathroom, Resident #1 reported that Staff I had yelled at her because she had raised the foot of her bed up too high. Staff I then took the remote away from her so she did not have access to the bed remote. Resident #1 then pushed her call light because she wanted the head of her bed lowered and wanted the bed remote back. Resident #1 then reported that Staff I came into her room yelling and threw the remote and the remote hit her wound vac. Resident #1 also reported to Staff F that if Staff F said anything she would lie because she didn't want to get Staff I into trouble. During an interview on 11/19/25 at 1:25 PM, Resident #1 reported staff were treating her well but staff could be rougher than she thought they needed to be. Staff needed to know what was wrong with her leg so they knew how to take care of her because she fell and broke her leg. She did not recall how she fell. The surveyor inquired about what happened regarding the aide and remote. Resident #1 reported the CNA took the remote for the bed and she called her back in (to her room). The CNA was not too happy, she threw the remote and it hit her wound machine. The CNA told her not to make the bed go up and down. Resident #1 stated she needed her head and legs raised to make herself more comfortable. Resident #1 said she knew how to run the bed because she had been doing it a long time, since she had lived at the facility over a year. She had operated the bed all along and nobody told her not to. Resident #1 thinks she made the CNA mad when she challenged her. The CNA told her she was not supposed to use the remote but nobody had told her she could not use it before. Resident #1 reported she was surprised when the CNA threw the remote and she thought it was childish and done in anger.In an interview on 11/19/25 at 3:00 PM, Staff F, CNA, reported she was not working on the night of the incident with Resident #1 and Staff I but the resident told her about what happened. Resident #1 was on the toilet and wanted Staff F to stay in the bathroom with her. Resident #1 looked at her and said Can I tell you something but I don't want you to repeat it. Resident #1 told Staff F she had the foot of her bed raised and Staff I came in and was yelling and got angry with her, and took the remote from the bed. Resident #1 said she pushed call light. She wanted her head down but didn't have the remote. Staff I got angry with her again and took the remote and threw it, and it hit the machine on the resident's leg. Resident #1 said if someone came and asked her about it, she would deny and say she forgot. Staff F stated she finished cares with Resident #1 and went and told Staff G what happened. Staff G called the on-call manager and she was told to fill out a form (grievance). Staff F reported she also wrote a statement about the incident. In an interview 11/19/25 at 3:20 PM, Staff G, LPN, reported Staff F came and told her what Resident #1 told her. Staff F told her that the CNA yelled at her for raising her bed up. The CNA came in and took the remote, lowered the bed, and placed the remote out of reach. Resident #1 put the call light on. The CNA yelled at her again and threw the remote and it hit the wound vac. Staff G had Staff F write a statement, and Staff G called Staff H, the on-call nurse, and told Staff H about the concerns. Staff G reported she was told to fill out a grievance report and had Staff F write a statement. Staff G reported she attached the statement to the grievance report, then put the information in a manilla envelope and placed it under the DOHS door. Staff G reported she was going to go talk to Resident #1 but she was resting. Staff G figured the managers would go talk to the resident in the AM and Staff G did not want to irritate Resident #1. In an interview 11/19/25 at 3:45 PM, the Executive Director reported Staff H no longer worked at the facility. In an interview 11/24/25 at 4:00 PM, Staff H, LPN, reported she had received abuse training through Relias (online program). Staff H reported she became aware of a situation with Resident #1 and Staff I when she was notified by Staff G around (continued on next page)

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	165607	A. Building B. Wing	11/25/2025

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10:30 PM about the CNA yelling at or toward Resident #1, and the call light or bed remote was thrown toward Resident #1. Staff H stated she figured at 10:30 PM, there was not much she could do so said she would deal with it in the AM. She told Staff G to just make sure the aide was not working with the resident. She told Staff G to slip something under the DOHS's door regarding the incident. Staff H confirmed she did not call or report the incident to DIAL because she thought they had 24 hours and she would talk to the DOHS in the AM. Staff H reported she spoke with DOHS around 8:15 AM the following day (on 11/13/25). In an interview on 11/20/25 at 9:30 AM, the DOHS, reported she became involved in knowing about the situation with Resident #1 when she came to work and found a grievance form under her door. The DOHS reported she did not get a call from anyone about it. She called the CQS right away after she read the grievance, and went to check on Resident #1 to make sure she was ok. The DOHS reported Staff I was suspended. Staff H got termed because she did not report the incident to management or the State.In an interview11/20/25 10:15 AM, Staff I reported she was doing room checks. Resident #1 had the remote by her bed but she did not think the resident should have it. Resident #1 was sometimes not in her right mind. When she went in to do a room check, Resident #1's bed was high in the air. Staff I reported she took the remote and moved the bed down. Resident #1 was yelling at her. She told Resident #1 not to scream at her when she got the remote, then she shut the door because Resident #1 was yelling. Staff I reported she did not remember where she put the remote. Staff I reported she went to tell the nurse she needed to come help her and that Resident #1 was putting the bed in the air. Staff J went in and gave back the remote. 2. A Complaint/Incident Investigation Report revealed the facility self-reported an allegation of abuse to DIAL on 11/03/25 at 5:29 PM. The incident occurred on 10/31/25 at approximately 9:20 AM. Staff A, Certified Nursing Assistant (CNA) notified Staff E, Registered Nurse (RN) that Resident #2 refused to take a shower. Staff E was upset and said she did not have time for this shit and followed Staff A into the resident's bathroom. Staff E told Resident #2 she had to take a shower and the resident said no. Staff E then pried the resident's hand off the chair and forcefully took off her shirt. Resident #2 was uptight and clenching her hand as Staff E removed the resident's hand and shirt, and yelled no stop, stop right now, no no. On 10/31/25 at approximately 9:45 AM, Staff A reported the incident. Staff E was removed from the unit.The MDS assessment dated [DATE] revealed Resident #2 had diagnoses of anxiety disorder, depression, osteoarthritis, and muscle weakness. The MDS recorded the resident had a BIMS score of 11 out of 15, indicating moderately impaired cognition. The MDS indicated the resident required substantial to maximum assistance for upper body dressing and partial to moderate assistance for showering/bathing. The MDS revealed the resident had no behaviors during the seven-day look-back period. The Care Plan revealed Resident #2 required assistance with ADL's (activities of daily living). The Care Plan directed staff to cue, reorient and supervise as needed, present one thought or command at a time, and leave the resident alone in a safe position and retry the task in a few minutes if the resident was resistive to care (initiated 8/26/24).A Progress Note dated 10/31/25 at 10:32 AM revealed the resident became very agitated during a shower and was refusing to get in the shower. Nurse assisted resident with removing her clothing. Resident alert and oriented x 3. Staff H documented the Safety Measures implemented at that time to encourage the resident to take a shower and if refusing, try again at a later time.The facility's investigative file provided to DIAL during the survey revealed the timeline of the incident: a. On 10/31/25 at 9:20 AM, Staff A, CNA, notified Staff E, RN, that the resident was refusing her shower. Resident #2 continued to refuse a shower at that time. Staff A reported that when she spoke with Staff E, Staff E she was upset and said I don't have time for this shit and she followed Staff A into the bathroom and started telling Resident #2 she had to take a shower. The resident said no. Staff E then pried the resident's hand off the chair and then forcefully took off her shirt. Resident #2 was uptight and clenching her hands and saying no, stop this, stop right now, no, no as Staff E removed the resident's hand and shirt. b. On 10/31/25 at 9:45 AM, Staff A reported the incident. Staff E was removed from the unit and interviewed. The Facility's Investigation File did not (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	list a date and time when the incident was reported to DIAL. In an interview on 11/20/25 at 1:50 PM, Staff C, Restorative Aide (RA), reported Staff A came to her and asked her if she worked at the facility. Staff A explained the situation that they had Resident #2 in the bathroom, Staff E was in the room and pried the resident's hand off of the chair and proceeded to take off her shirt. The CNA told Staff E she should not do that. The nurse left the room and said she was fed up with being there or fed up with the day. Staff A did not know who to tell. Staff C told her she would talk to someone and then went and talked to Staff D, Social Services (SS). In an interview on 11/20/25 at 1:30 PM, Staff D reported Staff C, RA, came to her on a Friday (10/31/25) and asked how she should proceed with a situation. Staff A was in the room with Resident #2 and Staff E was in the room. Staff A told her that Staff E removed the resident's hand from the rail and took her shirt off. Staff A told Staff E she needed to stop. Staff E walked out of the room and slammed the door. After that, Staff C told Staff A she would tell the appropriate people. Staff D reported she talked to the Executive Director and the DOHS. In an interview on 11/20/25 at 2:45 PM, the Executive Director reported the CQS and the DOHS were involved in the investigation of the incident with Staff E and Resident #2. In an interview on 11/25/25 at 10:55 AM, the CQS reported the facility expects the CNA to let the nurse know if a resident refused a shower so the CNA was letting the nurse know. The nurse was frustrated about that day. She started the investigation on a Friday and got staff statements and then determined to report the incident to DIAL the following Monday. In an interview on 11/25/25 at 11:10 AM, the Senior CQS reported they never tried to hide and not report abuse allegation. She attended the Leading Age conference in 5/2025. At that time, the DIAL Bureau Chief (BC) spoke and requested the facilities to gather information to determine if they had enough information to determine if it was really abuse. There had not been any situations that came up until the allegation in 10/31/25. There was confusion. The Leading Age Coordinator reached out to the DIAL BC and then an email was sent out to clarify the information brought up at the conference in 5/2025 related to reporting of abuse. The Senior CQS provided a copy of the email from the Leading Age Coordinator dated 11/18/25 to the surveyor.The facility's Abuse Policy and Resident Protection Plan last approved 7/2025 revealed any team member who becomes aware of abuse, mistreatment, neglect, or misappropriation shall immediately report to their immediate supervisor. Dependent Adult Abuse is the willful infliction of any physical, verbal, neglect, corporal punishment, or physical restraint. The Administrator and DON notified immediately and other officials in accordance with state law. The Executive Director, Administrator or DON will report the incident immediately, but no later than 2 hours after forming the suspicion. The facility must report allegations of neglect or mistreatment that do not result in serious bodily injury no later than 24 hours after forming the suspicion. Failure to report within mandated timeframes are subject to a civil money penalty.