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. 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 (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

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	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 intervention and immediately added it to the care plan. She stated with regard to Resident #20, she would do some research to find out which interventions were implemented. On 8/21/25 at 11:22 a.m., Staff K CNA stated Resident #20 got up on her own and fell. She stated they tried to toilet her every two hours but even with this, she got up by herself. When queried regarding any interventions that the facility directed her to carry out in order to prevent the resident from falling, Staff K could not name any. Staff K did say that she closed the bathroom door so the resident was not cued to get up but stated she figured this intervention out on her own. On 8/21/25 at 1:42 p.m., the DON stated she did not find any additional interventions for the resident on the care plan. She stated the team came up with interventions but they did not make it on the care plan. She stated she was not sure why this happened.

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on clinical record review, policy review, and staff interview, the facility failed to ensure staff attempted non-pharmacological interventions prior to the administration of as needed(prn) anti-anxiety medications for 1 of 3 residents reviewed for anti-anxiety medications(Resident #3). Along with the anti-anxiety medication a opiod analgesic (strong pain med) was also given in most cases at the same time with no non-pharmalogical interventions for relief of pain attempted, or waiting for effectiveness of either medication. The facility reported a census of 95 residents.Findings: The Minimum Data Set(MDS) assessment tool, dated 8/1/25, listed diagnoses for Resident #3 which included depression, mild cognitive impairment, and muscle weakness. The MDS stated the resident had physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) 1 to 3 days out of the 7 day review period. The MDS stated the resident had inattention and disorganized thinking. The Care Plan for R#3 identified a focus are as an alteration in musculoskeletal status related to left pubic fracture, lumbar disc degeneration, osteoarthritis, and knee pain initiated on 8/12/25 with the following interventions; Give analgesics as order by the physician. Monitor for side effects and effectiveness. Heat/cold applications as ordered and as tolerated.A NADV Clinical admission note dated 7/28/25 at 10:58 a.m. documented the following; Pain: location left hip. pain score: 6 stabbing. Frequency: multiple times a day. Relaxation techniques encouraged. Distraction techniques utilized. Non-medication interventions provided relief. Scheduled medication provided. The facility policy Psychotropic Use Guide-Routine/PRN, dated 3/2025, stated residents who used psychotropic drugs received gradual dose reductions and non-pharmacological interventions in an effort to discontinue these drugs.The August 2025 Medication Administration Record(MAR) listed the following orders:A. A 7/31/25 order for lorazepam(an anti-anxiety medication) 0.5 milligrams(mg) every 4-6 hours as needed for agitation. The MAR documented the resident received the medication at the following times: 8/1/25 at 7:59 p.m., 8/2/25 at 7:48 p.m., 8/4/25 at 7:00 p.m.B. An 8/5/25 order for lorazepam 0.5 mg twice daily as needed for agitation. The MAR documented the resident received the medication at the following times: 8/6/25 at 3:25 p.m. and 8:20 p.m., 8/7/25 at 10:00 a.m. and 8:01 p.m., 8/9/25 at 9:01 a.m., 8/12/25 at 8:23 p.m., 8/13/25 at 9:09 p.m., 8/14/25 at 2:33 p.m., 8/17/25 at 8:45 p.m., 8/1825 at 7:57 p.m.C. A 7/31/25 order for Oxycodone 2.5mg twice a day as needed for pain. The MAR documented the resident received the medication at the following times; 8/6/25 p.m. 8:00 p.m., 8/7/25 at 10:01 a.m., and 8:01 p.m., 8/9/25 at 9:02 a.m., 8/12/25 at 8:23 p.m., 8/13/25 at 9:09 p.m., 8/13/25 at 9:09 p.m., 8/14/25 at 2:36 p.m., 8/17/25 at 8:45 p.m.The MAR lacked documentation of non-pharmacological interventions staff attempted prior to the above administrations, or waiting for effectiveness between giving an additional as needed (PRN) medication. The resident's Progress Notes also lacked documentation of non-pharmacological interventions staff attempted prior to the above administrations. On 8/20/25 at 1:28 p.m., Staff A Registered Nurse(RN) stated prior to the administration of prn anti-anxiety medications, staff should document other non-pharmacological interventions attempted. On 8/20/25 at 3:27 p.m., the Director of Nursing(DON) stated staff should chart non-pharmacological interventions prior to the administration of anti-anxiety medications.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, and policy review, the facility failed to ensure that a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for 2 of 20 residents reviewed for care planning (Resident #7 and #8). The facility reported a census of 95 residents.Findings include:1. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #7 had diagnoses of non-Alzheimer's dementia and anxiety. The MDS also indicated that Resident #7 had delusions and rejected care 1 to 3 days in the 7-day look back period. The Physician's Orders revealed that Resident #7 was prescribed 1 milliliter (mL) of a compound ointment topically to inner wrist every 8 hours as needed for agitation. Each mL of compound ointment included: Lorazepam 1 milligram (mg), Diphenhydramine 12.5 mg and Haloperidol 2 mg. In an interview on 8/21/2025 at 9:32 AM Staff C, Licensed Practical Nurse (LPN) stated that she created the care plans for North and South [NAME]. Stated she gets the information for the care plans for new residents from their medications, diagnoses, assessments and through interviews. Staff C, LPN added that she looks at new orders that come in. Staff C, LPN stated that antipsychotic medications should be on the care plan as well. Stated that Haldol, even in a compound ointment, should be on the care plan as an antipsychotic. Staff C, LPN stated that Resident #7 did not have it on her care plan. She also stated she must have missed it as Resident #7 came in with no medications. 2. The Significant Change MDS assessment dated [DATE] revealed Resident #8 had diagnoses of senile degeneration of the brain and cerebral palsy. The MDS indicated the resident was on hospice. The Care Plan revised 7/21/25 revealed Resident #8 was on hospice care services. The care plan lacked information related to oxygen (O2). The Order Summary revealed an order for O2 via nasal cannula (NC) to keep the resident's O2 saturation above 90% (percent) as needed for shortness of breath and for comfort measures. The O2 order had a start date of 8/11/24. The Electronic Health Record (EHR) Weights and Vitals section documented O2 via NC on 5/23/25, 7/4/25, and 7/6/25. Observation on 8/18/25 at 1:32 PM revealed Resident #8 sat in a wheelchair in her room without O2 on. An O2 concentrator sat near the door in the resident's room. In an interview on 8/21/25 at 9:32 AM, Staff C, LPN, stated that she developed the residents' care plans for the North and South [NAME] units. Staff C reported she obtained information for the care plans from the resident's orders, medication list, diagnoses, assessment and through resident and staff interviews. Staff C stated she also looked at any new orders that came in. Staff C stated that oxygen should be on the resident's care plan. 3. The admission MDS dated [DATE] revealed Resident #2 had diagnoses of end-stage renal disease, diabetes mellitus, stage 3 sacral pressure ulcer, and neuromyopathy (damage to both peripheral nerves and muscles, resulting in muscle weakness, sensory loss, difficulty with movements, balance, and coordination). The MDS indicated the resident required substantial/maximal assistance with all transfers. (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	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission Care Plan dated 6/19/25 revealed Resident #2 is an assist of 1 with front wheel walker (FWW) for transfers. Review of Physician Progress note dated 8/19/25 documented Resident #2's use of EZ stand (mechanical device used to assist to standing position and transfer) for transfers. In an interview on 8/21/25 at 4:10 PM, Staff J, Assistant Director of Healthcare, RN, stated since admission Resident #2 requires the use of an EZ stand for transfers. A Comprehensive Care Plan Process policy last revised 12/2021 revealed the facility must develop and implement a comprehensive person-centered care plan to meet a resident's medical, nursing, mental and psychosocial needs. The comprehensive care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff interviews, and policy review, the facility failed to ensure safe and accurate delivery of oxygen therapy for one of three residents reviewed for respiratory care (Resident #86). The facility reported a census of 95 residents.Findings include:1. The admission Minimum Data Set (MDS) dated [DATE] revealed that Resident #86 had diagnoses of heart failure, hypertension, respiratory failure, pulmonary hypertension and congestive heart failure with hypoxia.The Care Plan initiated on 7/3/25 indicated that Resident #86 has oxygen therapy related to congestive heart failure (CHF) and gets oxygen via nasal cannula (nc) continuously. It lacked information related to the liters of oxygen flow ordered.The Clinical Physician's Orders dated 6/24/25 directed staff to provide the resident oxygen continuous at 4 liters via nc continuous, and two times a day check oxygen saturation levels with an indefinite end date.The Electronic Treatment Administration Record (EMAR) indicated that Resident #86 was to have the oxygen tubing and humidification unit changed weekly on Tuesdays. It also indicated that they were changed on 8/13/25.The Electronic Treatment Administration Record (ETAR) indicated that Resident #86 was receiving oxygen via nc at 4 liters continuous through the morning of 8/19/25. It was confirmed 2 times daily with an oxygen saturation test.Observations revealed the following:a. On 8/18/25 at 1:43 PM Resident #86 had the oxygen tubing in her nose but the room oxygen concentrator was not turned on.b. On 8/18/25 at 2:18 PM Resident #86 had oxygen on via nasal cannula but unable to see flow rate as visitor in room.c. On 8/19/25 at 9:00 AM Resident #86 was sitting in recliner in room with oxygen off and room concentrator off. Requested this surveyor put on or get staff to help.d. On 8/19/25 at 10:56 AM Resident #86 was sitting in her recliner with her eyes closed. The oxygen tubing and humidification unit for the concentrator were labeled 8/11/25. The oxygen was set at just under 2 liters via nasal cannula.e. On 8/19/25 at 2:29 PM the oxygen tubing and humidification unit for the room concentrator for Resident #86 were still labeled 8/11/25. Picture confirmation taken.f. On 8/20/25 at 8:34 AM Resident #86 was sitting in her recliner with oxygen tubing in her nose connected to the portable concentrator on her wheel chair. The portable concentrator was off. Tubing to portable oxygen concentrator was labeled 8/13/25.In an interview on 08/19/2025 at 9:05 Staff B, CNA stated that Resident #86 can be off of her oxygen when she is out of her room and it is as needed in her room. Stated she will put on Resident #86 if she is requesting it. In an interview on 08/20/2025 at 9:18 AM Staff A, RN stated that Resident #86's oxygen order was just changed to as needed. This surveyor informed Staff A, RN that Resident #86 had her oxygen tubing via nc on but the portable and room concentrators were off. Stated that was no ok and she went to Resident #86's room. She then switched Resident #86 from the portable oxygen concentrator to the room oxygen concentrator and plugged the portable oxygen concentrator in to a wall outlet. Stated the oxygen tubing is changed weekly. Staff A, RN noted that the humidification unit and it's short tubing were dated 8/11/25 and stated that she would change those. Stated current oxygen order is at 2 liters via nasal cannula as needed and can be from 2-4 liters. After questioning what the unit was currently set at, Staff A, RN stated 2 liters. She was looking at the settings from above. Stated that the line had to be in the middle of the bubble. This surveyor reminded Staff A, RN to read the settings from eye level. Staff A, RN looked straight on and stated it was not on 2 liters and increased the rate.In an interview on 8/20/2025 at 10:30 AM Staff C, LPN stated they got the verbal order from Hospice on 8/8/25 for the oxygen to be 4 liters nasal cannula as needed for dyspnea. Stated that staff were aware and they have been following that since then. Stated that they did not change the order under the orders tab in Point Click Care (PCC) as they did not have the signed written order back until 8/19/25. Stated that it is not acceptable for nurses to be charting in the EMAR that Resident #86 is getting 4 liters continuous when she is not. Also stated not acceptable for Resident #86 to be on 2 liters currently since the order says 4 liters as needed.In a document titled Oxygen Therapy and Portable Oxygen (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	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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Tank, lacked documentation on following doctor's orders related to proper liter flow or correctly reading liter flow on an oxygen concentrator. It also lacked direction on properly documenting oxygen usage.

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 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.

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on clinical record review, observation, staff interview, and policy review, the facility failed to assure a medication error rate of less than 5%. During observation of medication administration, the facility had 3 errors out of 27 opportunities for error resulting in an error rate of 11.11% (Residents #25 and #66). The facility identified a census of 95 residents.1. The Quarterly Minimum Data Set (MDS) Assessment, dated 7/3/25, revealed Resident #25 had a diagnosis of diabetes. The MDS documented the resident took insulin during the 7-day lookback period. The Medication Administration Record (MAR), dated August 2025, for Resident #25 listed Lispro 100 milligrams (mg)/milliliter (ml), inject subcutaneously (SQ) per sliding scale before meals for blood glucose (sugar) 0-150=zero units (U); 151-200=6U; 201-250=8U; 251-300=10U; 301-350=12U; 351-400=14U and scheduled at 7:00 AM, 11:00 AM and 4:00 PM. The MAR revealed Staff E, Registered Nurse (RN), administered 10 U SQ on 8/19/25 at 5:58 PM.On 8/19/25 at 4:26 PM, observation of Staff E, RN, revealed Staff E obtained Resident #25's blood glucose level which measured 280. Staff E then pushed Resident #25's wheelchair to a table in the dining room. In an interview during the observation, Staff E, RN, reported he planned to hold the administration of the Lispro Insulin until after the resident ate their supper due to concerns with food intake for the lunch and breakfast meals that day (8/19/25). On 8/19/25, continuous observation from 4:26 PM to 5:58 PM revealed the following:a. At 5:04 PM, Staff E, RN, administered Buspar 15 mg, Lorazepam 1mg, Metoprolol 12.5 mg and Nitrofuran 100 mg to Resident #25.b. At 5:07 PM, Resident #25 received her dinner meal of grilled cheese, tomato soup and a sliced fruit cup.c. At 5:31 PM, Resident #25 had finished eating and had consumed 75 percent of her meal.d. At 5:46 PM, Resident #25 was observed to have her eyes closed and neck flexed down while sitting at the table. e. At 5:53 PM Staff E,RN, woke up Resident #25 and pushed her wheelchair to her room.f. At 5:55 PM, Staff E, RN, administered 10 U of Lispro Insulin SQ via a flex pen to Resident #25's left lower outer abdominal area. Review of Resident #25's clinical record including physician orders, MAR and progress notes revealed a lack of documentation of physician orders or notification of the delay in administration of the Lispro insulin on 8/19/25. The nutrition intake record, dated 8/19/25, revealed Resident #25 ate 75 to 100 percent breakfast, lunch and dinner. On 8/21/2025 at 10:19 AM, the Director of Nursing (DON) reported the facility policy to notify the resident's physician if the nurse need to administer a medication outside of order parameters. The DON reported a nurse should not use nursing judgement to change an insulin order; the nurse needed to contact the physician in order to change an insulin order. The DON reported she recently provided education to her nursing staff on this same issue. The DON explained Staff E, RN, would not have received this education due to Staff E working through an agency and not directly through the facility. 2. The Electronic Health Record (EHR) Medical Diagnosis list revealed Resident #66 had a diagnoses of dysphagia (difficulty swallowing) and hypothyroidism (low functioning thyroid gland). A faxed Physician Communication and order, dated 1/15/25, included documentation of a request by facility nursing staff to change the administration time of Omeprazole and Levothyroxine. The ordered time had been at 5:30 AM every day, and the physician agreed to change the time of administration to be between 6:00 AM to 10:00 AM, as long as the Omeprazole was administered 20 to 30 minutes before breakfast, and Levothyroxine was administered on an empty stomach 1 hour before food intake. The EHR included an order summary of the following medications: a. Omeprazole 20 mg, take one capsule by mouth daily 30 minutes before meals and an order start date of 1/16/25. b. Levothyroxine 75 micrograms (mcg), take one tablet by mouth on an empty stomach at least 30 minutes before meals and an order start date of 1/16/25. Review of the MAR, dated August 2025, for Resident #66 revealed Staff F, Licensed Practical Nurse (LPN), administered Omeprazole 20 mg, one capsule by mouth 30 minutes before meals, and Levothyroxine 75 mcg one table by mouth on an empty stomach 30 minutes before meals. On 8/20/25 at 8:39 AM, observation of Resident #66 revealed the resident was sitting at a table in the dining room eating hot cereal. On 8/20/2025 at 8:57 AM, observation of Staff F, LPN, revealed Staff F (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	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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	placed the following medications into a pill cup: Aspirin 81 mg one tablet, Omeprazole 20 mg capsule, Levothyroxine 75 mcg one tablet, Calcium-Vitamin D3 600-800 mg one tablet, Gabapentin 300 mg one capsule, Lisinopril 10 mg one tablet, Metoprolol tartrate 50 MG one tablet, Vitamin D3 1000 units one tablet, and Sertraline 50 mg one tablet. Staff F separated out the 2 capsules, crushed the tablets, emptied the contents of the capsules into the crushed tablets. Staff L placed the medications into chocolate pudding. Resident #66 was sitting at the dining room table and had already ate breakfast. Staff L administered the medications by feeding bites of the pudding to the resident. The Assistant Director of Nursing (ADON) was present throughout the medication administration. On 8/20/2025 at 8:59 AM, when asked why the Omeprazole had been administered outside of the physician ordered parameter of 30 minutes before breakfast, Staff L, LPN, explained that she believed the resident was care planned to take Omeprazole with other medications, because the resident a hard time with swallowing and was very confused. On 8/20/2025 at 9:01 AM, the ADON explained that staff had probably not requested to have the before meals statement removed from the medication order. The ADON reported they needed to reach out to the pharmacy to have that statement removed. Review of Resident #66's clinical record including physician orders, MAR and progress notes revealed a lack of documentation of physician orders or notification of the delay in administration of the Omeprazole and Levothyroxine on 8/20/25. Review of the facility policy, titled Medication Administration, dated 8/2024, revealed staff administering medications would ensure medications were administered per physician orders and at the right time. Resident preference would be given for administration time unless the preference contradicted the physician order.

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on clinical record review, observation, staff interview and review of facility policy, the facility failed to give an insulin prior to the meal as ordered for one of one residents observed who received insulin during medication pass (Resident #25). The facility reported a census of 95 residents.The Quarterly Minimum Data Set (MDS) Assessment, dated 7/3/25, revealed Resident #25 had a diagnosis of diabetes. The MDS documented the resident took insulin during the 7-day lookback period. The Medication Administration Record (MAR), dated August 2025, for Resident #25 listed Lispro 100 milligrams (mg)/milliliter (ml), inject subcutaneously (SQ) per sliding scale before meals for blood glucose (sugar) 0-150=zero units (U); 151-200=6U; 201-250=8U; 251-300=10U; 301-350=12U; 351-400=14U and scheduled at 7:00 AM, 11:00 AM and 4:00 PM. The MAR revealed Staff E, Registered Nurse (RN), administered 10 U SQ on 8/19/25 at 5:58 PM.On 8/19/25 at 4:26 PM, observation of Staff E, RN, revealed Staff E obtained Resident #25's blood glucose level which measured 280. Staff E then pushed Resident #25's wheelchair to a table in the dining room. In an interview during the observation, Staff E, RN, reported he planned to hold the administration of the Lispro Insulin until after the resident ate their supper due to concerns with food intake for the lunch and breakfast meals that day (8/19/25). On 8/19/25, continuous observation from 4:26 PM to 5:58 PM revealed the following:a. At 5:04 PM, Staff E, RN, administered Buspar 15 mg, Lorazepam 1mg, Metoprolol 12.5 mg and Nitrofuran 100 mg to Resident #25.b. At 5:07 PM, Resident #25 received her dinner meal of grilled cheese, tomato soup and a sliced fruit cup.c. At 5:31 PM, Resident #25 had finished eating and had consumed 75 percent of her meal.d. At 5:46 PM, Resident #25 was observed to have her eyes closed and neck flexed down while sitting at the table. e. At 5:53 PM Staff E,RN, woke up Resident #25 and pushed her wheelchair to her room.f. At 5:55 PM, Staff E, RN, administered 10 U of Lispro Insulin SQ via a flex pen to Resident #25's left lower outer abdominal area. Review of Resident #25's clinical record including physician orders, MAR and progress notes revealed a lack of documentation of physician orders or notification of the delay in administration of the Lispro insulin on 8/19/25. The nutrition intake record, dated 8/19/25, revealed Resident #25 ate 75 to 100 percent breakfast, lunch and dinner. On 8/21/2025 at 10:19 AM, the Director of Nursing (DON) reported the facility policy to notify the resident's physician if the nurse need to administer a medication outside of order parameters. The DON reported a nurse should not use nursing judgement to change an insulin order; the nurse needed to contact the physician in order to change an insulin order. The DON reported she recently provided education to her nursing staff on this same issue. The DON explained Staff E, RN, would not have received this education due to Staff E working through an agency and not directly through the facility. Review of the facility policy, titled Medication Administration, dated 8/2024, revealed staff administering medications would ensure medications were administered per physician orders and at the right time. According to the American Academy of Family Physicians (AAFP) Insulin Lispro should be injected under the skin within 15 minutes before you eat.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, and policy review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 3 residents reviewed for pressure ulcers (Resident #92). The facility reported a census of 95 residents.Findings include:1. The Significant Change in Status Minimum Data Set (MDS) dated [DATE] revealed that Resident #92 had an unhealed, unstageable pressure injury presenting as a deep tissue injury.The Care Plan initiated on 4/8/25 indicated that Resident #92 has a pressure ulcer related to immobility. The Care Plan initiated the focus area with revision date of 4/9/25 documented the resident with self care deficits for activities of daily living related to dementia, and directed the staff to provide two staff to assist with toilet use, and transfers.The Electronic Health Record (EHR) indicated that the location of the pressure ulcer was located on the right dorsum of the first metatarsal.In an observation on 8/19/2025 at 2:44 PM Staff H, CNA Staff I, CNA performed toileting and transfer with Resident #92. Staff G, CMA was present also present. Staff H, CNA cleansed peri area and changed gloves without performing hand hygiene in between. Staff H, CNA then removed old pull-up, placed new pull up and pulled up Resident #92's pants. After Staff H, CNA and Staff I, CNA transferred Resident #92 to her Broda chair with a mechanical lift, Staff H, CNA grabbed Resident #92's water pitcher by the handle and gave Resident #92 a drink with her gloves still on. Finally, personal protective equipment was removed and hand hygiene was performed.In an observation on 8/21/2025 at 10:37 AM Staff D, LPN performed wound care to right inner foot pressure wound on Resident #92. Staff C, LPN was also present. Staff D, LPN took off the old dressing and proceeded to cleanse with wound cleanser without changing gloves. After cleansing and drying, she changed gloves without hand hygiene in between. When she finished with the dressing change, Staff D, LPN put away the cleanser in a cabinet in the room with the same gloves on and threw away her trash. Staff D, LPN then removed her gloves and, without gloves or hand hygiene, changed the trash. She then carried the trash to the door where she used hand sanitizer with the trash still in her hand.In an interview on 08/21/2025 at 11:30 AM the DON stated that hand hygiene should be performed between all glove changes and after removing a dirty dressing. Stated items such as cabinets, sanitizer bottles or water pitchers that were contaminated should be sanitized.In a document titled Infection Control Manual last revised 7/2022, a document titled Hand-Washing Technique indicated staff should always wash hands after handling a source that is likely to be contaminated, such as equipment, dressings, and secretions and excretions from residents. The document lacked information on hand hygiene between changing of gloves.

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, Centers for Disease Control and Prevention (CDC) guidelines, and staff interview, the facility failed to offer the pneumococcal vaccine to 1 of 5 sampled residents reviewed for immunizations (Resident #25). The facility reported a census of 95 residents.Review of CDC guidelines, dated 10/2024, revealed the following recommendations:Administer Prevnar 20 (PVC20), Prevnar 21 (PVC21), or Vaxneuvance (PVC15) for all adults 50 years or older who have never received any pneumococcal conjugate vaccine, or whose previous vaccination history is unknown.Review of the clinical record for Resident #25 revealed the following:The Quarterly Minimum Data Set (MDS) assessment, dated 7/3/25, identified an admission date of 7/12/24, the resident was over age [AGE], and had diagnoses that included diabetes and dementia. The assessment identified had a severe cognitive impairment. An Informed Consent for Pneumococcal Vaccine, dated 7/12/24, included a signature of authorization by the power of attorney (POA) for Resident #25 to receive the pneumococcal vaccine.On 8/20/25, review of the clinical record for Resident #25's immunization status revealed a lack of documentation on whether Resident #25 had ever received the Pneumovax (PPSV23) vaccine, or any of the pneumococcal conjugate vaccines, Prevnar 20 (PVC20), Prevnar 21 (PVC21), Vaxneuvance (PVC15) per CDC guidelines. On 8/20/2025 at 11:16 AM, the Director of Nursing (DON) explained the facility contracted with a pharmacy to track and oversee the administration of vaccines to the residents. The DON reported she had a spreadsheet with the residents and the vaccines they had received. She was unable to find evidence on the spreadsheet that Resident #25 had received the pneumococcal vaccine. The DON was unsure why the resident would not have received the vaccine.On 8/21/2025 at 10:27 AM, the DON confirmed Resident #25 had not received the pneumococcal vaccine. The DON contacted the pharmacy and the resident would be given the vaccine.Review of the facility policy, titled Infection Prevention Thru Immunization, dated 8/2025, revealed that all residents would be assessed for eligibility per CDC guidelines and offered the pneumococcal vaccine.