STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165795	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perry Lutheran Homes Eden Acres Campus	1300 28th Street Perry, IA 50220

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 - 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 clinical record review, policy review, resident and staff interviews, the facility failed to protect residents from abuse for which caused psychosocial harm for 3 of 4 resident reviewed (Resident #3, #4 and #2). On 12/19/25 during the night shift a nurse reported that multiple residents residing on B hall reported concerns regarding the conduct of Staff A, Certified Nursing Assistant (CNA). The staff's actions resulted in residents being scared of Staff A. The facility identified a census of 49 residents. Finding include:1. Resident #3's Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 14, indicating no impaired cognition. Resident #3 can hear adequately and could understand and be understood by others with no behavior or mood issues. Resident #3 required substantial to maximum assistance with sit to lying and lying to sitting on side of bed and rolling from left to right, functional limitation in range of motion to upper and lower extremity on one side, walker and wheelchair used for mobility device, and frequently incontinent of bladder. The MDS included diagnoses of heart failure, cerebrovascular accident (a medical condition where blood flow to part of the brain is suddenly interrupted, causing blood cells to die from lack of oxygen leading to weakness to a side of the body) hemiplegia (paralysis affecting one side of the body) history of pressure ulcer of the sacral region (the triangular area at the base of your spine) and a diuretic (a medications used to increase urine production, helping the kidneys flush out excess salt and water) used in the last 7 days.The Care Plan with an initiated date of 3/17/25, indicated Resident #3 required assistance of 1 with getting out of bed, may have bladder accidents, anticipate needs and provide prompt assistance as indicated.The Plan of Care Response History dated 12/19/25 at 2:51 AM, documented Resident #3 incontinent of urine.The facility's untitled page of resident interviews dated 12/20/25, documented Resident #3 stated that Staff A, Certified Nursing Assistant (CNA) told the resident to put the residents head down because Staff A, is not going to hurt her back (Staff A's) for the resident by assisting with turning. Resident #3 is scared of Staff A.The Social Service Note dated 12/22/25 at 11:10 AM, documented, met with resident this AM and resident states is having a good day so far.The Social Service Note dated 12/22/25 at 3:08 PM, documented, notified that resident had some concerns that needed addressed, Met with resident, Director of Nursing (DON) and social services. Concerns and questions were answered and went over. Resident stated that she feels better now and not worried anymore.The Social Service Note dated 1/5/26 at 1:55 PM, documented, met with resident twice last week both times resident was not scared or worried about anything at that time. Resident appeared to be pleasant and cheerful.The Social Service Note dated 1/6/26 at 2:21 PM, documented, met with resident today, she is doing fine. States she knows the staff member will not be back and is happy that with that.On 1/6/26 at 2:00 PM, Resident #3 stated that Staff A, was yelling and screaming in the hallway during the night shift on 12/19/25. Resident #3 explained that Staff A came into her room around 3:00 AM, and demanded that resident put (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 - Actual harm Residents Affected - Few	her head down while lying in bed because Staff A was not going to hurt her back for the resident. Resident #3 explained that she had an urinary accident in the pad and refused to put on the call light due to being scared of Staff A, and laid in a urine soaked brief until the next shift came on at 6:00 AM. Resident #3 did not report this until the Social Worker did an interview with the resident in the afternoon of 12/20/25, due to Resident #3 was fearful of retaliation.On 1/8/26 at 11:30 AM, Staff B, Social Worker, stated that Resident #3 was upset that Staff A, did not treat her with dignity and respect during cares on 12/19/25 and was scared of Staff A. 2. Resident #4's MDS assessment dated [DATE], documented a BIMS score of 14, indicating no impaired cognition. Resident #4 can hear adequately and could understand and be understood by others with no behavior or mood issues. Resident #4 was independent with activities of daily living but required supervision for shower/bathing. The MDS included diagnoses of hypertension (high blood pressure) diabetes mellitus, anxiety, depression, insomnia, and benign prostatic hyperplasia (enlargement of the prostate gland that puts pressure on the urethra, causing incomplete bladder emptying, urgency, frequency and weak urine stream). The MDS documented the resident received a depression medication and a diuretic medication in the last 7 days of the look back period.The Care Plan with an initiated date 3/10/24, indicated Resident #4 as independent with personal hygiene and toilet use, staff to converse while providing cares.The facility's untitled page of resident interviews dated 12/20/25, documented Resident #4 stated that around 4:00 AM, Staff A, came into his room without knocking and was bossy to him and told him to get up you are wet, threw his pad towards him and treated him like he was nothing. Resident #4 is scared of Staff A.The Social Service Note dated 12/22/25 at 11:08 AM, documented, checked in on resident this AM. Resident states he is having an okay day so far. The Social Service Note dated 1/5/26 at 1:59 PM, documented, met with resident twice last week. Resident felt safe and comfortable here at the facility. The Social Service Note dated 1/6/26 at 2:17 PM, documented met with resident today, states he is doing great.On 1/5/26 at 1:30 PM, Resident #4 stated that on 12/19/25, Staff A, came into his room without knocking, told him he was wet and threw a pad at him and told him to get up and change his soiled pad. Resident #4 stated that he felt he was not treated with dignity and respect and was scared of Staff A. Resident #4 stated that Staff A was yelling and raising her voice out in the common area by his room.On 1/5/26 at 3:30 PM, Staff A, verified that she was upset and her voice was loud and raised due to not having any staff help with answering call lights and taking care of the residents on B-hallway. Staff A reported that she was terminated on 12/20/25 by the Director of Nursing. On 1/8/26 at 11:30 AM, Staff B, Social Worker, stated that Resident #4 was upset that Staff A, did not treat him with dignity and respect on 12/19/25 and was scared of Staff A.3. The MDS for Resident #2 dated 11/22/25 documented a BIMS score of 6 indicating cognitive impairment. The MDS documented a mood severity score of 1 indicating minimal depression. The MDS documented she required substantial/maximal assistance with her activities of daily living and was frequently incontinent of urine. The diagnosis list documented Parkinson's disease.The facility's QA Investigation: Allegation of Abuse dated 12/20/25, documented the following:Summary of Situation: On 12/20/25 a nurse reported that multiple residents residing on B hall reported concerns regarding the conduct of Staff A. Residents described Staff A as not being kind and was rough during care and impatient.Actions Taken: Staff A was removed from the schedule and terminated on 12/20/25. Two residents were transferred to the emergency room (ER) for medical evaluation. Conclusion: Based on the information from the ER there was a determination to be consistent with abuse.The Progress Notes for Resident #2 documented the following:On 12/20/25 at 2:14 PM resident noted to be very anxious and tearful this morning till after lunch. When asked what is wrong states My husband is leaving me, nobody cares or loves me. Resident (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	complaining of chest discomfort.On 12/20/25 at 6:03 PM resident noted to have bruising to right medial thigh, left medial thigh and right lateral thigh. Resident stating that she is having discomfort to bilateral lower legs, noted to be very anxious and tearful. Physician notified and orders to send out for evaluation.On 12/21/25 at 1:57 AM resident returned from the hospital via family vehicle. Diagnosis per emergency room (ER) documented adult abuse confirmed, and acute cystitis.The Emergency Medical Services (EMS) report dated 12/20/25 at 5:55 PM documented they were called out for a patient with discomfort. Staff and family on scene. Staff advised the patient having discomfort from some bruising on her right leg and right side of her chest. Staff also advise that this is due to possible abuse from a staff member. The resident had a fall the previous night that was not reported, otherwise there is no trauma to account for the bruises. Patient complains of pain all over and whimpers when moved.The Hospital Emergency Department records dated 12/20/25 at 6:19 PM documented an injury that was unknown. Full body check with left lower and right lower pinpoint bruising noted. Small areas of bruising to the inner thighs. Old bruising to the right knee. Family reports their parent has been outwardly upset. Their mother told them that staff at the nursing home had told her that her husband does not want to talk to her anymore and he is with another woman. This patient's daughter works at the nursing home where the patient resides. This daughter reported she had to console her several times due to her becoming upset. The daughter reports her mother not wanting to eat. They report their mother stated that the staff at the nursing home were mean to her. The patient reported that she was put on the floor by lots of people. Her entire body is in pain. She told the provider it was a surprise attack. She stated the incident happened last night. Impression included: Adult physical abuse, confirmed, initial encounter. Acute cystitis, multiple contusions, assault by nursing home staff, chest wall pain and right hip pain.The Abuse Policy dated 2/2025, All residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation and any physical or chemical restraint not required to treat the residents medical symptoms.