STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165796	A. Building B. Wing	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anthony Nursing Home	406 East Anthony Street Carroll, IA 51401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, hospital record review, staff interviews and policy review, the facility failed to provide adequate nursing supervision to prevent accident and injuries for 1 of 3 residents reviewed (Resident #1) for falls. The facility failed to implement effective interventions and follow the care plan to prevent falls. Resident #1 was at risk for falls and had a history of repeated falls with trends. Resident #1 had eight falls from January 2025 to August 2025. On 6/1/25 Resident #1 had a fall in her room after attempting to self transfer from her wheelchair to her recliner, resulting in her hitting her head and sustaining a laceration to her forehead requiring an emergency room (ER) visit and 8 staples. On 8/8/25 she fell again in her room after attempting to self transfer from wheelchair to her recliner, resulting in her hitting her head and left hip pain. Resident #1 was transferred to the hospital for x-rays and revealed she had a left hip fracture which required surgical intervention. Within days after surgery Resident #1's condition declined, she developed pneumonia and passed away. The facility reported a census of 76 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS identified Resident #1 required partial/moderate assistance with bed mobility, transfers, toileting and ambulation. Resident #1's MDS included diagnoses of progressive neurological conditions, hypertension (high blood pressure), and depression. The MDS revealed Resident #1 had one fall with injury and two or more falls without injury since the prior MDS assessment. The Facility Incident Reports (IR) documented from January 2025 to August 2025 revealed Resident #1 fell on the following dates: 1/8/25, 1/26/25 x2, 5/2/25, 5/10/25, 6/1/25, 6/9/25 and 8/8/25.Resident #1's Fall Risk Evaluations documented the following scores indicating at risk for falls:12/19/24= 163/25/25=145/10/25= 187/1/25= 16The Care Plan with a target date of 10/2/25 identified Resident #1 required staff assistance with activity of daily living (ADLs) and was at risk for falls related to history of falls secondary to impaired balance, poor safety awareness, neuromuscular/functional impairment and the use of medications that may increase fall risks related to multiple diagnoses. The Care Plan interventions included the following:a. Staff to encourage Resident #1 to ask for assistance when wanting to transfer and ambulate- date initiated: 12/20/24b. Staff to encourage Resident #1 to participate in activities that promote exercise, physical activity for strengthening and improved mobility- date initiated: 12/20/24 c. Staff to ensure Resident #1 wearing appropriate footwear when ambulating or utilizing her wheelchair- dated initiated: 12/20/24, revised on 4/3/25d. Resident #1 to have a safe environment with even floors free from spills and/or clutter, adequate lighting and personal items within reach- dated initiated: 12/20/24, revised 4/3/25e. Resident #1 moved to a room closer to the nurse's station in February 2025 to be monitored more closely by staff when in her room- dated initiated: 12/20/24, revised 4/3/25f. Fall 1/8/25- Staff education to be aware of when family leaves and to make sure to keep wheelchair nearby, additional call light added (one by bed and one by recliner) and staff to encourage Resident #1 to use non-skid socks- date initiated 1/21/25g. Fall 1/26/25 at 8:45 AM- Staff educated to be aware of when Resident #1 was returning to her room to be available to assist her. Resident #1 educated to use her call light and wait for staff to assist her. A board was placed between her recliner and wall to prevent the chair from moving back- date initiated 2/18/25h. Fall 1/26/25 at 10:15 AM- Educate staff on use of proper equipment when transferring Resident #1- date initiated 2/18/25i. Fall 5/2/25- Educate staff not to leave Resident #1 unattended while on the toilet and make sure she was seated safely in a chair of her choice. Resident #1 preferred to stay in her room in her recliner for lunch- date initiated 5/5/25 j. Fall 5/10/25- Educate staff to attempt to assist Resident #1 to desired place prior to leaving her alone, checking back on her frequently during times of anticipated movement (going to a meal or activity)- dated initiated 5/10/25k. Fall 5/10/25- Apply auto-lock brake system to Resident #1 wheelchair- date initiated 6/5/25l. Fall 6/1/25- Staff to encourage Resident #1 to call for assistance when she returns to her room and wants to get in her recliner. A floor mat alarm obtained and placed that connected to the call light system- date initiated 6/15/25m. Fall 6/9/25- Educate the bath aide to assist Resident #1 back to her recliner after the bath instead of having her head back to her room on her own. Additional staff reminded to watch for Resident #1 wheeling herself in the hall, anticipating Resident #1 trying to transfer herself and assist her as they see her. n. Addendum 7/28/25- The floor mat alarm removed due to the alarm not working properly and Resident #1 pushed the mat out of the way when she was in the room. Resident #1's husband educated/reminded her to use the call light so staff are present when transfers- Revised 8/8/25. o. Fall 8/8/25- Staff to close Resident