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	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anthony Senior Services	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 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. Based on observations, clinical record review, facility investigative file review, staff interviews and facility policy review the facility failed to protect the resident's right to be free from physical abuse by a facility staff member for 1 of 3 residents (Resident #1). The facility reported a census of 73 residents. Findings include:According to the quarterly Minimum Data Set (MDS) assessment with a reference date of 3/17/2026, Resident #1 scored 0 on the Brief Interview of Mental Status (BIMS). A score of 0 suggested severe cognitive impairment. The MDS documented he had impairments to his bilateral upper and lower extremities and utilized a wheelchair. Resident #1 was dependent on staff for toileting hygiene, upper and lower body dressing, mobility, and toileting transfers. The MDS documented he was not on a toileting program, was frequently incontinent of urine and always continent of stool. The MDS documented Resident #1 received an antipsychotic during the review period. The following diagnoses were listed for Resident #1: Alzheimer's disease, heart failure, stroke, and non-Alzheimer's dementia.The Care Plan Focus Area with a revision date of 12/18/2025, documented Resident #1 required complete assistance of staff to complete Activities of Daily Living (ADLs). The care plan documented he required the assistance of 1 staff for dressing/undressing, total assistance due to cognitive impairment. He required the use of a stand-up lift. The care plan documented Resident #1 had poor comprehension and will become resistive/uncooperative. He required two-person assistance for toileting due to use of a stand-up left. He is frequently incontinent of urine and occasionally incontinent of bowel. He wears incontinent products and staff are to provide peri-care with every incontinent episode and as necessary.A second Care Plan Focus Area with a revision date of 1/16/2024, documented Resident #1 admitted to the facility with the diagnosis of Alzheimer's disease. Resident #1 is known to have episodes of sudden changes in mood and behavior, tendencies to display unwanted and unsafe behaviors such as standing and walking without assistance despite unsafe gait and history of falls, as well as being uncooperative or resistive of cares when needed. He also has the potential for increased behaviors to include becoming combative, unsafe wandering, attention seeking behavior, hallucinations and/or delusion. The care plan directed staff to attempt nonpharmacological interventions prior to using as needed (PRN) medications. Staff are to intervene as necessary to protect the rights and safety of other residents, approach/speak to Resident #1 in a calm manner, divert attention if needed, and remove him from the situation and take him to an alternate location as needed. Staff are also advised to minimize the potential for Resident #1's disruptive behaviors by offering tasks which divert his attention.A third Care Plan Focus Area with a revision date of 4/3/2024, documented Resident #1 had impaired cognitive function, impaired thought processes, short- and long-term memory deficits, impaired decisions making skills and impaired ability to communicate such as making his needs known and understand others related to his Alzheimer's diagnosis.The following Progress Notes documented:a) On 3/5/2026 at 7:18 PM Resident #1 leaning to the right in his wheelchair with his arm hanging over the side. He was repositioned numerous times and continued to put his arm over the edge of the chair and hang over itb) On 3/10/2026 at 5:49 AM Resident #1 was having difficulty using the mechanical lift during the night for toileting. He was not fully alert at this time, he would not hang on to the bars, just hanging from 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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	stand belt, head and arms hanging down. With verbal cues and assisting his fingers around the lift handle, he could not hang on. Staff had to hold on to the resident as he was hardly awake during the transferc) On 3/12/2026 at 7:15 PM when the Certified Nursing Assistants (CNAs) were helping the resident with bedtime cares, he became agitated with staff. Staff were trying to take his clothes off and stand him with the mechanical lift to use the toilet, Staff A CNA became increasingly irritated with resident and being short with him. Staff B held Resident #1's hands, trying to calm him down. Staff A then swatted at resident with an open hand causing a scratch to his right upper lip (1 centimeter (cm) x 1/2cm) that bled immediately, and a scratch to his right upper cheek (3cm long). CNA reported it to this nurse, proper documentation completedd) On 3/13/ 2026 at 6:08 AM Resident #1 rested in reclining chair in common area during the night with eyes closed per his usual. Repositioning completed and checks for toileting/toileted every 2 hours. He was cooperative with all cares during the night. Resident #1 tolerated the use of the mechanical lift with two staff assist. No agitation or aggression noted. A thin scratch to right cheek and scant amount of dried bloody drainage to upper right lip present. No other apparent injuries notede) On 3/13/2026 at 6:30 AM Resident #1 resting quietly, smiles when spoken to while sitting in recliner. Noted a faint pink scratch on his cheek near the right side of his nose and scant amount of dried blood right inner lower lipf) On 3/14/2026 at 10:11 AM noted a small bruise to Resident #1's right lower lip and pink areas to his right cheek. Resident pleasant with transfers this morning and caresg) On 3/14/2026 at 11:00 PM scratch to left cheek is healing, pinkish/red area noted. Resident #1's lower right lip has multiple areas of healingh) On 3/15/2026 at 5:47 AM Resident #1's left cheek is healing, bruise on his lower lip is purple in color; no complaints of paini) On 3/15/2026 at 1:12 PM Resident #1's activity/behavior as usual for him today. He continued to have very faint linear scratch on the right side of his face with a small bruise to his inner right lower lipj) On 3/16/2026 at 5:07 AM the scratch on Resident #1's cheek is almost healed, bruise on his lip is healing with a scab formedk) On 3/17/2026 at 8:50 AM a dark bruise to Resident #1's lip remained unchanged; scab is healed with only pink skin discoloration remaining.On 3/31/2026 at 1:10 PM Resident #1 sat in a recliner in the commons area with his wife sitting to the right of him. At 3:15 PM observed two staff members transfer Resident #1 from his recliner to his wheelchair with a mechanical lift. The resident was cooperative during the transfer. The resident was assisted to a table where an activity had taken place. No signs of injuries were noted to his face.The facility's investigative file included the following statements and summary:Staff B Certified Nursing Assistant (CNA) wrote the following statement: around 8:00 PM on 3/12/2026, myself and Staff A CNA were getting Resident #1 ready for bed. We first took him to the bath house to change his clothes. Before we got him on the mechanical lift we were changing his shirt. When doing that he was aggressive; like hitting and elbowing Staff A. Staff A was not doing anything to calm him down, it seemed as though she had a temper with him. We then got him up with the mechanical lift and brought him to the toilet. When we got him on the toilet, we started taking his pants off, and while doing that Resident #1 was being aggressive and hit Staff A. After I saw that, I then asked Resident #1 if he wanted to hold my hand and see if it would calm him down, which it did. As Staff A started putting his socks on, she hit Resident #1 in the face with an open hand, which cut his lip and scratched his cheek. I saw both things appear, and his lip started to bleed. After this happened, we got Resident #1 up from the toilet and finished all of his nightly cares, we then brought Resident #1 to his recliner with the mechanical lift for bed. As soon as Resident #1 was sitting in his recliner, Staff A reclined him in his chair and put his blanket on him. Staff B went to talk to Staff C, the nurse on duty to report it. Staff B signed and dated the hand written statement on 3/12/2026.Staff A wrote the following statement: at approximately 8:15 PM I assisted a non-verbal resident with evening ADLs in preparation for bedtime. The resident was visibly restless and agitated in his wheelchair. This behavior was unusual for him. A new CNA in training accompanied me with the mechanical lift. We transferred the resident to the bathroom and began assisting with dressing for bed. The resident remained agitated during the entire interaction and attempted to grab staff while providing care. We (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	assisted him in removing his shirt and pants, then transferred him to the toilet using the mechanical lift. His adult brief was slightly wet. While dressing him in clean clothing and preparing to remove his pants, the resident remained restless and moving his arms. While I was leaning down near his feet, I heard a smack sound and looked up. At that time, I saw the resident arm contact with side wall and the other CNA standing next to him. We attempted to verbally redirect and reassured him. We transferred the resident back to his wheelchair using the mechanical lift to returned him safely to his recliner. Later I notified the nurse how the resident had been agitated during care. Clarification: at no time did I strike or intentionally hit the resident. Staff A signed the handwritten statement.The following summary was documented: in a follow up interview with Staff B she was asked specifically at what point did Staff A hit Resident #1. She stated that she was holding both of Resident #1's hands while Staff A put on his socks and she reached up and swiped at his face causing the scratch and cut to lip. I asked Staff B if Resident #1 at the time was still aggressive and she stated no she was holding both his hands. In an interview with Staff A about the incident she described his behavior as being agitated and described the events of toileting similar to Staff B. She stated that resident was aggressive while being toileted while she was bent down putting on socks resident was hitting toilet assist bar and didn't remember if he hit her head. She added that resident seemed to calm down after toileting was complete and resident placed in recliner in lobby area. When asked if she struck at Resident #1 she stated I don't know the time I hit him. Stating she has never raised her hand towards any resident. Asked her how resident would have received an abrasion on lip and scratch and she didn't know that he got scratched or the abrasion. In conclusion the facility has determined that there was some degree of staff to resident contact. Whether it was swiping or open-handed slap/hit we believe there was contact made. Therefore, the facility has terminated employment with Staff A. The summary was completed by the Administrator.On 3/31/2026 at 1:26 PM Staff B stated around 8:00 PM on 3/12/2026 her and Staff A had assisted Resident #1 with getting ready for bed. They assisted him to the bathhouse to change him and brush his teeth. Resident #1 became aggressive when they started to change his clothes: he was hitting and punching at Staff A. After they were able to get his shirt on, they used the mechanical lift to assist him to the toilet. He was aggressive during that transfer but then he calmed down. Staff A took Resident #1's pants and socks off, then she put on new socks. Staff B asked Resident #1 if he wanted to hold her hands while Staff A continued to dress him. Resident #1 held Staff B's hands and then she saw Staff A bring up her right hand and with an opened hand, Staff A smacked Resident #1 on the face. Staff B then noticed a cut on Resident #1's lip and scratch on his cheek. Staff B stated she saw this happen and was in the bathroom the whole time Staff A was in there with Resident #1. Staff B stated Resident #1 did not do or say anything after this happened. She added he is mostly non-verbal but did have a surprised look on his face. Staff A did not say anything either. They continued to assist Resident #1 by assisting him to his wheelchair then to a recliner in the living room. He likes to sleep in the recliner out there. They got him in the recliner, his shoes off, placed a blanket on him and he went to sleep. Staff B stated she then went and spoke to Staff C Licensed Practical Nurse (LPN) about what she witnessed. Staff B denied seeing Resident #1 hitting his hands or face on the wall while they were assisting him. She stated she was with the resident and Staff A during the entire interaction. Staff B stated she stood to the left of Resident #1 and Staff A was crouched down in front of Resident #1, when she reached up and struck him in the face. Staff B felt Staff A had a temper with Resident #1; she seemed angry by the way she was acting and talking to him. Staff A raised her voice when speaking to Resident #1 and acting like she was not putting up with his behaviors. When he became agitated while they attempted to change his clothes, she would not stop, just yelled at him a bit. Resident #1 was acting like he did not want to be touched but Staff A would not stop trying to change his clothes. Staff B stated she talked to Resident #1 to calm him down and had him hold her hands as she did not want to irritate him anymore. Staff B stated she was still in training and was too nervous to offer ways to calm him down to Staff A. Staff B was read the statement she provided to the facility and she stated it was accurate.On 3/31/2026 at (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	2:13 PM Staff C stated Staff B came to her to report at about 8:00 PM on 3/12/2026 that Staff A hit Resident #1. Staff B told her they had assisted Resident #1 with getting ready for bed Staff A hit Resident #1 in the face causing scratches to his face. Staff C asked Staff B to write her statement as she called the nurse manager for guidance. Staff C stated after her and the charge nurse upstairs escorted Staff A out of the facility she assessed Resident #1. She noted a 3cm long scratch under his right eye and a 1-0.5cm cut to his lip. There was fresh blood present on his lip when she completed the assessment. Staff C stated Resident #1 appeared fine during her assessment, he did not know what was going on. She denied any ill effects with Resident #1 since this incident has occurred.On 4/1/2026 at 9:19 AM the Director of Nursing (DON) stated Staff A worked on the overnight shift and she occasionally saw her. She was always polite but no indication that she was aggressive or rude. Staff A worked part time usually working 6 overnight shifts in 2 weeks and would pick up additional hours here and there. The DON added she did work on the Assisted Living side of the building as well. The DON stated when staff are caring for residents that are displaying behaviors, they should ensure the resident is safe then walk away from the situation, cool down and reapproach. They recently had a staff in-service about how to approach residents with dementia and aggressive behaviors.The facility provided a policy titled Abuse Policy and Procedure with a revision date of 1/2026. The policy documented all residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subjected to abuse by anyone, including, but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.