

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165798	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER Hallmar Village		STREET ADDRESS, CITY, STATE, ZIP CODE 8900 C Avenue NE Marion, IA 52302	

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	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, facility policy review, and staff interviews, the facility failed to use safe transfer techniques when using a mechanical lift to transfer 2 of 3 (Resident #101 and Resident #102) which resulted in one resident incurring bilateral femur fractures. The facility failed to safely transfer 2 of 2 residents (Resident #101 and Resident #102) from the floor after a fall. The facility reported a census of 52 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment, dated 6/04/25, revealed Resident #101 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. The list of diagnoses included type 1 diabetes, congestive heart failure, and neuromuscular dysfunction of the bladder (loss of control due to nerve damage). The MDS indicated Resident #101 dependent for all transfers, which included going from a seated to standing position. The MDS revealed the resident unable to walk and utilized a wheelchair. The MDS documented Resident #101 had no falls since the previous assessment. Review of the Care Plan, date initiated 9/26/23, revealed a Focus area to address I have limited physical mobility d/t (due to) physical weakness DM (diabetes), COPD (chronic obstructive pulmonary disease), ASHD (arteriosclerotic heart disease), HTN (high blood pressure), renal disease and medications. Interventions included, in part: a. Assess my functional ability with bed mobility, transfers, walking, and locomotion upon admission, quarterly, annually, with a significant change and as needed. Date initiated: 10/2/23. b. I wear Draco boot (boot with a hard sole) to left foot with all standing, and blue boot on at other times. Date initiated: 1/4/24. c. PT (Physical Therapy), OT (Occupational Therapy) referrals as ordered, PRN (as needed). Date Initiated: 3/17/25. d. TRANSFERS: I require assist of two with a mechanical full body lift and green sling. Date initiated: 9/26/23. Review of the Care Plan, date initiated 9/26/23, revealed a Focus area to address I am at risk for falls d/t physical weakness, history of falls, diabetes, COPD, ASHD, HTN, renal disease and medications. Interventions included, in part: a. Alert resident of changes to the environment. Date initiated: 9/26/23. b. Be sure my call light is within reach, and encourage her to use it for assistance as needed. Date initiated: 3/17/25. c. Complete a fall risk assessment/evaluation quarterly and as needed. Date initiated: 10/2/23. d. Ensure that I am wearing appropriate footwear. Date initiated: 3/17/25. e. Follow facility fall protocol. Date initiated: 10/2/23. f. Give me my pain medication as ordered. Date initiated: 10/2/23. g. Orient to new environment, routine, and caregivers. Date initiated: 9/26/23. h. Place call light within reach and answer it promptly. Date initiated: 9/26/23. i. PT (physical therapy) evaluate and treat PRN (as needed). Date initiated: 9/26/23. j. Review information on past falls and attempt to determine the cause of falls. Record possible root causes and alter or remove potential causes if possible. Date initiated: 3/17/25. Review of the clinical record revealed a General Note entered on 6/07/25 at 3:50 AM, which documented This nurse assisted the CNA (Certified Nurse Assistant) with transferring the resident (Resident #101) to the toilet by [NAME] flex (brand name of a sit to stand mechanical device) around 0350 (3:30 AM), resident encouraged to push her call light when finished. Call-light and cell phone in hand. Review of a facility Incident Report, dated 6/07/25 at 5:20 AM, completed by Staff F, Licensed Practical Nurse (LPN), revealed Resident #101 had a controlled landing fall from a mechanical stand lift, in the resident's bathroom, with injuries noted to both right and left knees. The Incident Report identified a causal factor that Resident #101 was unable to support herself with the stand lift due to becoming weak and sliding downwards in the lift. Staff F identified a suggested intervention for Physical/Occupational Therapy to evaluate Resident #101 for an updated transfer status. Review of a General Note entered on 6/07/25 at 5:20 AM, revealed The resident pushed her call-light around 0520 to get off the toilet. This nurse and CNA headed into the residents bedroom to assist her off the toilet and back to her bed. The CNA grabbed the [NAME] flex (lift) and pulled it into the residents bathroom. Before lifting the resident up, this nurse checked the positioning of the resident feet on the [NAME] flex, feet were correctly re-positioned in place on the foot plate. The resident had her orotho shoe and grippy sock on her left foot, and grippy socks on her right foot, residents yellow sling was correctly faceted with both straps and attached to lift, resident red rolled up blanket was positioned in-between her thighs and knees, residents pillow was placed where her knees were resting on the silicone leg support. The resident had her elastic green bands positioned on the handles of the flex. The resident was then lifted from the toilet by this nurse. The resident stated I want to be lifted all the way up in the air. The hoyer was raised all the way up. Wheels were locked in place on the flex and the CNA began peri-care on the resident the resident was standing for a while and the CNA asked her if she would like to sit the resident</p>		