STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165798	A. Building B. Wing	06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmar Village	8900 C Avenue NE Cedar Rapids, IA 52402

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 - Minimal harm or potential for 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 observation, clinical record review, staff and resident interviews, the facility failed to supervise residents to ensure safety and freedom from abuse for one of 3 residents reviewed (Resident #1). On 4/15/26, staff found Resident #2 with Resident #1 in intimate situation. Resident #1 didn't have the ability to consent to the situation. The facility reported a census of 55 residents. Findings include:1. Resident #1's Minimum Data Set (MDS) dated [DATE] identified they had severe cognitive impairment (decline in mental state). Resident #1 required total dependence on staff to transfer from one surface to another, and used a wheelchair for locomotion (moving around). The MDS included diagnoses of Alzheimer's disease (a progressive brain disorder causing memory loss) and anxiety (excessive worrying). The Care Plan dated 4/4/25 noted Resident #1 experienced non-verbal communication, a fall risk, and used a wheelchair for locomotion. The plan identified Resident #1 had a communication problem, remained nonverbal at times, and displayed nonsensical (unrelated or incoherent) speech at times. Resident #1 had a fluency disorder (speech flow issue), which meant staff rarely or never understood Resident #1, and Resident #1 rarely or never understood others. It directed staff to monitor and document for physical or nonverbal indicators of discomfort or distress and follow up as needed. The Care Plan updated 3/18/25 added Resident #1 had a risk for abuse or neglect due to cognitive and functional limitations. The goal stated Resident #1's objective aimed to stay free from abuse or neglect by others or herself. It directed staff to follow the facility's Vulnerable Adult policy. On 6/22/26 at 9:45 AM witnessed Resident #1 sitting in her wheelchair at the lounge with an activity lap quilt on her lap. 2 other residents sat on a sofa near Resident #1. Resident #1 appeared alert, nonverbal, and smiling. On 6/22/26 at 2:15 AM observed Resident #1 sitting at the lounge in her reclining wheelchair with her eyes shut. On 6/23/26 at 8:30 AM Resident #1 sat at the dining room table with eyes open, a flat affect (lack of emotional expression), and remained nonverbal. 2. Resident #2's Minimum Data Set (MDS) dated [DATE] revealed Resident #2 had severe cognitive impairment, exhibited verbal and rejection of care behaviors, and ambulated (walked) independently. Resident #2's diagnoses included anxiety, depression (persistent sadness), dementia (brain decline) with agitation, and chronic kidney disease (long-term kidney damage). The Care Plan dated 4/23/26 noted Resident #2's behavior required intervention related to cognitive impairment as evidenced by inappropriate sexual behavior, disinhibition (lack of restraint), and inappropriate or unwanted touching. It directed staff to intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention, remove Resident #2 from the situation, take Resident #2 to an alternate location as needed, and monitor and document behavior episodes. The Facility Investigation Record noted on 4/15/26 at 3:43 PM, Staff A received a call to go to the Care Center from Staff B, Director of Nursing (DON), to report a resident-to-resident situation. Staff B relayed that Staff C, Registered Nurse (RN), called her at 3:42 PM to report staff found Resident #2 with his penis in Resident #1's hand. Resident #2 had a Brief Interview for Mental Status (BIMS) score of 4, indicating severely cognitively impaired, and Resident #1 had a BIMS score of 0, indicating severely cognitively impaired. On 4/15/26 at 3:45 PM, Staff A and Staff H, Interim Household (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 - Minimal harm or potential for actual harm Residents Affected - Few	and he should've called his daughter before coming. When asked why he changed rooms and moved upstairs, he couldn't recall. When asked if he had friends at the facility, he said that he had some. Staff D, Registered Nurse (RN) and Director of Nursing (DON), reported Resident #2 preferred his door closed. A sign on the door with his name on it assisted him in finding his room. He ambulated independently with a walker and required staff reminders to use it. On 6/23/26 at 9:20 AM witnessed Resident #2 sitting in the sunroom with a Certified Nursing Assistant (CNA) seated across the table from him. Resident #2 stated he worked as an engineer from the University of Iowa, lived in California for a bit, had a few friends here, and his wife passed away a few years ago. He couldn't recall changing rooms or floors and had no idea why it occurred. On 6/21/26 at 12:30 PM saw Resident #2 sitting at the dining room table with 2 men and a walker nearby. He communicated with his tablemates, stood up and took a few steps with his walker when finished, and sat back down when staff told him there'd be dessert. On 6/29/26 at 8:00 AM Staff B reported she worked at the facility from August 2025 until April 30, 2026. Staff B reported she didn't know of any physical contact between Resident #1 and Resident #2 prior to the incident on 4/15/26. On 4/15/26, at the time of the incident, Staff B sat in the conference room in a meeting until Staff C summoned her. When Staff B arrived, they staff already separated Resident #1 and Resident #2, and they already started Resident #2 on 1:1 supervision. Staff A interviewed Resident #2, who stated Resident #1 smiled at him and it felt very sweet. He thought when she smiled at him, the feeling became mutual. He noted Resident #1 often sat at the lounge with no one to talk to, and he felt bad for her. The police arrived, and he told them the same statement. Staff B possessed no knowledge of any prior physical contact between the two residents, and no staff reported any concerns prior to the incident. Staff B couldn't recall if Resident #2 went out to a bar or restaurant on 4/15/26. The family brought non-alcoholic wine for Resident #2. After the incident, Resident #2 attended a mental health appointment. On 6/23/25 at 10:45 AM Staff A reported she worked at the facility since May 2025. On the day of the incident, Staff B called her after staff found Resident #2 in the living room with his penis in Resident #1's hand. The aide who came upon them separated them and stepped around the corner to get the nurse. Resident #2 stood back up, so staff took him to his room, assessed Resident #1, and kept Resident #1 with them. Staff moved Resident #2 to another floor and provided one-to-one supervision. Resident #2's family felt shocked, took him to his doctor, and he received medication changes. They discussed his friend taking him out to drinking establishments with the family, and the family decided it didn't serve his best interest to go drinking with his friend. Police came to the facility, but Resident #1 couldn't provide a statement. Resident #2 said he believed it a consensual relationship. Police didn't pursue the matter because of his cognitive abilities. Staff A's knowledge included no sexual behaviors prior to the incident and no behaviors since. Staff received education regarding the abuse policy because management wanted to ensure staff knew what to do to keep everyone safe. On 6/22/26 at 12:15 PM Staff D reported she worked in her position since April 30, 2026, after working as a contract employee for 5 months prior. On the day of the incident, she received notification and responded immediately. They separated the residents, obtained staff statements, and called the police, family, and physician. Staff provided 1:1 supervision for Resident #2 after the incident occurred, and Staff C assessed Resident #1. Staff sat with Resident #1 to monitor her and to ensure she didn't feel upset. Resident #2 showed no further sexual behaviors, though he displayed combative behaviors when he didn't like redirection by staff. On 5/30/26 he did well, so they discontinued 1:1 supervision and started hourly checks. They installed an alarm on his door to alert staff if he left his room during the night hours. On 6/13/26 he had a combative incident with another resident, so they initiated 1:1 supervision again. On 6/22/26 at 10:55 AM Staff C reported she worked full-time at the facility since December 2026. Resident #2 showed no signs of sexual behaviors prior to the incident with Resident #1. Resident #2 acted like a gentleman, remained helpful, and stayed friendly with everyone without being touchy or inappropriate. The afternoon of the incident with Resident #1, Staff C sat at the nurse's station charting. The nurse's station featured a window facing the lobby, and she could see the lobby if she (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stood up. Resident #1 sat in a wheelchair in the lobby facing the television. Other residents typically sat there, but that day only Resident #2 sat in a chair watching television. He frequently walked around the facility independently. On 4/15/26, staff provided care for Resident #1 after lunch and moved her to the lobby due to a high fall risk. Staff E came to her and stated they had a situation where Resident #2 had his penis in Resident #1's hand. Staff E turned Resident #2 around and got his pants up. They tried to get Resident #2 back to his room, but he initially refused. Staff C assessed Resident #1 and washed her hands. She summoned Staff B, and they managed to get Resident #2 back to his room. Resident #1 didn't appear tearful, though she seemed briefly upset, and she smiled later when Staff C told her goodnight. Staff E reported she heard Resident #1 tell Resident #2 to go when she came upon the incident. Resident #1 remained nonverbal and only said yes or no, though she could show emotion. They separated the residents, completed an incident report, and provided 1:1 supervision for Resident #2. He had medication changes and attended follow-up appointments related to the incident for review. Staff C spoke to the police when they arrived. He had a friend who'd take him out and allow him to drink, but that no longer happened. They held a care conference after the incident where the provider spoke to Resident #2's Representative, and everyone agreed on the plan. Staff C never saw sexual behaviors prior, just agitation, and noted he seemed to cover up his dementia with his grouchiness. Staffing on the first floor included 3 to 4 aides on days and evenings, a medication technician, and a nurse. On 6/23/26 at 1:25 PM Staff C reported she never witnessed Resident #2 hold hands with Resident #1, and nobody reported anything prior to the incident. Typically, after meals, Resident #2 walked the halls. He came from Assisted Living, and it looked similar, which caused confusion for him, so staff attempted to redirect him. Staff C couldn't recall if Resident #2 went out that day because residents don't always remember to sign out or in. Resident #2 displayed verbal and physical behaviors toward staff, and he can become stubborn and angry when staff attempt to assist him. On 6/23/26 at 11:57 AM Staff F, Care Center Administrator, reported working at the facility for three weeks and noted no issues occurred with Resident #2 since the incident. The facility separated the residents, provided 1:1 supervision, and placed an alarm on his room door. The facility sought to move Resident #2 to another facility closer to family. Staff F had no knowledge of prior hand holding or physical contact before the incident. Resident #2 resisted care and showed physically aggressive behaviors, but no staff reported any inappropriate behaviors. The facility maintained a sexual consent policy. Regarding the situation with Resident #1 and Resident #2, when staff informed him, she's married, he expressed sorrow. Staff didn't perform an evaluation for sexual consent after the incident. He acted out regardless of his BIMS score, and he chose to act out. Staff F questioned how getting a sexual consent evaluation after the fact would prohibit it from occurring again, as it wouldn't have changed the outcome. They explained to him it qualified as inappropriate, and as soon as staff informed him, she's married, he said he felt sorry. On 6/22/26 at 12:50 PM Staff E reported working at the facility from 6:00 AM until 10:00 PM, generally on the first floor. On the day of the incident, she walked up the 160 hallway and observed Resident #2 on the side of Resident #1. He had his pants down to his mid-thigh and his underwear pulled down with one hand while holding her hand on his penis. Staff E asked him, for safety, to get his walker and sit on the opposite side of the room. He had his walker a few feet away. The nurse's station sits nearby, so she had him sit down on one side of the room and grabbed the nurse who stood about five feet away. Resident #2 didn't say anything when she told him he shouldn't do that. She told him to pull his pants up, and he complied. Resident #1 doesn't communicate much verbally, but Staff E heard Resident #1 tell Resident #2 no. Staff took Resident #2 to his room and Resident #1 to her room for an assessment. Resident #2 had no marks and seemed a bit sad. Resident #1 didn't speak but could answer yes if you ask her a question, and that's about all. Staff E had no knowledge of any other incidents. He displayed physical and verbal behaviors but nothing sexual with other residents. Resident #2 did touch Staff E's shoulders or her back, but she didn't know if he meant anything sexual by it, so she told him not to touch. On 6/23/26 at 1:35 PM Staff E reported she saw Resident #2 touch (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Few	policy dated May 2026 instructed staff recognize sexuality forms part of a person's identity. Individuals living with dementia continue to express closeness, affection, and intimacy, and the facility approach must honor the resident, protect dignity, and ensure emotional and physical safety for both residents. When contacting family regarding observed intimacy or relationships, staff must include the leadership team in the communication loop. Involvement of the primary medical provider remains a recommendation as a crucial member of the interdisciplinary team for a holistic approach in determining potential next steps and consent, and meeting as an interdisciplinary team with the family can benefit staff and families. Staff must continuously determine consent and work as an interdisciplinary team to discuss observations under the Vulnerable Adult Policy framework. Consent in dementia remains behavior-based, evaluated moment by moment. Consent is present when no signs of distress come from either resident, and behaviors indicate comfort, willingness, and reciprocation. The Observing Intimate Relationships for Residents with Dementia - Guidelines and Flowchart for Nurses policy dated May 2026 instructed staff on the indicators of consent:Signs of Likely ConsentSmiling, laughing, relaxed facial expressionAppears at ease; leaning inSeeks out the other personReturns touch (holding hands, hugging, leaning in)Maintains proximity; does not pull awayNo new pacing, irritability, fear, or restlessnessNo agitation during or immediately after the interactionNo crying or withdrawalCalm, content, or neutral afterward The Observing Intimate Relationships for Residents with Dementia - Guidelines and Flowchart for Nurses policy dated May 2026 instructed staff on the indicators of non-consent:Signs of Possible Non-ConsentFrowning, crying, yelling, verbal refusalIncreased confusion or fearPulling away or turning head/body awayPushing away touch; stiffening upAttempts to leave the interactionPacing, restlessness, shoutingSudden changes in mood or behaviorNegative or frightening statements The Observing Intimate Relationships for Residents with Dementia - Guidelines and Flowchart for Nurses policy dated May 2026 instructed staff on key principles: Look for comfort and reciprocation. Stop the interaction immediately if any signs of distress appear. Document clearly and often which observed behaviors supported consent or non-consent. Monitor consent ongoing; it can change day-to-day or moment-to-moment. Use the least intrusive intervention when unsure. Always prioritize resident dignity, privacy, and emotional well-being.