STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16A002	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iowa Veterans Home	1301 Summit Marshalltown, IA 50158

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 - Minimal harm or potential for 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, clinical record review, and facility policy review, the facility failed to ensure safe wheelchair transportation for 2 of 3 residents reviewed (Resident #12 and Resident #13). The facility staff failed to put on foot pedals when pushing residents in their wheelchair. The facility reported a census of 353 residents.Findings include: 1. Review of the Minimum Data Set (MDS) assessment, dated 6/24/25, identified Resident #12 had a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which indicated severe cognitive impairment. The list of diagnoses included non-Alzheimer's dementia, cancer, and diabetes mellitus. The MDS indicated Resident #12 depended on staff for all transfers, they couldn't walk and used a wheelchair for mobility. The Care Plan Focus initiated 9/10/24, reflected Resident #12 needed help with their day-to-day tasks, as he could fall, he needed assistance with maintaining his strength and ambulation. He required a secured environment for his safety. The Interventions included:a. Locomotion off the unit: one staff assist with a manual wheelchair.b. Locomotion on the unit: Resident #12 could propel himself at times, otherwise staff to assist.c. Wheelchair used for mobility. During an observation on 9/8/25 at 11:31 AM, Resident #12 sat at a dining room table in a high back, tilting wheelchair, positioned upright/sitting. A staff member approached him, backed him away from the table, turned the wheelchair around, and began to transport him out of the dining room without foot pedals attached to the wheelchair. Approximately 2 feet from the table, staff pushed Resident #12 in wheelchair over a threshold that transitioned from vinyl flooring to carpeted flooring, Resident #12 abruptly put both feet down on the floor which stopped forward motion of the wheelchair. Following this, the staff member left to retrieve foot pedals, applied them to the wheelchair, and continued transporting Resident #12. 2. Review of the MDS assessment, dated 8/12/25, revealed Resident #13 had a BIMS score of 7 out of 15, which indicated severe cognitive impairment. The list of diagnoses included non-Alzheimer's dementia, hemiparesis/hemiplegia (one-sided weakness or loss of sensation), and traumatic brain injury. The MDS indicated Resident #13 required partial to moderate staff assistance for all transfers, they couldn't walk and used a wheelchair for mobility.The Care Plan Focus, initiated 10/16/23, indicated Resident #13 needed assistance with their daily routine. The Interventions included:a. Locomotion off the unit: one staff assist with a manual wheelchair.b. Locomotion on the unit: independent mobility with a manual wheelchair.During an observation on 9/9/25 at 11:22 AM, Resident #13 sat in a wheelchair at the long edge of the dining room table, with foot pedals attached to the wheelchair, but not in use, folded away on the sides of the wheelchair. Resident #13 attempted to self-propel their wheelchair towards the head of table. Staff B, Registered Nurse (RN), approached and pushed Resident #13's wheelchair from the long side of table around to the short side of table without placing feet on the foot pedals. Resident #13's feet skimmed over the top of the floor during transport. During an interview on 9/9/25 at 3:00 PM, Staff B, Registered Nurse (RN), stated staff must put foot pedals on a wheelchair before they transport a resident for safety and to prevent injury. During an interview on 9/9/25 at 3:45 PM, the Nursing Services Director revealed they expected the staff to apply foot pedals to wheelchairs prior to transporting residents, to keep their feet off the floor. The facility provided an undated document titled, Standards of Care instructed under the section Safety Strategies for the facility to have wheelchair pedals used with all transport.