STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E277	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Story Medical Senior Care	710 S 19th St Nevada, IA 50201

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, family interview and policy review, the facility failed to report an allegation of alleged abuse to the State survey and certification agency for 1 of 3 residents reviewed for abuse (Resident #1). The facility reported a census of 57 residents. Findings include: The Minimum Data Set (MDS), dated [DATE], documented Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS documented diagnoses to include debility, cardiorespiratory conditions, heart failure, renal insufficiency, diabetes mellitus, unspecified macular degeneration, anxiety disorder and depression. The resident was dependent on toileting hygiene and required substantial/maximal assistance with toilet transfer. The Care Plan for Resident #1, revised on 4/11/25, included a focus area: resident unable to complete Activities of Daily Living (ADL's) independently. The Care Plan instructed staff under interventions: the resident required assistance of 1 staff into the bathroom to transfer to the toilet and the resident has very poor eyesight and wears glasses. She uses a lighted magnifying lens. When staff enter her room, she prefers staff to tell her their name, so she knows who she is talking to.Review of facility document Grievance Form dated 7/20/25 (Sunday), for Resident #1, completed by Staff A, Registered Nurse (RN), documented a family member reported that resident said someone that works there and it does not happen very often, pushes her, shoves her and yells at her and they get into shouting matches sometimes. Resident unable to say who it was but did say they sounded young. Under the Facility follow up section of the document, investigation by staff: Staff B, Director of Households, to talk to the resident. The section Findings of Dept. Heads documented see attached sheets. The section Follow Up Action Taken documented: 5 minute meeting about appropriate approaches, education to staff both facility and agency. The document was signed by Staff B and the Administrator on 7/22/25. Review of the attached sheets to the Grievance Form, undated, documented Staff B followed up with Resident #1 about how the weekend went, the resident stated well, it was good until I got into a yelling match with a CNA (Certified Nursing Assistant). Staff B documented the resident made it a point to say that she did all of the yelling, that the CNA didn't yell. She told Staff B that it happened on Saturday, during the day, unfortunately she is unable to identify who the CNA was. She said that the CNA entered her room saying, Well, I don't know your routine which made the resident mad/sad/feel bad. The resident told Staff B that she was shoved and plopped down on the toilet. The resident stated, well, maybe she didn't mean anything by it, maybe she didn't know how she made me feel, it's all over now, I'm not worrying about it, nothing like this has ever happened before. Staff B then asked the resident other than this incident, do you feel safe here to which the resident replied yes, I like most of the people that work here. Staff B documented she followed up with the resident and the Power of Attorney (POA) about the reported grievance from the weekend. The resident reported there was a misunderstanding between her and a staff member, she felt the CNA was a little rough with her and the CNA also stated to the resident she was new and did not know the resident's routine. There is no further documentation by Staff B related to the grievance. The additional sheets attached to the Grievance form included interviews of 11 residents on the unit where Resident #1 resided, no (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation as to who is conducting the interviews, dated 7/21/25 and 7/22/25, and an email sent by Staff A to the DON, the Administrator, Household Coordinator and Household mentors, dated 7/20/25 at 4:16 PM. The email included what was reported to Staff A by the family member regarding Resident #1. The email documented Staff A was in with the resident a few times in the morning and once in the afternoon and there was nothing said about this. The resident was upset this morning when Staff A went over there because no one answered her light, it had been 16 minutes. At 4:00 PM, Staff A went to the resident's room to follow up to see how she was feeling, a CNA was in the bathroom with the resident getting ready to assist to the bathroom, Staff A asked resident how she was feeling or if there was anything she could get for her. The resident denied any needs at this time, was smiling and said still had some nausea but much better. During an interview on 10/13/25 at 12:30 PM, the Administrator stated Staff A followed up on 7/20/25 after being informed by the family member of the concerns of abuse to Resident #1 by contacting the Director of Nursing (DON) and by going to see the resident who said she was good and had no concerns. The facility followed up with their full investigation starting on Monday, the 21st of July, 2025. The resident was never able to say who the staff person was, she said she was the one who yelled at the staff when the staff came into her room and said she did not know the resident's routine, which upset the resident. The resident did not know exactly when it happened, but thought it was on Saturday, the 19th of July. The facility had an agency staff working on the unit where the resident resides on that Saturday (the 19 of July), a CNA, Staff C. During their investigation they did not interview Staff C, separate Staff C from the resident or interview other staff working that day. They narrowed it down that it was more than likely Staff C Resident #1 was referring to. The Administrator stated a report was not made to the State Agency regarding the reported concerns of abuse to Resident #1. During an interview on 10/13/25 at 12:40 PM, Staff B, Director of Households, stated she followed up on the reported concern with Resident #1, she interviewed the resident on 7/21/25. Staff B stated residents on the unit where Resident #1 resided in July who had a BIMS of 13 and over were interviewed on 7/21/25 and 7/22/25. Staff B stated neither she nor other team members interviewed staff working that weekend, she stated there was an agency staff working that weekend as well. Staff B stated the resident does not do well with strangers and she does not like it when staff do not know her routine. Staff B stated she was notified of the grievance regarding Resident #1 on the 21st of July 2025. On that date, she interviewed the resident who said she yelled at a Certified Nursing Assistant (CNA) over the weekend when she was asked how her weekend went. She said she was the one who yelled at the CNA. The resident stated there was a misunderstanding between her and a staff member, she said she yelled at a CNA, it was on Saturday, but she did not know who the CNA was. She said the CNA entered her room and said she did not know her routine and this upset the resident. The resident told Staff B she was shoved and plopped on the toilet, and then said maybe she (the staff) did not know how it made her feel, and then said she isn't worried about it and said nothing like this happened before and she was over it. Staff B stated she did not question the resident more about her statement that she was shoved and plopped on the toilet, but asked her about feeling safe. Staff B stated she had an intention of following up with the resident with regard to her statement of being shoved and plopped on the toilet, however this did not take place. Staff B stated she believed the resident had the impression she was shoved and plopped, but did not believe that is what happened as the resident said maybe the staff did not know how she made her feel. The resident advised Staff B the incident took place on Saturday of that weekend, the 19th of July. Staff B acknowledged there are no dates or times on her documentation related to the grievance and facility investigation. Staff B acknowledged staff were not interviewed related to the reported concern in the grievance. During an interview on 10/13/25 at 1:45 PM, Staff A stated she recalled working on the 20th of July, she was the RN and charge nurse working a 6:00 AM to 6:00 PM shift. A family member of Resident #1 came up to her (unsure the exact time, but it was right around lunch time) and started yelling and swearing. The family member told her that Resident #1 just reported she had been pushed by a staff member, the family member did not (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	know who the staff member was. Staff A stated she went to check on the resident and she was good and did not need anything. Staff A stated the resident cannot see well and can get frustrated with staff at times, she has yelled at staff before. Staff A stated she did not hear any staff yell at the resident, however she was not working on the unit where the resident resides that weekend. The resident did not report to Staff A that anything happened to her by a staff member, however Staff A did not interview the resident about the reported concern. Staff A did not know the specific time the family member came to her to report the concerns, she said it was after lunch, around 1:30 PM. Staff A then contacted the DON by phone. The DON instructed her to fill out a grievance form and assess the resident. Staff A went down to the resident's room later in the afternoon, at 4:00 PM, and asked her if she was okay and if she needed anything. The resident said she was okay, she was smiling. Staff C was assisting the resident in the bathroom one of the times Staff A went to check on the resident, this was after the report was made to Staff A by the family member. During an interview on 10/13/25 at 2:00 PM, the Administrator and DON stated Resident #1 does not like it when a new staff member comes into her room, or someone she does not know. She does not like it when staff say they are new and say they do not know her routine. The Administrator and DON stated they believed Staff B was going to follow up with the resident again later in the week. They thought she did. The Administrator acknowledged there is no further documentation of another follow up to the resident's statement to Staff B that she was shoved and plopped down on the toilet. The Administrator stated an expectation this kind of statement is followed up on, and reported if needed. The Administrator acknowledged there needed to be a more thorough investigation and better documentation. The Administrator stated the facility did not make a self report to the State agency regarding the reported concerns. They did not separate the resident from any staff. The Administrator stated they care planned not to have agency staff work with the resident. Review of the staffing schedule for the 19th and 20th of July 2025 revealed Staff C worked on the 19th from 6:00 AM to 10:00 PM on the unit where Resident #1 resided. On the 20th of July Staff C worked a 6:00 AM to 2:00 PM shift. During an interview on 10/14/25 at 10:00 AM, the DON stated she received a telephone call from Staff A on 7/20/25 (unsure of the exact time) advising her that the family came to her and said something happened with a staff member where she talked loudly to Resident #1, but it was not recently. The DON stated she instructed Staff A to do education with staff to go slow with the resident and that staff did not need to talk loudly to her because she can hear. She instructed Staff A to fill out the grievance form and then to send an email to the team about the situation. The DON stated she read the email the next morning from Staff A which included the family member stating the resident said she was shoved, pushed and yelled at by a staff member. The DON then had Staff B go talk to the resident. The DON stated she also instructed Staff A to check on the resident on 7/20/25. The DON stated she would have done things differently if she knew up front that there was a report of the resident being pushed and shoved and yelled at, she would have called the Administrator and discussed other steps. The DON stated an understanding that if there are suspected abuse concerns with a staff member, steps need to be taken to ensure the resident's safety and a report of suspected abuse would need to be made to the State within two hours. The DON stated after reading the email the following morning and noting the report of a staff member at the facility pushed, shoved and yelled at the resident, she had Staff B interview the resident. The DON acknowledged a report was not made to the State agency regarding the resident stating she was shoved, pushed and yelled at by a staff member. During an interview on 10/14/25 at 10:30 AM, a family member of Resident #1 stated on 7/20/25 a visit took place at the facility with the resident, in the early afternoon. While the family member stepped out of the resident's room, the resident talked to another family member still in the room. When the family member returned to the room, the resident was crying and holding the hand of the other family member. The family member asked if everything was okay and the other family member said something happened. The resident then stated a CNA was mean to her and yelled at her, they got into a yelling match. The resident said she had used her call light to go to the bathroom and (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when the CNA came into her room she had gone in her brief. She said the CNA screamed that she had to clean up the resident. The resident said the CNA jerked her up out of her recliner chair and the resident yelled at her that she was hurting her. The resident said the CNA pushed her back into her chair. The family member asked the resident who the CNA was, the resident said she did not know her name, it was a staff member who did not work at the facility very often. The resident told the family member the CNA then got her up out of the recliner and took her to the bathroom and then dropped her down on the toilet. The resident said she told the CNA she was hurting her and the CNA yelled at her. The family member asked the resident more questions about the staff member and the resident said she had been working over the past few days, but did not work there very often. The resident said it happened within the last day or two. The family member said the resident was crying while reporting what happened. The resident said maybe the staff member was having a bad day and didn't know what she was doing, the resident said she felt helpless. The family member went to find the charge nurse and reported this to the charge nurse. Review of the facility policy Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, with a revision date of November 2024, 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. All allegations of Resident neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the Iowa Department of Inspections and Appeals, not later than two (2) hours after the allegation is made, if the events that cause the allegation result in serious bodily injury, or not later than twenty-four (24) hours if the events that cause the allegation involve neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation, but do not result in serious bodily injury.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, family interview and policy review, the facility failed to complete a thorough investigation and take steps to ensure resident safety after alleged abuse for 1 of 3 residents reviewed for abuse (Resident #1). The facility reported a census of 57 residents. Findings include: The Minimum Data Set (MDS), dated [DATE], documented Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS documented diagnoses to include debility, cardiorespiratory conditions, heart failure, renal insufficiency, diabetes mellitus, unspecified macular degeneration, anxiety disorder and depression. The resident was dependent on toileting hygiene and required substantial/maximal assistance with toilet transfer. The Care Plan for Resident #1, revised on 4/11/25, included a focus area: resident unable to complete Activities of Daily Living (ADL's) independently. The Care Plan instructed staff under interventions: the resident required an assistance of 1 staff into the bathroom to transfer to the toilet and the resident has very poor eyesight and wears glasses. She uses a lighted magnifying lens. When staff enter her room, she prefers staff to tell her their name, so she knows who she is talking to.Review of facility document Grievance Form dated 7/20/25 (Sunday), for Resident #1, completed by Staff A, Registered Nurse (RN), documented a family member reported that resident said someone that works there and it does not happen very often, pushes her, shoves her and yells at her and they get into shouting matches sometimes. Resident unable to say who it was but did say they sounded young. Under the Facility follow up section of the document, investigation by staff: Staff B, Director of Households, to talk to the resident. The section Findings of Dept. Heads documented see attached sheets. The section Follow Up Action Taken documented: 5 minute meeting about appropriate approaches, education to staff both facility and agency. The document was signed by Staff B and the Administrator on 7/22/25. Review of the attached sheets to the Grievance Form, undated, documented Staff B followed up with Resident #1 about how the weekend went, the resident stated well, it was good until I got into a yelling match with a CNA (Certified Nursing Assistant). Staff B documented the resident made it a point to say that she did all of the yelling, that the CNA didn't yell. She told Staff B that it happened on Saturday, during the day, unfortunately she is unable to identify who the CNA was. She said that the CNA entered her room saying, Well, I don't know your routine which made the resident mad/sad/feel bad. The resident told Staff B that she was shoved and plopped down on the toilet. The resident stated, well, maybe she didn't mean anything by it, maybe she didn't know how she made me feel, it's all over now, I'm not worrying about it, nothing like this has ever happened before. Staff B then asked the resident other than this incident, do you feel safe here to which the resident replied yes, I like most of the people that work here. Staff B documented she followed up with the resident and the Power of Attorney (POA) about the reported grievance from the weekend. The resident reported there was a misunderstanding between her and a staff member, she felt the CNA was a little rough with her and the CNA also stated to the resident she was new and did not know the resident's routine. There is no further documentation by Staff B related to the grievance. The additional sheets attached to the Grievance form included interviews of 11 residents on the unit where Resident #1 resided, no documentation as to who is conducting the interviews, and an email sent by Staff A to the DON, the Administrator, Household Coordinator and Household mentors, dated 7/20/25 at 4:16 PM. The email included what was reported to Staff A by the family member regarding Resident #1. The email documented Staff A was in with the resident a few times in the morning and once in the afternoon and there was nothing said about this. The resident was upset this morning when Staff A went over there because no one answered her light, it had been 16 minutes. At 4:00 PM, Staff A went to the resident's room to follow up to see how she was feeling, a CNA was in the bathroom with the resident getting ready to assist to the bathroom, Staff A asked resident how she was feeling or if there was anything she could get for her. The resident denied any needs at this (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	time, was smiling and said still had some nausea but much better. During an interview 10/13/25 at 12:30 PM, the Administrator stated Staff A, RN, followed up on 7/20/25 after being informed by the family member of the concerns of abuse to Resident #1 by contacting the Director of Nursing (DON) and by going to see the resident who said she was good and had no concerns. The facility followed up with their full investigation starting on Monday, the 21st of July, 2025. The resident was never able to say who the staff person was, she said she was the one who yelled at the staff when the staff came into her room and said she did not know the resident's routine, which upset the resident. The resident did not know exactly when it happened, but thought it was on Saturday, the 19th of July. The facility had an agency staff working on the unit where the resident resides on that Saturday (the 19 of July), a CNA, Staff C. During their investigation they did not interview Staff C, separate Staff C from the resident or interview other staff working that day. They narrowed it down that it was more than likely Staff C Resident #1 was referring to. The Administrator stated a report was not made to the State Agency regarding the reported concerns of abuse to Resident #1. The Administrator acknowledged the facility did not interview any staff during their investigation into the reported concerns. During an interview 10/13/25 at 12:40 PM, Staff B, Director of Households, stated she followed up on the reported concern with Resident #1, she interviewed the resident on 7/21/25. Staff B stated residents on the unit where Resident #1 resided in July who had a BIMS 13 and over were interviewed on 7/20/25 and 7/21/25. Staff B stated neither she nor other team members interviewed staff working that weekend, she stated there was an agency staff working that weekend as well. Staff B stated the resident does not do well with strangers and she does not like it when staff do not know her routine. Staff B stated she was notified of the grievance regarding Resident #1 on the 21st of July, 2025. On that date, she interviewed the resident who said she yelled at a Certified Nursing Assistant (CNA) over the weekend when she was asked how her weekend went. She said she was the one who yelled at the CNA. The resident stated there was a misunderstanding between her and a staff member, she said she yelled at a CNA, it was on Saturday, but she did not know who the CNA was. She said the CNA entered her room and said she did not know her routine and this upset the resident. The resident told Staff B she was shoved and plopped on the toilet, and then said maybe she (the staff) did not know how it made her feel, and then said she isn't worried about it and said nothing like this happened before and she was over it. Staff B stated she did not question the resident more about her statement that she was shoved and plopped on the toilet, but asked her about feeling safe. Staff B stated she had an intention of following up with the resident with regard to her statement of being shoved and plopped on the toilet, however this did not take place. Staff B stated she believed the resident had the impression she was shoved and plopped, but did not believe that is what happened as the resident said maybe the staff did not know how she made her feel. The resident advised Staff B the incident took place on Saturday of that weekend, the 19th of July. Staff B acknowledged there are no dates or times on her documentation related to the grievance and facility investigation. Staff B acknowledged staff were not interviewed related to the reported concern in the grievance. During an interview 10/13/25 at 1:45 PM, Staff A, RN, stated she recalled working on the 20th of July, she was the RN and charge nurse working a 6:00 AM to 6:00 PM shift. A family member of Resident #1 came up to her (unsure the exact time, but it was right around lunch time) and started yelling and swearing. The family member told her that Resident #1 just reported she had been pushed by a staff member, the family member did not know who the staff member was. Staff A stated she went to check on the resident and she was good and did not need anything. Staff A stated the resident cannot see well and can get frustrated with staff at times, she has yelled at staff before. Staff A stated she did not hear any staff yell at the resident, however she was not working on the unit where the resident resides that weekend. The resident did not report to Staff A that anything happened to her by a staff member, however Staff A did not interview the resident about the reported concern. Staff A did not know the specific time the family member came to her to report the concerns, she said it was after lunch, around 1:30 PM. Staff A then contacted the DON by phone. The DON instructed her to fill out a (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	grievance form and assess the resident. Staff A went down to the resident's room later in the afternoon, at 4:00 PM, and asked her if she was okay and if she needed anything. The resident said she was okay, she was smiling. Staff C was assisting the resident in the bathroom one of the times Staff A went to check on the resident, this was after the report was made to Staff A by the family member. During an interview 10/13/25 at 2:00 PM, the Administrator and DON stated Resident #1 does not like it when a new staff member comes into her room, or someone she does not know. She does not like it when staff say they are new and say they do not know her routine. The Administrator and DON stated they believed Staff B was going to follow up with the resident again later in the week. They thought she did. The Administrator acknowledged there is no further documentation of another follow up to the resident's statement to Staff B that she was shoved and plopped down on the toilet. The Administrator stated an expectation this kind of statement is followed up on, and reported if needed. The Administrator acknowledged there needed to be a more thorough investigation and better documentation. The Administrator stated the facility did not make a self report to the State agency regarding the reported concerns. They did not separate the resident from any staff. The Administrator stated they care planned not to have agency staff work with the resident. Review of the Care Plan for Resident #1 revealed a lack of intervention or planning to include agency staff not providing care or working with the resident. Review of the staffing schedule for the 19th and 20th of July 2025 revealed Staff C worked on the 19th from 6:00 AM to 10:00 PM on the unit where Resident #1 resided. On the 20th of July Staff C worked a 6:00 AM to 2:00 PM shift on the unit where the resident resided. Further review of the staffing schedule for July and August of 2025 revealed Staff C worked at the facility on 7/21/25, 7/22/25, 7/23/25, 7/24/25, 7/25/25, 7/28/25, 7/29/25, 7/30/25, 7/31/25, 8/1/25, 8/4/25, 8/5/25, 8/6/25, 8/7/25, 8/12/25, 8/13/25, 8/14/25, 8/15/25, 8/18/25, 8/19/25, 8/20/25, 8/21/25, 8/22/25, 8/25/25 and 8/26/25. These additional dates were not on the unit where Resident #1 resided. During an interview 10/14/25 at 10:00 AM, the DON stated she received a telephone call from Staff A on 7/20/25 (unsure of the exact time) advising her that the family came to her and said something happened with a staff member where she talked loudly to Resident #1, but it was not recently. The DON stated she instructed Staff A to do education with staff to go slow with the resident and that staff did not need to talk loudly to her because she can hear. She instructed Staff A to fill out the grievance form and then to send an email to the team about the situation. The DON stated she read the email the next morning from Staff A which included the family member stating the resident said she was shoved, pushed and yelled at by a staff member. The DON then had Staff B go talk to the resident. The DON stated she also instructed Staff A to check on the resident on 7/20/21. The DON stated she would have done things differently if she knew up front that there was a report of the resident being pushed and shoved and yelled at, she would have called the Administrator and discussed other steps. The DON stated an understanding that if there are suspected abuse concerns with a staff member, steps need to be taken to ensure the resident's safety and a report of suspected abuse would need to be made to the State within two hours. The DON stated after reading the email the following morning and noting the report of a staff member at the facility pushed, shoved and yelled at the resident, she had Staff B interview the resident. The DON acknowledged a report was not made to the State agency regarding the resident stating she was shoved, pushed and yelled at by a staff member. The DON acknowledged staff were not interviewed, including Staff C, and no other steps were taken regarding the reported concerns of suspected abuse. Review of the Electronic Health Record (EHR) revealed 14 of the 21 residents on the unit where Resident #2 resided in July of 2025 required assistance of 1 or more staff for completion of cares, such as toileting and transferring. During an interview 10/14/25 at 10:30 AM, a family member of Resident #1 stated on 7/20/25 a visit took place at the facility with the resident, in the early afternoon. While the family member stepped out of the resident's room, the resident talked to another family member still in the room. When the family member returned to the room, the resident was crying and holding the hand of the other family member. The family member asked if everything was okay and the other family member said (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E277	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Story Medical Senior Care	710 S 19th St Nevada, IA 50201

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	something happened. The resident then stated a CNA was mean to her and yelled at her, they got into a yelling match. The resident said she had used her call light to go to the bathroom and when the CNA came into her room she had gone in her brief. She said the CNA screamed that she had to clean up the resident. The resident said the CNA jerked her up out of her recliner chair and the resident yelled at her that she was hurting her. The resident said the CNA pushed her back into her chair. The family member asked the resident who the CNA was, the resident said she did not know her name, it was a staff member who did not work at the facility very often. The resident told the family member the CNA then got her up out of the recliner and took her to the bathroom and then dropped her down on the toilet. The resident said she told the CNA she was hurting her and the CNA yelled at her. The family member asked the resident more questions about the staff member and the resident said she had been working over the past few days, but did not work there very often. The resident said it happened within the last day or two. The family member said the resident was crying while reporting what happened. The resident said maybe the staff member was having a bad day and didn't know what she was doing, the resident said she felt helpless. The family member went to find the charge nurse and reported this to the charge nurse. Review of the facility policy Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, with a revision date of November 2024, documented it shall be the policy of this facility to implement written procedures that prohibit abuse, neglect, exploitation, and misappropriation of resident property. These procedures shall include the screening and training of employees, protection of residents and the prevention, identification, investigation, and timely reporting of abuse, neglect, mistreatment, and misappropriation of property, without fear of recrimination or intimidation. The facility will identify, through ongoing assessment, high-risk situations where abuse, neglect, or misappropriation of resident property may occur and provide appropriate intervention in such occasions. Upon receiving a report of an allegation of resident abuse, neglect, exploitation or mistreatment, the facility shall immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. If this involves an allegation of abuse by an employee, this will be accomplished by separating the employee accused of abuse from all residents.