STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165081	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Village Retirement	**600 Park Lane , Waterloo, Iowa, 50702**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Correction date: _____ The following deficiencies resulted from the investigation of complaint #3007471-C conducted July 6, 2026 to July 8, 2026. Complaint #3007471-C resulted in 2 deficiencies. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, clinical record review, interviews, and policy review the facility failed to monitor and maintain documentation of a resident's bruises for 1 of 1 residents reviewed (Resident #1). Additionally, the facility failed to obtain x-ray results for a resident with hip pain after falling for 11 days for 1 of 1 residents reviewed (Resident #3). The facility reported a census of 60 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) dated 4/21/26 listed diagnoses of weakness, edema (fluid swelling), and a history of falls. Resident #1's Brief Interview for Mental Status (BIMS) assessment showed a score of 13, indicating intact cognition. The assessment noted no skin concerns.	F0684		

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 reverse for further 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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F0684 SS = D	Continued from page 1 Resident #1's Care Plan (CP) created 4/22/26 directed nursing staff and Certified Nurses' Aides (CNAs) to conduct weekly skin inspections for redness, open areas, scratches, cuts, and bruises and to report changes to the nurse. On 7/6/26 at 11:03 AM Resident #1 stated falls occurred due to a prior stroke. Resident #1 reported bruises from the last fall on the head, face, and arm healed. Resident #1 couldn't provide the date of the fall. A Progress Note dated 5/3/26 at 10:31 PM documented Resident #1 fell from the edge of the bed and hit the head hard on the floor. A Progress Note dated 5/4/26 at 1:27 AM indicated Resident #1 had visible swelling on the right side of the head. The left pupil measured larger and non-reactive. After consultation with family and the provider, the facility sent Resident #1 to the Emergency Room (ER). On 7/8/26 at 10:33 AM Staff B, Registered Nurse (RN), stated the floor nurse usually documented bruising monitoring at least weekly on shower days in the assessment tab of the Electronic Health Record (EHR). Staff B stated the facility employed a skin nurse, but the nurse's focus remained mostly on wound treatment and pressure sores. A document titled Skin Check dated 5/6/26 at 3:15 PM, section 1.8, documented no skin issues. A Progress Note dated 5/13/26 at 8:49 PM titled Skin Check indicated no skin issues or new skin issues. A Progress Note dated 5/13/26 at 8:51 PM documented facial bruising from a previous fall showed various degrees of healing. The facility didn't provide documentation of the initial bruising assessment, location of bruises, size of bruises, or monitoring of bruising or swelling on Resident #1's head.	F0684		

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F0684 SS = D	Continued from page 2 On 7/8/26 at 3:55 PM the Director of Nursing (DON) stated the skin nurse tracked pressure sores and staff held a weekly skin meeting. The DON reported the EHR felt new to the facility and staff still navigated the documentation. The DON expected the documentation to reside in the skin module and acknowledged she didn't see the documentation for Resident #1. 2. Resident #3's Minimum Data Set (MDS) dated 4/21/26 documented diagnoses of osteoporosis (bone thinning), Alzheimer's disease (brain disorder), and a history of falls. Resident #3 received a BIMS score of 99, indicating an incomplete interview, and the staff assessment indicated cognition showed severe impairment with both long-term and short-term memory problems. Resident #3's EHR revealed Resident #3 fell on 6/20/26, 6/22/26, and 6/23/26. A Progress Note dated 6/24/26 at 6:00 PM indicated the facility received a fax from the provider's office about the 6/23/26 incident, yielding a new order for a right hip x-ray. The facility sent a return fax to the provider requesting clarification for the number of x-rays and asking if the order could include a portable x-ray. A Progress Note dated 6/26/26 at 11:35 AM reported the facility received a response from the provider for a STAT (immediately) portable x-ray of the right hip, 3 views, with diagnoses of pain, decreased mobility, and dementia (memory loss). A review of Resident #3's paper records and EHR on 7/6/26 showed no progress note documenting x-ray completion or results as of 1:05 PM. A document titled Patient Report dated 6/26/26 at 2:03 PM indicated Resident #3's x-ray revealed no acute fracture and mild degenerative changes. The document header showed the fax arrived at the facility on 7/7/26. On 7/8/26 at 3:36 PM Staff G, X-Ray Provider Representative, stated the company originally faxed the results to the facility at a number provided on	F0684		

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F0684 SS = D	Continued from page 3 6/26/26. Staff G noted on 7/7/26 at 9:06 AM the facility called for a refax and provided a different number. Staff G reported no indication the facility called between 6/26/26 and 7/7/26 to request the results. Staff G stated they don't fax the results to the doctor’s office because providers and patients move too much and sending them to the nursing home yields better results. On 7/8/26 at 3:47 PM Staff F, Provider's Clinic Nurse, confirmed they didn't receive the x-ray results until the facility faxed them on 7/7/26. Staff F responded to the facility on 7/8/26 at 9:49 AM. On 7/8/26 at 3:55 PM the DON stated the turnaround time for x-ray results depended on the x-ray provider. When asked about follow-up responsibility, the DON stated she thought the company faxed Resident #3's results to the primary care provider. The DON stated the facility faxed them yesterday. The DON confirmed staff didn't contact the x-ray provider or the primary care provider until 7/7/26. The Fall Reduction Policy and Procedure revised April 2023 directed staff to investigate and document fall circumstances, resident outcome, and staff response. The policy instructed the nurse to notify the primary care provider and implement an immediate intervention.	F0684		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, clinical record review, facility records, interviews, and policy review, the facility failed to provide adequate supervision for 2 of 3 residents reviewed for falls (Resident #1 and	F0689		

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F0689 SS = D	Continued from page 4 Resident #3). Resident #1 fell after a Certified Nurses' Aide (CNA) transferred them to the edge of the bed and then moved a wheelchair to the bathroom. Additionally, Resident #3 required assistance from a CNA, but the staff left them alone in the bathroom while the CNA assisted another resident. In addition, the facility failed to use foot pedals while pushing Resident #3 who needed assistance in their wheelchair. The facility reported a census of 60 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) dated 4/21/26 recorded diagnoses of a Cerebrovascular Accident (CVA, stroke), a history of falling, and weakness. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 13, indicating intact cognition. Section GG of the MDS recorded Resident #1 required substantial to maximal assistance (helper does more than half of the work) to transfer to and from a chair and a bed, and to move from sitting on the side of the bed to lying flat on the bed. Therapy Recommendations dated 12/1/25 directed staff to use a Standing Pivot Transfer (SPT) with a four-wheeled walker, right platform, and the assistance of two staff members for Resident #1. Resident #1's Care Plan (CP) included an intervention created 4/22/26 directing two staff members to transfer Resident #1 into or out of bed. An intervention updated 5/3/26 indicated Resident #1 had a fall, modifying the transfer instruction to an assistance of two staff members for all SPT with a platform walker and gait belt (transfer safety belt). On 7/6/26 at 10:48 AM Resident #1 sat in a wheelchair in the room wearing a leg brace on the right leg. Two staff members entered the room to provide continence care (toileting assistance), which included using a gait belt. On 7/6/26 at 11:03 AM Resident #1 stated sometimes one person and sometimes two people helped Resident #1 to bed, though Resident #1 believed staff always utilized two people since the last fall. Resident #1 reported the bruises on the head, face, and arm from the fall healed. Resident #1 couldn't provide the exact date of the fall.	F0689		

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F0689 SS = D	Continued from page 5 An Incident Statement dated 5/3/26 reported by Staff A, Certified Nurses Aide (CNA), to Staff B, Registered Nurse (RN), documented Staff A transferred Resident #1 to the incontinence pad (disposable bed pad) on the bed. Resident #1 sat upright, holding the bed side rail. Staff A placed the wheelchair inside the bathroom when Resident #1 leaned over and fell onto the floor, hitting the head. A Progress Note dated 5/4/26 at 12:49 AM documented Resident #1 returned to the facility from the hospital. Diagnoses included a fall and a contusion (bruise) of the right shoulder. Imaging of the cervical spine (neck bones) and head showed negative results. A CNA assisted Resident #1 to the bathroom and to bed. A Progress Note dated 5/4/26 at 1:27 AM documented discomfort on the right side of Resident #1's head with visible swelling, along with discomfort in the left hip and right shoulder. The note indicated Resident #1 maintained the ability to transfer with the assistance of one staff member and a gait belt. On 7/8/26 at 10:33 AM Staff B stated following the fall of Resident #1, staff assessed for pain, range of motion (joint movement), vital signs, and completed a neurological assessment (brain and nerve evaluation). Resident #1's pupils didn't show equal size, and Resident #1 received medication for blood clotting, so staff consulted the family and the doctor before sending Resident #1 to the hospital. Staff B indicated Staff A reported performing some of Resident #1's cares, sitting Resident #1 on the edge of the bed, and moving the wheelchair into the bathroom. As Staff A walked back, Resident #1 slid off the bed. Staff B confirmed only one CNA accompanied Resident #1 and believed the care plan allowed this setup. On 7/8/26 at 11:51 AM Staff C stated she wouldn't leave a resident on the side of the bed. She reported two staff members should stand on each side of the resident, hold the gait belt, and help pivot the resident from the wheelchair to the bed. The staff should then scoot the resident back onto the bed and swing the legs into place. Staff C felt the procedure offered greater safety for any resident. She stated Resident #1 normally required assistance of one staff member, but staff utilized two because	F0689		

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F0689 SS = D	Continued from page 6 Resident #1's right side remained weak. On 7/8/26 at 3:55 PM the Director of Nursing (DON) stated Staff A placed Resident #1 at the edge of the bed and moved the wheelchair out of the way into the bathroom. The DON expressed no problem with this action because Staff A didn't leave the room. She said Resident #1 simply fell forward. The DON confirmed only one CNA assisted Resident #1 because staff finished toileting, lotion, and hair care. When questioned if she expected the CNA to finish all cares and place Resident #1's feet up before moving the chair, she stated following the fall, the facility added therapy for trunk control (torso stability), and Resident #1's care plan now required getting Resident #1 fully into bed for safety. When asked if staff completed additional fall training after this incident, she stated staff mentioned it during one huddle (brief staff meeting). A document titled Nursing Meeting dated 5/12/26 - 5/13/26 didn't include Resident #1's incident. The daily huddle topic noted to make sure staff check fall interventions remain in place each time staff leave a resident alone in a room. The facility didn't maintain signatures to confirm the specific staff members who participated in the meeting or huddles. 2. Resident #3's Minimum Data Set (MDS) dated 4/21/26 documented diagnoses of osteoporosis (bone thinning), Alzheimer's disease (progressive brain disorder), and a history of falling. Resident #3 couldn't complete the BIMS assessment, resulting in a score of 99, indicating an incomplete interview. The staff assessment indicated severe cognitive impairment with both long-term and short-term memory problems. The MDS indicated Resident #3 required partial to moderate assistance (helper does less than half of the work) for toileting hygiene and depended entirely on staff for toilet transfers. Resident #3's Care Plan dated 3/26/26 included a focus area for Activities of Daily Living (ADL) self-care deficits related to impaired balance, dementia, and Parkinson's disease (nervous system disorder). Interventions included the assistance of one staff member for toileting and transfers, and notes designated Resident #3 at high risk for falls, requiring frequent checks and assistance to use the bathroom. An additional intervention dated 3/12/26 documented Resident #3 utilized a wheelchair for	F0689		

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F0689 SS = D	Continued from page 7 mobility. The plan directed staff to encourage Resident #3 to allow staff to move foot pedals out of the way during transfers because Resident #3 would pull them back and step over them. On 7/6/26 at 11:41 AM Staff E pushed Resident #3's wheelchair from a rust-colored chair in the common area to the dining room without foot pedals, covering a distance of approximately 50 feet. On 7/7/26 at 11:40 AM Resident #3 Representative stated awareness concerning Resident #3's numerous falls. Resident #3 Representative felt the falls related closely to memory loss, Parkinson's disease, and Resident #3 living out of habit without understanding the inability to perform tasks independently. Resident #3 Representative believed a staff member remained in the bathroom with Resident #3 whenever possible. A Progress Note titled Incident Note dated 6/20/26 at 11:15 AM documented a CNA assisted Resident #3 to the toilet. The CNA left the room to help another resident and advised an alternate CNA regarding Resident #3's presence in the bathroom. A housekeeper entered the room and discovered Resident #3 on the bathroom floor. The note included an immediate intervention directing staff to avoid leaving Resident #3 unattended while toileting. The facility didn't provide an associated incident report or alternative fall investigation documentation related to the 6/20/26 fall. On 7/8/26 at 10:23 AM Staff D stated she wouldn't leave a resident alone upon knowing the resident couldn't use the bathroom call light. She stated staff shouldn't leave Resident #3 alone in the bathroom, though Resident #3 refused to use the toilet if staff remained inside. Staff D noted CNAs often partially closed the door and stayed close to it, confirming she wouldn't leave the room. On 7/8/26 at 11:51 AM Staff C stated staff couldn't leave Resident #3 alone. She noted staff might step out of the bathroom but must stay in the room. She stated staff should never push a wheelchair without foot pedals.	F0689		

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F0689 SS = D	Continued from page 8 On 7/8/26 at 12:21 PM Staff E stated Resident #3 could use his feet to move the wheelchair and frequently moved foot pedals back into place after staff adjusted them to the side. When asked if pushing the wheelchair without pedals constituted normal practice, she stated she might perform the action under certain circumstances but usually avoided it. She acknowledged completing this action before. On 7/8/26 at 3:55 PM the DON stated she believed Resident #3 remained on the bathroom floor for 15 minutes or less from the time the CNA left the bathroom until the housekeeper discovered him. She said her investigation of the call lights revealed multiple alarms activated at that time, so she didn't believe the CNA notified of Resident #3's status managed to check on him. She stated she suggested staff stand outside the door when Resident #3 rejected their presence in the bathroom, though she acknowledged staff didn't always follow this practice. When asked if staff should leave Resident #3 alone, she answered no, based on the care plan. The DON stated she expected foot pedals on a wheelchair if staff pushed a resident. She reported no awareness of additional fall training for staff after this incident. The Fall Reduction Policy and Procedure revised April 2023 directed staff to investigate and document fall circumstances, resident outcomes, and staff responses. The policy instructed staff to provide education on fall prevention at mandatory CNA and nurse meetings.	F0689		