STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165322	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottage Grove Place	2115 First Avenue SE 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and staff interviews the facility failed to provide appropriate supervision to prevent a fall that resulted in fracture of the resident's right scapula (shoulder blade) and pain for one of three residents reviewed (Resident #1). The facility reported a census of 55 residents. Findings include:Resident #1 admitted to the facility on [DATE] from Assisted Living after she had a fall that resulted in a fracture of the left humerus (upper arm). The MDS (Minimum Data Set) dated 10/28/2025 revealed the resident had severely impaired cognitive skills for daily decision making, required substantial/maximum assistance to transfer from one surface to another, required supervision while eating, and had a history of falls with fracture in the prior 6 months. The resident had diagnoses including fractures, hypertension, diabetes, and dementia. The Care Plan initiated 10/22/2025 identified the resident had a risk for wandering related to dementia. It directed staff to be aware of the resident's tendency to wander and allow wandering in spaces where resident can be safely monitored and cannot harm self.The Care Plan initiated 10/23/25 reported the resident admitted to the facility related to a fracture of the upper end of the left humerus (bone of the upper arm), with a goal to get stronger with therapies. The Care Plan revealed the resident had a fall history including a fall within one month of admission, fall within 2-6 months prior to admission, and a fracture related to a fall withing the past 6 months. The resident required staff assistance to transfer with a mechanical lift, used a wheel chair for mobility and had an immobilizer to the left upper extremity at all times.The Care Plan initiated 10/23/25 identified the resident had a risk for falls related to limited mobility, assistance needed with functional abilities, unspecified fracture of the left humerus, personal history of TIA's (transient ischemic attack, a temporary blockage of blood flow to the brain), vascular dementia and Alzheimer's disease. The Care Plan instructed staff to assist the resident with ambulation and transfers per therapy recommendations, determine resident's ability to transfer, evaluate fall risk on admission and as needed. If fall occurs, alert provider, initiate frequent neuros (evaluates brain and nervous system functioning) and bleeding precautions. If resident is a fall risk, initiate fall precautions, keep door open when able, especially at night, keep call light near and personal items within reach. The Care Plan indicated the resident had a fall at the facility on 11/3/2025 when she slid out of bed with no injury noted.Fall risk evaluations dated 10/22/2025 and 11/28/2025 revealed the resident had a fall risk. The facility Self Report regarding Resident #1's accident with major injury on 11/28/2025 at 1:00 p.m. explained the resident had an unwitnessed fall in the dining room shortly after lunch. Staff found the resident on the floor seated upright with legs extended. The resident could not explain what happened. She could move all extremities, though she consistently guarded her right shoulder. The facility notified the physician and orders were obtained for cervical spine and right shoulder X-rays. [Portable X-ray company name redacted] confirmed they would arrive that same day. On 11/29/2025, during a follow up (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 0689 Level of Harm - Actual harm Residents Affected - Few	assessment, the resident had increased pain and [Portable X-ray company name redacted] confirmed they would not be able to come until 12/1/2025. The facility notified the physician and sent the resident to the Emergency Department for urgent evaluation. The imaging showed she had a fracture of the right scapula (shoulder blade) and returned with a right arm sling. The ED (Emergency Department) note dated 11/29/2025 reported Resident #1 had an unwitnessed fall yesterday at the nursing facility. The resident had a hematoma to the right forehead, right shoulder pain and arrived with a shoulder immobilizer on the left shoulder. Dementia at baseline, worse today per EMS (emergency medical services). She indicated she is having pain in her right shoulder. She also has a contusion to the right side of her face. Patient is unable to provide any significant history due to her dementia. Imaging resulted in acute fracture of the distal tip of the right acromion, superiorly displaced. (where the collar bone connects to the shoulder blade), and no acute abnormality of the chest, cervical spine, abdomen or pelvis. The CT of the head found no evidence of intracranial hemorrhage (bleeding inside the skull), fracture of other acute findings. The resident discharged back to the facility with a right arm sling. On 1/5/2026 at 4:10 P.M. Staff A, Administrator reported the following: Two aides were in the dining room and there was a brief moment where there was no supervision. When they returned they found Resident #1 on the floor. The facility had cameras downstairs but not angled so could see when staff entered and exited the dining room. The residents needed to be under supervision when they were in the dining room, eating. It appeared that Staff C, LPN (Licensed Practical Nurse) went down, assessed another resident, told staff told staff to lay that resident down and then left. Staff A explained did a full education, a write up, a re-education with all staff. Per Staff A, did it immediately and all staff in person, and did some education electronically. Staff A explained staff knew not to leave residents unattended, and the facility was integrating the dining room supervision into new hire orientation. Staff A explained did not have a specific policy regarding dining room supervision. Staffing downstairs was two staff on days and evenings, one on the night shift with access to the float staff to come down and assist, and the ADON (Assistant Director of Nursing) had her office downstairs as well.On 1/6/2026 at 8:25 A.M, Staff A, Administrator added the x-ray delay was due to bad weather, had scheduled with [Portable X-ray company name redacted], they said they could come the same day, and when they did not come, they said they could not come until 12/1. So, the nurse called the physician and they sent her to the ED. The two aides received verbal education at the time of the incident, spoke about it at a nurse's meeting, and did postings in each mail box. Staff A explained the ADON's office was down there, but she did not work the day of the fall. On 1/5/2026 at 12:06 p.m., Staff B, ADON reported the resident had resided in the assisted living section prior to coming to the nursing home. At assisted living she had a fall and fractured her left shoulder. She moved over to long term care and had been working with therapy. Staff tried to keep her in the hallway with them for supervision. She had a previous fall on 11/3/2026 where she slid out of bed. She also had a low bed. On 11/28/2025, two aides, Staff E and Staff F left the dining room to lay another resident down. The Director of Nursing at the time of the incident, no longer worked at the facility, and the Administrator did the investigation. Staff B did not work on 11/28/2025, the day the resident fell in the dining room. On 1/5/2026 at 1:45 p.m., Staff F, CNA/Medication Aide reported on 11/28/2025 she worked downstairs as the Medication Aide from 10 A.M. - 2 P.M. Resident #1 fell in the dining room around 1 p.m. Staff E was the CNA and was assisting the residents with eating, and Staff F passed medications in the dining room. Lunch is served around noon. Staff C, Licensed Practical Nurse (LPN) came down and told Staff E and Staff F to lay another resident down so she could get a urine sample. Staff E and Staff F excused themselves and took the other resident to to her room and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	put her in bed. Staff C was in the dining room when they left with the other resident. When Staff E and Staff F returned to the dining room, about 8-10 minutes later, a male resident yelled he had seen Resident #1 fall but he could not do anything about it. Staff F observed Resident #1 laying on her right side with the wheelchair nearby. She had been at a table in her wheelchair when they left the room. Staff F asked her what she was doing and she said I don't know, and pointed to her right arm. She already had a sling on her left arm. Staff F called upstairs and asked Staff C to come downstairs. They assisted the resident up into her wheelchair and Staff C assessed her. Staff F indicated Staff C knew they had left the dining room to lay the other resident down. Per Staff F, had been told to have one person in the dining room at all times, and further explained communication was exchanged at monthly meetings and group texts. Staff F failed to recall if she received education immediately following the resident's incident.On 1/5/2026 at 3:15 p.m., Staff E, CNA reported she worked downstairs when Resident #1 fell on [DATE] along with Staff F. They were both in the dining room during lunch. Staff E fed residents while Staff F passed medication. Another resident had been refusing to eat and did not seem right so she called upstairs and informed Staff C. Staff C came down and told Staff E and Staff F to lay the resident down. They took that resident from the dining room in her wheelchair, and Staff C left the dining room and went back upstairs. Staff E and Staff F were gone about 15 minutes as they had to transfer the resident to bed using a stand up lift and provide cares. On the way to the dining room, a laundry aide reported someone was on the floor. When they returned to the dining room, no staff were present, and Resident #1 lay on the floor. Staff E called for Staff C to come downstairs. Staff C assessed the resident and they assisted the resident up off the floor and into her wheelchair. She did not initially complain of pain. They were educated about not leaving residents in the dining room without staff present. Residents were still eating when they left the dining room with the other resident. Staff E left around 2 p.m. at the end of the shift. Lunch is served around noon. Staff C asked them what transpired. Staff C came down and told them to lay a resident down; she did not mean later. Staff E explained two staff were scheduled in the downstairs unit. Staff E and Staff F were the only two staff in the dining room that day during lunch.On 1/6/2026 at 8:30 a.m., Staff C, LPN reported she worked on 11/28/2025 and got a call from staff downstairs. They asked her to come down and assess a female resident who was not acting right. She went down and saw two staff, Staff E and Staff F in the dining room assisting residents at the noon meal. Staff C told Staff E and Staff F to lay the resident down when they did lay downs. A little while later they called upstairs and said Resident #1 had fallen. Staff E and Staff F reported they had left the dining room to lay the other resident down. They should have pulled all of the residents from the dining room prior to laying her down. It was discussed at a monthly meeting that there should always be one person in the dining room. Staff C explained she called the physician, got an order for an x-ray and called [Portable X-ray company name redacted]. [Portable X-ray company name redacted] said they would get her that day. Resident #1 denied pain, however she grabbed her right shoulder. Staff C left at the end of the shift around 2 p.m. and did not work the following day. She learned that [Portable X-ray company name redacted] did not come that day and the resident went to the ED the next day.On 1/6/2026 at 2:30 p.m., Staff G, LPN reported working on 11/28/2025 from 6 p.m. until 6 a.m. on 11/29/2025. Staff G knew Resident #1 waited for an x-ray, and when Staff G she checked on Resident #1, the resident was sleeping. Staff G checked assessed her and had no concerns. Staff G would typically do treatments downstairs from approximately 7 - 9 p.m. Staff G informed the next staff that [Portable X-Ray company name redacted] did not come. She did not recall staff reported the resident complained of pain. On 1/5/2026 at 3:35 p.m., Staff H, RN (Registered Nurse) reported she worked on (continued on next page)

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