STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165372	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elm Crest Retirement Community	2104 12th Street Harlan, IA 51537

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, family and staff interviews, clinical record review and policy review, the facility failed to ensure that staff used safe transferring techniques for 1 of 4 residents reviewed. Resident #4 had many falls and required 2 staff assistance. On 9/12/25 he had another fall while being transferred from the toilet to the wheel chair with just one staff. The facility reported a census of 46 residents. Findings include:According to the Minimum Data Set (MDS) dated [DATE], Resident #4 had a Brief Interview for Mental Status (BIMS) score of 12 (moderate cognitive deficit.) The resident had impairment on both sides of the lower extremities. He required substantial assistance with sit to lying, and toilet transfers. His diagnoses included renal insufficiency, neurogenic bladder, diabetes mellitus and Cerebrovascular Accident (CVA) and chronic pain. The Care Plan (CP) for Resident #4 showed that he was at risk for falls because he was unsteady on his feet, and needed assistance. On 4/7/25, the CP was updated to include and intervention that 2 staff would assist for transfers until he was cleared by Physical Therapy (PT.) On 9/12/25, an intervention was added to the CP that Resident #4 would be an assist of 2 with transfers when there was no grab bar available. Resident #4 needed assistance with dressing, personal hygiene and bathing due to CVA. He had moderate cognitive impairment, and was not always able to understand others. On 11/13/25 at 8:30 AM, Resident #4 was sitting at the breakfast table. He was in a wheel chair, looked confused, and there was a catheter tube along the side of his leg. The Nursing Notes for Resident #4 included the following: a. On 4/7/25 at 7:45 PM, the resident was found on the floor in his room in front of the wheel chair. The intervention was to not have resident alone in his room b. On 4/9/25 at 9:37 PM, he was lowered to the floor while being transferred to bed. The intervention was to have 2-person assistance. c. On 4/30/25 at 4:59 PM, the resident was lowered to the floor when being transferred by 2 Certified Nurse Aides (CNA.) They did not put his shoes on or put on gripper socks. d. On 9/12/25 at 2:51PM, the resident slide to the floor in front of the toilet in the tub room. He was leaning against the wheel chair and reported no pain or injury. A Fall Risk Assessment, dated 9/12/25 at 11:53 AM, showed that Resident #4 was found to be at risk for falls with 1-2 fall in the previous 3 months. A notification to the doctor on 4/9/25, showed that the resident was showing decreased weakness and was unable to transfer with 1 assist as usual. Staff requested services for Physical Therapy/Occupational Therapy (PT/OT) evaluation and treatment. An Occupational Therapy Discharge summary dated [DATE], showed that OT had provided visual and written instructions to demonstrate how to provide transfers with a walker and that the resident needed assistance of 2 staff. A Physical Therapy Treatment Encounter note dated 8/8/25, showed that Resident #4 needed maximum assistance of 2 to go from sit to supine, and maximum assist of 2 to complete bed mobility and transfers. On 11/13/25 at 9:25 AM, PT staff acknowledged that on 4/10/25, PT/OT started working with Resident #4. When he was discharged , they kept him an assist of 2 and shared a video for staff on how to properly transfer him with 2 staff. On 11/13/25 at 1:15PM Staff D, CNA, said that on 9/14/25, a staff member from PT helped her get Resident #4 to the toilet off the shower room. They transferred him to the toilet and left him alone for a little while. Staff D then went back in by herself to get him off the toilet and into the wheel chair. She said that she used a gait belt and pivoted him to the wheel chair, but he wasn't back far enough on the seat and he slid down onto the floor. Staff D said that she wasn't sure if he was a 1 or 2 assist at the time, things change so often.On 11/13/25 at 11:45 AM, a family member for Resident #4 said that she visits the resident every day. She said that the resident was able to stand with the walker and turn to the bed or toilet and there would be 1 or 2 staff assisting him, it just depended on who was working. On 11/13/25 at 12:20 PM, Staff C, CNA, said that Resident #4 required 1 assistance for transfers, but can be two sometimes. On 11/13/25 at 12:00 PM, the Director of Nursing (DON) said that she was not working at the facility when Resident #4 had the fall in September. She acknowledged that according to the recommendations from therapy, they should be using 2 staff to transfer the resident. According to the undated facility policy titled: Fall Prevention Program, each resident would be assessed for fall risk and would receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Each resident risk factor and environmental hazards would be evaluated when developing the resident comprehensive plan of care. Interventions would be monitored for effectiveness the plan of care would be revised as needed.