STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165479	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calvin Community	4210 Hickman Road Des Moines, IA 50310

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and policy review, the facility failed to complete a discharge summary, including a recapitulation of stay, and failed to provide a discharge summary to the resident/family for 1 of 1 residents reviewed for discharge (Resident #65). The facility reported a census of 55 residents. Findings include:The admission Minimum Data Set (MDS) dated [DATE] documented Resident #65 admitted to the facility on [DATE] and had diagnoses to include fractures and other multiple trauma. Review of the clinical record for Resident #65 revealed the resident discharged from the facility on 9/23/25. The clinical record lacked a discharge summary and a recapitulation of stay for Resident #65 and further lacked documentation a discharge summary was provided to the resident and/or the family. The clinical record did not contain a signed discharge summary. During an interview 12/17/25 at 4:00 PM, the Assistant Director of Nursing (ADON) stated he is the one, along with the unit manager, who completes the discharge summary, which includes the recapitulation of stay, for residents who discharge from the facility. The discharge documents are printed and the resident and/or family sign the discharge summary and a copy of this is placed in the clinical record for the discharged resident. The ADON acknowledged the recapitulation of stay was not completed for Resident #65 and a discharge summary was not fully completed or signed. The ADON stated an expectation these forms are completed and signed for each resident discharged from the facility. Review of the facility document Discharge Checklist, undated, documented the unit manager will complete discharge summary/transition of care, print of discharge summary/transition of care and place in discharge folder, once discharge summary/transition of care is signed by the resident/family, upload all discharge paperwork into the electronic health record before giving the folder to the resident. The DON/ADON will complete discharge recapitulation/discharge summary in electronic health record observations.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record review, staff interview, policy review, and Resident Assessment Instrument manual the facility failed to develop a comprehensive care plan that included behaviors/interventions for residents receiving psychotropic medications(anti-anxiety, antipsychotic, and antidepressants) for 4 of 5 residents reviewed (Residents #3,#6, #2, and #44). The facility reported a census of 55 residents. Findings include: 1.The MDS completed 11/3/25 revealed Resident #3 with a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Diagnoses include major depressive disorder, recurrent, and moderate. The MDS indicated the use of antianxiety and antidepressant medications. The Physician Orders for Resident #3 listed the resident received Trazadone (start date 10/28/25) and Wellbutrin (antidepressants) (start date 10/27/25) daily. The Care Plan, last revised on 11/19/25 , noted Resident #3's use of an antidepressant with a goal of the resident's use of medication will result in maintenance in the resident's functional status. Interventions included administering medication as ordered and monitor and report labs as indicated by the physician. The Care Plan failed to identify targeted behaviors of depression Resident #3 was being treated or monitored for. The Care Plan lacked resident-specific non-pharmacological interventions staff may utilize for the resident. 2. The Quarterly MDS completed 10/17/25 revealed Resident #6 with a BIMS of 3, indicating severe cognitive impairment. Diagnoses include dementia, anxiety disorder, depression, and delusional disorders. The MDS indicated the use of an antipsychotic and antidepressant medication. The Physician Order Report for Resident #6 listed Seroquel (antipsychotic) daily (start date 10/14/25) and Sertraline(antidepressant) daily (start date 12/09/25). The Physicians order also included an order for Melatonin every night for treatment of insomnia with start date of 7/14/25. The Care Plan, last revised 10/8/2525, noted Resident #6's use of an antidepressant with a goal the resident will not exhibit signs of drug related sedation, hypotension, or anticholinergic symptoms. Interventions included administering medication as ordered, monitoring resident's functional status, and pharmacy consultation as indicated. The care plan included the resident received antipsychotic medication with additional interventions of AIMS (abnormal involuntary movement test)every 6 months or more often if indicate, attempt a gradual dose reduction according to recommendations, monitor resident's behavior and response to medication. The Care Plan itself failed to identify resident-specific targeted behaviors that Resident #6 was being treated or monitored for. The Care Plan lacked resident-specific non-pharmacological interventions staff may utilize for the resident. 3.The MDS completed 12/1/25 revealed Resident #2 with a BIMS of 15, indicating intact cognition. Diagnoses include anxiety and major depressive disorder, severe, with psychotic symptoms. The MDS indicated the use of antianxiety and antipsychotic medications. The Physician Order Report for Resident #2 listed the following medication orders: Mirtazapine 15 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mg daily (antidepressant) (start date of 11/24/25); Venlafaxine 150 mg daily (antianxiety/antidepressant) (start date 11/24/25); and Aripiprazole 5 mg daily (antipsychotic) (start date 11/25/25). The Physicians Order Report documented the resident admit date as 11/24/25. The Care Plan, last revised on 12/12/25, noted Resident #2's use of an antidepressant with a goal the resident will not exhibit signs of drug related sedation, low blood pressure, or anticholinergic side effects (such as dry mouth, constipation, and confusion). Interventions included administering medication as ordered, monitoring resident's functional status, and pharmacy consultation as indicated. The Care Plan failed to identify targeted behaviors of depression Resident #2 was being treated or monitored for. The Care Plan lacked resident-specific non-pharmacological interventions staff may utilize for the resident. The Care Plan failed to identify the use of the antipsychotic, possible medication side effects, resident-specific targeted behaviors to monitor, and resident-specific non-pharmacological interventions. 4.The Quarterly MDS completed 12/5/25 revealed Resident #44 with a BIMS of 3, indicating severe cognitive impairment. Diagnoses include depression and stroke. The MDS indicated the use of an antidepressant medication. The Physician Order Report for Resident #44 listed Sertraline 125 mg daily (antidepressant). The Care Plan, last revised 12/11/25, noted Resident #44's use of an antidepressant with a goal the resident will not exhibit signs of drug related sedation, low blood pressure, or anticholinergic side effects (such as dry mouth, constipation, and confusion). Interventions included administering medication as ordered, monitoring resident's functional status, and pharmacy consultation as indicated. Review of the Behavior Analysis Report, from 6/1/25-12/17/25, showed staff documentation of observed resident behaviors. During the above timeframe, staff documented Resident #44 displaying episodes of cursing/screaming, grabbing, hitting, kicking, scratching, and rejecting cares. Interventions staff documented on the report included back rub, calm environment, one-on-one, position change, and redirection. The Care Plan itself failed to identify resident-specific targeted behaviors of depression Resident #44 was being treated or monitored for. The Care Plan lacked resident-specific non-pharmacological interventions staff may utilize for the resident. During an interview on 12/17/25 at 4:00 PM, the Director of Nursing reported resident-specific targeted behaviors should be identified on resident Care Plans. During an interview on 12/18/25 at 10:30 AM, the MDS Coordinator explained they initiate and update resident Care Plans with scheduled assessments. With regards to psychotropic medications, such as antidepressants or antipsychotics, the MDS Coordinator acknowledged adding the use of these to Care Plans. They do not address resident-specific targeted behaviors or interventions as this is more psycho-social and out of their area of expertise. During an interview on 12/18/25 at 11:35 AM, Staff A, Director of Social Services, explained they provide limited input to resident Care Plans. They do not enter information related to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident-specific behaviors or non-pharmacological interventions. The policy Care Planning-Interdisciplinary Team, revised March 2022, documented the following: a.Comprehensive, person-centered Care Plans are based on resident assessments and developed by an Interdisciplinary Team (IDT); b.The IDT includes but is not limited to: resident attending physician; registered nurse with responsibility for the resident; other staff as appropriate or necessary to meet the needs of the resident, or as requested by the resident. The 2024 Resident Assessment Instrument 3.0 Version 1.1.9.1 October 2024, pages N-5 and N-6, High-Risk Drug Classes: Use and Indication, documented the following: As part of all medication management, it is important for the interdisciplinary team to consider non-pharmacological approaches. Educating the nursing home staff and providers about non-pharmacological approaches in addition to and/or in conjunction with the use of medication may minimize the need for medications or reduce the dose and duration of those medications. With regards to care planning, target symptoms and goals for use of these medications should be established for each resident. Progress toward meeting the goals should be evaluated routinely. Possible adverse effects of these medications should be well understood by nursing staff. Educate nursing home staff to be observant for these adverse effects. Implement systematic monitoring of each resident taking any of these medications to identify adverse consequences early.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on electronic health record (EHR) review and staff interviews, the facility failed to transcribe and initiate a physician order for Sertraline on 1 of 5 residents reviewed for medications (Resident #44). The facility reported a census of 55.Findings include: The MDS completed 12/5/25 revealed Resident #44 with a BIMS of 3, indicating severe cognitive impairment. Diagnoses include depression and stroke. The MDS indicated the use of an antidepressant. Review of scanned Visit Progress Notes from the medical providers revealed the following: 1. The Advanced Registered Nurse Practitioner (ARNP) documented on 7/1/25 the use of an antidepressant Sertraline 75 mg daily. The ARNP noted Resident #44 often combative with cares and wrote a new order to increase Sertraline to 100 mg daily. The scanned Progress Note was acknowledged by the signature of an unidentified facility staff member2. The facility's Medical Director documented on 7/22/5 the Sertraline was to be increased to 100 mg but current orders show at 75 mg3.The ARNP documented on 8/7/25 the current order of Sertraline at 75 mg with Resident #44 having episodes of pinching and hitting staff. New order written to increase the Sertraline to 100 mgThe EHR Progress Note dated 7/2/25 at 11:16 AM showed facility nursing staff acknowledged the ARNP visit on 7/1/25 and documented new orders. Sertraline Order History Report revealed the following doses:1.50 mg daily ordered on 6/2/26 2.75 mg daily ordered on 6/25/25 3.100 mg daily ordered on 8/7/25 4.125 mg daily ordered on 10/8/25During an interview on 12/18/25 at 145pm, the Assistant Director of Nursing (ADON) explained non-emergent orders from ARNP routine visits are obtained from their dictated visit notes. These are typically received approximately 1-2 days later. Facility nursing staff will transcribe new orders into the EHR and print out for ARNP signature. The ADON acknowledged the order to increase Sertraline to 100 mg on 7/1/25 was missed by the previous unit manager. The Facility Administrator explained they do not have a specific policy regarding transcribing or initiating physician orders.

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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. Based on observation and staff interviews, the facility failed to provide services to protect the resident from accident or hazards by transporting a resident in a wheelchair without foot pedals (Resident #48). The facility reported a census of 55. Findings include: The Minimum Data Set (MDS) assessment completed 11/28/25 revealed Resident #48 with a Brief Interview for Mental Status score of 15, indicating intact cognition. Diagnoses include heart failure and vascular dementia. The MDS noted Resident #48 utilizes a wheelchair independently. The Care Plan, last updated 11/21/25, documented Resident #48 requires assistance with ambulation. Interventions include the use of a wheelchair for longer distances, such as going to the dining room.During an observation on 12/17/25 at 12:20 PM, Staff B, Registered Nurse, pushed Resident #48 from the nursing station to the dining room, which is over 100 feet, without foot pedals. Staff B did not assess if the resident had foot pedals attached to the wheelchair. Once staff started pushing the wheelchair, Resident 48# immediately lifted their feet off the ground and held them up until they reached the final destination. The resident's feet were noted to be dangling very close to the floor. During an interview on 12/17/25 at 12:25 PM, Staff B confirmed Resident #48 did not have foot pedals on their wheelchair. Staff B acknowledged pedals should have been used when pushing the resident in their wheelchair. During an interview on 12/17/25 at 4:00 PM, the Director of Nursing (DON) states foot pedals should be on wheelchairs when staff push residents. The DON noted staff education regarding the use of foot pedals was reviewed during October ‘25 nursing staff meeting. The Facility Administrator explained they do not have a specific policy regarding transporting or assisting residents in wheelchairs.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interviews and policy review, the facility failed to store medications in a safe manner when the medication cart was unlocked and not within eyesight of the Registered Nurse (RN) responsible for the cart. The facility reported a census of 55 residents. Findings include:During a continuous observation on 12/18/25 beginning at 10:00 AM, observed the medication cart located by the elevator on 3rd floor unlocked. Two residents were near the unlocked medication cart and a male person, appeared to be a visitor to the facility, retrieved a cup from the medication cart and the water pitcher and poured a glass of water, touching the unlocked medication cart. A staff person was not by the medication cart or within eyeshot of the medication cart. At 10:04 AM Staff C, Licensed Practical Nurse (LPN), walked down the hallway from the opposite end of the hallway and by the cart and locked the cart. During an interview 12/18/25 at 10:05 AM, Staff C stated he locked the medication cart as he walked by the cart, however it was not his medication cart today, he locked it as he noticed it was unlocked. Staff C stated the medication cart is Staff B's cart this morning, Registered Nurse (RN), and Staff B was in another room with a resident. During an observation on 12/18/25 at 10:10 AM, Staff B, RN, came out of a resident room and acknowledged she left the medication cart unattended and unlocked. During an interview on 12/18/25 at 10:11 AM, the Director of Nursing (DON) reported an expectation that all medication carts are locked, especially when unattended and out of view of staff. Review of the facility policy Administering Medications, revised April 2019, documented during administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, facility policy, and the Food and Drug Administration (FDA) food code the facility failed to prepare food under sanitary conditions, in order to reduce the risk of contamination and foodborne illness when a staff member failed to cover facial hair (beard and mustache) while preparing food. The facility reported a census of 55 residents. Findings include: Observation on 12/17/25 at 10 AM, Staff D, [NAME] prepared food for 2 residents on a pureed diet for the lunch meal. Staff D had facial hair including beard and mustache, not covered by net. Interview on 12/18/2025 at 12:31 PM the Administrator (ADM)stated if you could grab a hand full of beard it would be expected that the facial hair should be covered in the kitchen. The ADM stated the facility had not had an issue before with staff and facial hair and not thought about it. Facility Uniforms/Hair Restraints policy directed all employees shall wear protective hair covering in the form of a hairnet or facility hat. The FDA Food Code (Section 2-402.11) requires food employees to wear effective hair restraints-such as hats, hair coverings, nets, and beard restraints-to prevent hair from contacting exposed food, clean equipment, and single-service items. These must be worn in food preparation areas, but are generally not required for staff only serving wrapped items.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on electronic health record (EHR) review, resident interview, and staff interview, the facility failed to document and update resident records related to a change in medical condition due to an urinary tract infection (UTI) for 1 of 17 records reviewed (Resident #10). The facilty reported a census of 55. Findings include: The Minimum Data Set (MDS) Assessment completed 12/1/25 revealed Resident #10 with a Brief Interview for Mental Status score of 13, indicating intact cognition. The MDS noted the resident is frequently incontinent. The Physician Order Report documented the use of Ciprofloxacin (Cipro), an antibiotic, starting 12/13/25 and ending on 12/23/25. The rationale for its use was noted as other injury of unspecified body region. The EHR failed to identify the rationale for Cipro use. No documentation found explaining resident symptoms, discussions with a Care Provider prior to the antibiotic use, or accepting and initiating orders for additional testing. During an interview on 12/16/25 at 3:15 PM, Resident #10 acknowledged the use of an antibiotic due to a UTI. Resident #10 recalled notifying nursing staff about UTI symptoms, specifically increased frequency, urgency and burning.During an interview on 12/16/25 at 3:50 PM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) both acknowledged the lack of documentation regarding the use of Cipro. The DON obtained a screenshot of a text conversation between facility nursing staff and the Advanced Registered Nurse Practitioner (ARNP). Nursing requested an order for a urine analysis for Resident #10 due to frequency and burning. The ARNP agreed. This text conversation occurred on 12/11/25. The Facility Administrator explained they do not have a specific policy regarding EHR documentation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews and policy review, the facility failed to use proper hand hygiene and infection control practices during medication administration and wound care and further failed to use full Enhanced Barrier Precautions (EBP) during wound care for 1 of 1 residents reviewed (Resident #38) for pressure ulcers. The facility reported a census of 55 residents. Findings include:During a continuous observation on 12/17/25 beginning at 7:25 AM, observation of Staff B, Registered Nurse (RN) administer medications to residents on the 3rd floor. Staff B administered medications to a resident after taking a blood pressure and heart rate reading with a wrist blood pressure cuff that contained both plastic and cloth. Staff B did not sanitize her hands or the shared wrist blood pressure cuff before or after the medications were administered. Staff B then prepared medications for a separate resident and administered the medications, she did not sanitize her hands before or after. Staff B then prepared medications for three other residents, without sanitizing her hands before or after the administration of medications for the residents. Staff B used the wrist blood pressure cuff on another resident, without sanitizing the equipment before or after. Staff B was observed to touch several surface areas in between medication administrations, including resident wheelchairs, hands of residents, clothing of residents, the medication cart, the wall railing and the inside of cups used to place medications to bring to the residents for administration. During an interview 12/17/25 at 11:55 AM, the Director of Nursing (DON) stated an expectation of staff is to sanitize or wash their hands in between resident medication administration. The DON stated shared equipment should be cleaned/sanitized in between residents, if the equipment can be cleaned. Review of the facility policy Administering Medications, revised April 2019, documented staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. Review of the facility policy Hand Hygiene with Alcohol based hand rub, dated 3/2/23, documented when hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands before preparing or handling medications. Review of the facility policy Infection Control Policy, with a review date of 5/16/23, documented the Infection Control policy will include environmental cleaning and disinfection, including cleaning/disinfection of resident care equipment, including shared equipment. 2. Resident #38's MDS dated [DATE], revealed a Brief Interview for Mental Status (BIMS) unable to be conducted as resident is rarely/never understood. Facility matrix provided on 12/15/25 revealed R#38 with a Stage 3 pressure wound (tissue damage that results in full thickness tissue loss). Observation on 12/17/25 at 1:15 PM, revealed Staff B, Registered Nurse with gloved hands and no gown on, removed an old dressing from a wound on R#38's right foot, cleansed the wound, removed her gloves, and with no hand hygiene completed applied new gloves, applied ointment to the wound, and a dressing. Interview on 12/17/25 at 1:25 PM, the Director of Nursing stated R#38 wound care did not require Enhanced Barrier Precautions (EBP) (use of gown and gloves) with wound care as the wound was not a chronic, non-healing wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Centers for Disease Control Enhanced Barrier Precautions signage posted in facility hallway revealed the following: a. Wear gloves and a gown for the following high-contact resident care activities: wound care, any skin opening requiring a dressing. Interview on 12/18/2025 at 12:56 PM, Staff B confirmed she did not complete hand hygiene after cleaning the wound and before applying the treatment, just changed gloves. Interview on 12/18/2025 at 1:55 PM, the Assistant Director of Nursing stated an expectation of staff to change gloves and complete hand hygiene after cleaning a wound and before applying the new treatment.