STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165798	A. Building B. Wing	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmar Village	8900 C Avenue NE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review, resident, family, and staff interviews, and policy review the facility failed to ensure dignified care for 1 of 3 residents reviewed for dignity (Resident #31). The resident was left on a bed pan for over 3 hours with her call light out of reach. The facility reported a census of 44 residents.Findings include:Minimum Data Set for Resident #31 dated 7/9/25 revealed diagnoses of neurogenic bladder (disruption of nerve signals between the brain, spinal cord, and bladder that led to problems storing and emptying urine), non-Alzheimer's dementia, anxiety, and chronic pain. Section GG documented the resident was dependent on staff for hygiene and toileting hygiene, and transferring to the toilet was not attempted due to medical condition or safety.The Care Plan for Resident #31 dated 7/3/24 indicated the resident also had neurogenic bowel (loss of bowel control due to nerve damage) and a suprapubic catheter. As of 7/22/24, staff were directed to to treat the absence of bowel function per facility protocol or standing orders. As of 9/25/24, staff were directed to assess bowel and bladder function upon admission, quarterly, and per policy as needed. During an interview with the resident and her spouse on 9/29/25 at 1:05 PM, they reported the resident had been left on the bedpan for hours at least once on May 9 (2025) and again in July (7/13/25). When the resident's spouse visited May 9, the resident was also in the same clothes as the day before. During the incident in July her call light had not been placed close enough for her to call staff. The resident's spouse stated the call light was out of reach again yesterday (9/28/25) when they came for a visit. During this conversation Resident #31 stated she was afraid when she felt alone.A Progress Note titled General Note dated 7/13/25 at 5:15 PM documented the resident's POA (Power of Attorney) approached staff to report his wife had been on the bed pan since 2:00 PM when he left.A Progress Note titled General Note dated 7/13/25 at 6:32 PM revealed the Certified Nurses Aides (CNAs) did not give each other report at 2:00 PM and the CNA coming on duty did not know Resident #31 was put on the bed pan. The CNA was educated she was still responsible for checking her residents every 2 hours and when she came on duty. The nurse assessed and found the resident's skin was intact and without bruising. She did have a red ring around her buttock that was consistent with sitting on a bed pan.During an interview with Staff A, CNA on 10/2/25 at 11:43 AM she reported that Resident #31 complained 'every time' staff put her on the bed pan. She stated that after the last concern in July the facility started using a timer on her door.During an interview with the Director of Nursing on 10/2/25 at 12:18 PM when asked if she knew of bed pan concerns with the resident she stated she knew there was a history of that. She said there was a recent concern that some staff were using the timers on their phones instead of the one on the door and this was concerning to the resident's spouse.The facility admission Packet included a document titled Resident Rights revised August 2022. It indicated residents had a right to a dignified existence and self-determination. The facility must treat each resident with respect and dignity and care for residents in a manner and environment that promoted maintenance or enhancement of his or her quality of life.

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on clinical record review, resident interviews, resident council minutes, call light device reports, staff interviews, and policy review the facility failed to provide sufficient nursing staff to ensure resident needs were met in a timely manner. During the survey residents reviewed for call lights reported waiting for 20 to 45 minutes for call lights to be answered and stated staff turned call lights off without completing cares. The facility reported a census of 44 residents. Findings include:A document titled Quality Concern Form dated 7/2/25 documented a resident waited 20 minutes for a second Certified Nurses Aide (CNA) to help with their transfer.A document titled Resident Council Meeting Minutes Template dated 7/14/25 documented 7 residents and 6 facility staff attended the meeting. The notes indicated call lights were 'still' not being answered in a timely manner and there was a new process for lights over 15 minutes. A resident reported to attendees that her call light was on for 30 minutes. Staff indicated they would access the call light report.A document titled Resident Council Meeting Minutes Template dated 8/11/25 included a call light follow up. The resident stated there was improvement but she still had call lights of 30 minutes. The new business section documented another resident reported aides came in, shut off the call light, and didn't come back to help for 20-30 minutes.A document titled Resident Council Meeting Minutes Template dated 9/8/25 revealed aides continued to shut off the call light without assisting them and the concerned resident felt the aides did it on purpose to get the light to go to management staff. Another resident continued to have lights of 30 minutes.The Administrator provided a report titled Device Activity Report dated from 9/24/25 12:00 AM to 10/1/25 11:59 PM which documented 33 instances of call lights between 16 minutes 4 seconds and 41 minutes 45 seconds on the second floor. During an interview on 9/29/25 with a resident who asked not to be identified, a family member reported they felt frustrated that the resident's call light was often out of reach when they came to visit. They stated it happed just the day before (9/28/25). They reported being present when staff entered the room for a call light, turned it off, and left without providing care. The aide stated they would be back in a minute and the family member reported a wait that time of 40 minutes. They stated wait times other days were 20 minutes to 45 minutes with the call light on, and up to 3 hours when the call light was turned off by an aide.During an interview on 9/29/25 at 12:11 PM another resident stated she attended resident council meetings where residents complained about call lights. She requested help looking into call lights because she waited about a half hour for a call light on 9/28/25 and it wasn't the first time. She knew it was that long because she checked her watch when she pulled the cord.During an interview with Staff A, Certified Nurses Aide (CNA) on 10/2/25 at 11:43 AM she acknowledged residents complained about the length of call lights and was aware there were family concerns as well. She reported a resident complained about being left on a bed pan and the call light not in reach.During an interview with the Director of Nursing on 10/2/25 at 12:18 PM she confirmed she expected call lights to be answered within 15 minutes and stated she knew there was a history of call light issues. She did not think there were current issues with turning call lights off or leaving residents on the bedpan too long, and thought the length of lights was getting better.The resident admission Agreement revised January 2017 documented Basic Care Services were included in the daily room rate. This included nursing and personal care services and other services as required by law. The section titled Resident Rights documented a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside of the facility. The facility must treat each resident with respect and dignity, and care for each resident in a manner and environment that promotes maintenance or enhancement of quality of life.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, employee file review, and facility policy review, the facility failed to ensure insulins were stored in a locked treatment cart for 1 of 2 medication storage carts observed, and failed to label insulin with date opened to ensure medicine was not expired for 1 of 1 insulin administrations observed (Resident #4). The facility additionally failed to ensure medications were safely administered to 1 of 4 residents (Resident #5) reviewed for medication administration, when medications were given to a family member to administer to a resident. The facility reported a census of 44 residents.Findings include: 1. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #4 had the diagnoses of Type 2 Diabetes Mellitus and received insulin injections daily.Review of the Care Plan, initiated [DATE], identified Resident #4 being at risk for alteration in blood glucose levels related to diagnosis of Diabetes Mellitus and instructed staff to give medications as ordered. Review of Resident #4's Order Summary revealed an active order for Novolog (Insulin Aspart) injection solution 100 units per milliliter (mL), with instructions to inject 10 units subcutaneously daily with meals for Diabetes Mellitus. The order was initiated on [DATE]. During an observation on [DATE] at 10:59 AM, Staff D, Registered Nurse (RN) prepared Resident #4's insulin pen at the first floor treatment cart. When queried if Resident #4's Novolog insulin pen had an opened or expiration date identified on label, Staff D stated the opened date was usually written on a sticker. Staff D revealed that the sticker for date identification had been left blank on Resident #4's Novolog insulin pen. Staff D denied having knowledge of when the insulin was opened or expired. Staff D, continued to Resident #4's room and administered the Novolog insulin injection. During an interview on 10/0125, at 9:30 AM, the Assistant Director of Nursing (ADON), revealed an expectation to label insulin pens with open and expiration dates to ensure medication was not expired. When queried about a resource for nursing staff to identify length of time insulin pens would expire after opening, the ADON stated that would be a good idea due to finding undated items. During an interview on [DATE], at 12:20 PM, the Director of Nursing (DON) revealed an expectation to label insulin pens with the open date to ensure insulin had not expired. The DON revealed the expectation of undated insulin pens to be discarded and replaced to ensure insulin administered was not expired. The facility policy, titled Medication Administration Policy, dated [DATE], directed, in part: Procedure Medication Administration Dates will be placed on medication container to monitor for expiration date if applicable. Expiration dates will be reviewed prior to administration of medication. 2. During an observation on [DATE] at 10:59 AM, Staff D, Registered Nurse (RN) prepared Resident #4's insulin pen at the first floor treatment cart, located in the dining room. The treatment cart, which contained insulins and medicated creams, remained unlocked as Staff D left the cart to enter Resident #4's room. During an interview on [DATE] at 10:20 AM, Staff D, RN, stated medication and treatment carts must be locked when staff leave the cart. During an interview on [DATE] at 12:20 PM, the DON revealed the expectation of treatment carts to be locked when not in use, to ensure safe storage of resident insulins and medicated treatments.3. Review of the MDS assessment dated [DATE] revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated moderate cognitive impairment. The list of diagnoses included osteoarthritis, anxiety disorder, depression, and other signs and symptoms with cognitive functions and awareness. The MDS indicated Resident #5 utilized antidepressant and antianxiety medications. Review of the Care Plan initiated on [DATE] revealed Resident #5 required someone to help read instructions, pamphlets, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or other written material from the doctor or pharmacy and instructed staff to provide assistance when needed. The Care Plan identified Resident #5 had the potential for depressed mood related to anxiety, major depressive disorder, and statements regarding wanting to die, instructed staff to administer medications as ordered.During an interview on [DATE] at 1:35 PM, Resident #5's family member stated that during a visit to facility on [DATE], Resident #5 was having increased pain which family believe caused Resident #5 to have agitation and anxiety. Family member stated she walked to the medication cart, located near 1st floor dining room, and requested antianxiety medication for Resident #5 from Staff E, Trained Medication Assistant (TMA). The family member stated that Staff E asked, Do you want me to give it to her, or do you want to? and gave the family member a Trazodone pill to administer to Resident #5. The family member reported walking down a long hallway from dining room, turning a corner, and walking down another long hallway to Resident #5's room with the Trazodone pill. The family member stated she administered the Trazodone to Resident #5 without staff present, and claimed Staff E remained at the medication cart. Review of the facility's grievance log, dated [DATE], revealed Resident #5's family member had reported a concern that occurred on [DATE], in which Staff E gave the family member Resident #5's Trazodone pill to administer to the resident. The facility listed action taken related to grievance was placing Staff E on administrative leave pending investigation on [DATE]. Review of Staff E's employee file revealed a form titled, Employee Corrective Action Notice, dated [DATE], for a written warning. The form revealed the description of issue, on [DATE], Staff E was observed preparing a medication (Trazodone) for a resident and handing it to a family member, resident's family member then proceeded to walk down the hallway with the medication, out of sight, while Staff E remained at medication cart near the nurse's station. The corrective action revealed that Staff E was unable to verify that the resident took the medication, which violated the six rights of medication administration. The corrective action form was signed by Staff E and Facility Administrator on Aug. 20, 2025. During an interview on [DATE] at 12:20 PM, the DON stated family members should not be given resident medication or administer medications to residents. The DON reported that Staff E had been suspended and educated when Resident #5's Trazodone was given to a family member. Review of the facility policy, titled Medication Administration Policy, dated [DATE], identified the policy statement was to ensure safe, effective, and timely drug therapy, to provide for an accurate and concise documentation system. The section A. Medication Administration directed, in part: 1. RN's, LPN's and TMA's will administer medications as ordered by the attending Physician/NP.2. The 8 rights of drug administration will be followed when administering all medication.Rights per the policy included the following: Right resident, Right drug, Right dose, Right dosage form (i.e. liquid, solid, crushed, etc.), Right route, Right time, Right reason, and Right documentation. 5. Medications prepared by authorized personnel are administered by that same staff member.