

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165158	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER Azria Health Clarinda		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Manor Drive Clarinda, IA 51632	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on clinical record review, facility investigation review, staff interviews and policy review the facility failed to report a reportable event to the appropriate facility staff members after the alleged event took place. Which lead to the facility failing to report to the State Agency within 2 hours of the alleged event. The facility reported a census of 52 residents. Findings include: According to the Annual Minimum Data Set (MDS) assessment tool, with a reference date of 5/8/2025, Resident #1 had a Brief Interview of Mental Status (BIMS) score of 2. A BIMS score of 2 suggested severe cognitive impairment. The MDS documented she experienced hallucinations, delusions, displayed physical and verbal behavioral symptoms for 1-3 days during the 7-day review period. Resident #1 did not exhibit rejection of evaluation or care and did not wander. Resident #1 utilized a wheelchair for mobility and was always incontinent of urine and bowel. She was dependent of staff for eating, oral hygiene, toileting hygiene, shower/bathing, personal hygiene, toilet transfers. The MDS indicated Resident #1 received the following medications during the 7-day review period: antianxiety, antidepressant, and an opioid. The following diagnoses were listed for Resident #1: stroke, coronary artery disease, thyroid disease, Alzheimer's disease, anxiety, glaucoma, insomnia, and cellulitis. The Care Plan focus area with an initiation date of 5/20/2024 documented she was dependent on staff for meeting emotional, intellectual, physical, spiritual and social needs related to physical limitations. A second Care Plan focus area with an initiation date of 5/22/2024 documented Resident #1 had an Activities of Daily Living (ADL) self-care performance deficit related to stroke, anxiety, macular degeneration. The Care Plan documented she did not ambulate, utilized a wheelchair for locomotion, and was dependent on staff for mobility. She was dependent on staff to make significant position changes while in bed; she required the assistance of two staff with bed mobility. She was also totally dependent on two staff for toilet hygiene and incontinence management. The Care Plan directed staff to check and change her in the morning, before and after meals, before bed and as needed. Resident #1 did not use the toilet, she was incontinent. Staff are to encourage the resident to participate to the fullest extent possible with each interaction. A third Care Plan focus area with an initiation date of 5/28/2024 documented Resident #1 had impaired cognitive function/dementia or impaired thought processes related to short term memory loss. A fourth Care Plan focus area with an initiation date of 6/10/2024 and revision date of 6/9/2025 documented Resident #1 had alteration in her mood and behaviors as evidenced by yelling out to staff, disrobing, confusion (not knowing where she is) and worried/anxious feelings related to stroke and anxiety, cursing, grabbing, hitting and spitting at staff during cares. On 6/3/2025 resident made a comment about wanting someone to shoot her. Resident was sent to the emergency room (ER) to make sure she was not a danger to herself. She was sent back after being evaluated and determined she was not a danger to herself. Staff were directed to provide an opportunity for positive interaction, attention and to stop and talk with her as they pass by her. Staff were also encouraged to provide redirection to resident when using foul language. Staff are to use a clam approach, tell her what is being done prior to providing cares. If the resident is punching and hitting staff during cares, staff are to monitor for agitation and if safe, step back to allow her to calm down. The nurse is to be updated to assess her if she's in pain and give an as needed (PRN) pain medication. Staff are encouraged to talk through what is bothering the resident. Staff are to introduce themselves, speak slowly and clearly so that the resident understands staff when providing cares/speaking with resident. A fifth Care Plan focus area with an initiation date of 5/12/2025 documented Resident #1 had delirium or an acute confusion episode related to acute disease process, dementia. Staff are to redirect and provide gentle reality orientation as required. The facility investigative file contained the following summary: On 7/9/2025 at approximately 4:30 PM the Director of Nursing (DON) was notified by the Assistant Director of Nursing (ADON) that on 7/6/2025 Staff A Certified Nursing Assistant (CNA) witnessed Staff B CNA forcefully grab Resident #1's arm and push it down then stated stop hitting me while completing cares on Resident #1. Staff A stated she immediately reported the incident to Staff C Registered Nurse (RN), the charge nurse. The facility was unable to review the incident with the resident due to a BIMS score of 2. The DON notified the Administrator after the incident was reported to her on 7/9/2025. Staff B was immediately suspended pending the investigation. During the investigation, initially it was reported the incident happened on 7/6/2025. Follow up with Staff A, she stated it did not happen on 7/6/2025 it happened on 7/2/2025. Facility staff were all educated on what abuse is, the different kinds of abuse and how to properly report abuse. The facility investigative file included the following statement from Staff A: On Sunday 7/6/2025 we were lavin</p>		