STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165158	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Clarinda	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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, resident interviews, clinical review and policy review. The facility failed to respond to call lights in a timely manner for 4 of 4 residents reviewed (Resident #1, #15, #14, and #47). The facility reported a census of 60 residents. Findings Include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #1 had a Brief Interview for Mental Status (BIMS) of 00 that indicated severe cognitive impairment. The MDS further indicated that Resident #1 was dependent on staff for toileting hygiene, personal hygiene and transfers. On 5/4/26 at 12:35 PM a continuous observation revealed Resident #1's Wife turned the call light on. At 12:40 PM a Certified Nursing Assistant (CNA) entered the room Resident #1's Wife stated to that CNA Resident #1 wanted assistance to lay down in bed. That CNA stated she had to go find a lift and another staff member first. That CNA exited the room and went into room [ROOM NUMBER]. A second CNA entered the room, stated she needed to get a lift, a second staff and exited the room. At 12:46 PM Staff J, Licensed Practice Nurse (LPN) entered the room and turned off the call light. At 12:47 PM Resident #1's Wife turned the call light back on. Resident #1 remained in the wheelchair. At 12:54 PM Staff C, CNA and Staff D, CNA entered Resident #1's room with hoyer lift and assisted Resident #1 from wheelchair into bed. Continuous observation revealed the request for transfer assistance was not completed for a total of 19 minutes. 2. The MDS dated documented Resident #15 had a BIMS of 15 that indicated no cognitive impairment. The MDS further indicated that Resident #15 was dependent on staff for toileting hygiene, personal hygiene and transfers. On 5/4/26 at 11:37 AM Resident #15 stated the facility needed more help because they are so short staffed. Resident #15 explained she frequently had to wait over 20 minutes for the call light to be answered. She continues to explain that the staff would shut the light off, say they will come back and not return. Resident #15 had a sign documented to not shut my light off until you have met my needs. On 5/7/26 at 9:07 AM the Director of Nursing (DON) stated her expectation was the call light response time to be less than 15 minutes. The DON acknowledged a concern with staff shutting off the call light before the residents' needs were met and stated she expected the call light to remain on until the resident was cared for. 3. Review of Resident #14's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognitive functioning. Interview on 5/4/26 at 11:41 AM with Resident #14 revealed that call lights often take up to 30 (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	minutes to be answered. Resident #14 then revealed that he watches the clock, and can read the time to tell how long it takes. 4. The MDS dated [DATE] documented Resident #47 had a BIMS of 11 indicating moderate cognitive impairment. On 5/4/26 at 2:17 PM Resident #47 stated on the PM shift it took up to an hour at times but longer than 15 minutes almost nightly to respond to the call light. Review of document dated 3/19/26 and 4/16/26 titled, Resident Council Minutes recorded concerns with call light times / length of time for call light response. Review of policy revised 9/22 titled, Answering the Call Light documented the purpose of the procedure was to ensure timely responses to the resident's requests and needs. Staff were to answer the resident call system timely. When staff answer an auditory request for assistance, identify yourself and politely respond to the resident by his/her name. If the resident needed assistance, indicate the approximate time it would take for the response.

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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 observations, staff interviews, clinical record review, and policy review, the facility failed to ensure universal infection control measures and Enhanced Barrier Precautions (EBP) were maintained. The facility failed to ensure appropriate hand hygiene was completed during personal care for Resident #1, during wound care for 1 of 2 residents (Resident #41), during medication administration and during catheter care for 1 of 2 residents (Resident #5). The facility also failed to ensure appropriate Personal Protective Equipment (PPE) was worn for a resident that required EBP during catheter care (Resident #37). The facility reported a census of 60 residents.Findings Include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #1 had a Brief interview for Mental Status (BIMS) of 00 that indicated severe cognitive impairment. The MDS documented Resident #1 was dependent on staff for all Activities of Daily Living (ADL) and was always incontinent. On 5/4/26 at 12:54 PM an observation of a transfer completed by Staff C, Certified Nurse Assistant (CNA) and Staff D, CNA revealed Staff C and Staff D transferred Resident #1 with a hoyer lift into bed. Hand hygiene was performed and gloves were applied by both Staff C and Staff D. Both staff repositioned Resident #1, removed the hoyer sling and removed the resident's pants. Staff C grabbed a brief off the bedside table, Staff D removed Resident #1's brief and placed a towel in between the residents legs. Staff C completed personal care to buttocks, applied a clean brief and cream to buttocks without changing gloves or performing hand hygiene. Staff C repositioned the resident onto his back and continued with personal care to his groin and applied cream to the inner groin. Staff C secured Resident #1's brief and both Staff C and Staff D removed gloves. Staff D lifted Resident #1's legs while Staff C placed a pillow under them both. Staff C and Staff D performed hand hygiene. Staff D lowered the bed and placed the call light on the resident's chest. 2. The Minimum Date Set (MDS) dated [DATE] documented Resident #41 had a Brief Interview for Mental Status (BIMS) of 5 indicated severe cognitive impairment. The MDS documented a diagnoses of diabetes, that the resident has an open area and recieves application of nonsurgical dressings and ointments/medications. On 5/6/26 at 2:01 PM an observation revealed Staff E, Licensed Practical Nurse (LPN) entered Resident #41's room, completed hand hygiene, applied a gown, applied gloves and laid a barrier on resident #41's bedside table. Staff E opened supplies and laid them on the barrier. Staff E placed foam dressing, silicone faced foam border dressing and a sterile water bottle on the barrier. Staff E removed gloves and performed hand hygiene. Staff E applied new gloves and prepped two washcloths, one with soap and water and one with just water. Staff E cleansed the wound to the left shoulder of Resident #41. Staff E took the glove that was holding the dirty washcloth, turned the glove into itself keeping the washcloth inside the glove and placed it onto the back of the toilet. Staff E applied a new glove to that hand without performing hand hygiene. Staff E utilized the second washcloth with the opposite hand with only water to cleanse the wound and turned the glove inside itself, keeping the washcloth inside the glove and placing the glove onto the back of the toilet. Staff E applied a new glove to that hand without completing hand hygiene. Staff E opened the blue foam dressing and cut into the shape for the wound. Staff E poured sterile water, wrung out the dressing and applied blue foam dressing to the wound bed and covered it with a foam border dressing. Staff E removed gloves and performed hand hygiene. Staff E applied new gloves, opened skin prep packaging, pulled down Resident #41's sock and applied skin prep to the left outer ankle. Staff E grabbed white heel protectors out of the closet, applied them to both feet, removed the barrier from the bedside table, removed the gown, removed gloves and performed hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/5/26 a continuous observation of medication administration revealed Staff F, Licensed Practice Nurse (LPN) performed medication administration to 6 residents in a row without performing hand hygiene before or after medications were gathered and administered. On 5/6/26 a continuous observation of medication administration revealed Staff G, Certified Medication Aide (CMA) performed medication administration without performing hand hygiene before administering medications to a resident. On 5/6/26 at 12:06 PM, an observation of Staff H, Licensed Practical Nurse (LPN) revealed Staff H removed the medication from the narcotic box. Staff H counted the medication and documented the count in the narcotic book on the medication cart. While attempting to dispense the medication into a medication cup, the tablet dropped onto the narcotic book and fell onto the top of the medication cart. Staff H picked up the tablet with an ungloved hand and placed it into the medication cup. Staff H proceeded to administer the medication to the resident without replacing the medication and without performing hand hygiene before, during or after the medication was administered. On 5/7/26 at 9:07 AM the Director of Nursing (DON) acknowledged concerns when staff did not complete appropriate hand hygiene with catheter care, medication administration, personal care and wound care. The DON acknowledges concerns with EBP not being worn during catheter care. The DON stated medication should be discarded once it had been contaminated from falling onto the narcotic book and a new medication administered to the resident. 3. The MDS dated [DATE] documented Resident #5 had a BIMS of 3 indicating severe cognitive impairment. The MDS documented Resident #5 was dependent on staff for toileting. Observation on 5/6/26 on 2:04 PM of Resident #5's catheter emptied by Staff I, CNA/Bath aide. Observed Staff I completed hand hygiene, donned gown, applied gloves, and applied a gait belt around the waist of Resident #5. Staff I assisted with standing in the bathroom with stand bars on the wall, assisted Resident #5 when turned to the left to sit on the toilet. Staff I removed Resident #5's sweat pants, removed gloves, with no hand hygiene completed. Staff I adjusted catheter leg bag, applied gloves, placed barrier on the ground, placed a graduated cylinder on a barrier, cleansed catheter bag tip, emptied urine from catheter bag with 25cc emptied from the bag. Staff I removed gloves with no hand hygiene, applied gloves, cleansed buttocks, pulled brief up, pulled sweat pants up, and assisted resident in turning to the right to sit in the wheelchair. Staff I removed gloves, removed gait belt, and completed hand hygiene. Staff I applied gloves, emptied graduated cylinder into the toilet, cleansed graduated cylinder, graduated cylinder placed in a plastic bag, doffed gown, removed gloves and hand hygiene completed. On 5/7/26 at 9:07 AM the Director of Nursing (DON) stated she expected hand hygiene to be completed when staff moved from a contaminated body site to a clean body site during resident care and with glove changes as well. Review of policy revised 8/19 titled, Handwashing / Hand Hygiene documented hand hygiene should be completed before and after direct contact with residents, before preparing or handling medications, before performing any non-surgical procedures, before and after handling an invasive device (e.g., urinary catheters), before handling clean or soiled dressings, before moving from a contaminated body site to a clean body site during resident care, after contact with resident's intact skin, after contact with blood or bodily fluid, after handling used dressings, after handling contaminated equipment, before entering isolation precaution settings and after entering isolation precaution settings. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The MDS assessment dated [DATE] revealed Resident #37 had diagnoses of obstructive uropathy (a blockage in the urinary tract backing urine into the kidney) and a multi-drug resistant organism (MDRO) (a superbug; germs or bacteria that are resistant to three or more families of antibiotics). The MDS recorded the resident did not have an indwelling catheter. The Care Plan revised 4/1/26 revealed Resident #37 had an indwelling catheter and had recurrent urinary tract infections related to a MDRO ESBL (extended-spectrum beta-lactamase) (a bacteria). A foley catheter placed by urology was added to the care plan on 4/24/26. The Care Plan directed staff to use enhanced barrier precautions (EBP's) in accordance with Centers for Disease control (CDC) guidelines, and use the appropriate personnel protective equipment. Resident #37's Electronic Health Records revealed Special Instructions:Use EBP's for ESBL in the urine. The Order Summary revealed to do catheter care every shift. Observation on 5/4/26 at 12:01 PM revealed an EBP sign on the door by Resident #37's room. A plastic bin containing gowns sat by the wall in the room. During observation on 5/5/26 at 1:24 PM, Staff A, certified nursing assistant (CNA) washed her hands and donned a pair of gloves. Staff A drained the urine contents from Resident #37's catheter bag into a graduate container. Staff A clamped the catheter port, took an alcohol swab and cleansed the end of the port. Staff A emptied the graduate into the toilet, turned the sink faucet on with her gloved hand and rinsed the graduate with water. Staff A placed the graduate on the back of the toilet, removed her gloves, turned the sink faucet on, and washed her hands. Staff A did not wear a gown for EBP's. In an interview on 5/5/26 at 1:45 PM, Staff A reported she had worked at the facility for 2 to 3 weeks and she was shown how to do things during orientation. Staff A reported a gown and gloves worn for EBP's whenever a resident had a catheter. In an interview on 5/6/26 at 10:52 AM, Staff B, CNA, reported Resident #37 had bacteria in her urine. Staff had to wear a gown and gloves when they took care of Resident #37 or handled the catheter. In an interview on 5/6/26 at 12:26 PM, the Infection Preventionist (IP) reported she completed hand hygiene, EBP and peri care audits monthly. The IP stated she expected a gown worn whenever staff performed catheter care and wound care. An EBP policy dated 9/2024 revealed EBP's utilized to prevent the spread of MDRO's. A gown and gloves are used during high contact care activities such as handling a catheter.