

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/06/2026
NAME OF PROVIDER OR SUPPLIER Azria Health Winterset		STREET ADDRESS, CITY, STATE, ZIP CODE 1015 West Summit Winterset, IA 50273	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and policy review, the facility failed to carry out appropriate food safety practices to prevent foodborne illness for 1 of 1 meal services observed. The facility reported a census of 51. Findings include: During a continuous lunch service observation on 6/24/26 from 11:30 AM to 1:30 PM, the following was noted: 1. Artificial nails were worn by both the Certified Dietary Manager (CDM) and Staff G, social services. Staff G seen prepping drinks for residents for the meal. The CDM completed various lunch tasks during the observation including prepping hot drinks and cooking hamburger patties for residents 2. The hair net worn by the CDM did not entirely cover their hair as bangs were exposed. In addition to meal prep, the CDM also seen operating the dish machine (working with soiled and clean equipment) and prepping resident room trays 3. Staff H, Cook, seen preparing a cold meat and cheese sandwich with their bare hands. No gloves or utensils were used to obtain the bread, lunch meat and cheese from their respective packages and positioned on the bread. In an interview on 6/25/25 at 11:15 AM the Registered Dietitian (RD) voiced artificial nails are not acceptable in a food service or kitchen setting. The RD also voiced all hair, including bangs, need to be enclosed in hair nets. In an interview on 6/25/26 at 3:00 PM, the CDM acknowledged dietary staff should not be touching ready-to-eat resident food with bare hands. The policy Food Preparation and Service, version 2.1 (H5MAPL0333) 7 2022 10 2022 10 23, outlined the following: 1. Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness 2. Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks 3. Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food 4. Food and nutrition services staff keep fingernails trimmed and clean. The Food and Drug Administration Food Code 2022 noted the following: 1.2-302.11 (B) Unless wearing gloves in good repair, a food employee may not wear fingernail polish or artificial fingernails when working with exposed food 2.2-402.11 (A) Hair Restraints Effectiveness: Except as provided in (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, equipment, utensils, and linens and unwrapped single-service and single-use articles.		

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on clinical health record review, observations, resident interviews, staff interviews, and policy review, the facility failed to supervise resident medication administration for 2 of 3 residents reviewed (Residents #2 and #3). The facility reported a census of 51. Findings include: 1. The Minimum Data Set (MDS) Assessment completed on 3/12/26 revealed Resident #2 with a Brief Interview for Mental Status score of 11 out of 15, indicating moderate cognitive impairment. Diagnoses include aphasia (brain disorder affecting communication), asthma, and diabetes. Current Physician Orders noted the following medications for Resident #2: a. Asmanex 120 metered dose 2 puffs inhaled by mouth two times daily (treatment for asthma); b. Azelastine 137 microgram/spray 1 spray in both nostrils two times daily (treatment for asthma); and c. Fluticasone 50 micrograms/act 1 spray in both nostrils two times daily (treatment for allergies). During an observation on 6/23/26 at 9:45 AM, Resident #2 seen self-administering two different nasal sprays in their room without nursing staff present. They then placed the two sprays in disposable cup which had an inhaler in it as well. Resident #2 explained staff will leave these medications in the room for him to administer when more convenient for him. The resident stated they self-administer with no issues. This is done two times a day, per the medication orders. Upon review, the clinical health record lacked a Physician Order for Resident #2 to self-administer medications. The record also lacked assessments to indicate Resident #2 not only safe to self-administer medications but can so accurately. The Care Plan lacked interventions indicating Resident #2 can self-administer medications. In an interview on 6/23/26 at 11:15 AM, Staff A, Licensed Practical Nurse (LPN), acknowledged leaving medications in Resident #2's room for them to self-administer. Staff A believes the resident is competent and reliable to take appropriately. In an interview on 6/24/26 at 10:20 AM, Staff B, Registered Nurse (RN), acknowledged leaving medications in Resident #2's room for them to self-administer. During the interview, Staff B excused themselves as this was a reminder to check and remove the nasal sprays and inhaler from the resident's room. The medications had been provided to the resident shortly before the interview. Staff B explained Resident #2 alerted and orientated and administers medications by himself. 2. The MDS Assessment completed on 5/3/26 revealed Resident #3 with a BIMS score of 15 out of 15, indicating intact cognition. Diagnoses include coronary artery disease (heart disease), dysphagia (swallowing difficulties), and macular degeneration (eye disease that blurs vision). During an observation on 6/23/26 at 10:45 AM, a plastic medicine cup with a large green tablet in it was noted on Resident #3's bedside table. The resident explained it was Tums (antacid) and had been there a couple of days. Upon review, the clinical health record lacked a Physician Order for Tums and for Resident #3 to self-administer medications. The record also lacked assessment to indicate Resident #3 not only safe to self-administer medications but can do accurately. The Care Plan lacked interventions indicating Resident #3 can self-administer medications. In an interview on 6/23/26 at 11:00 AM, Staff C, LPN, confirmed the green tablet on Resident #3's bedside table was Tums. When asked, the resident explained to Staff C a girl provided the medication (2 tablets) when they asked for it. They took 1 of the tablets and not the other. Staff C removed the remaining Tums from the room. Staff C explained the facility does not have any standing orders or protocols for medication use. All medications are ordered by the primary care providers. If the medication is not routine and used occasionally, the frequency is typically written as PRN (as needed). In an interview on 6/25/26 at 10:50 AM, the Director of Nursing, DON, stated assessments should be completed to ensure residents are physically and cognitively capable of self-administering medication. The DON also noted nursing staff should be present if residents self-administering medications to ensure the proper dosage is (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	consumed.The policy Administering Medications, version 2.1 (H5MAPL0028), outlined residents may self-administer medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.The policy Self-Administration of Medications, version 1.3 (H5MAPL0812) 1 2023, outlined the following: a. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident b. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is reassessed periodically based on changes in the resident's medical and/or decision-making status		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on facility document review, resident interview, staff interviews, and policy review, the facility failed to ensure residents free from abuse for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 51. Findings include: The Minimum Data Set (MDS) Assessment completed on 5/19/26 revealed Resident #1 could not complete a Brief Interview for Mental Status (assessment of one's cognition). This is a decline from the previous MDS completed on 2/16/26 where the score was 6 out of 15 and indicated severe cognitive impairment. Diagnoses include cancer and non-Alzheimer's dementia. The Care Plan for Resident #1 indicated the need for staff assistance to complete daily tasks. This included the assist of 1-2 staff members to stand and pivot for transfers, which includes showers and toileting (initiated on 2/18/26). Resident #1 was independent with bed mobility from 9/3/24 through 6/3/26. The Care Plan noted Resident #1 at risk for falls due to confusion, anxiety, insomnia, and poor safety awareness. Interventions include to anticipate and meet resident needs. The Care Plan also noted an increased risk for alterations in comfort due to breast cancer, anxiety, and insomnia. Interventions include to monitor sleep/wakefulness and offer non-medicinal interventions for anxiety (initiated 11/28/23). The Care Plan directed nursing staff to anticipate and meet the residents needs, with documented start date of 8/21/23. The Care Plan did not direct staff to keep the resident out of her bedroom to provide increased supervision. A 5-day investigation summary was submitted to the state agency after a facility self-report regarding abuse allegations was sent on 4/16/26. The document summarized Staff E, Licensed Practical Nurse (LPN) allegedly made Resident #1 stay up in a wheelchair, removed Resident #1's room identifiers, and unplugged Resident #1's personal phone. The census summary for Resident #1 showed an admission date of 8/15/23 to a room in the facility's south hall. On 3/13/26, the resident moved to a room located in the north hall. This move was to a different part of the facility and different staff providing cares. March and April 2026 Daily Assignment Sheets showed Staff E, Licensed Practical Nurse (LPN) was the scheduled nurse on the north hall for the 6 PM to 6 AM shift. Between 3/13/26 to 4/15/26, Staff E worked a total of 14 shifts on the north hall and directly with Resident #1. The facility document of staff statements detailed the interview with Staff F, former Director of Nursing. Staff F confirmed Staff E's actions towards Resident #1. This included removing name identifiers from the resident's room, unplugging the resident's phone at the start of their shift, and keeping the resident awake and up in her wheelchair with the nurse. Staff F stated these were fall interventions and were in place to protect the resident. The facility document of staff statement detailed the interview with Staff E on 4/16/26. When asked if they had refused to allow Resident #1 or any other resident to go to bed when asked, Staff E denied. Staff E explained Resident #1 was a significant fall risk if and had behaviors if goes to bed too early. If it is too early, Staff E will redirect and encourage the resident to follow them. Staff E noted the resident's safety awareness is bad and will have the resident hang out with the them until tired. Staff E denied forcing a resident to self-propel themselves in the halls to make them tired. Staff E answered Resident #1 would follow them down the halls but never forced. Staff E acknowledged removing Resident #1's room name plate after discussing with the Director of Nursing. Staff E felt it was effective as the resident would then ask staff for assistance. If it was too early to go to bed, the resident would be redirected. Staff E stated if they did not do this, Resident #1 would self-transfer and potentially hurt themselves. Staff E did not believe this caused increased sadness or anxiety. Staff E denied unplugging Resident #1's personal phone in their room. Staff E explained they would take the resident to the nurse's station to visit with family. Staff E noted Resident #1 with poor (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	safety awareness and doesn't understand their fall risk. Staff E felt what they did was effective despite other employees not liking what was being done. The facility document of staff statements detailed an interview with Staff P, Certified Nursing Assistant (CNA). Staff P reported Resident #1 is discouraged from going to bed when Staff E works. Staff E will have the resident follow them around. The facility document of staff statements detailed an interview with Staff Q, CNA. Staff Q reported Resident #1 is in the wheelchair a lot overnight. Staff E keeps the resident with them in the hall. In a confidential resident interview on 6/22/26, a resident recalled seeing Staff E pushing Resident #1 around until tired despite the resident calling out. The resident noted when Staff E worked, Resident #1 stays up later when compared to other nurses. The resident explained staff typically will lay Resident #1 in bed around 7:30-8:00 PM. However they have observed Staff E pushing Resident #1 up and down the halls from 6:30 to 9:00 PM. Other staff members would try to intervene and help to assist Resident #1 and Staff E would decline. When this occurred the resident recalled Staff E responding with I got this. I know what I'm doing. In an interview on 6/23/26 at 11:15 AM, Staff A, LPN, voiced mornings where they had to replace Resident #1's room name plate due to it being removed. This started when the resident changed rooms to the north hall. Staff A was not aware if this was a Care Plan intervention. In an interview on 6/23/26 at 3:30 PM, Staff D, LPN, explained working overnights with Staff E frequently. Staff D had cared for Resident #1 prior to the resident's move to the north hall. From their understanding the move was to provide Resident #1 with a less stimulating environment as the south hall can be rather active. Staff D described an incident where they observed Resident #1 asleep in their wheelchair and starting to slide out. The resident was outside another resident's room while Staff E was in that room, with the door closed, providing cares. Staff D offered to have the CNA put Resident #1 in bed. Staff E declined stating the resident will stay there and may fall if placed in bed/room. Staff D recalled seeing Resident #1 up most of the night in their wheelchair. When they would walk by, the resident would grab their pant leg and ask to go to bed. In another incident Staff D noted Staff E pulling Resident #1 in their wheelchair while pushing a medication cart during evening medication pass. Lastly, Staff D detailed an incident, which occurred on 4/5/26 (Easter) around 8:00 PM. Staff D was in the north hall when Resident #1 reached out for their hand and said I don't have a room here. She told me I don't have a place to sleep. Staff D reassured the resident and took them to their room. Staff D noticed the room name plate removed and the phone had been unplugged. When trying to reconnect the phone, Staff E intervened and mentioned the resident is to receive calls at the nurse's station only. While in the room, Resident #1 wanted to lay down but Staff E took them out of the room. In an interview on 6/24/26 at 9:45 AM, Staff R, LPN, described Resident #1 as confused and always asking for help. However Staff R believes the resident able to alert staff of their immediate needs or discomfort. Staff R noted Resident #1's typical bed time is around 7:00 PM. In an interview on 6/24/26 at 11:05 AM, Staff I, CNA, explained Resident #1 would typically talk to family in their room around 7:00 PM and then in bed around 8:00 PM. One night, estimated to be 4/14/26 at 8:30 PM, Resident #1 was speaking out they wanted to go the bed. Staff I noted a sense of desperation to the request and offered to do so. Staff E declined the assistance and mentioned the resident needed to stay by them. Staff I reported seeing sticky notes covering Resident #1's room name plate with the door shut. In an interview on 6/24/26 at 2:20 PM, Staff J, CNA, explained Resident #1 historically yells out wanting to go to bed or help me. However, Staff J believes the resident able to alert staff for immediate needs (using bathroom, not liking something). Staff J acknowledged Resident #1 does try to get up on their own and attempt to self-transfer, which is not safe. When working with other nurses, the CNAs are able to intervene and assist with cares. Immediate needs were being addressed. When working with Staff E, CNA assistance is declined. Staff (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E would comment that the resident was going to stay with them. Immediate needs may not be addressed in a timely manner. Staff J feels Resident #1 became more desperate with requests for staff help. Staff J recalled an incident which occurred at approximately 8:30 PM. Staff J had assisted Resident #1 to the bathroom and then placed in bed. A short time later, Staff E asked where Resident #1 was. Staff J explained the resident was in bed, quiet and sleeping. Staff E stood in the resident's doorway, flipped on the light, and said to the resident I know what you're doing. You're getting up. The Resident #1 was removed from bed and placed back in the wheelchair. Staff J acknowledged observing Staff E removing Resident #1's room name plate. When the name plate is removed, Resident #1 seen actively looking for room and calling out Where's my room?. In an interview on 6/24/26 at 3:00 PM, Staff K, CNA, recalled an incident which occurred at approximately 8:30 PM. Resident #1 was in their wheelchair and asking to go to bed. Staff K attempted to care for the resident but Staff E said no. Staff K noted observations where Staff E was pushing Resident #1 down a hall with the medication cart. Other CNAs would offer to put the resident to bed but Staff E would not allow. Staff K observed Staff E removing Resident #1's room name plate and stating to the resident this isn't your room. Staff K also noted a mechanical lift in front of Resident #1's room to block entry. In an interview on 6/24/26 at 3:20 PM, Staff L, CNA, explained they typically work the overnight shift (10 PM to 6 AM) on the south hall. Staff L acknowledged Resident #1 does try to get up on their own. However, they believe there is a reason for it and that Resident #1 can alert staff to immediate needs. At times, they would see Resident #1 self-propelling in their wheelchair at night. On one occasion, Staff L heard Resident #1 say they were ready for bed and offered to put the resident in bed. Staff E intervened stating not right now as the resident would keep getting up. Staff L then offered to sit with the resident exclusively for a short time but Staff E declined stating I got this. Staff L recalled another situation where they heard Staff E say to Resident #1 You need to stay in the chair (recliner) despite the resident saying she wanted to go to bed. In an interview on 6/29/26 at 1:35 PM, Staff M, Registered Nurse (RN), recalled an incident, which occurred towards the end of March, when they were at the facility visiting. Staff E was completing the evening medication pass and had Resident #1 with them. Staff E would ensure the resident was with them and not wheel themselves away. Resident #1 was heard saying I want to go home and I want to go to bed. Staff E's response was No, you have to stay here with me. Don't want you to fall. Staff M explained this continued for approximately an hour. Staff M described the situation as odd. In an interview on 6/29/26 at 2:30 PM, Staff N, CNA, described Resident #1 as restless and repetitive. However, they believe the resident could alert staff of immediate needs. Staff N had observed Staff E keeping Resident #1 from their room for safety reasons to prevent falls. This included removing the resident room name plate. Staff N noted Staff E would take resident up and down the hall, having the resident self-propel themselves in a wheelchair when able. Resident #1 would have their head down stating I'm tired. Take me back to my room. Staff N recalled a time when Resident #1 was sitting in a recliner located in near the nurse's station. The resident was calling out they wanted to go to bed to sleep. Staff E elected to keep the resident in the recliner to keep an eye on them. Staff N had not observed other nurses implanting these types of interventions; Staff E was the only one. In an interview on 6/25/26 at 3:50 PM, Staff O, RN/MDS Coordinator, acknowledged Resident #1 had progressively declined over the past 6-8 months. The move from the south hall to the north hall was in response to a cluster of falls the resident experienced. Staff O explained they oversee resident Care Plans. With regards to Resident #1, Staff O explained there were no Care Plan interventions which directed staff to remove the room name plate or any other room identifiers. Prior to changing rooms, it was encouraged to identify and assist Resident #1 in locating their room. There were no specific Care Plan interventions stating the (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident would be self-propelling themselves around with nursing. Typically, when staff providing 1:1 care, staff will meet the resident where they are at. Staff O explained they attend morning meetings where falls and other resident-specific topics discussed. They do not recall any of these interventions being discussed. In an interview on 6/29/26 at 9:45 AM, Staff F, described Resident #1 as a high fall risk, anxious, and repetitive. The resident would often say they wanted to lay down and then immediately want up. Several interventions had been tried (medication adjustments, medical work-up for acute infections, staff providing 1:1 time). Staff F acknowledged different staff members had approached them regarding Staff E's treatment towards Resident #1 (keeping up in wheelchair, removing room identifiers, and unplugging personal phone). Staff F noted these were not Care Plan interventions as still trialing to see if effective. Staff F did not believe Staff E was mistreating the resident and instead providing alternative fall interventions. Staff E had a tendency to take tasks on themselves so as not to burden others. Staff F recalled a specific incident which occurred around 7:30 PM. Resident #1 was trying to enter their room as wanted to lay down. Staff E redirected the resident back into the hallway. Staff F did not believe the interaction was inappropriate nor was the resident mistreated. In an interview on 6/29/26 at 12:30 PM, the Chief Operating Officer (COO) acknowledged the regional corporate team was made aware of abuse allegation involving Resident #1 during a routine facility visit on 4/15/26. An investigation was then initiated. The COO interviewed Staff E as part of the investigation. When discussing the rationale of keeping the resident up/not putting to bed when asked, Staff E mentioned if Resident #1 goes to bed too early, they would fall. It was unclear what Staff E meant by too early or what time that was. The COO explained to Staff E that resident have the right to fall. However, Staff E did not believe the resident understood her fall risk. The COO did not feel the phone issue was a concern. When facility staff spoke to family, they reported never seeing it unplugged and was OK with the resident taking calls at the nurse's station. After the conclusion of the investigation, the COO did not believe there was mistreatment or abuse of Resident #1. The policy Resident Rights, version 1.2 (H5MAPL0768), noted the following: 1. Employees shall treat all residents with kindness, respect, and dignity 2. Federal and state laws guarantee certain basic rights to all residents of the facility, which include a. Dignified existence b. Treated with respect, kindness, and dignity c. Free from abuse, neglect, misappropriation of property, and exploitation d. Self-determination		

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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. Based on facility document review, staff interviews, and policy review, the facility failed to report to the state agency within the required time frame a suspected case of resident abuse and neglect for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 51. Findings include: The Minimum Data Set (MDS) assessment completed on 2/16/26 revealed Resident #1 with a Brief Interview for Mental Status score of 6 out of 15, indicating severe cognitive impairment. Diagnoses include cancer and non-Alzheimer's dementia. In an interview on 6/23/26 at 3:30 PM, Staff D, Licensed Practical Nurse (LPN), stated they sent a text message to the facility administrator and the Director of Nursing (DON) on 4/5/26. The text discussed questionable actions towards Resident #1 by Staff E. This included removing room identifiers (name plate, sign), unplugging their personal phone, and not allowing the resident to go to bed when asked. Staff D explained the DON responded to the text stating they did not believe Staff E was mistreating the resident. These were intervention the nurse put in place to keep the resident safe. The facility's self-report summary document, provided on 6/22/26, showed an allegation of abuse involving Resident #1 was reported and submitted to the state agency on 4/16/26. In an interview on 6/23/26 at 3:30 PM, Staff D, Licensed Practical Nurse (LPN), stated they sent a text message to the facility administrator and the Director of Nursing (DON) on 4/5/26. The text discussed questionable actions towards Resident #1 by Staff E. This included removing room identifiers (name plate, sign), unplugging their personal phone, and not allowing the resident to go to bed when asked. Staff D explained the DON responded to the text stating they did not believe Staff E was mistreating the resident. These were intervention the nurse put in place to keep the resident safe. In an interview on 6/25/26 at 3:30 PM, the Administrator acknowledged receiving a group text message from Staff D on 4/5/26. The DON was included on the group text. The Administrator explained they did not respond to the text as the DON was addressing. The Administrator does not recall discussing this further with the DON. In an interview on 6/29/26 at 945 AM, Staff F, former DON, acknowledged receiving the text message from Staff D and voiced the actions described were implemented as fall preventions. They did not believe the resident was being mistreated. Staff F also acknowledged other staff members approaching them with the same concerns previously. In an interview on 6/29/26 at 3:00 PM, the Chief Operating Officer explained the facility's abuse policy and protocol should be initiated when an allegation of potential abuse reported. This is regardless if the staff believe to be true or not. The COO stated the abuse protocol should have been initiated. The policy Abuse, Neglect, Exploitation, or Misappropriation-Reporting and Investigating, revised Sept'22, outlined the following: 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state laws 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility b. The facility's medical director c. The resident's representative and attending physician 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury		

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NAME OF PROVIDER OR SUPPLIER Azria Health Winterset		STREET ADDRESS, CITY, STATE, ZIP CODE 1015 West Summit Winterset, IA 50273	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on facility document review, staff interviews, and policy review, the facility failed to investigate suspected resident abuse and neglect for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 51. Findings include: The Minimum Data Set (MDS) assessment completed on 2/16/26 revealed Resident #1 with a Brief Interview for Mental Status score of 6 out of 15, indicating severe cognitive impairment. Diagnoses include cancer and non-Alzheimer's dementia. In an interview on 6/23/26 at 3:30 PM, Staff D, Licensed Practical Nurse (LPN), stated they sent a text message to the facility administrator and the Director of Nursing (DON) on 4/5/26. The text discussed questionable actions towards Resident #1 by Staff E. This included removing room identifiers (name plate, sign), unplugging their personal phone, and not allowing the resident to go to bed when asked. Staff D explained the DON responded to the text stating they did not believe Staff E was mistreating the resident. These were intervention the nurse put in place to keep the resident safe. The facility's self-report summary document, provided on 6/22/26, showed an allegation of abuse involving Resident #1 was reported and submitted to the state agency on 4/16/26. The facility document of staff statements detailed the interview with Staff F, former Director of Nursing. Staff E confirmed the questionable behaviors by a specific staff member towards Resident #1 were accurate. Staff F denied completing an investigation as the actions were fall interventions to protect the resident. There was not a need to report or investigate. A 5-day investigation summary was submitted to the state agency after the self-report was sent on 4/16/26. The document summarized the Administrator and the Director of Nursing (DON) were both aware of staff concerns surrounding a specific nurse's implemented fall interventions for Resident #1. The Administrator indicated the DON was investigating and concluded there was no mistreatment by the staff involving Resident #1. On 6/25/26, the Administrator was unable to locate documentation that a facility investigation was completed regarding potential abuse concerns involving Resident #1 prior to the one initiated on 4/16/26. In an interview on 6/29/26 at 9:45 AM, Staff F, former DON, acknowledged multiple staff approached them regarding concerns surrounding treatment of Resident #1. Staff F described themselves as a working DON (active on resident units, reviewing clinical records) and voiced constantly investigating. Staff F explained no formal investigation or documentation was completed. They did not believe mistreatment occurred and the suspected staff member continued to provide cares to Resident #1. In an interview on 6/29/26 at 3:00 PM, the Chief Operating Officer (COO) explained the facility's abuse policy and protocol should be initiated when an allegation of potential abuse reported. This is regardless if staff believes to be true or not. The COO stated the abuse protocol should have been initiated. The policy Abuse, Neglect, Exploitation, or Misappropriation-Reporting and Investigating, revised Sept'22, outlined the following: 1. All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported 2. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents 3. The investigator consults daily with the administrator concerning the progress/findings of the investigation 4. Upon conclusion of the investigation, the investigator records the findings of the investigation on approved documentation forms and provides the completed documentation to the administrator		