STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165188	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Winterset	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 0574 Level of Harm - Potential for minimal harm Residents Affected - Many	The resident has the right to receive notices in a format and a language he or she understands. 47582 Based on observation and staff interview the facility failed to post required notifications of survey agencies, and other support for advocacy. The facility also failed to provide accessibility of the survey results. The facility reported a census of 51. Findings include: Surveyor observations throughout the survey week on 5/6/24, 5/7/24, and 5/8/24 revealed no information posted on how to contact state agencies. Previous survey results were not posted within the long term care facility. During a facility tour and interview with the Administrator, the Regional support personnel and the Maintenance Director on 5/8/24 at 9:00 am, it was observed that the required postings with list of names, mailing and email addresses, and telephone numbers of all pertinent State regulatory and informational agencies and advocacy groups were not displayed in the areas accessible to residents. In an interview with the Administration on 5/8/24 at 9:00 am, she could not immediately locate the binder with previous survey results. After locating the binder, the review of the content in the binder revealed no updated information available since the year of 2021. The Administrator confirmed the binder was not updated since 2021 and did not contain the required latest survey results. The Administrator provided a policy titled Grievances effective date 05/2023 which documented the following: Information regarding filing Grievances is posted in a prominent area in the community. This information includes the identification of external agencies, as required by state and federal regulations, along with contact information.

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

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 05/09/2024

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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 - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47582 Based on clinical record review, staff interviews, and policy review, the facility failed to develop comprehensive care plans for 1 of 8 residents reviewed (Resident #30). The facility reported a census of 51 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #30's admitted [DATE] and had diagnosis of bipolar disorder and non-Alzheimer's dementia. The MDS revealed a Brief Interview of Mental Status (BIMS) of 12, indicating moderate cognitive impairment. The MDS also documented in Section F under preferences for customary routine and activities that it was very important to Resident #30 to take care of their personal belongings and/or things and to choose what clothing to wear. During an interview with Resident #30 on 5/6/24 at 1:50 PM, she stated her laundry was frequently returned with her clothes missing and her bed pads were not returned. She reported it to staff multiple times but they did not return her missing items to her every time. During an interview with Staff P, Housekeeping Supervisor, on 5/7/24 at 9:55 am, she stated Resident #30 frequently makes statements her laundry is not hers. In those instances, she takes laundry back and holds it until the resident makes those statements again then she offers the laundry again. During the Electronic Record Review (EHR), the Care Plan lacked information regarding the resident's history of making statements about missing laundry items or effective interventions. In an interview with Staff A, Social Services Designee, on 05/07/24 at 11:52 AM, she revealed a Grievance Log entry made on 2/1/24 of Resident #30 reporting missing laundry. She recalled notifying the Director of Nursing (DON) and asking the Laundry Department about missing laundry. During that process she learned that Resident #30 had a history of trust issues that were present at the time of admission to the facility. She also stated the Care Plan should have been updated to reflect the history of such behavior and interventions and that she had the ability to update the Care Plan but did not. A review of the facility provided policy titled Azria Care Plans, Comprehensive Person-Centered revised March 2022, documented care palms to be person-centered and include interventions after data gathering, problems and their causes, and to be reviewed when there has been a change in resident ' s condition.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on clinical record review, observation, staff interview, and policy review the facility failed to follow physician's orders and ensure interventions in place to prevent pressure ulcer development for one of three residents reviewed for pressure ulcer risk (Resident #2). The facility reported a census of 51 residents. Findings include: The Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had diagnoses of diabetes, cancer, and hip fracture. The MDS documented the resident had a risk for pressure ulcer and had an unhealed Stage 2 pressure ulcer. The MDS revealed the resident on hospice. The MDS assessment dated [DATE] revealed Resident #2 had a Brief Interview for Mental Status score of 5 which indicated severely impaired cognition. The MDS indicated the resident had a risk for pressure ulcers, and had dependence on staff for bed mobility and transfers, The Care Plan revised 3/13/24 revealed the resident had a history of pressure ulcer and a potential for pressure ulcer development related to immobility. The resident had contributing diagnoses of diabetes, coronary artery disease and peripheral vascular disease. Staff directives included the following; reposition resident frequently and float heels, administer treatments as ordered an monitor for effectiveness, weekly tretment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate The Order Summary Medication Review Report dated 4/11/24 and signed by the physician on 4/16/24 revealed foot protectors to bilateral feet while in bed (started on 7/5/23). The Braden scale assessment (used for predicting pressure ulcer risk) dated 4/26/24 revealed the resident had a high risk for pressure ulcer developing. Progress Notes revealed the following: a. On 2/28/24 at 12:25 PM, resident seen by the wound nurse. Resident repositioned routinely with offloading as she allows. Resident usually allows heel protectors and heel offloading. b. On 3/14/24 at 1:12 PM, pressure area resolved. c. On 4/26/24 at 1:10 PM, resident chairfast. Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. Observations revealed the following: a. On 5/7/24 at 10:30 AM, resident lying in bed. Bunny (foam) boots lying in recliner by the bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 5/7/24 at 11:19 AM, Resident #2 lying in bed on her back. No bunny boots on. Feet lying on mattress. Staff N, Certified Nursing Assistant (CNA) and Staff D, Certified Medication Assistant (CMA), provided cares then transferred the resident into a broda chair. No bunny boots or protective boots placed on the resident's feet. A sign on the wall by the resident's bed revealed bunny boots on when in the chair. c. On 5/7/24 at 12:15 PM, bunny boots still lying in recliner. d. On 5/7/24 at 1:30 PM, the resident sat in a broda chair with a blanket over her, and pink slippers on her feet. The bunny boots were lying in recliner in the resident's room. e. On 5/7/24 at 2:00 PM, resident lying in bed on her back. Bunny boots lying in recliner. On 5/8/24 at 11:40 AM, resident sat in broda chair by the nurse's station eating a rice krispy bar. Bunny boots sat on the bed in the resident's room. During an interview on 5/7/24 at 11:50 AM, Staff N, CNA, reported she had worked at the facility for 1 1/2 yrs. She normally worked in the back hall but worked on the 100 hall on 5/7/24. Staff D told her what the residents needed for cares or she could look at the communication book to know what each resident needed for cares. During an interview on 5/7/24 at 1:48 PM, Staff K, Licensed Practical Nurse (LPN) reported skin assessments done on residents weekly. Resident #2 had a history of pressure sores. Protective boots placed whenever the resident in bed. Protective boots documented on the treatment administration record (TAR). Staff K confirmed she documented the protective boots on when she saw Resident #2 earlier in the day on 5/7/24. At the time, Resident #2 sat in a broda chair across from the nurse's station and had pink slippers on. During an interview on 5/8/24 at 3:10 PM Staff H, MDS Coordinator, reported she got information to do MDS assessments and care plans from the resident's electronic health record, progress notes, therapy notes, and her evaluation on the resident. Staff H reported Resident #2's information in the EHR. Protective boots placed whenever Resident #2 in bed per the physician's order. Staff H reported Resident #2's care plan indicated staff needed to float heels. During an interview on 5/9/24 at 10:45 AM, the Director of Nursing (DON) reported she expected staff to float heels, use a foot buddy or pillows to float the resident's heels in bed or the chair. The DON confirmed Resident #2 had bunny boots and her bunny boots in the recliner. The facility's Prevention of Pressure Injuries policy revised 4/2020 revealed a pressure injury screening tool used to determine risk factors. Interventions designed to reduce or eliminate modifiable risk factors, including positioning and pressure redistribution/support surfaces for reducing the risk of pressure injury. Appropriate medical devices used to minimize tissue damage and use of support surfaces based on the residents' risk factors and in accordance with current clinical practice. A Comprehensive Person-Centered Care Plan policy revised 3/2022 revealed the Care Plan described the services to attain and maintain the resident's highest practicable physical well-being.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on clinical record review, staff interview, employee file review, and policy review the facility failed to ensure two staff present while using a mechanical lift for a resident transfer, and staff failed to ensure sling straps removed from a mechanical lift when transferred a resident from the wheelchair to the bed for one of three residents reviewed for falls (Resident #3). The facility reported a census of 51 residents. Findings include: The Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 had diagnoses of cerebral palsy, deep vein thrombosis (DVT), and muscle weakness. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented the resident required extensive assistance of two for bed mobility, and total dependence on two staff for transfers. The MDS indicated he had no falls. The MDS assessment dated [DATE] revealed the resident had a fall with an injury. The Care Plan revised 10/29/23 revealed the resident had a risk for falls related to cerebral palsy and impaired mobility. The care plan documented the resident had a fall out of bed on 10/19/23 and had an abrasion to the left forehead. A mechanical lift audit and sling inspections initiated 10/19/23 and added to the care plan. The care plan also directed staff to use two staff members for transfers with a mechanical lift. A fall risk evaluation dated 8/10/23 revealed a score of 9, which indicated the resident had a risk for falls. The Progress Notes documented as follows: a. On 10/19/23 at 8:02 PM, Staff M, Certified Nursing Assistant (CNA), called Staff O, Licensed Practical Nurse (LPN), and reported there had been a fall. Staff O was in another room on the 300 hall, and Staff M was in Resident #3's room on the 100 hall. Staff O found the resident on the floor, lying on his back with a cushion behind his head. The bed was in high position. Staff M stated he had used a Hoyer lift to transfer the resident to the bed. He tried to pull the lift away from the bed and there was resistance. The CNA was looking at the wheels as he continued to tug at the handles on the lift. Resistance then stopped and when the CNA turned to the resident, the resident was on the floor. Resident #3 stated he did not hurt anywhere. The resident was able to move all extremities freely. Five minutes later, the CNA reported the resident had a bruise at his left forehead. b. On 10/20/23 at 2:51 PM, no noted additional injuries post fall. Tylenol given as needed for general discomfort/soreness. Small hematoma (bruise) above left eye. Neuro checks within normal parameters. A skin evaluation dated 10/25/23 revealed the abrasion to the resident's forehead healed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An Incident Report dated 10/19/23 at 8:02 PM, revealed Staff M, CNA, told Staff O he used a mechanical lift per plan of care to move Resident #3 from the wheelchair to the bed. He placed the resident into bed and pulled the lift machine away from the bed. There was some resistance. The CNA checked to see if the wheels (on the lift) were stuck on something. When he turned to the resident, the resident was on the floor next to his bed. The chain on the lift next to the resident's left shoulder was still hooked up to the sling under the resident. The resident was unable to say accurately what happened. The resident denied injuries or pain, and able to move all extremities. Resident lying on the floor on his back with a cushion under his head. Vital signs included: blood pressure 188/95, pulse 70, respirations 24, pulse oximetry 91 percent on room air. Staff assisted the resident into bed. Five minutes later, Staff M alerted Staff O the resident had a swollen area to his left forehead. The area measured 2.5 x 2 inches. Neuro checks within normal limits. Resident #3 alert and answered questions appropriately except he stated the President (of the United States) was Bush. During an interview on 5/7/24 at 11:50 AM, Staff N, CNA, reported another staff person told her what residents needed for cares or she looked at the communication book to know how a resident transferred. During an interview 5/8/24 at 1:22 PM Staff M, CNA, reported he had worked at the facility 2 years. Resident #3 used a mechanical lift for transfers. Staff M reported he asked the resident what they needed done when he provided cares. On the day Resident #3 had a fall, Staff M reported he transferred the resident from the wheelchair to his bed. He unhooked the sling straps from the lift. He thought the straps were all unhooked but he apparently didn't push one strap off far enough. He was told after the incident to make sure he always had two people whenever he used a mechanical lift for transfers. The strap on the upper left shoulder was caught. He thought it was the wheels on the lift that were stuck or not working. When he pulled the lift back further, it finally came loose. When he looked down, he saw the resident on the floor. The resident ended up getting a bruise on his forehead. Staff M reported the nurse told him from that day forward to make sure he had a second person. He needed a spotter and never to put the resident in bed unless he had a second person. Staff M reported people don't show up for work or called in to work, and often times worked short. Staff M reported he received 1-2 weeks of orientation but also had experience prior to working at this facility. During an interview 5/9/24 at 10:45 AM, the Director of Nursing (DON) reported she didn't know if Staff M had an orientation checklist or if he completed competency for the mechanical lift during orientation. The ADON (Assistant Director of Nursing) did audits and new staff orientation related to infection control. The staffing coordinator may also do some competency checkoffs. The DON reported whenever a resident had a fall she did a root cause analysis to figure out what happened. When Resident #3 had a fall from the mechanical lift, the CNA thought he had the straps disconnected. It was the perfect storm with the roommate talking and caused distraction. She provided education, and went over (mechanical lift) competency after the incident with Staff M. During an interview 5/9/24 at 11:30 AM, the Staffing Coordinator reported she doesn't do anything with staff orientation. She completed lift audits until the ADON took over this task two years ago. The Staffing Coordinator confirmed she had not completed any audit or competency for use of mechanical lift devices within the past year. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview 5/9/24 at 11:37 AM, the ADON reported she went over donning/doffing PPE (personal protective equipment), hand hygiene, and employee health screening information with new employees. The ADON stated she doesn't go over use of mechanical lift devices or complete staff competency checklist with the CNA's. Staff M's employee file revealed a disciplinary action record dated 10/20/23 revealed: On 10/19/23, Resident #3 fell out of bed and was pulled to the floor due to the mechanical lift sling remained attached. CNA operated the mechanical lift independently. The corrective action included review of lift policy, as well as all lifts required two persons for transfers. Lift policy and education administered prior to Staff M returning to work. Employee Statement included the following: The resident's roommate was talking, and caused distraction. Staff M also thought the anti-rollbacks (on the mechanical lift) caused resistance. Staff M thought the sling was detached from the lift. Other staff was assisting another resident. It was an accident. Employee File reviewed on 5/8/24 revealed Staff M was hired on 2/1/22. The employee file/record lacked an orientation checklist or mechanical lift competency signed off by facility staff to deem the employee competent in use of mechanical lift. The employee file included a written statement by Staff M regarding fall 10/19/23 at 8 PM on Resident #3. Resident #3 was on the bed, Staff M believed the sling was disconnected from all 4 points of the lift, so the mechanical lift pulled away from bed. The mechanical lift had springy resistance to going further after lift about 3 feet away from the bed. CNA checked around the wheels as he continued to tug on the handles (on the lift). Resistance then stopped but when turned to remove the mechanical lift sling (under the resident), Resident #3 was on the floor next to the bed. The left shoulder strap was still connected to the lift. Nurse called and a cushion placed under the resident's head. The facility's policy for Using a Mechanical Lift Machine revealed at least two nursing assistants needed to safely move a resident with a mechanical lift. Staff must be trained and demonstrate competency using the specific machines or devices utilized in the facility. The procedural steps included: a. Slowly lower the resident to the receiving surface when the transfer destination is reached. b. Detach the sling from the lift once the resident's weight is released. c. Carefully remove the sling from under the resident. Be mindful of the resident's position and balance. A competency assessment for Using a Mechanical Lifting Machine revealed at least two nursing assistance needed to safely move a resident with a mechanical lift. A mechanical lift may be used when transferred a resident from the chair to bed. The procedural steps included: a. Attach sling straps to the sling bar b. Ensure sling attached to the clips and it is properly balanced (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	c, Lift the resident 2 inches from the surface to check stability of attachments, sling and weight distribution. d. Slowly lift the resident. Only lift as high as necessary to complete the transfer. e. Slowly lower the resident to the receiving surface. f. Once the resident's weight is released, detach the sling from the lift. g. Carefully remove the sling from under the resident. Be mindful of the resident's position, balance and skin.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on clinical record review, observation, and staff interview, the facility failed to ensure residents provided a diet with finger foods per resident preference to maintain nutrition and weight for one of three residents reviewed for nutrition maintenance (Resident #1). The facility reported a census of 51 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had diagnoses of Alzheimer's disease, dementia, GERD (gastric reflux), diabetes, and anemia. The MDS recorded the resident had a Brief Interview of Mental Status score of 5, indicating which indicated severely impaired cognition. The MDS indicated the resident was on a therapeutic diet and had dependence on staff for eating. The MDS recorded the resident weighed 145 pounds (lbs). The MDS also indicated the resident on hospice. The Care Plan revised 4/28/24 revealed the resident at nutrition risk related to diminished appetite and intakes that started in 10/2022 and resulted in significant weight loss. The resident also had limitations in her ability to perform activities of daily living (ADL's) related to dementia and limited mobility. The staff directives included provide set-up assistance for eating and offer assistance as she allowed. The care plan documented the following interventions and dates: o Dietician to evaluate and make diet change recommendations PRN (as needed) (initiated 11/25/19) o Provide and serve supplements as ordered (initiated 1/11/23) o Regular texture, finger foods. Serve diet as ordered. Offer finger foods when available. Honor food preferences and special requests as able. Oatmeal at breakfast. Staff to assist with feeding as needed. (initiated 3/20/24) The Physician's Order Summary revealed: a. General diet with regular texture. Resident to have finger foods at meals except breakfast as she ate hot cereal (started 11/15/19). b. Nutritional supplement (Med Pass) 2 ounces three times a day (TID) started on 12/21/23. Weights recorded in the electronic health record (EHR) for Resident #1 included: 10/6/23 154.2 lbs. 11/3/23 156.2 lbs. 12/1/23 148.8 lbs. 1/3/24 144.2 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/6/24 140.4 lbs. 3/6/24 145.2 lbs. 4/2/24 143.0 lbs. 5/3/24 142.8 lbs. A Mini Nutrition Screening assessment dated [DATE] revealed the resident had a risk of malnutrition. The resident weighed 171.5 lbs. An Annual RD (Registered Dietician) evaluation dated 3/20/24 revealed a diet order for general/regular/finger foods, and Med Pass supplement 2 ounces Three Times a Day (TID). The resident preferred to eat in her room/bed. Weight 145 lbs. Resident continues on hospice care. The resident receives finger foods at meals per family and hospice request. Nursing checked on her during meals and assisted her as needed. The progress note dated 2/21/2024 at 3:13 PM revealed the resident's weight 140.4 lbs. BMI 24.2. The resident had shown a significant weight loss over the past 90 days. She continued on hospice care and ate in her room per her preference. Hospice recommended finger foods as her family feels she may eat better if served this diet. Nursing reports good acceptance of super cereal, so this intervention will continue at breakfast. Continue on Med Pass supplement 2 oz. TID. Ok to discontinue ice cream as an intervention as resident is now on finger foods. Weight loss was deemed unavoidable in May of 2023. Physician aware of weight loss. Monthly weight monitoring continued. Observations revealed the following: a. On 5/6/24 at 12:39 PM, Resident #1 sat in bed with head of bed (HOB) up and eyes closed. A plate of food (spaghetti, mixed vegetables, and bread). sat on an overbed table in front of her but the food was untouched. At 1:15 PM, the resident continued to lay in bed with eyes closed. The plate of food had a lid over it. b. On 5/7/24 at 12:55 PM, resident lying in bed with HOB up. A plate of food (bun with meat, stuffing, brussel sprouts, and a bowl of jello) sat on an overbed table in front of her. c. Continuous observation on 5/8/24 at 12:15 PM to 01:30 PM, no staff entered room to cue or assist resident with feeding. Resident continued to sit in bed with tray of food in front of her. Plate of food on overbed table included sandwich (2 slices of bread with pot pie/vegetable mix inside), bowl of spinach, and bowl of pudding. A small bowl of orange slices lying on lap. The food was untouched. The dietary food slip documented the diet as finger foods. During an interview 5/7/24 at 1:48 PM, Staff K, Licensed Practical Nurse (LPN) reported Resident #1 on hospice. The resident is able to feed herself, and her food intakes varied. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 5/8/24 at 1:45 PM, the RD dietician reported she completed nutrition assessments weekly on the residents. A skin and weight meeting held weekly with the dietary manager, MDS nurse, Director of Nursing (DON), and RD to go over resident weight concerns. The MDS nurse faxed information to the physician regarding recommendations. Whenever she noted weight loss concerns, she typically made recommendation for a supplement. The RD reported Resident # 1 had weight loss and a supplement recommended twice a day, then increased to TID starting in 12/2023. Resident #1's weight stable since supplement changed to TID. Resident #1 on a regular diet with finger foods. The dietician stated finger foods considered as foods the resident could pick up and eat. She would not consider bread with pot pie, spinach, and pudding in a bowl as finger foods. She provided staff education a while ago about finger foods. She planned to locate a list of finger foods with options for staff to provide to the resident. During an interview 5/8/24 at 1:55 PM, Staff L, Registered Nurse reported Resident #1 able to feed self. She doesn't always accept help from staff. Resident fluctuated with eating. She gave the resident a supplement when she gave her medications. The resident's family requested to give the resident finger foods. During an interview 5/9/24 10:15 AM, the DON reported when diet limited, can make things worse, and resident will potentially eat less. The DON stated she would request to have finger foods as an option, in addition to offering other items on the menu that the resident liked. The resident still liked to eat some things on the menu, but when limited to just finger foods, there was a chance she may eat less or nothing at all. 46873 2. During kitchen observation on 5/7/24 from 12:18 pm to 1:00 pm, lunch trays were prepared for all residents of the facility eating lunch meal. The menu for the day was documented as: [NAME] Pork Roast Stuffing Brussel sprouts Dinner roll/margarine Fruited lime gelatin Beverage Resident #1's tray ticket was noted to direct staff to serve finger foods. The following food was prepared for Resident #1: [NAME] Pork Roast, served with 2 slices of bread as a sandwich Brussel sprouts (continued on next page)

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 05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Winterset	1015 West Summit Winterset, IA 50273

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Stuffing Fruited lime gelatin On 5/8/24 at 1:33 pm, the Registered Dietitian (RD)stated that when the entree is meat, for a finger food diet, it should be served in a bun or in bread. She stated it was fine to serve the brussel sprouts as finger food. The RD said the stuffing and the gelatin should not have been served and should have been substituted. Potato chips or cheese puffs could have been substituted as a starchy item in place of the stuffing. The RD stated she spoke to the cooks quite a bit and had provided in-services over the last few months on food service and the puree process and sanitation. She stated she planned to speak to the kitchen staff and provide further education about more finger foods. At the time, the RD provided the surveyors a list of finger foods for dementia patients used by the kitchen staff to substitute food items.

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 05/09/2024

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 46873 Based on record review, staff interviews, and facility job description review, the facility failed to ensure the dietary service manager met the required qualifications of a Dietary Manager, in the absence of a full-time dietitian. During initial kitchen walk through on 5/6/24, at 9:28 am, Staff F, Dietary Manager stated she had not taken the course to become a certified dietary manager. She said her prior background was working as a Certified Nurse Aide (CNA) and a Dietary Aide. The facility provided a certificate of Staff F having completed ServSafe training on 3/14/24. On 5/8/24 at 3:11 pm, the Administrator stated Staff F is enrolled in an Iowa Food Manager Certification Course which she will be completing through the healthcare association. She stated it is a self paced course and she anticipated Staff F would have completed within the month. She stated Staff F had worked as a CNA and a medication aide at the facility prior to being hired as the Dietary Manager role. The facility documented Dietary Manager-2-Job Description, revision date 2/21/21, documented the following: Required Education and Experience: Certified Dietary Manager (CDM) within one year of employment.

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 05/09/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Winterset		STREET ADDRESS, CITY, STATE, ZIP CODE 1015 West Summit Winterset, IA 50273	

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50471 Based on observations, staff interviews, the 2022 Food and Drug Administration (FDA) Food Code, and facility policy review, the facility failed to maintain sanitary practices by improperly storing food. Findings include: On 5/6/24 9:15 am during initial walk through, the following was observed: A pitcher of tomato juice was in a refrigerator labeled with used by date of 4/27/24. A visibly soiled tub with two uncovered glasses of juice was observed on the shelf of a refrigerator. In the walk in cooler, what appeared to be a pound cake in an undated, zippered food storage bag was seen placed on top of a package of turkey lunch meat. In the dry storage room, bag of pasta was observed on a shelf opened to air with no open date. Additionally, a bag of brownie mix was also observed open with no open date. On 5/7/24 at 11:37 am the Dietary Manager stated she expected juice glasses to be covered and stored in a clean bin. On 5/8/24 at 1:33 pm, the Registered Dietitian stated her expectation is for the bottom shelf of the walk in cooler to be dedicated to meats and any bread or cakes should be stored on a higher shelf. Chapter 3, Section 202.15, package integrity, of the 2022 FDA Food Code documents: Food packages shall be in good condition and protect the integrity of the contents so that the Food is not exposed to adulteration or potential contaminants. The facility policy Azria Food Receiving and Storage revised October 2017 included the following documentation: Policy statement is Foods shall be received and stored in a manner that complies with safe food handling practices. Point number 8: All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by).