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	03/10/2025

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 49990 Based on clinical record review, facility policy review, and staff interview, the facility failed to provide the resident with proper notice when the facility initiated a discharge before the resident had exhausted their Medicare Part A benefit days for 1 of 3 residents reviewed (Resident #20). The facility reported a census of 50. Findings include: Review of the clinical records for Resident #20 show the resident's Medicare Part A began on 12/26/2024 when he entered the facility. The same record indicated the resident was discharged from skilled services on 02/11/2025. An Advanced Beneficiary Notification (ABN) CMS-10055 was present in the file, but no record of the required Notice of Medicaid Non-Coverage (NOMNC) CMS-10123 was found. An email was sent on 03/05/2025 at 12:27 PM from the state surveyor to the facility Administrator requesting clarification and asking for a copy of the NOMNC if there was one available. An email was received on 03/05/2025 at 01:03 PM from the Facility Administrator clarifying that the staff member normally responsible for providing proper notice was not in the facility at the time this was required, and as a result the NOMNC had not been provided to Resident #20 or his representative. In an interview on 03/10/2025 at 03:52 PM the Facility Administrator acknowledged the CMS-10123/NOMNC was required to be given to the resident or his representative at least two calendar days before a resident is to be discharged from skilled services. She acknowledged this was not done. Review of a facility provided document titled Notice of Covered and Non-Covered Services, with a last revised date in March of 2021, documented the following: If changes in coverage are made to items and services covered by Medicare or Medicaid, residents are notified in writing as soon as possible.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on Electronic Health Records (EHR) review, observations, policy review, resident interview and staff interview the facility failed to provide the residents with a comfortable homelike environment by not repairing damages in resident rooms for 5 of 17 residents (Resident #11, #31, #33, #43 and #47). The facility reported a census of 50 residents. Findings include: 1. The Annual Minimum Data Set (MDS) dated [DATE] for Resident #31 documented a Brief Interview for Mental Status (BIMS) of 13 which indicated no cognitive impairment. Observation on 3/3/25 at 12:10 PM in Resident #31's room revealed drywall behind the head of the bed chipped with deep grooves and missing paint. Drywall to the left of Resident #31's bed under the window also had missing paint with grooves of missing drywall. On 3/3/25 12:15 PM Resident #31 stated he had never asked but would like the paint behind his bed and the area of dry wall fixed on the wall beside his bed. 2. The MDS dated [DATE] for Resident #33 documented a BIMS of 12 indicating mild cognitive impairment. Observation on 3/4/25 at 9:37 AM in Resident #33 ' s room revealed a quarter sized area of missing paint with several deep grooves that had been painted over behind the resident's chair. On 3/4/25 at 9:38 AM Resident #33 stated she would like to have the areas repaired but doesn't want to put the facility out. 3. The Quarterly MDS dated [DATE] for Resident #43 documented a BIMS of 05 which indicated severe cognitive impairment. Observation on 3/4/25 at 9:10 AM revealed paint missing on the wall to the left of the bathroom approximately 8 - 10 inches by 2 inches with a second quarter sized area of missing paint. Observation also revealed 4 areas about 3 inches by 1 inch above the light fixture on the wall. On 3/4/25 at 9:11 AM Resident #43 stated she used to have an old calendar to the left of the bathroom door. Resident #43 stated when she moved in a calendar was peeled off and the tape removed the pain. Resident #43 stated the missing paint bothered her a bit she had planned on covering the area because the missing paint is a bit of an eyesore. Resident #43 stated she would like it repaired but had not asked anyone to fix it. Resident #43 stated she had thoughts of covering the area with a picture or something. 4. The Admission MDS dated [DATE] for Resident #47 documented a BIMS of 14 which indicated no cognitive impairment. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation in Resident #47's room on 3/4/25 at 10:45 AM revealed 2 large areas of different colored paint near the head of the bead under the window. Chipped paint behind the chair and near the light. On 3/4/25 10:47 AM Resident #47 stated she had entered the facility about 2 weeks ago. Resident #47 stated the missing paint is a bit of an eye sore but had been like that since she moved in. Resident #47 stated she thought they would have painted prior to someone moving in but the facility did not. On 3/5/25 at 4:46 PM Staff K, Certified Medication Assistant (CMA)/ Certified Nursing Assistant (CNA) stated she had turned in fix slips for broken remotes, when a bed would not move up and down and a pull shade was broken. Staff K stated maintenance repaired those issues. Staff K acknowledged that a few rooms up front and a few in the back have paint missing on the walls and grooves in the dry wall. Staff K stated she did not fill out the slips personally because she was told the paint and dry wall issues were already addressed. Staff K acknowledged there were some scratches on the wall in room [ROOM NUMBER]. Staff K stated she did not report the scratches in room [ROOM NUMBER]. Staff K stated she was told multiple people had written the concern up about scratches, missing paint, and grooves in the dry wall. Staff K stated she did not remember who stated they wrote the concerns up. On 3/5/25 at 5:11 PM Staff L, CNA stated she had reported environmental concerns to maintenance a couple of times. Staff L stated she could not remember what those concerns were but she had reported environmental concerns. Staff L stated she worked on all the halls. Staff L stated she had noticed missing paint and grooves in the drywall in resident rooms. Staff L stated papers had been filled out for the maintenance man. Staff L acknowledged those areas did not get repaired. Staff L stated she remembered reporting the 100 and 300 halls. Staff L stated she had not heard any of the residents complain about the paint or grooves. On 3/5/25 at 5:37 PM Staff M Maintenance Director stated the way that staff reported environmental issues are with fix it tickets. Staff M stated he does not get very many fix it tickets. Staff M stated he went through once every other month and touched up walls. Staff M stated he does not document repairs or touch ups. Staff M stated he saved the fix it tickets for so long and then threw them in the shred box. Staff M stated he kept them till the box was full and then shreds the tickets. Staff M acknowledged he knew the walls needed to be touched up and when he had a chance he went down the hall and tried to paint. Staff M stated the dry wall and paint is a constant thing. Staff M stated might not have filled the grooves but they got painted over. Staff M stated most of the time they try to have the rooms touched up or fixed prior to the residents moving into the room. Staff M stated that he heard concerns about paint all the time that is why he rotates through touching up the room. Staff M stated he does not repair a particular room usually repaired by hallway. Staff M stated he tried to repair each entire hall once every couple months. Staff M stated if the staff say that the resident has a concern about it then he would try to complete the repair faster. Staff M acknowledged the wall in room Resident #47's had grooves and were then repaired with drywall and primer paint. Staff M acknowledged the repair was prior to Resident #47's admission and entry into the room. Staff M stated he did not know how he missed repainting the area. Staff M stated the grooves are repaired about every six months but covers the grooves in paint until he can get back to them when he paints the hall. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/5/25 at 6:08 PM the Administrator stated the process for environmental concerns such as missing paint, grooves in the drywall, broken shades or window repairs is to fill out a fix it ticket. The Administrator stated if it is reported to her verbally she would just call Staff M and tell him. The Administrator stated when residents discharge they do a room readiness check and the rooms are checked frequently. The Administrator stated drywall and paint should be completed as needed. The Administrator stated there was not a procedure for checking rooms for repairs. The Administrator stated she had not had any residents report any concerns with paint or dry wall. The Administrator stated she would have expected that the paint would have been completed in Resident #47's room prior to the resident entering the room. The Administrator stated she would have expected that the trim would have been repaired in room [ROOM NUMBER]. Review of policy titled Maintenance Service revised 12/09 documented the maintenance department was responsible for maintaining the buildings, grounds, and equipment in a safe operable manner at all times. Maintenance personnel will provide routinely scheduled maintenance service to all areas. The maintenance director was responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner. A copy of the maintenance schedule shall be provided to each department director so that appropriate scheduling can be made without interruption of services to residents. Records shall be maintained in the maintenance director's office. 47582 5. The Quarterly MDS dated [DATE] for Resident #11 documented a BIMS of 06 which indicated severe cognitive impairment and an admitted [DATE]. An observation of Resident #11 room on 3/3/25 at 3:37 pm revealed the majority of the wall by the bed had multiple areas of dented drywall, scratched and chipped paint and discoloration, including a taped piece of electrical wire that had no immediate purpose. The main window was missing an entire trim, exposing sharp edges of the drywall. During an interview with Resident #11 on 3/03/25 at 3:37 pm stated the wall looked damaged since she moved in there and she expected it to be fixed but it hasn't occurred to this day. During an observation of the 400 hallway on 3/4/25 at 9:45 am, the following rooms were noted to have less than homelike environment: room [ROOM NUMBER]. The right side window mesh screen hung loosely, not secured inside the window frame. The window to the outside was missing an entire trim, exposing sharp drywall edges. The privacy curtain divided the room in the middle and had multiple brownish splatter stains throughout the lower half area. The vacant bed had a broken electrical cord that was hanging loose with exposed wires. The vanity above the hand sink was wrapped with loose cable wires. The top of the shared clothing closet was cluttered with food rest devices. Several areas on the walls noted to have chipped paint. Rooms 406. The main window was missing an entire trim, exposing sharp drywall edges.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on Medication Administration Record (MAR) - Treatment Administration Record (TAR), Electronic Health Records (EHR), policy review, and staff interviews the facility failed to represent an accurate assessment of the resident's status during the observation period of the MDS by not accurately assessing the use of a wander guard for 1 of 3 residents reviewed (Resident #43). The facility reported a census of 50 residents. Finding include: 1. The Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #43 documented a Brief Interview for Mental Status (BIMS) of 5 which indicated severe cognitive impairment. On 3/4/25 at 1:00 PM an observation of a wander guard present on Resident #43's walker. Review of EHR titled Progress notes dated 2/17/25 entered by Staff U documented Resident #43 was ambulating by herself in the room and in the hallway with walker unsteady gait at times. Staff assisted as the resident would allow. Resident #43 yelled at staff I can do it and the resident wandered towards the exit doors. Staff redirected Resident #43 away from exit doors. Resident #43 had become visibly upset with redirection. Resident currently in room talking to self and stuffed animals. Review of Resident #43's MDS dated [DATE] documented in Section P - Restraints and Alarms wander/elopement alarms were not used. Review of Resident #43's EHR titled, Medication Administration Record and Treatment Administration Records documented an order to check the placement and function of wander guard each shift. Review of Resident #43's EHR titled Care Plan documented a risk for wandering/elopement identified. On 3/5/25 at 12:17 PM Staff C, MDS Coordinator stated she does fill out the MDS section P titled Restraints and Alarms. Staff C stated the portion with wander/elopement alarms should have identified that Resident #43 utilized a wander guard. On 3/5/25 at 12:53 PM the DON acknowledged in Resident #43's MDS section P Restraints and Alarms does not have wander/elopement alarms identified. The DON stated the facility's expectation was the MDS would have identified the use of wander guard in section P. The DON acknowledged the MDS was coded inaccurately. The DON stated the facility's expectation was the MDS would be coded accurately. Review of policy revised 3/22 titled Azria Comprehensive Assessments documented comprehensive assessments are conducted to assist in developing person-centered care plans. Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) user manual. A significant error was an error in an assessment when the resident ' s overall clinical status was not accurately represented. A significant error reflects incorrect coding of the MDS.

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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 electronic record review, resident interview and staff interviews the facility failed to provide a comprehensive care plan for 1 of 8 residents reviewed (Resident #11). The facility reported a census of 50 residents. Finding include: The Minimum Data Set (MDS) dated [DATE] for Resident #11 documented a Brief Interview for Mental Status (BIMS) of 06 indicating severe cognitive impairment and an admitted [DATE]. The MDS revealed Resident #11 had a diagnosis of stroke, age related osteoporosis and muscle weakness, and depended on staff assistance with most of the Activities of Daily Living (ADLs). The Care Plan for Resident #11 documented a focus area for limitations in the ability to perform ADLs related to cognitive impairment and a history of stroke. Interventions put in place were to apply carrot to the left hand in the morning and remove after lunch. A review of the clinical record for Resident #11 revealed a physician order on 1/4/2024 to apply left hand splint each morning and remove after lunch. An observation of Resident #11 on 3/3/25 at 3:37 pm revealed left hand contracture without a brace or a carrot. A follow up observation of Resident #11 on 3/06/25 at 09:45 am revealed no brace or carrot present on the left hand. In an interview on 03/06/25 at 09:56 am Staff R, Restorative Aide (RA) stated Resident #11 typically wore a splint on her left hand due to contracture and confirmed the splint was not on due to possibly being lost in the laundry. In an interview on 03/06/25 at 11:04 am the Director of Nursing (DON) confirmed that Resident #11 wore a splint and also a carrot, a device simply held in a hand, to the left hand for contracture prevention and it should be applied as ordered. In a follow up interview on 3/10/25 at 10:09 am DON stated she updated the MDS and the Care Plan to reflect the brace and carrot and contracture prevention management. She stated the therapist was a new grad and didn't specify that the carrot and the brace are 2 different devices to be applied to the left hand.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on Electronic Health Record (EHR) review, staff interview, policy, and Medication Administration Records - Treatment Administration Records (MAR-TAR) review the facility failed to provide needed services in accordance with professional standards by leaving medications in the residents room for self administration without visualization of the nurse for 4 of 12 residents (Resident #8, #31, #33 and #41). The facility reported a census of 50 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #8 documented a Brief Interview for Mental Status (BIMS) of 15 which indicated no cognitive impairment. Observation on 3/6/25 at 8:21 AM revealed Staff E, Licensed Practical Nurse (LPN) obtained medications, knocked on Resident #8's door, entered the room, applied gloves, placed medications on bedside table in front of Resident #8, returned to medication cart for new glucose machine on 3/6/25 at 8:24 AM, Resident self administered medications with sips of water outside of view of Staff E, LPN, obtained a different glucose machine, returned inside of Resident #8's room on 3/6/25 at 8:26 AM, performed a blood glucose level test, left Resident #8's room, and returned to the medication cart. 2. The Annual MDS dated [DATE] for Resident #31 documented a BIMS of 13 which indicated no cognitive impairment. Observation on 3/3/25 at 12:27 PM in Resident #31's room revealed white-colored cream on the bedside table in a medication cup. On 3/3/25 at 3:03 PM Staff H, LPN stated she had not put the magic butt paste on Resident 31 that day. Staff H, LPN stated she had not left the cream in there today. Staff H, LPN acknowledged there was no other cream besides the magic butt cream and the cream sitting on the bedside table was magic butt cream. Staff H, LPN stated she would not leave the medication in the room. Staff H, LPN stated if the medication was refused she would have disposed of it. 3. The Annual MDS dated [DATE] for Resident #33 documented a BIMS of 12 which indicated mild cognitive impairment. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 3/6/25 at 7:43 AM revealed Staff E, LPN gathered medications prior to entering the residents room, knocked on the Resident #33's door, entered the room, obtained gloves, applied the Lidocaine patch to right hip, applied Lidocaine patch to left hip. On 3/6/25 at 7:50 AM a staff knocked on the door and asked for money for another resident. Staff E. LPN left the Resident #33's room with medications sitting on the bedside table and left room to obtain money for the staff member. Resident #33 self administered medications without visualization by the nurse. Resident #33 spilled a little water on her lap. Resident #33 asked the surveyor where the nurse went. On 3/6/25 at 7:52 AM Staff E returned to Resident #33's room. Staff E, LPN knocked on the door and entered, Staff E, LPN left the room again, Staff E, LPN refilled water from the medication cart and returned to the room. Staff E, LPN asked what happened when noticed the water in Resident #33's lap, Resident #33 stated that she wobbled a little with the medication and water and spilled a little, Staff E, LPN returned to the medication cart and documented vitals and threw away trash. On 3/6/25 at 11:12 am, the Director of Nursing (DON) stated the nurse administering medications should not have been turning her back to the resident while the resident was taking medications. The DON stated the nurse was required to monitor the resident while medications were administered. The DON stated medications should not have been left in the residents room. The DON acknowledged none of the residents in the facility have the ability for self administration of medications. The DON stated an self administration assessment would have to be completed, physician notified and she was not sure if the facility had a policy on resident self administration. Review of policy titled Administering Medications revised 4/19 documented medications were administered in a safe and timely manner, and as prescribed. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. Residents could self-administer their own medications only if the attending physician, in conjunction with an interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. 47582 2. The Quarterly MDS dated [DATE] for Resident #41 documented a BIMS of 13 indicating intact cognition. The MDS revealed Resident #41 had a diagnosis of non-Alzheimer's dementia and Grover's disease, also known as transient acantholytic dermatosis (a skin condition characterized by itchy, red, and raised spots, often on the trunk). During an interview with Resident #41 on 3/03/25 at 3:28 pm, this writer observed him applying a lotion to his trunk out of a medication cup while he was alone in his room. Resident #41 revealed it was a medicated cream that a nurse told him to apply himself and the staff only applied the cream to his back area since he couldn't reach it. A review of the clinical record for Resident #41 documented a physical order on 2/20/25 for Diclofenac Sodium External Gel 1%, topical, apply to back topically as needed for discomfort twice daily. In an interview with the Director of Nursing (DON) on 3/06/25 at 12:19 pm, she confirmed Resident #41 shouldn't have been self-administering a physician prescribed medication unless he had an order from a physician specifying it which there was no such order.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47582 Based on record review, observation, and staff interviews the facility failed to assist residents with activities of daily living by not completing grooming tasks for 2 of 8 residents reviewed (Resident #11 and #26). The facility reported a census of 50 residents. Finding include: 1. The Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #11 documented a Brief Interview for Mental Status (BIMS) of 06 which indicated severe cognitive impairment. The MDS revealed Resident #11 had a diagnosis of stroke, age related osteoporosis and muscle weakness, and depended on staff assistance with most of the Activities of Daily Living (ADLs). The Care Plan for Resident #11 documented a focus area for limitations in the ability to perform ADLs related to cognitive impairment and a history of stroke. Interventions put in place were to provide staff assistance with personal hygiene. An observation of Resident #11 on 3/3/25 at 3:37 pm revealed patches of facial hair that were noticeably long and unshaved. A follow up observation of Resident #11 on 3/06/25 at 09:45 am patches of facial hair remained unshaved. In an interview on 3/06/25 at 11:04 am the Director of Nursing (DON) confirmed that Resident #11 was to be shaved during bathing and staff had adequate knowledge of her needs. The DON stated her expectation was for staff to carry out the grooming needs of the resident. 2. The Quarterly MDS dated [DATE] documented Resident #26 depended on staff to complete personal hygiene needs. An observation of Resident #26 on 3/3/25 at 4 pm and on 3/4/25 at 12 pm revealed dried up crust around both eye lids, covering eye lashes. A review of Resident #26 clinical record titled Task: GG-Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene) documented on 3/3/2025 staff completed personal hygiene at 9:19 am. On 3/4/25 staff documented at 9:37 am the task Not Applicable with no additional explanation. An observation on 3/06/25 at 9:32 am of Resident #26 revealed no concerns with grooming and hygiene, no crust noted around eye lids and lashes. In an interview on 3/10/25 at 10:09 am with the Director of Nursing she stated her expectation was for staff to provide hygiene and grooming to residents who needed staff assistance.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47673 Based on Electronic Health Record (EHR), policy review, observation, and staff interviews the facility failed to protect residents from hazards, accidents and injuries by not securing 2 shower rooms with the presence of chemicals, sharp razors, and biohazard containers, inappropriate ambulation assistance and failed to secure the wheelchair while dining for 4 of 17 residents (Resident #16, #32, #39, and #43). The facility reported a census of 50 residents. Finding include: 1. The Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #43 documented a Brief Interview for Mental Status (BIMS) of 05 which indicated severe cognitive impairment. On 3/4/25 at 1:00 PM an observation revealed a wander guard present on Resident #43's walker. Review of Resident #43's EHR titled, Medication Administration Record and Treatment Administration Records (MAR-TAR) documented an order to check the placement and function of a wander guard (device that triggers an alarm at exits to alert staff that a resident is near an exit) each shift. Review of Resident #43's EHR titled Care Plan documented a risk for wandering/elopement identified. Review of EHR titled Progress notes dated 2/17/25 entered by Staff U, Licensed Practical Nurse (LPN) documented Resident #43 was ambulating by herself in the room and in the hallway with walker with an unsteady gait at times. Staff assisted as the resident would allow. Resident #43 yelled at staff I can do it and the resident wandered towards the exit doors. Staff redirected Resident #43 away from the exit doors. Resident #43 had become visibly upset with redirection. Resident currently in room talking to self and stuffed animals. Review of EHR documented Resident #43 resided in room [ROOM NUMBER]. Review of document titled Floor Plan revealed room [ROOM NUMBER] was across the hall from the shower room on hall 100. (continued on next page)

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Azria Health Winterset	1015 West Summit Winterset, IA 50273

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/04/25 10:51 AM Staff O, Certified Nursing Assistant (CNA) stated she does only the baths at the front of the facility. Staff O stated she bathed residents in rooms on the 100 and 300 hall. Staff O, CNA stated if she was going to be away from the shower room for a while she was supposed to shut the door. Staff O, CNA stated if she went on break then she would shut the door. Staff O, CNA stated if she would be getting a resident up she would shut it. Staff O, CNA stated she did not always shut the door when she was going to the supply room. Staff O, CNA stated she does not know the rule on when to shut the door. Staff O, CNA stated she probably should shut it all the time. Staff O, CNA stated Resident #43 wanders and occasionally would come to her in or near the shower room and ask for her hair rollers. Staff O, CNA stated sometimes Resident #43' hair rollers are kept in the shower room. Staff O, CNA acknowledged the concentrated bleach was kept in the cabinet and acknowledged there was not a lock on the cabinet. Staff O, CNA acknowledged the shampoo, disinfectant wipes, razors, biohazard container, hair, and body products are not locked up in the cabinet. Staff O, CNA stated sometimes when she pulled the shower room door shut it would not latch. Staff O, CNA stated she had not brought that to the administrators attention because it just recently started doing that. On 3/4/25 at 11:02 AM Staff E, LPN stated she frequently found the shower room door open and would pull the door shut. Staff E, LPN stated one day Resident #43 was looking for her hair rollers in the shower room by herself without staff present. Staff E stated she was going through the cabinet and was where she found her hair rollers. Staff E, LPN stated the Director of Nursning (DON) came and talked to Resident #43 about not going into the shower room by herself. On 3/4/25 at 11:09 AM Staff P, CNA stated usually there should be a lock on the cabinet where all the supplies and chemicals are kept. Staff P, CNA acknowledged the shower room door was open currently, no staff was present, and it was not supposed to be. Staff P, CNA stated the cabinet used to have a lock. Staff P, CNA stated it had been a while since the cabinet had had a lock on it. Staff P, CNA stated there are residents that wander. Staff P, CNA stated Resident #43 would go in the shower room and look around in the shower room. Staff P, CNA stated she had found Resident #43 in the bathroom unattended. Staff P, CNA stated she had caught Resident #43 a time or 2 when she wasn't in showers. Staff P, CNA stated she occasionally forgot to shut the shower room door. Observation on 3/4/25 at 11:10 AM on 100 hall of bathroom door open. The DON entered the shower room on 3/4/25 at 11:13 AM. On 3/4/25 at 11:16 AM no staff returned to the bathroom Staff P, CNA shut the door once we exited the room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/4/25 11:39 AM the DON stated the shower room door should be shut all the time. The DON stated the shower room door should be shut if there was no staff or residents in the shower room. The DON stated the shower room door is locked so the chemicals are not required to be locked up in the room because the door is locked. The DON stated she had never witnessed and staff have not brought to her attention that residents were in the shower room unattended. The DON stated on the 100 and 300 hall there are residents that wander. The DON stated she did not think there was a person on the 100 and 300 hallways that truly wandered. The DON stated the residents all have a purpose. The DON stated Resident #43 does not wander. The DON stated she did not remember if Resident #43 was in the shower room by herself and did not remember if the shower aide was in there with Resident #43. The DON stated Resident #43's hair rollers were put in the bathroom to prompt her to ask for assistance with them. The DON stated she did have a conversation with the staff. The DON stated the conversation was about Resident #43 entering the shower room. Stated had a conversation with Staff O about Resident #43 entering the shower room. The DON stated she told Staff O Don't leave the door open. The DON stated it was just an in the moment verbal conversation. The DON stated she was not sure but she may have followed Resident #43 into the shower room. The DON stated Resident #34 complains about the hair rollers being in the bathroom. Stated Resident #43 used a hair dryer with rollers and that is not safe. The DON stated it had not been brought to her attention that the shower room door does not latch appropriately. The DON stated the chemicals are a danger and water on the floor could cause a resident to fall. The DON stated she did not think Resident #43 would ingest something but you just never know. On 3/4/25 at 11:52 AM the Administrator stated she had not been informed that the shower room door did not latch appropriately. Review of policy titled Hazardous Areas, Devices, and Equipment revised 7/17 documented all hazardous areas, devices and equipment in the facility would be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible. A hazard was defined as anything in the environment that had the potential to cause injury or illness such as open areas or items that should be locked when not in use. Any element of the resident environment that had the potential to cause injury and that is accessible to a vulnerable resident was considered hazardous. The safety committee would recommend measures to ensure that vulnerable residents cannot access hazardous areas in the facility (locks, alarms, supervision, etc.). The safety committee will periodically check for the implementation and integrity of measures intended to prevent residents from accessing hazardous areas. 47582 2. a. Observation on 3/4/25 at 9:24 am revealed a door to the shower room on hallway 400 was wide open and no staff present in the room. The shower room contained a bottle labeled concentrated Clorox and several shaving razors and 2 sharp containers. Other items noted in the room were gallon-size lotion containers. 2 cupboards storing various mentioned items were unlocked. One of the cupboards contained a key inside of it. b. During an interview on 3/04/25 at 9:55 am Staff S, CNA revealed Resident #16 resided on hallway 400 and had a history of wandering. She further stated if the door to the shower room was left open she could see Resident #16 going in there unsupervised due to a history of wandering behavior. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Quarterly MDS dated [DATE] for Resident #16 documented a BIMS of 06 which indicated severe cognitive impairment and a diagnosis of Alzheimer's disease. The MDS indicated Resident #16 used a wandering/elopement alarm device. A review of the Care Plan for Resident #16 documented a focus area for elopement risk and wandering related to impaired safety awareness, and memory deficit. Interventions directed staff to distract the resident from wandering, to provide a safe environment and to apply a wander guard. c. The Quarterly MDS dated [DATE] for Resident #32 documented a BIMS of 03 which indicated severe cognitive impairment and a diagnosis of Alzheimer's disease. The MDS indicated Resident #32 used a wandering/elopement alarm device. A review of the Care Plan for Resident #32 documented a focus area for risk of elopement and wandering. Interventions directed staff to apply a wander guard. The Care Plan indicated Resident #32 resided on 400 hallway where the shower door was observed to be left open with no staff supervision for periods of time. d. During a continuous observation on 3/04/25 at 10:29 am through 11:02 am, a staff member observed utilizing the shower room to provide baths to 2 residents. Between each resident, the staff member left the shower room for several minutes at a time leaving the door wide open and unsupervised. During this observation, at 10:46 am facilities maintenance staff went inside the shower room to clean the fire sprinkler with an air compressor and after exiting, the door remained open. At 11:02 am the staff member who gave baths exited the room and pulled the door closed. 49990 3. The Significant Change MDS for Resident #39, dated 12/30/2025, documented the BIMS score as 07, which indicated severe cognitive impairment. It documented the following relevant diagnoses: Non-Alzheimer's dementia, Huntington's Disease, and anxiety disorder. It documented the resident demonstrates difficulty making himself understood and his needs known. It also documented the resident was dependent upon staff for eating, personal hygiene and cares, dressing, and that he requires substantial support to walk. It did not document his use of a wheelchair. The Mayo clinic defined Huntington's disease as a progressive inherited neurological condition which causes those with the disease to lose control over their bodies as nerve cells in their brains die. This results in chorea - involuntary, rapid, jerky movements that may impact the hands, face, and limbs. These conditions worsen over time. In a direct observation on 03/04/2025 at 12:55 PM, Resident #39 was seen being pushed by Staff P, CNA in a wheelchair while wearing gripper socks. It was noted at this time the wheelchair lacked foot pedals, and Resident #39's feet were dragging on the ground and frequently jerking in the path of the chair wheels. Resident #39 was placed at the table, and the locks on his wheelchair were not engaged. The resident experienced near constant episodes of chorea impacting his legs, causing him to rock back and forth in the wheelchair and moving him away from the table while Staff P, CNA assisted him in feeding. At 12:59 PM Staff P finally moved Resident #39 closer to the table and engaged the wheelchair brakes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A direct observation on 03/04/2025 at 01:17 PM revealed Staff P, CNA again pushing Resident #39 in a wheelchair without foot pedals. Again, Resident #39's feet were dragging and experiencing spastic movements that placed his feet and legs in the path of the wheelchair wheels. In an interview on 03/10/2025 at 03:46 PM with Staff I, CNA, she stated they are instructed to never push a resident in a wheelchair without foot pedals. She was aware of Resident #39 and acknowledged she had seen Resident #39 being pushed without pedals before, and acknowledged he often used his wheelchair to get around the facility without pedals. In an interview on 03/10/2025 at 03:50 PM with Staff J, CNA, she agreed they are instructed to not push residents in wheelchairs without foot pedals. She was unsure of the reason why, but believed it had to do with potential injuries. In an interview on 03/10/2025 at 03:23 PM with Staff H, LPN she stated you should never push a resident in a wheelchair without securing their feet in foot pedals. This is to avoid injury to the resident. In an interview on 03/06/2025 at 11:14 AM with the DON, she stated the expectation was for staff to use foot pedals when assisting a resident in a wheelchair to avoid injury.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 47673 Based on Electronic Health Records (EHR), staff interview, and observation the facility failed to implement policies and procedures regarding the technical aspect of feeding tubes by pushing enteral formula with a piston syringe into feeding tube for 1 of 1 residents (Resident #5). The facility reported a census of 50 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #5, dated 1/15/2024 documented a Brief Interview for Mental Status was not completed. MDS indicated Resident #5 was rarely/never understood. The MDS documented utilization of an enteral feeding tube. The Residents Care Plan directed staff to check placement of the feeding tube prior to intermittent feedings, and to see if there are signs of intolerance, with the initiated date of 7/13/17. Review of Resident #5's Medication Administration Record (MAR) documented enteral feeding five times a day with Jevity 1.5. Give 237 mL with 30 mL water flush before and after. Observation In Resident #5's room on 3/5/25 at 1:07 PM revealed Staff N, Licensed Practical Nurse with gowns and gloves. Staff N had Jevity 1.5. enteral formula present on the bedside table. Staff N attached the enteral tube extension attached to the enteral tube. Staff N utilized 30 mL water for flush. Staff N empted full carton of formula into the graduated cylinder. Staff N poured 50 cc formula into the syringe, then 60 cc formula poured into the syringe. Staff N stated she pushes the piston of the syringe to get the formula flowing better. Staff N utilized a piston to push the formula. Staff N stated she did not know if it was acceptable to push formula. Staff N poured 30 mL of formula into the syringe and 30 cc water flush completed after enteral supplement. Staff N completed a residual check after the formula was administered. On 3/5/25 at 1:24 PM the DON stated the residual should have been checked before and not after. The DON stated Resident #5 did not have purposeful speech. The DON stated the residual check was required to ensure Resident #5 had digested all the previous formula and to prevent dumping. The DON stated she does not agree with pushing the formula and to utilize gravity flow for bolus feedings. The DON acknowledged Resident #5 had bolus feedings. Review of policy with revised date 11/18 titled Azria Enteral Tube Feeding via Syringe documented the nurse should verify placement, fill the syringe with prescribed amount of enteral feeding to be given. Unclamp the tube and allow feeding to flow by gravity.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 35434 Based on clinical record review, policy review, and staff interview, the facility failed to ensure staff documented non-pharmacological interventions attempted prior to the administration of an as needed (prn) medication for 1 of 1 residents reviewed for prn anti-anxiety medications(Resident #6). The facility reported a census of 50 residents. Findings include: The Quarterly Minimum Data Set (MDS) assessment tool, dated 2/5/25, listed diagnoses which included non-Alzheimer's dementia, anxiety disorder, and depression. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 1 out of 15, which indicated severely impaired cognition. The facility policy Administering Medications, revised April 2019, stated medications were administered in accordance with prescriber orders. The January 2025 Medication Administration Record (MAR) listed an 8/5/24 order for Ativan(an anti-anxiety medication) 0.5 milligrams (mg) by mouth every 24 hours as needed for anxiety. The MAR documented the resident received the medication on dates which included 1/1/25, 1/10/25, 1/12/25, 1/15/25, 1/20/25, and 1/29/25. The MAR lacked documentation of non-pharmacological interventions attempted prior to the above administrations. The February and March 2025 MARs listed a 2/4/25 order for Ativan 0.5 mg by mouth every 24 hours as needed for anxiety. The MARs documented the resident received the medication on dates which included 2/21/25, 2/26/25, and 3/3/25. The MARs lacked documentation of non-pharmacological interventions attempted prior to the above administrations. The resident's Progress Notes lacked documentation of non-pharmacological interventions attempted prior to the above administrations. A 5/28/17 Care Plan entry directed staff to attempt non-pharmacological approaches to assist in the redirection of behaviors. An 11/22/24 Care Plan entry stated the resident utilized anti-anxiety medications. On 3/6/25 at 3:30 p.m., via phone, the Director of Nursing(DON) stated prior to the administration of prn anti-anxiety medications, staff should document non-pharmacological interventions. On 3/6/25 at 3:37 p.m., via email, the Administrator stated the facility did not have a policy specific to the administration of prn medications.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on observations, staff interviews, policy, Electronic Health Records (EHR) and Medication Administration Records - Treatment Administration Records (MAR-TAR) the facility failed to ensure the residents were free of significant medication errors to 1 of 6 residents reviewed (Resident #8). The facility reported a census of 50 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #8 documented a Brief Interview for Mental Status (BIMS) of 15 which indicated no cognitive impairment. MDS also documented a diagnosis of type 2 diabetes. Review of EHR for Resident #8 titled MAR-TAR documented physicians order for Humalog Lispro insulin to be administered per sliding scale if 100-120 give 4 units. (Humalog Lispro insulin onset time is 0-15 minutes, with a peak time of 30 to 90 minutes) An observation 3/6/25 at 8:21 AM revealed Staff E obtained medications for Resident #8, knocked on the door entered the room, entered the room, applied gloves, obtained alcohol wipe cleansed middle finger, obtained glucose strip, blood glucose machine placed on bedside table blood sample obtained from left hand index finger, blood glucose machine placed on bedside table, utilized lancet, blood glucose 108, obtained insulin from medication cart, alcohol wipe utilized to cleans rubber septum of insulin pen, 4 units drawn up without 2 units wasted for insulin pen priming, cap of pen removed, alcohol used to cleanse insulin administered to right thigh, insulin taken back out to medication cart, and placed back in medication cart. On 3/6/25 at 11:12 AM the DON stated the insulin pen should have been primed with 2 units prior to dialing the dose to be administered. Review of policy revised 9/14 titled Azria Insulin Administration documented nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery systems prior to their use. According to the Lily Kwick Pen user manual dated 11/01/2016 with revision date of July 2020 if you do not [NAME] before each injection, you may get too much or too little insulin. Request for policy for insulin delivery policy provided by the facility included only procedure for insulin injections via syringe.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on observations, staff interviews, documents, Electronic Health Records (EHR), Medication Administration Records - Treatment Administration Records (MAR-TAR) and policy review the facility failed to ensure medications at the facility were labeled in accordance with currently accepted professional principles when the label for a medication did not match the order and the medication was administered to 1 of 6 residents reviewed (Resident #33). The facility reported a census of 50 residents. Findings include: 1. The Annual Minimum Data Set (MDS) dated [DATE] for Resident #33 documented a Brief Interview for Mental Status (BIMS) of 12 which indicated moderate cognitive impairment. MDS also documented a diagnosis of pain that was unspecified. Review of Resident #33 MAR-TAR dated 3/1/25 to 3/31/25 documented a physician order with order date of 2/20/25 at 11:37 PM for Oxycodone 5 mg 1 tablet to be administered every 4 hours for pain. Review of Resident #33's medication bubble pack label documented Oxycodone 5 mg tablet to be administered 1 tablet every 4 hours as needed for post operative and chronic back pain. Observation on 3/6/25 at 7:43 AM revealed Staff E, Licensed Practical Nurse (LPN) remove Resident #33's Oxycodone 5 mg tablet from bubble pack. Staff E then administered the medication to Resident #33. On 3/6/25 at 7:42 AM Staff E, LPN stated the Oxycodone is scheduled every 4 hours on the MAR - TAR. Staff E stated the Director of Nursing (DON) would know more about why the label and the MAR - TAR did not match. Staff E stated there was discussion with a couple doctors about that order and the DON could speak more to that. Staff E stated she would call the pharmacy about that once she was done with medication pass that morning. Review of document titled Refill E-Script Approval dated 2/28/25 documented an order for Oxycodone 5 mg give 1 tablet every 4 hours as needed for post operative and chronic back pain. With attention Staff E wrote on the document. Review of Resident #33's EHR dated 2/20/25 titled Progress Notes entered by Staff G, Registered Nurse (RN) documented that clarification was received via fax from physician to discontinue as needed Oxycodone. Review of Resident #33's EHR dated 2/21/25 titled Progress Notes entered by Staff F, RN documented fax received with clarification. Okay for Oxycodone 5 mg every 4 hours routinely. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of document titled Provider Letter dated 2/21/25 documented the physician received a handwritten note Resident #33's Tylenol order said with Tramadol. Resident #33 was not on Tramadol. Tramadol had since been discontinued and Oxycodone was used in its place. Prescription had been created that stated Resident #33 was to have Oxycodone scheduled as well as needed. Clarification made that only the scheduled dose will be ordered as Resident #33 did use it routinely. The as needed order may be discontinued. On 3/6/25 at 10:14 AM the DON acknowledged Resident #33's bubble pack label for Oxycodone 5 mg did not match the order. The DON stated she would expect for the medication labels to match the order. The DON stated the nurse should have compared the label to the MAR. The DON stated the nurse should have contacted the physician to clarify the order. The DON stated the medication should have been clarified by now. The DON stated she expected the label of the current medication would be changed to reflect the current order. On 3/6/25 at 10:56 AM the DON stated Resident #33 returned from the hospital in the middle of February. The DON stated that the discharge order had both PRN and routine orders for Oxycodone. The DON stated the order had been clarified and the PRN was discontinued at that time. The DON stated the pharmacy reached out to the physician for a refill and sent the wrong order and the nurse did not clarify after medication was received. The DON stated when a medication is received at the facility and there was a discrepancy found the nurse should have called the pharmacy first and clarify the order with the physician. The DON acknowledged the medication discrepancy should have been caught by the nurse that received the medications from the pharmacy and the discrepancy was not noticed. The DON acknowledged the discrepancy should have been noticed during medication administrations. Review of policy revised 4/19 titled Administering Medications directed staff as follows; the individual administering the medication should check the label to verify the right resident, right medication, right dosage, right time and right route of administration before giving the medications.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on observation, staff interview, and policy review the facility failed to store food in accordance with professional standards by not labeling and dating open food items, by not completing chemical sanitization checks appropriately for a low temperature dish machine, completion of hand hygiene by staff, completion of hand hygiene with the residents, and by not sanitizing surfaces in the kitchen with the appropriate chemical concentration. The facility reported a census of 50 residents. Findings include: 1. A continuous observation in the kitchen on 3/3/25 from 9:40 AM - 10:15 AM revealed in the 2 door stand up refrigerator a box of orange juice, apple juice, and cranberry cocktail all open and undated. In the Walk in freezer a box of chicken cordon bleu open to the air with bag open and box with 2 hamburgers open to the air with bag open. On 3/3/25 at 9:50 AM Staff A, Certified Dietary Manager (CDM) stated the dish machine service provider tested the chemicals for the low temperature dish machine once a month. Staff A stated test strip results are not recorded. Staff A acknowledged the facility had a low temperature dish machine. Staff A stated the facility did not test the chlorine dish machine. Staff A asked Staff B, [NAME] if the tear strips labeled QT40 were the strips to utilize for dish machine check. Staff A completed 4 strip tests in a row. Staff acknowledged no change in the test strips that were utilized for all 4 tests. Staff A acknowledged the test strip should not be 0 and there should have been a change in color. Staff A completed a test of the 2 sanitization buckets with the same strips labeled QT40. Staff A acknowledged both sanitization buckets revealed 0 and no change in color of the strip. Staff B acknowledged she had just made the sanitizing buckets and she was going to clean the serving table off first and then check the chemical in the bucket. Staff A stated the other sanitizing bucket was recently filled as well. Staff A checked that bucket also read 0 with no color change. Staff A acknowledged the test strip should not be 0 and there should have been a color change. Staff A left the kitchen at 10:00 AM and returned at 10:10 AM. Staff A returned and stated the staff had tested with the wrong test strips for the dish machine. Staff A repeated the test to the sanitizing bucket and again revealed 0 no color change in the strip. Staff A stated there was a kink in the line that filled the sanitizing buckets and that was the reason for a result of 0. Staff B revealed meal tables had been cleaned for after breakfast. Staff A stated corporate expected dish machine temperatures to be sent but not chemical test strips. Staff A repeated the test to the low temperature dish machine with correct test strips for chlorine with a result of 200 Parts Per Million (PPM). Staff A acknowledged the box of chicken cordon bleu and box of hamburgers should have had the bags closed with the box closed. Staff A acknowledged the orange, apple, and cranberry cocktail juice boxes should have open dates. Staff A stated then the dish machine was supposed to be checked daily. On 3/3/25 at 10:00 PM Staff B, [NAME] acknowledged the facility did not keep track of the low temperature dish machines chemical strip test results. Staff B stated she utilized the tear strips for dish machine checks and sanitizing bucket checks. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/10/25 at 12:07 PM Staff D, Technician for dish machine manufacturer acknowledged that the facility was one that he serviced. Staff D acknowledged the facility had a low temperature dish machine. Staff D stated he recommended daily chemical tests, follow the facility's policy, or to follow the regulations for that state. Staff D stated he did not know how often it should be checked. Staff D stated the test strips for the low temperature dish machine should read between 50 and 110 PPM. Staff D stated he would recommend that the sanitation tubs were checked as well per the regulations or the facility's protocol. Staff D stated he brought strips down to the facility on [DATE] or 3/7/25. Staff D stated the tear strips are labeled QT40 for the sanitizing bucket. Staff D stated the other strip was for testing the low temperature dish machine and that test strip tested for chlorine. Staff D stated the stick strip was supposed to be used in the low temperature dish washer and the strip test that tears off labeled QT40 was for the sanitizing buckets. Review of policy revised 11/22 titled Azria Sanitization documented Low-Temperature Dishwasher (Chemical Sanitization): Wash temperature (minimum 120 F); final rinse with minimum 50 parts per million (ppm) hypochlorite (chlorine) on dish surface in final rinse; and the chemical solution is maintained at the correct concentration, based on periodic testing, at least once per shift, and for the effective contact time according to manufacturer's guidelines. Service area wiping cloths are cleaned and dried or placed in a chemical sanitizing solution of appropriate concentration. Review of policy revised 10/17 titled Azria Food Receiving and Storage documented all foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date). 49990 2. During a direct observation on 03/04/2025 at 10:57 AM, Staff B, Cook, was observed cutting vegetables at a preparation table. During the preparation, Staff B left the vegetables and began pulling several pans out from another the station behind her. She touched several surfaces before returning to chop the vegetables without performing hand hygiene. A direct observation on 03/04/2025 at 11:13 AM revealed Staff B stirring a large container of chicken pot pie filling with a slotted spoon, placing the slotted spoon on a visibly soiled surface without a barrier, and then picking up and using the same spoon to stir another container of the food item. During this observation, Staff B switched tasks twice, leaving the containers unattended and touching numerous other surfaces outside of the preparation area. She returned to food preparation without performing hand hygiene. Staff B then used a flexible rubber spatula to scoop the food item into a container to puree, placed the spatula on the same soiled surface without a barrier. She used the soiled spatula to puree the main entree before switching to a new spatula, which she also placed on a soiled surface and used multiple times. A direct observation of the dining room service on 03/04/2025 at 12:48 PM revealed Staff V, Certified Medication Aide (CMA), enter the kitchen and without performing hand hygiene begin to assist two residents with eating. Staff V went back and forth between both residents, on two occasions touching her face, and did not perform hand hygiene. At 1:09 PM, after both residents had finished eating, Staff V sanitized her hands after assisting a resident with washing his face. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/10/2025 at 03:46 PM with Staff I, CNA, she stated you should wash your hands or use hand sanitizer before she assisted a resident with eating. She stated you should only assist one resident at a time, and if you touched anything outside of the eating utensils you should wash your hands before resuming them with eating assistance. In an interview on 03/10/2025 at 03:50 PM with Staff J, CNA, stated she is expected to clean her hands before entering the dining room, and then before assisting residents with their meal. If you help another client or touch anything other than the utensil you use to serve them food you must also wash or sanitize hands. In an interview on 03/10/2025 at 03:23 PM with Staff H, Licensed Practical Nurse (LPN), She stated the process for assisting residents with eating is to first sanitize your hands, then verify the diet. If you are assisting two residents you should sanitize or wash your hands in between each resident. In an interview on 03/06/2025 at 10:10 AM with the Certified Dietary Manager (CDM), she acknowledged more hand sanitation and a barrier was required during the kitchen preparations. She also stated anyone who assists a resident with eating is required to sanitize their hands before they begin, if they touch anything outside of the dining table, and if they switch to another resident. In an interview on 03/06/2025 at 11:14 PM with the Director of Nursing (DON) stated her expectation is for staff to sanitize or wash their hands before assisting a resident and again after they touch anything outside of the dining table.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on observation, Electronic Health Records (EHR), Medication Administration Records-Treatment Administration Record (MAR-TAR), document review, policy review, and staff interview the facility failed to provide adequate sanitization to shower chair between residents, failed to provide influenza testing and communicate with public health during outbreak and failed to provide appropriate infection prevention practices during administration of medications to 2 of 7 residents reviewed (Resident #8, and #33), and contact with Resident#31 whom had a dressing. The facility reported a census of 50 residents. Findings include: 1. The Annual Minimum Data Set (MDS) dated [DATE] for Resident #31 documented a Brief Interview for Mental Status (BIMS) of 13 which indicated no cognitive impairment. Review of Resident #31's MAR - TAR a physician order to monitor scabbed areas to the left shin daily for wound care. Observation on 3/3/25 at 12:27 PM revealed Staff Q, Certified Nursing Assistant (CNA)/ Social Services entered Resident #31's room. Staff Q did not complete hand hygiene then touched the wound on Resident #31's left shin, then pulled a blanket down over the residents left shin. Staff Q then exited the residents room without performing hand hygiene. Observation on 3/5/25 at 7:50 AM revealed Staff N, Licensed Practical Nurse (LPN) prepared medication, no hand hygiene was completed, knocked on door, medications taken into residents room, medications given with sips of water and Miralax, trash taken to garbage can at medication cart. Staff N then pushed the medication cart down the hall to the next resident's room. Staff N stopped in front of room [ROOM NUMBER], medication cup obtained, keys removed from pocket, and started preparing medications. No hand hygiene completed by Staff N for this entire observation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A continuous observation on 3/6/25 from 7:32 AM to 8:45 AM revealed Staff E, LPN did not complete hand hygiene, gathered medications prior to entering a Resident#33's room, knocked on the residents door, entered the room, obtained gloves, applied Lidocaine patch to right hip, and applied Lidocaine patch to left hip. At 3/6/25 at 7:50 AM a CNA knocked on the door and asked for money for another resident. Staff E left room [ROOM NUMBER] A at 7:50 AM. Staff E walked to the medication cart and removed gloves. Staff E completed the task for the staff requesting money. Staff E returned to the room on 3/6/25 at 7:52 AM, knocked on the door and entered, no hand hygiene completed and applied gloves. Staff E administered an eye drop to the left eye, tissue utilized for the left eye, then administered an eye drop to the right eye and tissue utilized for the right eye. Staff E removed gloves, nurse obtained nebulizer, Ipratropium poured into nebulizer, nebulizer applied, nebulizer machine turned on, obtained blood pressure, gathered trash, returned to the medication cart, documented vitals on the computer, obtained keys to medication cart, unlocked the cart, returned blood pressure cuff to medication cart, locked cart pushed cart down to room [ROOM NUMBER] (Resident#8). Staff E obtained medications from the medication cart drawer, started removing medications from bubble packs and gathered medications for the resident in room [ROOM NUMBER] prior to entering the residents room. On 3/6/25 at 8:21 AM Staff E knocked on room the resident in room [ROOM NUMBER]'s door, entered the room, applied gloves, obtained alcohol wipe cleansed middle finger, obtained glucose strip, utilized lancet, obtained blood sample and blood glucose machine had a failure in functioning. On 3/6/25 at 8:24 AM Staff E left room [ROOM NUMBER], returned to the medication cart for another glucose machine, obtained a different glucose machine and obtained another lancet. Tasks were all completed by Staff E with gloves on. On 3/6/25 at 8:26 AM Staff E entered room [ROOM NUMBER], blood glucose machine placed on bedside table, blood sample obtained from left hand index finger, blood glucose machine placed on bedside table, blood glucose 108, scratched her face with the gloves on and obtained blood pressure. Staff E left room [ROOM NUMBER], returned to the cart to obtain another medication, unlocked the computer, unlocked the medication cart drawers, removed gloves, completed no hand hygiene, browsed the computer for orders, obtained insulin from medication cart, utilized an alcohol wipe to cleanse the rubber septum of insulin pen, 4 units drawn up, applied gloves, micro kill cleansing wipe obtained from medication cart drawer, glucose machine wiped down then wrapped and medication bubble pack card fell on the floor. Staff E picked up the medication bubble pack card off the floor with gloves on. Staff E returned the micro kill cleansing wipe to medication cart, removed gloves, obtained alcohol wipe, applied gloves, completed no hand hygiene, insulin taken into room, cap of needle removed, alcohol used to cleanse area on right thigh, insulin administered to right thigh, insulin taken back out to medication cart, Staff E returned to the computer, removed her glasses from face, removed the needle from insulin pen unlocked medication cart, insulin returned to the medication cart and removed gloves. Staff E pushed the medication cart down to the dining room and prepared medications for the next resident without performing hand hygiene. On 3/6/25 at 11:48 AM Staff T, LPN/Assistant Director of Nursing (ADON) / Infection Preventionist (IP) stated she would expect hand hygiene to be completed during medication administration, between residents, after removal of medications and with any glove changes. Staff T stated gloves are required with resident contact. Staff T stated hand hygiene should be completed prior to and after all resident contact. Staff T stated she would not expect a wound to be touched if not needed. Staff T stated if a wound was required to be touched gloves should always be worn. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/6/25 at 11:12 AM the DON stated hand hygiene should have been completed between residents. The DON stated the facility ' s expectation was hand hygiene would have been completed prior to and after resident contact. The DON stated depending on the surfaces the staff came in contact with without hand hygiene and the appropriate use of gloves the spread of bacteria or illness could happen. The DON stated she would like to have seen hand hygiene after every glove change. The DON stated the blood glucose machine should have been on a barrier. Review of policy revised 8/19 titled Azria Handwashing/Hand Hygiene documented the facility considers hand hygiene the primary means to prevent the spread of infections. Hand hygiene should be completed before and after direct contact with residents, before preparing or handling medications, before moving from a contaminated body site to a clean, after contact with a resident's intact skin, after contact with blood or bodily fluids, and after removing gloves. 47582 2. During an observation of the shower room on hallway 400 on 3/04/25 at 9:28 am revealed a brown-colored stain on the shower chair. At 9:41 am Staff S, Certified Nursing Assistant (CNA) observed taking a resident into the shower to provide bathing assistance. During an interview on 3/04/25 at 9:55 am Staff S, CNA revealed she gave a shower to the resident noted during 9:28 am observation mentioned above. When questioned if the shower seat was washed and sanitized prior to use for showering the resident, Staff S, CNA stated she did not. Upon inquiry on how she would typically sanitize the shower area during use, she demonstrated using a bottle of concentrated Clorox and wiped the shower chair using a washcloth with bare hands. She further stated she did not have to do anything else besides spraying the Clorox and wiping with the same rag and felt comfortable using the Clorox without wearing gloves as she was comfortable using the chemical because she used it at home as well. She confirmed Clorox was the only cleaner the facility provided to disinfect the shower area between and after residents' use. In an interview with the Housekeeping Manager on 3/04/25 at 12:04 pm, who held the role as a contracted company for the past 3 years, revealed the facility has used Clorox as a choice of disinfectant for shower rooms and shower equipment. She stated that the bottles labeled concentrated Clorox were actually diluted by her and all staff were able to dilute it as needed. She revealed the dilution process was completed by eye-balling the level of Clorox concentrate with water, and water making up the majority of the final product, then tested using a test strip but no documentation was completed measuring the strength of each bottle or dates. She also stated her department uses an actual disinfectant intended for healthcare use during once-a-day shower rooms deep cleaning. She could not provide an answer for the reason facility staff/CNAs were using Clorox and not the healthcare grade disinfectant. She stated that's how things have always been and didn't know who would direct which cleaning agent to use for CNAs but it was not her call. She agreed that the Clorox was not the proper chemical to use for this type of healthcare facility. She also stated she has not discussed this concern with the facility's Administrator or Director of Nursing about Clorox as being an ineffective cleaner. 49990 3. During a review of facility respiratory illness tracking and treatment from November 2024 through February 2025, questions arose as to the testing criteria for COVID-19 and Influenza. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In November, 3 respiratory infections were documented. Testing was performed for COVID-19 but not for Influenza. In December, 2 respiratory infections were documented. Testing was performed for COVID-19 but not for Influenza. In January, 5 respiratory infections were documented. Testing was performed for COVID-19 but not for Influenza. In February, there were again 3 respiratory infections documented. COVID-19 testing was performed for all residents, and Influenza testing was performed on two residents after one resident tested positive for Influenza. In an interview on 03/04/2025 at 10:22 AM with the Infection Preventionist (IP), it was questioned what diagnoses the residents had been given, and she was asked why COVID testing had been performed but influenza testing had not. She stated the residents had been diagnosed with pneumonia, but only the Resident in February had tested positive for Influenza. She stated the facility does have influenza tests in the facility but they have a batch order for COVID testing and do not have a batch order for influenza testing. She stated they only test for influenza when they have had a resident or staff member test positive. That would prompt influenza testing for residents with respiratory symptoms. She stated she was unaware the surrounding areas were experiencing a large Influenza outbreak during the months reviewed. She stated she had last been in contact with [NAME] County Public Health sometime in October. Review of the Iowa Department of Health and Human Services Virus Surveillance Report, week 9, shows a large spike in influenza throughout the state from December through February. Review of the Centers for Disease Control and Prevention (CDC), regulations and recommendations for Long Term Care (LTC) state that residents residing in nursing facilities should be tested for both SARS-CoV-2 and Influenza when they show symptoms of respiratory illness.