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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Winterset	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, and policy review the facility failed to sanitize a mechanical lift during use between 4 residents. In addition, the facility failed to transport linen in a manner to prevent contamination. The facility reported a census of 50 residents. Findings include:1. During a continuous observation that began on 3/16/26 at 1:45 PM, Staff A, Certified Medication Aide (CMA), exited a semi-private resident room after using a mechanical lift to transfer one resident and stored it against the wall in the hallway. They didn't sanitize the mechanical lift after the resident's transfer.Staff B, Certified Nurse Aide (CNA), took the mechanical lift into another semi-private resident room with Staff A and transferred one resident into a chair. Staff A brought the mechanical lift out of the residents' room and placed it in the hallway. They failed to sanitize the mechanical lift sanitized before or after the resident's transfer.At 1:50 PM, Staff A and Staff C (CNA) took the mechanical lift into another semi-private resident room and transferred a resident. The staff failed to sanitize the mechanical lift before or after the resident's transfer.At 1:52 PM, Staff C exited the residents' room with the mechanical lift. Staff C and Staff D, CMA, took it into another semi-private resident room. They failed to sanitize the mechanical lift before or after the resident's transfer.On 3/18/26 at 10:42 AM, Staff B stated she forgot to sanitize the mechanical lift between resident transfers on 3/16/262. On 3/16/26 at 2:44 PM, watched Staff E, CNA, transported linen (draw pads, gowns, blankets) on an uncovered cart down a resident hallway. A policy titled Laundry and Bedding, Soiled revised [DATE] indicated clean linen is protected from dust and soiling during transport and storage to ensure cleanliness.On 3/19/26 at 7:38 AM, the Director of Nursing (DON) stated staff should've cleaned the equipment between residents and they should've covered the linen during transport.

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 - Few	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** Based on clinical record review, observation, staff interview, and policy review the facility failed to provide a homelike environment by not placing sheets on residents' beds for 2 of 5 residents (Resident #22 and #28) reviewed. The facility reported a census of 50 residents. Findings include:1. Resident #22's Minimum Data Set (MDS) assessment dated [DATE] revealed an admission date of 2/11/22 from a short-term general hospital stay. The MDS further indicated Resident #22 had diagnoses of stroke, non-Alzheimer's dementia, and hemiplegia (severe or complete paralysis on one side of the body).On 3/16/25 at 2:15 PM observed Resident #22 lying in bed without a sheet on the mattress. Resident #22 reported the facility did have a sheet, but just not on their bed.2. Review of Resident #28's MDS dated [DATE] revealed an admission date of 2/2/24 from a short-term general hospital stay. The MDS further indicated Resident #28 had diagnoses of pulmonary embolus (a sudden blockage in a lung artery), heart failure, non-Alzheimer's dementia, and a need for assistance with personal care.On 3/16/26 at 2:34 PM observed Resident #28 lying in bed without a fitted sheet, lying on top of the mattress.Interview 3/17/26 at 2:06 PM Staff G, Certified Nursing Assistant (CNA), reported they're not supposed to put fitted sheets on the air flow mattresses, but put a pad under the resident. Staff G confirmed Resident #28 should have a sheet on his mattress.Interview 3/17/26 at 2:09 PM Staff H, CNA, explained sheets should be on all beds unless it is an air flow bed. Staff H confirmed Resident #28 should have a fitted sheet on his mattress.On 3/17/26 at 2:27 PM Staff I, CNA, revealed she saw sheets not on beds, but they are beds with airflow mattresses. Staff I added those mattresses should have a bed pad under the resident. Staff I continued if it is not an air flow mattress then it should have a fitted sheet.On 3/17/26 at 2:55 PM the Director of Nursing (DON) said she expected the air flow mattress to not have a fitted sheet, only a pad placed under the resident. The DON added the other mattresses should have a fitted sheet as this would make it more homelike.Follow up interview on 3/18/26 at 11:05 AM the DON reported she believed it was best practice to not have sheets on low flow mattresses, and only to use a bed pad. The DON added something like this, the facility would educate the staff to have sheets on low flow mattresses.Review of a facility provided policy titled, Homelike Environment revised February 2021 directed:a. The facility staff and management maximize the characteristics of the facility that reflect a personalized, homelike setting which include clean bed and bath linens that are in good condition.

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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. Based on clinical record review, staff interview, guidance from the October 2025 Resident Assessment Instrument (RAI) 3.0 User's Manual, and facility policy review, the facility failed to accurately reflect the status of 1 of 2 sampled residents on hospice care in the Minimum Data Set (MDS) Assessment (Resident #35). The deficient practice created the potential for the resident to not receive appropriate treatment and services. The facility reported a census of 50 residents. Findings include:The MDS of Resident #35, dated 2/11/26 was a significant change in status assessment. The MDS identified a Brief Interview for Mental Status Score of 14, which indicated intact cognition. The MDS coded the resident's prognosis, at section J1400, that the resident did not have a condition or chronic disease that resulted in a life expectancy of less than 6 months (hospice care is generally for patients with a terminal prognosis of six months or less to live, as certified by a physician). The MDS recorded that the resident was not receiving Hospice care, at section O0110K1. The facility's MDS Coordinator signed section J and O as completed on 2/25/26 certifying the document accurately reflected the resident assessment information for the resident. On 3/16/26 at 1:02 p.m. the facility provided the Resident Matrix which identified Resident #35 was currently receiving hospice services. Review of Resident #35's electronic medical record (EMR) revealed he returned to the facility from a hospital stay on 2/5/26 and the facility admitted him to hospice care that day. During an interview on 3/19/26 at 9:20 a.m., the MDS Coordinator said they completed the Resident #35's significant change in status MDS assessment due to his admission to hospice care. She acknowledged it was her error in failing to code the resident's prognosis accurately (section J1400) and failing to code that the resident was in a hospice program (section O0110K1). Review of the October 2025 RAI 3.0 User's Manual revealed a significant change in status assessment was required to be performed when a terminally ill resident enrolls in a hospice program. and remains a resident at the nursing home and the Manual directed to code:J1400: Prognosis as yes for the resident who was receiving hospice services and to code no if the resident was not receiving hospice services. O0110K1: Hospice care for residents identified as being in a hospice program. Review of the facility's policy Resident Assessments, revised December 2023, revealed the MDS coordinator was responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments. and .persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. To correct the passive past tense examples in the provided text, you can rephrase them to use the active past tense.

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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** Based on observation, clinical record review, staff interview, and policy review the facility failed to provide adequate oral care for 1 of 3 residents (Residents #9) reviewed. The facility reported a census of 50 residents. Findings include:Resident #9's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 was dependent on staff for oral hygiene, eating, and toileting hygiene. The MDS further Resident #9 had diagnoses of non-traumatic brain dysfunction, cerebral palsy, seizure disorder, and severe intellectual disabilities. Review of Resident #9's Care Plan with a revision date of 2/28/26 revealed an intervention for Resident #9 reveal dependency on staff for assistance with brushing teeth. On 3/16/26 at 2:45 PM witnessed Resident #9 with heavy plaque build up on their teeth. On 3/17/26 at 1:30 PM noted Resident #9's toothbrush in the medicine cabinet in an unopened and unused plastic wrapper. On 3/17/26 at 2:09 PM Staff A, Certified Nursing Assistant (CNA), explained it is very difficult to brush Resident #9's teeth. Staff A confirmed the staff haven't brushed Resident #9's teeth twice a day as they should. On 3/17/26 at 2:27 PM Staff I, CNA, verified the staff didn't brush the teeth twice a day on residents who needed assistance. Staff I confirmed Resident #9's toothbrush was still in the plastic, and that the residents' teeth should be brushed twice a day. On 3/17/26 at 2:33 PM Staff F, Licensed Practical Nurse (LPN), confirmed the staff didn't brush residents' teeth brushing twice a day as the staff get busy and forget to complete it. On 3/17/26 at 2:55 PM the Director of Nursing (DON) explained she expected the staff to do oral care twice a day. Review of a facility provided policy titled, Mouth Care revised February 2018 instructed the staff to provide oral care to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent oral infection.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interview, and policy review, the facility failed to provide supplemental oxygen as ordered for 1 of 1 resident reviewed for respiratory care (Resident #48). The facility reported a census of 50 residents.Findings include:Resident #48's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Resident #48 required setup assistance with eating, moderate assistance with showering, showering transfers, and lower body dressing, maximal assistance with footwear, and supervision with all other Activities of Daily Living (ADLs) and mobility. The MDS included diagnoses of anemia, chronic obstructive pulmonary disease (COPD), and syncope and collapse (temporary loss of consciousness caused by sudden drop in blood flow to the brain with rapid recovery). The MDS reflected she used supplemental oxygen within the 7-day lookback period.The Care Plan revised 11/26/25 directed staff to provide Resident #48 with 2 liters per minute (LPM) of continuous oxygen via nasal cannula (tubing with 2 hollow prongs to fit into the nostrils).The Electronic Health Record (EHR) included a physician's order dated 1/12/26 for oxygen 1 L via nasal cannula (L/NC) every hour as needed (PRN) for shortness of breath (SOB)/comfort (low blood oxygen level).The Oxygen Saturation Summary indicated Resident #48's most recent documented pulse oximeter level (blood oxygen level - O2 sat) on 3/10/26.On 3/16/26 at 3:06 PM, observed Resident #48 using their oxygen. The oxygen concentrator set at 2 L/NC.On 3/17/26 at 3:22 PM, Staff F, Licensed Practical Nurse (LPN), stated the nursing staff administer Resident #48's oxygen based on the physician's order.On 3/17/26 at 3:29 PM, observed Resident #48 sitting in her wheelchair at the nurses' station wearing nasal cannula tubing connected to an oxygen tank that was turned off. Resident #48's EHR did not contain any documented O2 sat levels since 3/10/26.On 3/17/26 At 3:36 PM, Staff F stated he hadn't checked Resident #48's oxygen or tubing yet.A policy titled Oxygen Administration revised October 2010 directed staff to review the physician's order or facility protocol for oxygen administration. It also directed staff to assess the resident's vital signs and oxygen saturation while the resident is receiving oxygen therapy.On 3/19/26 at 7:38 AM, the Director of Nursing (DON) stated staff should have assessed Resident #48's need for more than 1 L/NC of oxygen. If needed, they should contact the physician to get the order changed. If the assessment indicated no need for an oxygen increase, then staff should've followed the physician's order.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, policy review, resident, and staff interviews, the facility failed to provide non-pharmacologic pain management for 1 of 1 resident reviewed (Resident #7). The facility reported a census of 50 residents.Findings include:Resident #7's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #7 required setup assistance with eating, moderate assistance with showering, showering transfers, and putting on footwear. The MDS listed she required supervision with all other Activities of Daily Living (ADLs) and mobility. The MDS included diagnoses of diabetes mellitus, heart failure, muscle wasting (when your muscles get smaller and weaker over time, often due to illness or not using them.), morbid obesity (excessive weight), and degenerative disc disease (condition in which spinal discs break down due to wear and tear causing chronic lower back pain). The MDS reflected she had constant pain that frequently affected her sleep. She received pain medication and non-medication interventions for pain in the 7-day lookback period.The Electronic Health Record (EHR) included the following physician's orders:a. 9/3/24: A scheduled 10 milligram (mg) narcotic (a powerful, often addictive, pain-relieving drug that affects the brain and body.) pain medication every 6 hours b. 12/24/25: 650 mg of Tylenol every 6 hours as needed for pain. c. 12/29/25: Directed staff to document non-pharmacological pain management intervention with the following information: 1 = Deep Relaxation 2 = Heat to the site 3 = Cold/Ice to the site 4 = Massage 5 = Meditation 6 = Music 7 = Going to bed 8 = Quiet Place 9 = Repositioning 10 = Aromatherapy 11 = Guided imagery 12 = Other/See progress NoteThe Care Plan Focus revised 11/19/25 indicated Resident #7 used pain medication therapy. The Intervention directed staff to manage pain per physician treatment orders.Resident #7's January - March 2026 Medication Administration Records (MAR) printed 3/17/26, documented the following: 4 daily doses of oxycodone administered between 1/1/26 - 3/17/26. Tylenol Administrations: January 2026: 15 dosesFebruary 2026: 8 doses March 2026: 5 doses.Pain ScoresJanuary 2026: 4 severe and 44 moderate documented pain scores out of 62 evaluations February 2026: 6 severe and 34 moderate documented pain scores out of 56 evaluationsMarch 2026 (1st - 17th): 2 severe and 23 moderate documented pain scores out of 34 evaluations No documented non-pharmacologic interventions between 1/1/26 - 3/17/26.On 3/16/26 at 2:24 PM, Resident #7 stated her oxycodone medication didn't help her pain as much as she'd like. The Tylenol didn't have an effect on her pain at all. She added the facility hasn't done anything non-pharmacological to help with her pain.A policy titled Pain Assessment and Management revised March 2020 indicated non-pharmacological interventions may be appropriate alone or in conjunction with medications. It also indicated pharmacological interventions may be prescribed to manage pain, however they do not usually address the cause of pain and can have adverse effects on the resident.On 3/19/26 at 7:38 AM, the Director of Nursing (DON) stated staff should've offered non-pharmacologic interventions and, if ineffective, should've contacted the physician for other options.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, document review, resident interview, staff interview, and policy review the facility failed to provide an adequate amount of nursing staff to assure residents safety by not responding to call lights in a timely manner for 3 of 6 residents reviewed (Residents #15, #20, and #22). The facility reported a census of 50 residents.Findings include:1. Resident #15's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The MDS listed Resident #15 as dependent on staff for assistance with sitting to standing, chair/bed-to-chair transfers, and toileting.Interview on 3/16/26 at 1:49 PM Resident #15 reported the call lights often took longer than 15 minutes. Resident #15 added she could read a clock, and that is how she can tell. 2. Resident #20's MDS dated [DATE] revealed a BIMS score of 15, indicating intact cognitive functioning. Resident #20 required moderate assistance with sitting to standing, chair/bed-to-chair transfers, and toileting. Interview on 3/16/26 at 1:03 PM Resident #20 explained the call lights usually took 15 minutes or longer. Resident #20 added the call lights lasted up to 30 minutes. Resident #20 explained he watched the clock, and can tell time. 3. Resident #22's MDS dated [DATE] revealed a BIMS score of 12, indicating moderate cognitive impairment. The MDS listed Resident #22 as dependent on staff for assistance with toileting hygiene, personal hygiene, upper and lower body dressing. Interview on 3/16/26 at 2:14 PM Resident #22 reported the call lights could take longer than 15 minutes. Resident #22 added he watched the tv and could tell how long it took. Interview on 3/17/26 at 2:06 PM Staff G, Certified Nursing Assistant (CNA), said she saw call lights lasting longer than 15 minutes. Staff G added sometimes the staff don't see the lights on, when they are in the dining room. Interview on 3/17/26 at 2:09 PM Staff H, CNA, verified she saw call lights last longer than 15 minutes. Interview on 3/17/26 at 2:27 PM Staff I, CNA, reported she saw call lights last 15 minutes or longer. Interview on 3/17/26 at 2:33 PM Staff F, Licensed Practical Nurse (LPN), explained he saw call lights last longer than 15 minutes. Staff F reported the facility had a lot of 2 assist residents in the facility. The staff get tied up with assisting and call lights can last longer than 15 minutes. Interview on 3/17/26 at 2:55 PM the Director of Nursing (DON) revealed she expected the staff to answer the call lights in 15 minutes or less. A facility provided document titled, Device Activity Report dated 3/1/26 revealed several call lights ranging from 16 minutes to 52 minutes in length. A facility provided policy titled, Answering the Call Light revised September 2022 instructed the staff to answer the call system timely.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility policy review, and United States (US) Food and Drug Administration (FDA) 2022 Food Code review, the facility failed to serve food in a manner that complied with safe food handling practices during one of two observed meal services. The facility reported a census of 50 residents. Findings include: Observation on 3/16/26 of the noon meal started at 12:26 p.m. in the facility's Main Dining Room revealed:At 12:40 p.m. Staff J, Certified Nurse Aide (CNA), served Resident #50 their meal in a divided plate. After they placed the food in front of Resident #50, they left the table to return to the kitchen.At 12:41 p.m. Staff J ran through the dining room from the kitchen and picked up the meal they served Resident #50 and removed it from in front of him. Staff J then served that same meal to Resident #45, who sat at another table in the dining room.At 12:49 p.m. when asked if she removed Resident #50's plate she served to them and served it to Resident #45, Staff J agreed she removed the plate after she served it and then re-served that same meal to another resident. During an interview on 3/17/26 at 1:15 p.m. when inquired what should have happened if someone served a meal to a resident in error, the Dietary Manager replied she would remove the meal and provide the correct meal to the resident and inform the Director of Nursing (DON) of the error. When asked regarding the meal that had been served, she responded the meal that was served was contaminated and should not be served to another resident or returned to the kitchen, but should be disposed of in the trash. During an interview on 3/17/26 at 3:27 p.m. discussed the DON the noon meal service on 3/16/26 and the observation of Staff J serving a meal to Resident #50 and then removed the meal and re-served the same meal to Resident #45, due to serving by mistake. When asked what they should have done with the meal served by mistake, the DON replied they should have disposed of the meal. When inquired why they shouldn't serve that meal to another resident, the DON responded it was an infection control breach and they should have disposed of that meal in the trash. She stated she knew of the situation that had occurred at the noon meal service, she agreed Staff J made a mistake by serving that served meal to another resident. She stated the facility had a lot of newer staff and they recently hired Staff J.Review of the facility's Employee New Hires report revealed Staff J had a Hire Date of 1/20/26. Review of the facility's policy Food Preparation and Service, revised 10/23/22, directed employees to prepare and serve food in a manner that complies with safe food handling practices.Review of the U.S. Food and Drug Administration 2022 Food Code revealed regarding the re-service of food, Chapter 3, Section 306.14 stated regarding Returned Food and Re-Service of Food that . after being served. and in the possession of a consumer, food that is unused or returned. may not be offered as food for human consumption.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. The Minimum Data Set (MDS) of Resident #35 dated 2/11/25 identified a Brief Interview for Mental Status (BIMS) score of 14, which indicated his cognition was intact. The MDS coded Resident #35 needed partial/moderate assistance to eat. The MDS listed Resident #35 as dependent on staff for hygiene tasks, dressing, transfers, to shower or bathe, and used a manual wheelchair. The MDS described Resident #35 as always incontinent of both bowel and bladder. The MDS included diagnoses of cerebral palsy, Cerebral palsy (CP) (a disorder of movement and posture caused by damage or abnormal brain development, usually before birth, resulting in varied impaired muscle control and coordination.), dysphagia (difficulty swallowing), diabetes mellitus, and cognitive communication deficit. The MDS failed to identify his terminal prognosis (J1400) and hospice care (O0110.K1).The Care Plan revised 3/5/26, identified the following Focuses:a. Resident #35 had an increased risk for limitations in his ability to perform Activities of Daily Living (ADL). The Interventions directed the following: i. Resident #35 needed supervision with meals and reminders to swallow. ii. Resident #35 needed the assistance of one to two staff with all his ADLs. b. Resident #35 had a potential risk for inability to maintain nutrition and identified the resident required a pureed diet (smooth, pudding-like foods that require no chewing) with honey thick liquids (modified fluids with a slow-pouring, syrupy consistency). c. Resident #35 had a terminal prognosis related to a stroke and received hospice care. The Interventions instructed staff to work effectively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met.The Care Plan failed to identify the following:a. Hospice provider and the specific services and functions they would provide in coordinating their services with those the nursing home would continue to provide. b. The structure of the Care Plan established between the nursing home and the hospice provider and that the resident's Care Plan was divided into two portions, one maintained by the nursing home and the other maintained by the hospice. c. The location of the hospice Care Plan. These failures created the potential for the coordinated Care Plan to be inconsistent and not current in meeting the needs of the resident for both his hospice care and nursing home care.Review of Resident #35's electronic medical record (EMR) revealed three scanned documents from his hospice provider:A one-page document, titled Hospice diagnosis code, dated 2/5/26, regarding patient billing.A thirteen-page document, titled Hospice reports, dated 2/25/26, that contained a Patient Fact Report and Medication Profile. This document included the hospice clinical team names, discipline, and contact information; Care Needs, Goals, and Interventions; and Medications prescribed. An eight-page document, titled Hospice records, dated 3/11/26, regarding physician orders and Care Plan. This document included the resident's hospice Care Plan and identified care needs, goals, interventions, and disciplines responsible (Registered Nurse, Licensed Practical Nurse, Hospice Aide, Social Worker, Chaplain, and Volunteer).During an interview on 3/18/26 at 3:45 p.m. the Director of Nursing (DON), reported the facility worked with three hospice providers. Some provided three-ring binders at the facility that kept resident specific information. Resident #35's hospice provider didn't provide the facility with a binder. The DON stated the facility received e-mails from the hospice providers that contained resident specific information. The facility scanned the information into the resident's EMR. She agreed they could make improvements with the hospice providers to facilitate the care coordination and communication with hospice and facility staff. During an interview on 3/19/26 at 9:20 a.m. the MDS Coordinator revealed she had worked at the facility for three years, and had the responsibility for developing and updating resident Care Plans. She stated that the hospice providers come to the facility weekly and the facility invited the hospice provider to the resident Care Plan conferences. She stated the services provided by the hospice provider varied by the needs of the individual resident. She agreed Resident #35's Care Plan didn't identify the structure of the Care Plan established by the nursing home and the hospice as divided into two portions. One maintained by the nursing home and (continued on next page)

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	03/19/2026

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the other maintained by the hospice. She agreed Resident #35's Care Plan didn't identify the location of the hospice Care Plan. Review of the Hospice Agreement with Resident #35's hospice provider reflected they would provide the most recent hospice plan of care specific to each patient. Which would include the names and contact information for hospice personnel involved in hospice care of each patient. The Hospice Agreement stated the plan of care will identify the care and services needed and must specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the plan of care. Review of the facility's Hospice Program policy, dated January 2024, revealed the facility designated the IDT [Inter-Disciplinary Team] to coordinate care provided to the resident by the facility staff and the hospice staff. Collaborating with hospice representatives and coordinating facility staff participation in the hospice Care Planning process for residents receiving these services. Coordinated Care Plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility in order to maintain the resident's highest practicable physical, mental and psychosocial well-being.