STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165224	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Ayr Health Care Center	1504 East South Street Mount Ayr, IA 50854

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and policy review the facility failed to prepare, serve and distribute food in accordance with food service safety for general practices of mealtime service. The facility reported a census of 24 residents. Findings include: Observed during the initial kitchen visit on 4/11/26 at 9:10 AM the following:The Cook's Refrigerator had an incomplete temperature log with missing data for 4/8 and 4/10/26.The bottom of the upright freezer contained a milky white frozen substance and crumbs across the bottom. The freezer contained a 5 gallon container of ice cream on the top shelf and frozen meats on the bottom shelf. Observed during the meal service on 4/12/26 at 11:50 AM Staff D, Dietary Aide, complete the following:The staff donned gloves without hand hygiene.Staff D used the right hand to cut the pie and load the sliced pie onto the pie server.Using the left gloved hand Staff D obtained dessert plates, placed them on the counter and touched the pie slices moving them off the pie server onto the dessert plates. Staff D obtained a bowl with the left gloved hand from a different part of the kitchen, placed it on the counter, and continued touching the pie slices while moving them onto a dessert bowl and plates from the pie server.Staff D completed the process of using the left hand to touch dessert plates and the slices of pie while removing them from the pie server for 16 pieces of pie.Staff D removed gloves and washed her hands.On 4/11/26 at 9:20 AM the Food Service Supervisor when asked about the incomplete temperature logs stated she expected the staff to complete the log(s) as required and had spoken with the staff about this task.On 4/12/26 at 1:00 PM the Food Service Supervisor stated when serving pie the staff should use a pie server and a fork to move the pie from the pie pan to the serving dishes. The Food Service Supershould not touch the pie with gloved or non-gloved hands. When looking at the bottom of the upright freezer, the Dietary Manager acknowledged that melted ice cream was on the bottom and should have been cleaned up. 4/12/26 at 1:15 PM the Administrator concurred that cleaning of kitchen appliances and logging of temperatures needed to be completed; as well as staff should not be touching food and serving dishes with the same gloved hand. The facility's Food Service Hand Hygiene and Glove Use Policy, dated 4/9/25, revealed that hand washing should occur for at least 20 seconds before and after glove use. The document provided that gloves should be changed when touching contaminated surfaces and after any interruption. The facility's Chest Freezer Policy signed 2/11/12 revealed the kitchen chest freezer should be cleaned monthly consisting of unplugging one freezer at a time, moving items to another freezer, defrosting, washing with hot detergent water, rinsing, sanitizing , air drying/wiping with clean dry cloth, plugging in the freezer, cooling to zero and replacing the food. The facility's General Cleaning Guidelines signed 2/11/12 revealed all items should be cleaned after use, immediately as possible using basic cleaning rules of washing, rinsing and sanitizing unless specified otherwise. The facility's Refrigeration Equipment Temperature Policy revealed temperatures should be taken and recorded daily on all refrigeration equipment to ensure food was stored at appropriate temperatures.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to notify the Long-Term Care State Ombudsman of a transfer to the hospital for 2 of 2 residents (#13, #28). The facility reported a census of 24 residents.Findings include:1.Resident #13's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition. It included diagnoses of high blood pressure, coronary artery disease (heart blood vessels), diabetes mellitus, thyroid disorder, and non-Alzheimer's dementia. It revealed the resident was dependent with shower transfers, required maximal assistance with bathing, setup assistance with eating and oral hygiene, supervision with all other Activities of Daily Living (ADLs), and was independent with all other mobility.A Health Status Progress Note dated 3/03/26 at 10:56 PM revealed the resident sustained a fall and was transferred to the hospital for an evaluation. A subsequent Health Status Progress Note dated 3/04/26 at 1:30 AM revealed the resident returned to the facility. The Care Plan dated 3/04/26 included a fall intervention regarding the resident's room environment.An undated Notice of Transfer Form to Long-Term Care Ombudsman document did not include Ombudsman notification of Resident #13's transfer to the hospital on 3/03/26.2. Resident #28's Discharge MDS dated [DATE] identified a BIMS score of 15 out of 15 which indicated completely intact cognition. It included diagnoses diabetes mellitus and hypothyroidism. It revealed the resident was dependent with tub and shower transfers, required moderate assistance with bathing, supervision with car transfers, setup assistance with eating, dressing, and personal hygiene, and was independent with all other ADLs and mobility. It also revealed that 3/28/26 was the resident's planned discharge date .A Health Status Progress Note dated 3/28/26 at 8:17 AM indicated Resident #28 was discharged home with family. An undated Notice of Transfer Form to Long-Term Care Ombudsman document did not include Ombudsman notification of Resident #28's discharge home on 3/28/26.On 4/12/26 at 9:05 AM, the Administrator stated he wasn't aware Resident #13's transfer required Ombudsman notification due to the short amount of time she was away from the facility. He also stated he overlooked Resident #28's discharge Ombudsman notification because it occurred on a weekend day.An undated policy titled Transfer Discharge Notification Policy indicated it was the responsibility of the facility to notify the long term care ombudsman monthly of the transfer to hospital and discharges that may occur.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review the facility failed to complete a Pre-admission Screening and Resident Review (PASRR) for 1 of 1 residents (Resident #5), who was diagnosed with a new mental disorder diagnosis since admission to the facility. The facility reported a census of 24 residents.Findings include:Review of the facility provided document Pre-admission Screening and Resident Review (PASRR) completed on 12/29/21 identified the following: Diagnoses of major depression (current), anxiety disorder (current) and mental retardation. No substance related disorder, diagnosis of dementia/neurocognitive disorder.No known mental health symptoms affecting the individual's ability to think through or complete tasks which she should be physically capable of completing. No known recent or current mental health symptoms.No mental health services now or in the past.Medications of Abilify 30 mg for depression, Clonazepam 1.5 mg for anxiety and Sertraline 150 mg for depression. Level I Positive, No Status Change. No Level II required at this time, no status change. Level II was completed on 10/21/21 with a non-time limited approval which will remain valid. Level II not currently required. If exacerbation related to mental illness or discrepancy in reported information then status change should be submitted.The clinical record census disclosed Resident #5 was admitted to the facility on [DATE].The Minimum Data Set (MDS) assessment dated [DATE] for Resident #5 identified a Brief Interview for Mental Status (BIMS) score of 15/15 indicating normal cognition. The MDS recorded no mood or behaviors during the reporting period. The MDS documented diagnoses that included: anxiety disorder, depression and psychotic disorder. The MDS documented the resident received antipsychotic, antianxiety and antidepressant medication on 7 out of 7 days of the assessment reference period. The MDS assessment dated [DATE] for Resident #5 recorded the resident displaying other behavioral symptoms not directed toward others for 1 to 3 days over the last 14 days. The document revealed diagnoses of anxiety disorder, depression and psychotic disorder. The MDS documented the resident received antipsychotic, antianxiety and antidepressant medication on 7 out of 7 days of the assessment reference period.The MDS assessment dated [DATE] for Resident #5 recorded no mood or behaviors during the reporting period. The MDS documented diagnoses of anxiety disorder and depression. The MDS documented the resident received antipsychotic, antianxiety and antidepressant medications during the last 7 days of the assessment reference period. The Care Plan revised 11/11/25 identified the resident had a behavioral problem due to delusional disorder which she exhibits paranoia likely related to mild intellectual disorder (revised 5/26/25). The Care Plan identified staff interventions of therapy for mood/behaviors monthly and target behaviors including thoughts of having no friends, no one likes her or others are picking on her - paranoia. The clinical record's medical diagnoses included: Delusional disorder (paranoid) dated 5/13/25 during stay.Generalized anxiety disorder dated 10/25/21 admission.Major depressive disorder dated 10/25/21 admission.Mild intellectual disabilities dated 10/25/21 admission. The clinical record's physician orders included:Clonazepam .5 mg. 1 tablet three times daily (TID) related to generalized anxiety disorder 4/9/26.Aripiprazole (Abilify) 12.5 mg. 1 tablet daily (QD) related to delusional disorder 5/14/25.Aripiprazole 10 mg. 1 tablet QD related to delusional disorder revised 5/13/25.Sertraline 50 mg. Give 2.5 tablets QD for generalized anxiety disorder, major depressive disorder, recurrent, mild. The clinical record's progress note titled Health Status Note on 5/13/25 at 4:39 PM revealed nursing would like to review options for other medications if possible for anxiety, mood swings and temper tantrums. The entry included medication and diagnosis list reviewed and updated with diagnosis of paranoid delusional disorder.The clinical record's progress note titled Consulting Pharmacy Note on 5/13/25 at 2:52 PM included the primary care physician documented approval for a gradual drug reduction of Abilify to 10 mg AM and 12.5 mg PM with a diagnosis of paranoid delusions as the resident had a history of paranoia. The document included (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acknowledgement by the pharmacy of updating the new diagnosis. In an interview on 4/12/26 at 2:45 PM the Director of Nursing (DON) stated she completed the PASRR for the facility. The DON concurred that the most recent PASRR was completed on 12/29/21 and the diagnoses and non-treatment/identification of mental health symptoms contained within it. When reviewing the current physician orders and diagnoses, the DON admitted that a new PASRR should have been completed with the additional diagnosis of delusions. The DON stated a new PASRR should be completed with medication and diagnosis changes, severe behaviors that would trigger a Level II or if a resident was no longer demonstrating previously identified behaviors. In an interview on 4/13/26 at 9:30 AM the Administrator acknowledged he was made aware of the missed PASRR and that one should have been completed with the addition of a new mental health diagnosis. The facility policy titled Preadmission Screening and Resident Review (PASRR) dated 4/12/26 directed staff that a new PASRR evaluation must be initiated when there is a significant change in condition including a new diagnosis of mental illness, intellectual disability or related condition and recommendation for specialized services. The document disclosed the interdisciplinary team was responsible for identifying these changes and notifying the appropriate staff to initiate a PASRR review.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observations, staff interviews, and policy review, the facility failed to properly protect resident information from unauthorized access by leaving 2 residents' information accessible when staff walked away from the Electronic Health Record (EHR) laptop. The facility reported a census of 24 residents. Findings include: On 4/11/26 at 11:44 AM, Staff A, Licensed Practical Nurse (LPN) walked away from the medication cart located in the lobby to get a cup for a resident. The laptop was open and Resident #16's medication list was visible on the screen. Resident #6 was continuously wandering around the lobby.At 11:46 AM, Staff A returned to the medication cart and stated she usually closes the laptop but thought her task would be completed quickly.At 11:57 AM, Staff A walked away from the medication cart in the lobby to administer medications to a resident in the dining room. The laptop was open and Resident #10's medication list was visible on the screen. A policy titled Securing Resident Records Policy dated 9/12/25 indicated it was the policy of the facility to ensure the confidentiality, security, and integrity of all resident records, including both electronic and paper records, in accordance with CMS regulations, HIPAA requirements, and facility standards. It also indicated All staff are responsible for protecting resident information from unauthorized access, use, or disclosure at all times.On 4/13/26 at 1:52 PM, the Director of Nursing (DON) stated staff should've locked the laptop screen before leaving the medication cart.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews, and policy review, the facility failed to implement infection control practices by manipulating a catheter drain spigot with gloves previously used during resident transfer (Resident #1). The facility reported a census of 24 residents.Findings include:Resident #1's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 09 out of 15 which indicated moderately impaired cognition. It included diagnoses of cancer, benign prostatic hyperplasia (BPH - enlarged prostate), kidney failure, and neurogenic bladder (bladder dysfunction caused by nerve damage). It indicated the resident required setup assistance with eating, maximal assistance with oral hygiene, showering, and turning in bed, and was dependent with all other Activities of Daily Living (ADLs) and mobility. It also indicated the resident had an indwelling catheter (urinary catheter) in the 7-day look-back period.An Orders-Administration Progress Note dated 2/26/26 revealed the resident's indwelling urinary catheter was changed due to decreased urine output. It indicated the catheter would be changed monthly and as needed.The Care Plan revised 12/24/25 indicated the resident had an indwelling catheter and directed staff to wear a gown and gloves when performing high-contact resident care activities.During a continuous observation on 4/12/26 that began at 8:41 AM, Staff B, Certified Nurse Aide (CNA) and Staff C, CNA transferred Resident #1 in a mechanical lift from his wheelchair to his recliner. After the resident was seated in his recliner, Staff B used the same gloves and grabbed the urine measuring cylinder in a plastic bag, raised the resident's right pant leg, held the cylinder in her left hand, unscrewed the urine drainage bag spigot with her left hand, and emptied the urine into the cylinder. Staff B wiped the spigot tip with an ETOH pad, closed the spigot, and emptied the urine into the toilet. Hand hygiene nor a glove change were performed throughout the observed process.At 8:46 AM, Staff C stated Staff B should have performed hand hygiene and changed her gloves prior to accessing the resident's urinary catheter bag.At 9:05 AM, Staff B stated she didn't feel she missed a hand hygiene or glove change opportunity throughout the transfer and accessing the urinary drainage bag process. She also stated touching reusable equipment and resident linen or clothes with gloved hands does not contaminate the gloves.A policy titled Catheter Care Procedure - Indwelling or Suprapubic Catheters dated 8/28/25 indicated it was the policy of the facility to provide catheter care at least twice daily and directed staff to always use standard precautions and hand hygiene.A policy titled Facility Wide Infection Control reviewed 1/20/23 indicated standard precautions will be implemented in the following manner:HandwashingWash hands after touching blood, body fluids, secretions, excretions, and contaminated items, regardless of whether gloves are worn. Wash hands immediately after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients and environment. It may be necessary to wash hands between tasks and procedures on the same resident to prevent cross contamination of different body sites. (Refer to handwashing procedures.)A plain soap will be used for routine handwashing, unless otherwise specified.On 4/13/26 at 1:48 PM, the Director of Nursing (DON) stated staff should've performed hand hygiene and changed gloves prior to accessing the resident's urinary drainage bag.