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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>165320 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>02/19/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Zearing Health Care, LLC |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>404 East Garfield St<br>Zearing, IA 50278 |  |

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

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441</b></p> <p>Based on record review, staff interview and policy review, the facility failed to report an allegation of abuse timely for 1 of 1 residents reviewed for alleged abuse (Resident #1). The facility reported a census of 35 residents.</p> <p>Findings include:</p> <p>Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) of 11, indicating moderate cognitive impairment. The MDS included a diagnosis of Huntington's disease (causes nerve cells in the brain to decay over time, affecting the person's movements, thinking ability, and mental health).</p> <p>The Care Plan Focus revised 10/27/22 described Resident #1 as a smoker, who required supervision to smoke.</p> <p>During an interview on 2/17/25 at 12:25 PM, Staff A, Certified Nurse Aide (CNA), reported she worked with Staff B, CNA, and Staff C, CNA, on 1/3/25. After she came in the building after she took residents out to smoke, Resident #1 came up to smoke late. Staff A reported as she assisted another resident take off her coat, Resident #1 grabbed a smoking protector. Staff D, Registered Nurse (RN), yelled at Resident #1 saying it was too late to smoke. As Resident #1 tried to go out the door, Staff D pulled her arm and grabbed her away from the door. Resident #1 then walked down the hallway to her room. Staff A reported Staff B and her wrote written statements, then slid them under the Administrator's door but the statements never got to the Administrator.</p> <p>During a follow-up interview on 2/17/25 at 12:51 PM, Staff A reported witnessing Staff E, Licensed Practical Nurse (LPN), grab Resident #1's other arm when she tried to go outside to smoke and moved her away from the door. Staff A stated she didn't separate the alleged abuser from the residents because her brain froze.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an interview on 2/17/25 at 12:42 PM, Staff B explained on 1/3/25 Resident #1 didn't come with the other residents for their 8:00 PM smoke break, adding she came up at 8:06 PM. Staff B described Staff D, RN, as adamant Resident #1 couldn't go out to smoke since she came late. At that time Resident #1 became very upset and began having behaviors. Staff B reported Staff D and Staff E grabbed Resident #1 in the triangle area by the nurse's station and the beginning of the 200 hallway, then dragged her down the hall to the inside of her room while Resident #1 screamed and tried to get out of their grasp. Staff B reported Resident #1 screamed for 1/2 an hour because she couldn't go out to smoke. Staff B reported she couldn't write a statement at the time of the incident due to being busy but wrote one out the next day with the dates and times, then turned it into the office. Staff B explained she reported the allegation within 24 hours as the facility didn't have anyone to report it to that night due to the involvement both of the nurses working.</p> <p>During an interview on 2/17/25 at 1:25 PM, Staff C reported as she came out of the dining room on 1/3/25 around 8:00 PM, she saw Staff D coming onto her shift, then she saw Staff D yank Resident #1's right arm. Staff C explained Resident #1's had her back to the wall by the exit door, when Staff D told her they wouldn't allow her to go outside and smoke because she missed the smoke break. Staff C reported Resident #1 left the doorway area and walked down to her room independently. Staff D walked the opposite direction following the incident. Staff C reported Staff E also yelled at Resident #1 but like a puppet as she followed Staff D. Staff C reported she would have seen if Staff E grab Resident #1's other arm, which she didn't as Staff E stood behind Staff D. Staff C stated Staff A and Staff B told her what they witnessed and she told them to report it to whomever they needed to tell. Staff C stated she reported the incident to the Assistant Director of Nursing (ADON) at work the next time, the next Tuesday, she saw her at work.</p> <p>Review of facility policy titled, Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated October 2022 indicated all allegations of resident abuse should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative. All allegations of resident abuse shall be reported to the Iowa Department of Inspections and Appeals no later than 2 hours after the allegation is made. If the person in charge is the alleged abuser, the staff member shall directly report the abuse to the Department immediately, pursuant to the deadlines established above.</p> <p>During an interview on 2/18/25 at 3:40 PM, the Administrator reported he first learned of the allegation of abuse against Resident #1 on 1/10/25 after Staff A's staffing agency, who employed her, contacted him via the phone reporting Staff A reported the alleged abuse to the staffing agency. The Administrator added he expected the staff report allegations of abuse right away.</p> |  |  |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441</b></p> <p>Based on record review, staff interviews, policy review and staff timecard punch detail, the facility staff who witnessed an alleged abuse to a resident on 1/3/25 failed to report the incident to the facility administration or the Department of Inspections, Appeals, and Licensing. Due to the facility's staff failing to report the alleged abuse to the Administration, the facility Administration failed to separate the alleged abuser from the resident for 1 residents reviewed for alleged abuse (Resident #1). The Administrator reported he didn't learn of the situation until 1/10/25, allowing the alleged abuser to continue to work with Resident #1 and other residents in the facility for approximately 7 days after the incident. Please refer to deficiency F609 for additional information. The facility reported a census of 35 residents.</p> <p>Findings include:</p> <p>Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) of 11, indicating moderate cognitive impairment. The MDS included a diagnosis of Huntington's disease (causes nerve cells in the brain to decay over time, affecting the person's movements, thinking ability, and mental health).</p> <p>The Care Plan Focus revised 10/27/22 described Resident #1 as a smoker, who required supervision to smoke.</p> <p>During an interview on 2/17/25 at 12:25 PM, Staff A, Certified Nurse Aide (CNA), reported she worked with Staff B, CNA, and Staff C, CNA, on 1/3/25. After she came in the building after she took residents out to smoke, Resident #1 came up to smoke late. Staff A reported as she assisted another resident take off her coat, Resident #1 grabbed a smoking protector. Staff D, Registered Nurse (RN), yelled at Resident #1 saying it was too late to smoke. As Resident #1 tried to go out the door, Staff D pulled her arm and grabbed her away from the door. Resident #1 then walked down the hallway to her room. Staff A reported Staff B and her wrote written statements, then slid them under the Administrator's door but the statements never got to the Administrator.</p> <p>During a follow-up interview on 2/17/25 at 12:51 PM, Staff A reported after she witnessed Staff E, Licensed Practical Nurse (LPN), grab Resident #1's other arm when she tried to go outside to smoke, she didn't separate the alleged abuser from the residents because her brain froze.</p> <p>During an interview on 2/18/25 at 3:40 PM, the Administrator reported he first learned of the allegation of abuse against Resident #1 on 1/10/25 after Staff A's staffing agency, who employed her, contacted him via the phone reporting Staff A reported the alleged abuse to the staffing agency. The Administrator added he expected the staff report allegations of abuse right away.</p> <p>Review of Staff D's timecard punch detail reflected she worked the following dates and times, after the alleged incident prior to her suspension:</p> <p>a. 1/3/25: 7:58 PM-6:20 AM</p> <p>b. 1/4/25: 7:58 PM-6:37 AM</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>c. 1/5/25: 9:52 PM-6:26 AM</p> <p>d. 1/7/25: 8:00 PM-6:23 AM</p> <p>e. 1/8/25: 7:58 PM-6:39 AM</p> <p>f. 1/9/25: 7:53 PM-6:26 AM</p> <p>Review of facility policy titled, Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated October 2022 indicated upon an allegation of resident abuse, the facility shall immediately implement measures to prevent further potential abuse of residents.</p> |  |  |