STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165320	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Zearing Health Care, LLC	404 East Garfield St 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, resident, and staff interviews, the facility failed to treat residents with dignity and respect while assisting with their activities of daily living (ADL) for 2 of 5 residents reviewed (Residents #1 and #2). The facility reported a census of 32 residents. Findings include:1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] listed an admission date of 3/14/22. The MDS identified a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. Resident #1 required supervision or touching assistance with eating and substantial/maximal assistance with mobility. The MDS included diagnoses of Huntington's disease and non-Alzheimer's dementia.The Care Plan Focus revised 8/6/25 reflected Resident #1 had a potential nutritional problem related to swallowing issues. The Interventions instructed the following:a. Resident #1 needed a calm, quiet setting at meals with adequate time to eat.b. She used curved utensils, a Kennedy cup (spill proof cup with handle and straw), and a lip plate to promote independence with eating.c. She ate a pureed diet with nectar thickened liquids.The Care Plan Focus dated indicated Resident #1 had a risk for skin integrity and falls related to choreatic movements (involuntary, jerky, and unpredictable muscle movements), poor balance, and impaired ambulation due to Huntington's disease. The Interventions directed to wear a soft helmet for safety.During an interview on 8/26/25 at 8:54 AM, Staff B, Registered Nurse (RN), stated on 7/30/25 around 5:30 PM, she entered the dining room and found Staff A, Certified Nursing Assistant (CNA), sitting next to Resident #2 at the dining table. She witnessed Resident #1 leaning forward in her chair with her head (wearing her soft helmet) down under the table. At the time Staff A used her personal phone. As Staff B approached the table she asked Staff A, what was happening? Staff A responded loudly and aggressively, She fucking does this all the time. She fucking throws her food on the floor. She won't fucking let you feed her. Staff B stated, They (CNAs) weren't doing anything, the resident didn't purposely do these things. Staff B, continued speaking, while Staff A used her phone on speakerphone with her boyfriend, who also used loud profane language. Staff C, CNA, interjected by saying okay, enough with the 'F' word. Staff A continued laughing and persisted with her behavior. Resident #1 had food all over her with her helmet shifted, covering her eyes and obstructing her vision. Staff B stated she then positioned herself between Staff A and Resident #1 to de-escalate the situation. While cleaning up Resident #1, she spoke gently in an effort to comfort her. Staff B assisted Resident #1 with eating the remainder of her meal without issue. While assisting Resident #1, Staff A continued making sarcastic verbal remarks including Yeah, she doesn't talk, but when I'm in her room and she doesn't like something, she'll fucking let it rip then.In an interview on 8/26/25 at 10:45 AM, Staff C explained, Resident #1 had crazy uncontrolled movements because of having Huntington's chorea, that caused her to repeatedly drop her spoon and the CNAs constantly had to pick it up. On 7/30/25 as the CNAs help the resident's eat supper, Resident #1 leaned forward, reaching down under the table to grab her spoon that fell on the floor. Because of the material of Resident #1's helmet it kept catching on the underside of the table making it so she couldn't sit back up. At the time Staff B, asked what was going on, they had to move the table so Resident #1 could sit back up. Staff C added Staff A got frustrated and used the F bomb saying she did this all the fucking time. An interview on 8/26/25 at 1:24 PM, Staff D, CNA, reported Resident #1 kept dropping her silverware. When Staff B approached asking what happened, Staff A responded she does this all the fucking time. Staff B helped Resident #1 eat the rest of her meal. During an interview on 8/27/25 at 11:35 AM, Staff A, stated Resident #1 got stuck under the table. Staff A and another CNA had to move the table for her to be able to sit back up. At that time Staff B entered the dining room and said I've never seen her (Resident #1) like this. Staff A, acknowledged she responded out of frustration, she does this all the fucking time. 2. Resident #2's MDS assessment dated [DATE] identified a BIMS score of 12, indicating moderate cognitive impairment. Documented behaviors including delusions and other behaviors not directed towards other. Resident #2 used a wheelchair and could propel self. The MDS included diagnoses of stroke, schizophrenia, anxiety disorder, borderline personality disorder, and a history of falls.The Care Plan Focus revised 8/14/25, indicated Resident #2 had an indwelling urinary catheter. The Care Plan Focus revised 9/18/23 identified Resident #2 had a behavior problem related to borderline personality disorder. The Interventions directed the following:a. At times, using a stern mom voice is the only way to get Resident #2 to focus on reality and not hallucinations.b. Caregivers provide an opportunity for positive interactions and attention. They should stop and talk to her as they pass her The Care Plan Focus revised 12/5/19 reflected

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to separate residents from alleged perpetrator of verbal abuse in a timely manner for 1 of 1 resident reviewed for abuse (Resident #1). The facility reported a census of 32 residents.Findings include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE] listed an admission date of 3/14/22. The MDS identified a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. Resident #1 required supervision or touching assistance with eating and substantial/maximal assistance with mobility. The MDS included diagnoses of Huntington's disease and non-Alzheimer's dementia.The Care Plan Focus revised 8/6/25 reflected Resident #1 had a potential nutritional problem related to swallowing issues. The Interventions instructed the following:a. Resident #1 needed a calm, quiet setting at meals with adequate time to eat.b. She used curved utensils, a Kennedy cup (spill proof cup with handle and straw), and a lip plate to promote independence with eating.c. She ate a pureed diet with nectar thickened liquids.The Care Plan Focus dated indicated Resident #1 had a risk for skin integrity and falls related to choreatic movements (involuntary, jerky, and unpredictable muscle movements), poor balance, and impaired ambulation due to Huntington's disease. The Interventions directed to wear a soft helmet for safety.During an interview on 8/26/25 at 8:54 AM, Staff B, Registered Nurse (RN), stated on 7/30/25 around 5:30 PM, she entered the dining room and found Staff A, Certified Nursing Assistant (CNA), sitting next to Resident #2 at the dining table. She witnessed Resident #1 leaning forward in her chair with her head (wearing her soft helmet) down under the table. At the time Staff A used her personal phone. As Staff B approached the table she asked Staff A, what was happening? Staff A responded loudly and aggressively, She fucking does this all the time. She fucking throws her food on the floor. She won't fucking let you feed her. Staff B stated, They (CNAs) weren't doing anything, the resident didn't purposely do these things. Staff B, continued speaking, while Staff A used her phone on speakerphone with her boyfriend, who also used loud profane language. Staff C, CNA, interjected by saying okay, enough with the 'F' word. Staff A continued laughing and persisted with her behavior. Resident #1 had food all over her with her helmet shifted, covering her eyes and obstructing her vision. Staff B stated she then positioned herself between Staff A and Resident #1 to de-escalate the situation. While cleaning up Resident #1, she spoke gently in an effort to comfort her. Staff B assisted Resident #1 with eating the remainder of her meal without issue. While assisting Resident #1, Staff A continued making sarcastic verbal remarks including Yeah, she doesn't talk, but when I'm in her room and she doesn't like something, she'll fucking let it rip then. Staff B, stated she didn't address any concerns about the incident with Staff A. She added she knew Staff A didn't work with Resident #1 for the rest of the shift. Staff B explained she contacted the Administrator around 9:00 PM, when things calmed down. The Administration instructed Staff B to send Staff A home. Staff B added, she should have pulled Staff A aside and had her leave the facility at the time of the incident and reported it to the Facility Administrator at that time. In an interview on 8/26/25 at 10:45 AM, Staff C explained, Resident #1 had crazy uncontrolled movements because of having Huntington's chorea, that caused her to repeatedly drop her spoon and the CNAs constantly had to pick it up. On 7/30/25 as the CNAs help the resident's eat supper, Resident #1 leaned forward, reaching down under the table to grab her spoon that fell on the floor. Because of the material of Resident #1's helmet it kept catching on the underside of the table making it so she couldn't sit back up. At the time Staff B, asked what was going on, they had to move the table so Resident #1 could sit back up. Staff C added Staff A got frustrated and used the F bomb saying she did this all the fucking time. Staff C stated Staff A stayed at the dining table assisting another resident finish eating dinner and continued to provide care for residents throughout the shift. Staff C, reported being confused when she received a call the next day about the incident with Resident #1. The situation happened at supper around 5-6 PM, Staff B didn't act on the situation at all. Staff C said Staff B should have asked someone to stay for Staff A and sent her home. An interview on 8/26/25 at 1:24 PM, Staff D, CNA, reported, Resident #1 kept dropping her silverware. When Staff B approached asking what was going on, Staff A responded she does this all the fucking time. At the time, Staff B assisted Resident #1 eat the rest of her meal. Staff D, stated her shift ended at 6:30 PM and Staff A still worked when she left. During an interview on 8/27/25 at 11:35 AM, Staff A, stated Resident #1 got stuck under the table. Staff A and another CNA had to move the table for her to be able to sit back up. At that time Staff B entered the dining room and said I've never seen her (Resident #1) like this. Staff A, acknowledged she responded out of frustration, she does this