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	06/30/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, resident interview and policy review, the facility failed to complete and document appropriate assessments and interventions for the necessary care and services, to maintain the residents' highest practical physical well-being for 1 of 3 residents reviewed (Resident #7) for skin. The facility reported a census of 34 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. The MDS identified Resident #7 required partial/moderate assistance with putting on/taking off footwear and was independent with transfers/ambulation. The MDS included diagnoses of diabetes mellitus with diabetic nephropathy (kidney damage caused by poorly controlled diabetes). The Care Plan with a target date 9/7/26 revealed Resident #7 had diabetes mellitus. The care plan directed staff to monitor, document, and report to Physician as needed for signs/symptoms of infection to any open areas such as redness, pain, heat, swelling or pus formation. In addition, the care plan directed staff to refer to podiatrist for foot care needs. The Progress Note dated 5/21/26 documented Resident #7 received a shower and a blister to the back of the left heel was identified from her sandals. Review of the clinical record lacked skin assessments, interventions and treatment for the left heel blister. The clinical record lacked documentation Resident #7's Physician was notified of the blistered area. Resident #7's care plan lacked information regarding the skin impairment to the left heel. On 6/24/26 at 10:59 AM, the Director of Nursing (DON) reported she could not locate Physician notification regarding the blister to the left heel. She said the skin nurse was not aware of the area so there were no skin sheets or skin assessments completed. On 6/24/26 at 11:15 AM, the DON said she expected a skin assessment, Physician notification, intervention and follow up assessments completed when a blister was identified. On 6/24/26 at 11:20 AM, observation revealed Resident #7 had sandals on her feet with a strap that went around the back of her heels. Resident #7 had a Band-Aid in place to the back of the left heel. Resident #7 reported she had a Band-Aid on her left heel so the area did not get worse. She said the strap on the sandals rub on the back of her heel. She said the sandals she had on were the only sandals she could wear due to her neuropathy. She said the area on the back of the left heel comes and goes and that the area was dry. Resident #7 said she would ask for a Band-Aid for the left heel and the staff would give it to her. She said she advocated for herself and took good care of her feet since she was a diabetic. The facility policy titled Skin Management revised November 2018 documented skin assessment findings would be documented on the head-to-toe skin check form. Any alterations or changes in skin integrity, any break in resident's skin including skin tear, bruises, abrasions, ulcers, rash, surgical wounds, are to be recorded in the skin book. The policy documented a change of condition form to be completed and a new physician's order obtained for a new incident of compromised skin integrity. The nurse would assure treatments, interventions, care plan, and the appropriate skin documentation records were initiated in a timely manner according to practice guidelines.

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

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	06/30/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	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** Based on clinical record review, staff interviews, observations, and facility policy, the facility failed to perform smoking assessments to identify hazards for residents who smoked, suffered burns while smoking, and failed to implement new interventions to replace the ineffective ones to prevent further burns or decrease the risk burns for 3 of 3 residents (Resident #6, #8, #9) reviewed for smoking. The facility reported a census of 34 residents. Findings include:1. Resident #6's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The MDS identified Resident #6 required partial or moderate assistance with bed mobility and substantial or maximal assistance with transfers and oral hygiene. The MDS documented Resident #6 had functional limitations in range of motion and impairments on both sides for the upper and lower extremities. The MDS included diagnoses of non-Alzheimer's dementia (brain function decline) and Huntington's disease (neurodegenerative disorder). The Safe Smoking assessment dated [DATE] documented Resident #6 didn't smoke safely. The assessment documented Resident #6 didn't have fine motor skills needed to securely hold the cigarette. The assessment revealed Resident #6 required supervision by staff, volunteers, or family at all times when smoking. The assessment documented Resident #6 must wear a smoking apron or cape and use a clothes pin (adaptive device to hold the cigarette) while smoking. The Care Plan with a target date of 7/8/26 revealed Resident #6 smoked and required supervision when she smoked. The care plan directed the following interventions:10/13/22: All smoking materials will remain at the nurses' station10/27/22: Resident #6 to be monitored by staff while smoking10/27/22: Resident #6 to smoke only in designated areas10/24/25: Attempt redirection with Resident #6 when she wants to smoke and it isn't time6/23/26: Verify with staff if Resident #6 has or hasn't been out to smoke before telling her no Resident #6's Care Plan lacked documentation regarding safety interventions per the smoking assessment which included the smoking apron and clothes pin. The Progress Note on 2/18/26 documented Resident #6 had two areas that resembled burns to her abdominal area. The note documented staff obtained an order to apply Silvadene cream (topical antibiotic cream) twice a day (BID) until healed. The Skin Condition Record dated 2/18/26 documented two burns to the abdomen. The assessment didn't document the degree of burn. The assessment documented epithelial tissue type and bright red surrounding skin color. The areas measured the following:#1 (lower abdomen)- 1.0-centimeter (cm) x 1.2 cm#2 (upper abdomen)- 0.9 cm x 0.9 cm The Progress Note dated 2/24/26 documented the Nurse Practitioner (NP) conducted rounds at the facility and received an update on Resident #6's status. Staff received new orders to apply Silvadene cream to burn areas BID until healed. Review of the February 2026 Medication Administration Record (MAR) revealed staff didn't start the Silvadene treatment on 2/18/26 per the progress note. The treatment started on 2/24/26. The Progress Note dated 2/24/26 documented staff applied the initial scheduled application of Silvadene to the two burn sites on the trunk and abdominal region. The sites presented bright red in color with a blistered appearance but no longer intact. The note documented maintained safe smoking measures including a flame-resistant apron, staff supervision, and a cigarette held via an adaptive device. The Progress Note dated 2/28/26 documented Resident #6 had difficulty sitting still and dropped her cigarette a total of six times. The Progress Note dated 3/4/26 at 3:05 PM documented new cigarette burns to the lower abdomen and left thigh. The note documented staff assessed and measured the areas, and obtained a new order to apply Silvadene cream to the areas. The Skin Condition Record dated 3/4/26 documented two burns to the lower abdominal area and left thigh. The assessment didn't document the degree of burn. The assessment documented epithelial tissue type and normal surrounding skin color. The areas measured the following:#1 (Left thigh)- 2.0 cm x 1.5 cm x 0.1 cm#2 (abdomen)- 0.5 cm x 0.4 cm The Physician order dated 3/4/26 at 9:02 PM documented (continued on next page)

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	06/30/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Silvadene to the abdomen and bilateral thighs due to burns BID until healed. The Skin Condition Record dated 3/4/26 lacked any documentation regarding a burn to Resident #6's right thigh. The Clinical Record lacked documentation that staff notified Resident #6's family regarding the burns and treatment order on 3/4/26. The Progress Note dated 3/7/26 documented Resident #6's dressing to the left thigh remained clean, dry, and intact, and a Silvadene treatment remained in place on the pubis area (groin area) due to cigarette burns. Review of the Clinical Record lacked any additional smoking assessments or safety interventions after the burns occurred on 3/4/26. The Progress Note dated 3/17/26 documented Resident #6 had various burn sites on her bilateral hands that presented with intact blistered areas. The burn site on the left inner thigh presented with dark red or brown intact scabbing. The Clinical Record lacked any skin assessments, treatments, or notification to the Physician regarding the burns or blistered areas on Resident #6's hands on 3/17/26. Review of the Clinical Record lacked any additional smoking assessments or safety interventions after the burns occurred on 3/17/26. The Progress Note dated 3/25/26 documented Resident #6 had several burn sites on bilateral hands. The note lacked clarity on whether the burns arrived as new or existed from 3/17/26. The note documented staff continued to monitor Resident #6's smoking of cigarettes to ensure safety. The note indicated even with staff available to watch Resident #6, burns continue to occur often and staff would likely begin a discussion on Resident #6's inability to remain safe while smoking. The Clinical Record lacked any skin assessments, treatments, or notifications to the Physician or family regarding the burn areas on Resident #6's hands on 3/25/26. Review of the Clinical Record lacked any additional smoking assessments or safety interventions after the burns occurred on 3/25/26. The Progress Note dated 4/6/26 documented Resident #6's cigarettes became stuck to her lips, resulting in a small burn to the upper chest. The Clinical Record lacked any skin assessments, treatment orders, or notifications to the Physician or family regarding the burn to Resident #6's chest on 4/2/26. Review of the Clinical Record lacked any additional smoking assessments or safety interventions after the burn occurred on 4/2/26. The Progress Note dated 4/8/26 documented the nurse reached out to Resident #6's sister to provide an update on Resident #6's condition. The note documented Resident #6 had been forgetting how to smoke and put the cherry (burning tip) of the cigarette towards her mouth. The note documented Resident #6 switched to a vape. On 6/29/26 at 11:10 AM, the Director of Nursing (DON) verified staff completed the last written smoking assessment for Resident #6 in February 2026. The DON reported she'd reassessed Resident #6 and identified that Resident #6 changed regarding her smoking but didn't put it in writing. When asked what new safety interventions staff put in place when the burns occurred, the DON said they switched Resident #6 to a vape at the beginning of April 2026. On 6/29/26 at 12:40 PM, the DON verified she didn't have any skin assessments for Resident #6's burns to her hands or chest. On 6/29/26 at 9:43 PM, Staff H, Licensed Practical Nurse (LPN) reported that she'd passed on in a report to the day shift that staff needed to evaluate Resident #6 for switching to a vape. Staff H said Resident #6 had started going downhill and she'd mentioned switching to a vape a while ago (3 to 6 months ago). Staff H said she'd taken Resident #6 out to smoke, just the two of them, and at times Resident #6 would hold the clothes pin and smoke, and at other times she'd drop the cigarette. She said she'd tell Resident #6 to slow down and take her time. She said she'd watch Resident #6 very carefully and ensure her smoking apron remained on and covered her neck and legs. She said when staff finally switched Resident #6 to a vape, Resident #6 made the comment that someone finally listened. When asked if Resident #6 sustained injuries from smoking, she said yes. She said staff performed treatments on Resident #6's bilateral thighs. She said one thigh required a bandage but she couldn't recall which one. Staff H said Resident #6 also had areas on her chest and abdomen. Staff H said due to Resident #6's burns, the facility needed to switch her to a vape. When asked if any staff members ever voiced concerns about Resident #6's smoking, she said yes, some Certified Nursing Assistants (CNAs) would voice that Resident #6 smoked too fast or didn't hold the clothes pin. She said sometimes Resident #6 would flick her wrist and she'd have concerns about where the cherry (continued on next page)

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	06/30/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	from the cigarette would end up or that she'd touch her hands with it. She said she'd instruct Resident #6 to slow down and calm down while smoking. When asked if Resident #6 would follow the instructions or cues, she said not necessarily but they tried. On 6/30/26 at 10:03 AM, Staff E, Registered Nurse (RN) reported she knew that the Silvadene treatment started right away on 2/18/26. She commented that staff must not have transcribed the order right away. On 6/30/26 at 10:07 AM, Staff C, Registered Nurse (RN) reported Resident #6 would burn herself occasionally while smoking. Staff C said if she witnessed Resident #6 burn herself while smoking, she'd stop the smoking and take her inside to assess the area. She said if the area blistered and remained intact, she'd leave it open to air. She said if the area remained open, she'd cleanse the area and cover it with a non-adherent dressing or wrap. She said Resident #6 did pretty well about leaving the dressing alone. Staff C said Resident #6 would get burns on her hands frequently. She said when it comes to interventions at the facility, staff have to think outside the box. She said staff want to keep a resident safe but let them enjoy the time they have left. She said she did make a suggestion of using [NAME] gloves when Resident #6 smoked to keep the cigarette cherry away from her skin. She said she felt uncertain whether the suggestion went anywhere. Staff C said she thought the [NAME] gloves would allow Resident #6 to keep smoking, remain safe, and stop the burns on her hands. She said discussions occurred about the family providing a vape. She said when she left the facility at the end of March 2026, Resident #6 still smoked cigarettes with the smoking apron and clothes pin. On 6/30/26 at 9:12 AM, the DON reported she didn't have any other documentation to provide for Resident #6. She said it took a while for Resident #6 to accept the vape. She said she'd been in contact with Resident #6's family member multiple times to keep her updated. The DON said she could do a better job at documenting the notifications. She said she hopes reviewers look at the whole picture. She said the facility performed a lot of interventions and that the facility housed 20 residents with Huntington's disease. She said she understood that if staff don't document it, then it didn't happen. 2. Resident #8's Minimum Data Set (MDS) dated [DATE] assessment identified a Staff Assessment for Mental Status, indicating severely impaired cognition. The MDS identified Resident #6 depended on staff with oral hygiene and chair or bed-to-chair transfers. The MDS documented Resident #8 had functional limitations in range of motion and impairments on both sides for the upper and lower extremities. The MDS included diagnoses of non-Alzheimer's dementia (brain function decline), Huntington's disease (neurodegenerative disorder), and chorea (involuntary movements). The Safe Smoking assessment dated [DATE] documented Resident #8 didn't smoke safely. The assessment documented Resident #8 didn't have fine motor skills needed to securely hold the cigarette. The assessment revealed Resident #8 required supervision by staff, must wear a smoking apron or cape, and must use a clothes pin while smoking. The Care Plan with a target date of 7/23/26 revealed Resident #8 enjoyed smoking. The care plan directed the following interventions:3/26/20: Resident #8 to smoke in designated areas only6/29/26: Resident #8 to have supervision while smoking9/16/21: Resident #8 to use a clothes pin to hold the cigarette to prevent burns to fingers3/26/20: Resident #8 to use smoking apron while smoking3/26/20: Smoking materials are kept at the nurses' station The Skin Condition Record dated 3/4/26 documented a cigarette burn to the right collar bone that measured 0.8 cm x 1.2 cm. The assessment didn't document the degree of burn or wound characteristics. The form documented staff received a verbal order for Silvadene to the area BID until healed. The Progress Note dated 3/5/26 documented Resident #8 had a burn mark on her right clavicle. The note documented the wound nurse held awareness of the injury and staff completed a skin sheet. Resident #8's March 2026 Medication Administration Record (MAR) lacked documentation of a Silvadene treatment to Resident #8's clavicle. Review of the Clinical Record lacked any additional smoking assessments or safety interventions after the burn occurred on 3/4/26. The Progress Note dated 4/23/25 documented a cigarette burn on Resident #8's first knuckle of her left hand. The clinical record lacked documentation of any treatment for the burn area. The Skin Condition Record dated 4/23/26 documented a cigarette burn on the left first knuckle that measured (continued on next page)

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	06/30/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	1.0 cm x 0.7 cm. The assessment didn't document the degree of burn. The assessment documented no exudate (drainage) and normal surrounding skin color and wound edges. Review of the Clinical Record lacked any additional smoking assessments or safety interventions after the burn occurred on 4/23/26. The Progress Note dated 6/22/26 documented a burn or blister on Resident #8's left index finger. The note documented staff applied Silvadene to the area. The Skin Condition Record dated 6/22/26 documented a burn on the left first finger that measured 0.5 cm x 1.0 cm. The assessment didn't document the degree of burn. The assessment documented no exudate (drainage) and a bright red surrounding skin color. The Progress Note dated 6/23/26 documented the Nurse Practitioner (NP) conducted rounds at the facility and gave a new order to apply Silvadene cream to the burn on the finger BID until healed. On 6/29/26 at 9:43 PM, Staff H reported Resident #8 frequently sustained burns on her hands and clavicle. She said Resident #8 currently had a burn on her left index finger that staff treated with Silvadene. She said interventions in place for Resident #8 included a smoking apron, supervision, and a clothes pin. Staff H said she'd made comments to the day shift about switching Resident #8 over to a vape and staff told her Resident #8 wouldn't like it. Staff H said Resident #8 getting burns created a safety issue and something required adjustment. On 6/29/26 at 12:47 PM, Staff A, Registered Nurse (RN) reported she felt Resident #8 should use a vape. She said Resident #8 doesn't have the ability to hold the cigarette and her hands don't cooperate. Staff A said once in a while she'd brushed ashes off Resident #8's smoking apron. She reported Resident #8 currently had a burn on her finger and staff applied Silvadene to it. On 6/30/26 at 9:13 AM, Resident #8 sat outside in a reclining wheelchair with a smoking apron on. Resident #8 sat across from Staff J, Registered Nurse (RN). Resident #8's skin remained exposed around her neck and clavicle area. Resident #8 held the clothes pin with the cigarette and then threw it on the ground and concrete on the right side of her chair. Staff J didn't see Resident #8 throw the cigarette on the ground. Staff J looked in the other direction while smoking her own cigarette. Resident #1 picked up the cigarette off the ground and gave it to Staff J for disposal. Staff J made the comment, that's what happens when you look away for a second. On 6/30/26 at 10:05 AM, observed Resident #8's left index finger with a small, dry scabbed area with a small amount of redness around it. 3. Resident #9's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. The MDS identified Resident #9 required supervision or touching assistance with eating, and substantial or maximal assistance with oral hygiene and transfers. The MDS documented Resident #9 had functional limitations in range of motion and impairments on both sides for the upper and lower extremities. The MDS included diagnoses of non-Alzheimer's dementia (brain function decline), Huntington's disease (neurodegenerative disorder), chorea (involuntary movements), and tobacco use. The Safe Smoking assessment dated [DATE] documented Resident #9 didn't smoke safely. The assessment documented Resident #9 didn't have fine motor skills needed to securely hold the cigarette. The assessment revealed Resident #9 required supervision by staff, must wear a smoking apron or cape, and must use a clothes pin while smoking. The assessment documented Resident #9's family refused a vape and that the family held awareness of the risks and wanted to continue with the cigarettes. The Care Plan with a target date of 7/23/26 revealed Resident #9 enjoyed smoking. The care plan directed the following interventions:9/11/25: Resident #9 to smoke in designated areas only9/11/25: Resident #9 to use smoking apron while smoking9/11/25: Smoking materials are kept at the nurses' station9/11/25: Resident #9's family supplies smoking/tobacco supplies9/11/25: Resident #9 has 4 cigarettes per day, after meals and before bed at 8 PM The Progress Note dated 3/24/26 documented Resident #9 attended the 3 PM supervised smoking session. Staff reported Resident #9 leaned significantly forward while smoking, which caused an increased risk for a self-inflicted burn due to poor positioning and poor trunk control related to the progression of chorea. Resident #9 couldn't maintain an upright position and the staff member extinguished the cigarette due to safety concerns. The Progress Note dated 4/9/26 documented Resident #9 wouldn't sit up and kept burning herself with the cigarette, so staff took the (continued on next page)

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	06/30/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	cigarette away. The Progress Note dated 4/10/26 documented Resident #9 leaned significantly forward when smoking, which made it difficult for her to safely hold a cigarette. The Progress Note dated 4/26/26 documented Resident #9 demanded a cigarette. While outside, Resident #9 required several prompts to sit upright in the wheelchair while she smoked because she leaned down frequently, which caused staff concerns for a risk of falling. The Progress Note dated 6/28/26 documented Resident #9 smoked outside in the wheelchair with a smoking apron on. Resident #9 repeatedly leaned forward, requiring close supervision due to the nurse's concern about her falling from the wheelchair. Resident #9 finished smoking her cigarette, staff removed the cigarette, and she became verbally and physically aggressive with the staff. On 6/29/26 at 12:47 PM, Staff A reported she held concerns with Resident #9 smoking and felt she should use a vape. Staff A said Resident #9 leaned forward and needed constant reminders to sit up straight. She said it concerned her when Resident #9 leaned forward while smoking a cigarette. On 6/29/26 at 9:43 PM, Staff H reported Resident #9 leaned forward when she went out to smoke. Staff H said switching Resident #9 to a vape would represent a great change. She said she feared Resident #9 would either burn herself or fall face forward onto the concrete. She said she passed it on in a nurse-to-nurse report a couple of months ago but nothing changed. The Resident Smoking Policy dated August 2018 directed that facility staff or a resident's competent visitor must supervise all smoking residents unless staff assessed them as a safe smoker following completion of the smoking assessment. The policy instructed that the interdisciplinary team may complete a smoking evaluation at any time deemed necessary, which may result in a re-classification of smoking status. The Smoking Policy - Residents dated July 2017 directed the facility to establish and maintain safe resident smoking practices. The policy instructed staff to consult with the Attending Physician and the DON to determine if safety restrictions need placement on a resident's smoking privileges based on the Safe Smoking Evaluation. The policy directed staff to re-evaluate a resident's ability to smoke safely quarterly, upon significant physical or cognitive changes, and as determined by staff. The policy instructed that staff note any smoking-related privileges, restrictions, and concerns on the care plan, and alert all personnel caring for the resident to these issues. The policy directed that the facility may impose smoking restrictions on a resident at any time if staff determined that the resident cannot smoke safely with available levels of support and supervision. The policy instructed that any resident with restricted smoking privileges requiring monitoring must have the direct supervision of a staff member, family member, visitor, or volunteer worker at all times while smoking.

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	06/30/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, physician interview and policy review, the facility failed to obtain a follow up urinalysis (UA) after completion of an antibiotic for a urinary tract infection (UTI) as ordered by the Physician for 1 of 3 residents reviewed (Resident #5). The facility reported a census of 34 residents.Findings include: Resident #5's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS identified Resident #5 was dependent on staff with transfers to the toilet and toileting hygiene. The MDS documented Resident #5 was always incontinent of bowel and bladder. Resident #5's MDS included diagnoses of Huntington's disease (neurodegenerative disorder) and non-Alzheimer's dementia. The Care Plan with a target date 6/18/26 lacked documentation regarding Resident #5's urinary incontinence or risk for UTIs. The Progress Note dated 3/20/26 documented a new order was received to obtain UA with culture and sensitivity (C&S) if indicated. According to the note the UA was obtained via sterile technique. The Progress Note dated 3/22/26 documented the UA culture was positive for E-coli (bacteria that normally lives in the intestines). New orders were received to start Cipro (antibiotic) 500 mg (milligrams) twice a day for 10 days and to recheck a UA in 14 days. The final Microbiology Report dated 3/22/26 documented the UA culture grew out greater than 100,000 cFu/ml (colony-forming units per milliliter) Escherichia coli (E-Coli). Resident #5's April 2026 Medication Administration Record directed staff to recheck the UA with a start date of 4/6/26. The MAR documented 9 on 4/7/26 which indicated to see the nursing progress notes. The Progress Note on 4/7/26 documented staff was waiting for direction from Resident #5's Physician on using a straight catheter to obtain the UA per the night nurse request. Review of the Clinical Record lacked documentation a clarification order was received from the Physician or that the UA was obtained. On 6/23/26 at 1:45 PM, Resident #5's Primary Care Physician (PCP) reported she had ordered an antibiotic for a UTI and wanted the UA rechecked to ensure the UTI was resolved. She said she wanted to make sure Resident #5 was comfortable. The PCP reported she was not aware the UA was not obtained and would have expected the order to be followed. On 6/23/26 at 3:43 PM, the Assistant Director of Nursing (ADON) reported she could not locate any documentation that Resident #5's UA was rechecked per the physician order. The facility policy titled Urinary Tract Infection/Bacteriuria revised April 2018 documented the physician and nursing staff would review the status of individuals who are being treated for a UTI and adjust treatment accordingly. Follow up urine cultures after antibiotic treatment are not indicated routinely, but may be helpful if the symptoms are not resolving or complications are present.

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	06/30/2026

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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review the facility failed to implement weight loss interventions in a timely manner for 2 of 3 residents reviewed (Resident #6 and #3) for weight loss. The facility reported a census of 34 residents. Findings include:1. Resident #6's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The MDS identified Resident #6 required substantial or maximal assistance with eating. The MDS included diagnoses of non-Alzheimer's dementia (brain function decline) and Huntington's disease (neurodegenerative disorder). The MDS documented Resident #6 experienced signs and symptoms of a swallowing disorder including loss of liquids or solids from the mouth when eating or drinking, holding food in the mouth or cheeks, maintaining residual food in the mouth after meals, and coughing or choking during meals or when swallowing medications. The MDS documented Resident #6 received a mechanically altered diet and a therapeutic (healing) diet. The Care Plan (CP) with a target date of 7/8/26 documented Resident #6 maintained an impaired or altered nutritional status. The CP directed the following interventions:10/13/22: Consult a dietitian per order10/13/22: Consult speech therapy if staff suspected swallowing issues10/13/22: Encourage intake of nutritional supplements between meals10/13/22: Provide companionship during mealtime11/18/25: Pureed diet with nectar thickened liquids12/30/25: Resident #6 ate in the dining room at a table for supervision and safety2/9/26: Two handled cup with lids and a Dycem (non-slip) mat on the table The Progress Note (PN) dated 4/7/26 documented staff transferred Resident #6 to the emergency room for an elevated temperature. The PN dated 4/8/26 documented Resident #6 admitted to the hospital with aspiration pneumonia (serious lung infection from inhaling foreign material) and received intravenous (IV) antibiotics. The PN dated 4/10/26 documented Resident #6 returned from the hospital and recorded a weight of 138.8 pounds (lbs.). The Hospital Discharge summary dated [DATE] documented a discharge weight of 95.7 lbs. The Weight Summary (WS) documented the following weights over the last six months and the scale staff used to obtain the weights:12/1/25 - 101.2 lbs.- standing1/12/26 - 108.4 lbs.- standing1/27/26 - 109 lbs.- wheelchair2/9/26 - 107.4 lbs.- standing3/9/26 - 110.2 lbs.- standing4/14/26 - 104.4 lbs.- standing6/5/26 - 91.0 lbs.- wheelchair The Dietary Note (DN) dated 4/15/26 revealed the Registered Dietitian (RD) requested a reweight to verify a weight change. The RD documented she'd follow up once staff obtained the new weight. The Consultant Dietitian Report (CDR) dated 4/22/26 requested a reweight for Resident #6. The report documented the request in red ink and directed staff to complete the items in red prior to the next RD visit. The CDR documented Resident #6 experienced a 5.3% weight loss in one month and lost 5.8 lbs. The DN dated 4/23/26 documented the completion of the quarterly assessment. Resident #6 maintained a current weight of 104.4 lbs., which reflected a 5.3% weight loss in one month and a 4.2% weight loss in three months. The RD documented she'd follow up once staff obtained a reweight and offered no new dietary recommendations. Review of the Clinical Record (CR) lacked documentation that staff notified the Physician or family of the 5.3% weight loss in one month. The facility paper form titled Monthly Weights for April 2026 documented Resident #6 weighed 104.4 lbs. Someone crossed out the 104.4 lbs. weight and documented a new weight of 98 lbs. The form lacked dates regarding when staff obtained the weights, and the electronic medical record (EMR) didn't contain the 98 lbs. weight. The CR lacked documentation that staff notified the RD of the 98 lbs. weight. The facility paper form titled Monthly Weights for May 2026 documented Resident #6 weighed 93.8 lbs. The form lacked a date regarding when staff obtained the weight, and the EMR didn't contain the 93.8 lbs. weight. The CR lacked documentation that staff notified the RD of the 93.8 lbs. weight. The CDR dated 5/9/26 requested a reweight for Resident #6 for the second month. The PN dated 6/4/26 documented the facility received an email from the Nurse Practitioner (NP) containing an order to increase the house supplement to 120 milliliters (ml) three times a day due (continued on next page)

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	06/30/2026

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 0692 Level of Harm - Actual harm Residents Affected - Few	to recent weight loss. The PN titled Weight Change Note (WCN) dated 6/10/26 documented a current weight of 91 lbs. on 6/5/26. Resident #6 weighed 110.2 lbs. on 3/9/26, reflecting a 17.4% weight loss (19.2 lbs.) in three months. Resident #6 weighed 101.2 lbs. on 12/1/25, reflecting a 10.1% weight loss (10.2 lbs.) in six months. On 6/24/26 at 11:52 AM Staff I, Dietitian reported that staff sometimes struggled to obtain reweights from the facility. She said without the reweights, she based her assessments on the EMR documentation. Staff I verified nobody notified her of any reweights for Resident #6. Staff I reported she only possessed access to the weights documented in the EMR. She said she never saw any weights on a paper form. Staff I said she worked remotely so she didn't have a way of knowing about weights unless the facility emailed her. She said the facility held awareness of her remote work status. She said she moved out of state and the facility's staff held the responsibility to document weights in the EMR. Resident #3's Minimum Data Set (MDS) dated [DATE] assessment identified a BIMS score of 14, indicating intact cognition. The MDS identified Resident #3 required supervision or touching assistance with eating. The MDS included diagnoses of Huntington's disease (neurodegenerative disorder). The MDS documented Resident #3 received a therapeutic diet. The CP with a target date of 7/6/26 documented Resident #3 faced a risk for aspiration (inhaling foreign material) related to dysphagia (difficulty swallowing). The CP directed the following interventions:9/11/25: Assist with eating or drinking as needed9/11/25: Diet as ordered9/11/25: Observe Resident #3 during meal times for any signs and symptoms of aspiration or difficulty swallowing9/11/25: Staff to report any signs or symptoms of aspiration to the nurse (choking, eyes watering, coughing) The WS documented the following weights over the last three months:3/22/26 - 190.8 lbs.3/29/26 - 184.4 lbs.4/14/26 - 189 lbs.4/26/26 - 183.4 lbs.5/10/26 - 180 lbs.5/18/26 - 183.4 lbs.5/24/26 - 180.4 lbs.5/31/26 - 177.8 lbs.6/5/26 - 175.2 lbs.6/7/26 - 176.2 lbs.6/21/26 - 172.2 lbs. The PN titled WCN dated 6/10/26 documented Resident #3 experienced a significant weight loss in the past three months. Resident #3's current weight measured 176.2 lbs. and his weight on 3/22/26 equaled 190.8 lbs., representing a 7.7% weight loss in three months (14.6 lbs.). The RD recommended adding a house supplement of 120 ml every day to promote weight stability. The facility form titled Physician Fax dated 6/10/26 documented Resident #3 experienced a significant weight loss in the last three months. The form recommended the house supplement of 120 ml every day to promote weight stability. The NP agreed with the recommendation and signed the form on 6/16/26, six days after the RD made the recommendation. None of the facility nursing staff noted the form. Review of the CR and June 2026 Medication Administration Record (MAR) revealed staff didn't start the house supplement per the Physician order. Resident #3 weighed 172.2 lbs. on 6/21/26 and lost an additional 4 lbs. since the RD made the recommendation on 6/10/26. On 6/23/26 at 1:45 PM the NP reported she held awareness of Resident #3's recent weight loss. She said she addressed the Physician Fax form dated 6/10/26 onsite on 6/16/26. She said the facility didn't fax or call her about the weight loss. The NP reported she'd expect staff to start supplements within 24 hours. She said this demonstrated a lack of process and communication at the facility. On 6/23/26 at 2:32 PM the Assistant Director of Nursing (ADON) acknowledged staff hadn't started Resident #3's supplement. She said she hadn't noted the form herself so she knew staff hadn't started the supplement. The ADON said she didn't hold awareness of the form and didn't feel sure how the form entered the medical record. She said the dietitian arrived as a new staff member and she'd never met her. She said the dietitian comes in late in the afternoons. When asked about staff notifying the Physician a week after staff noted the weight loss, she said she'd expect staff to email the information to the NP but she didn't see that information documented on the form either. She said the facility had some work to do with the dietitian. The ADON requested to have the form placed on her desk so she could address it. On 6/23/26 at 2:38 PM the ADON said she added the supplement to the June MAR. The Weight Management policy lacking a date instructed the facility to provide care and services related to weight management in accordance with state and federal regulations. The policy directed the following procedures:Staff must complete monthly weights by the fifth of each month.Dietary staff must evaluate all weights by the seventh of (continued on next page)

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	06/30/2026

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 0692 Level of Harm - Actual harm Residents Affected - Few	each month.Staff must obtain a reweight for any weight changes of plus or minus three lbs. from the previous weight unless the physician ordered other parameters.Staff must obtain all reweights immediately, and a licensed nurse must visualize the reweight process.Staff must document all weights in the resident's EMR.The resident's nurse must notify the physician and the resident or Resident Representative of any significant unexpected or unplanned weight changes and document the notification in the resident's EMR.

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	06/30/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility investigation file, observation, staff interviews, and facility policy review, the facility failed to have two staff members present when narcotic medications were destroyed for 4 of 4 residents reviewed for controlled substance use (Resident #1, #2, #3, #4). Additionally, the facility failed to remove expired medications from the medication cart in a timely manner (Resident #3 and Resident #4) and have a system in place to adequately dispense and reconcile controlled drugs (Resident #1 and #6). The facility reported a census of 34 residents. Findings include:1. Resident #1's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS identified Resident #1 functioned independently with bed mobility, transfers, and ambulation. The MDS included diagnoses of Huntington's disease (neurodegenerative disorder). The MDS documented Resident #1 received opioid medication during the last 7 days. Resident #1's March 2026 Medication Administration Record (MAR) revealed an order for Methadone Hydrochloride (HCL) (opioid medication) 10 milligrams (mg)- give 9 tablets in the morning for pain management related to Huntington's disease. The order started on 3/24/26 and ended on 3/28/26. A Physician order dated 3/27/26 directed staff to change Resident #1's Methadone 90 mg in the morning to liquid form. The March 2026 MAR revealed an order for Methadone HCL oral solution 10 mg/5 milliliters (ml)- give 90 mg in the morning for pain with a start date of 3/28/26. The Controlled Drug Receipt/Record/Disposition form for Resident #1 documented the facility received 90 tablets or 10 doses of Methadone (10 mg) on 3/23/26 from the pharmacy. The form documented Staff C, Registered Nurse (RN) on 3/28/26 at 9:30 PM destroyed 54 Methadone tablets via the drug buster (drug disposal system) without a witness. The Controlled Drug Receipt/Record/Disposition form for Resident #1 directed staff to administer Methadone Concentrate 10 mg/ml- take 9 ml (90 mg total) daily. The form on 4/16/26 at 8:15 AM documented staff administered 9 ml and left 117 ml. A note written next to the two nurses' signatures documented staff wasted 4 ml. On the next line on the form dated 4/16/26 at 8:27 AM documented staff administered 4 ml and left 113 ml. The May 2026 MAR directed staff to give Methadone Oral Concentrate 10 mg/ml- give 44 mg by mouth twice a day (BID) for pain related to opioid dependence (opioid addiction) with a start date of 5/22/26 and end date of 5/25/25. The Controlled Drug Receipt/Record/Disposition form for Resident #1 revealed staff didn't update the form on 5/22/26 with the new Methadone orders. The form documented on 5/22/26 at 12:40 PM, Staff D, Licensed Practical Nurse (LPN) gave 4.4 ml with a negative balance of 1.2 ml left. According to the record, the bottle contained 3.2 ml when Staff D administered the medication. Staff A, Registered Nurse (RN) documented a note on the next line adjusting the remaining amount in the bottle to 4 ml. On 6/24/26 at 2:30 PM, Staff E, Registered Nurse (RN) reported she spilled Resident #1's Methadone during administration on 4/16/26. Staff E said she'd measured the Methadone using a syringe and put the 9 ml in a medication cup. She said after the medication spilled, 5 ml remained in the cup so she knew 4 ml spilled out. On 6/25/26 at 9:24 AM, Staff D verified she documented the negative 1.2 ml on the narcotic record with Staff A present as a witness. She said the stopper in the bottle holds liquid and once she removed the stopper, the liquid came out. She said she'd enough to give 4.4 ml per the order because she removed the stopper. She said she then adjusted the remaining amount in the bottle with Staff A to reflect what remained in the bottle. On 6/25/26 at 2:25 PM, Staff A said staff struggled to see the marks on the Methadone bottle so they marked the bottle with some tape. She said Staff D needed to give 4.4 ml and the bottle contained more than the 3.2 ml documented on the narcotic record. Staff A said ideally the bottle shouldn't contain enough to give the dose, which caused a negative balance on the narcotic record. She said after Staff D administered the 4.4 ml, she dumped out the medication into a medication cup and then measured the medication with a (continued on next page)

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	06/30/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	syringe. She said 4 ml remained and she updated the record. She said the syringes don't fit well in the stopper and some of the medication gathers around the stopper. She said the liquid bottles aren't ideal. She said they couldn't do better than eyeballing it unless they dumped out the medication each time and measured with a syringe each time. 2. Resident #2's Minimum Data Set (MDS) dated [DATE] assessment identified a BIMS score of 15, indicating intact cognition. The MDS identified Resident #2 functioned independently with bed mobility, transfers, and ambulation. The MDS included diagnoses of Huntington's disease (neurodegenerative disorder). The March 2026 MAR revealed an order for Adderall (central nervous system stimulant) 10 mg in the morning for ADHD (attention deficit hyperactivity disorder) related to Huntington's disease. Staff put the medication on hold starting 3/5/26 and discontinued it on 3/24/26. The Controlled Drug Receipt/Record/Disposition forms for Resident #2 documented the facility received 30 tablets of Adderall 10 mg on 2/23/26 and received an additional 30 tablets on 3/20/26 from the pharmacy. The forms documented Staff C on 3/28/26 at 9:30 PM destroyed 51 Adderall tablets via the drug buster without a witness. 3. Resident #3's Minimum Data Set (MDS) dated [DATE] assessment identified a BIMS score of 14, indicating intact cognition. The MDS identified Resident #3 functioned independently with bed mobility, transfers, and ambulation. The MDS included diagnoses of Huntington's disease (neurodegenerative disorder). The February 2026 MAR revealed an order for Clonazepam (central nervous system depressant) 1 mg BID for Huntington's Disease with a start date of 10/31/25 and end date of 3/11/26. Review of the Clinical Record revealed Resident #3 entered the hospital on 2/16/26 and returned to the facility on 3/11/26. The Hospital Discharge Summary on 3/11/26 directed Resident #3 to stop taking the Clonazepam medication. Resident #3's Clonazepam medication remained in the medication cart during Resident #3's hospitalization and stayed in the cart after its discontinuation until 3/28/26. The Controlled Drug Receipt/Record/Disposition form for Resident #3 documented the facility received 30 tablets of Clonazepam 1 mg on 2/10/26 from the pharmacy. The forms documented Staff C on 3/28/26 at 9:30 PM destroyed 24 Clonazepam tablets via the drug buster without a witness. 4. Resident #4's Minimum Data Set (MDS) dated [DATE] assessment identified a staff assessment for mental status, indicating severely impaired cognition. The MDS identified Resident #4 required substantial/maximal assistance with bed mobility and transfers. The MDS included diagnoses of hypertension (high blood pressure), non-Alzheimer's dementia (brain function decline), and restless leg syndrome (uncomfortable leg sensations). The MDS documented Resident #4 received hospice care while residing at the facility. The Pharmacy Review form dated 7/9/25 documented Resident #4 had an order for Lorazepam 0.25 mg by mouth every four hours as needed. The form documented to continue the medication for 180 days and reevaluate. The January 2026 MAR documented staff discontinued the Lorazepam order on 1/12/26. The clinical record lacked documentation that the physician re-evaluated the order for Lorazepam. Resident #4's Lorazepam medication remained in the medication cart after its discontinuation on 1/12/26 until 3/28/26. The Controlled Drug Receipt/Record/Disposition form for Resident #4 documented the facility received 30 tablets of Lorazepam 0.5 mg (60 doses 1/2 tab each) on 6/18/25 from the pharmacy. The forms documented Staff C on 3/28/26 at 9:30 PM destroyed 57 1/2 doses of Lorazepam via the drug buster without a witness. 5. Resident #6's Minimum Data Set (MDS) dated [DATE] assessment identified a BIMS score of 9, indicating moderately impaired cognition. The MDS identified Resident #6 required partial/moderate assistance with bed mobility and substantial/maximal assistance with transfers. The MDS included diagnoses of non-Alzheimer's dementia (brain function decline) and Huntington's disease (neurodegenerative disorder). The June 2026 MAR revealed an order for Clonazepam 0.5 mg give 0.25 mg BID for mood disturbance (Give 1/2 tab BID to equal 0.25 mg). The order had a start date of 6/3/26. Review of the Controlled Drug Receipt/Record/Disposition form for Resident #6 revealed the directions on the form didn't match the physician order on the June 2026 MAR. The form documented the facility received 60 tablets of Clonazepam 0.5 mg tablets on 4/10/26. Someone crossed out the quantity received of 60 and wrote the number 30 next to it. The number of (continued on next page)

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	06/30/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented doses equaled 30. On 6/17/26 at 2:00 PM, observation of Resident #6's Clonazepam medication card revealed the pharmacy label on the card directed to administer Clonazepam 0.5 mg take 1 tablet by mouth BID and take 1 tablet by mouth daily as needed. On the top right-hand corner of the medication card, black marker writing directed to take 1/2 tab (0.25 mg) BID and one tab (0.5 mg) every 24 hours. The medication card had 8 whole tablets in the card. Observation of the back of the medication card revealed several pieces of tape demonstrating staff previously put the Clonazepam medication back into the card to use at a later time. The Director of Nursing (DON) attended the observation and reported the facility commonly taped the unused half tablet back in the medication card for the next dose. On 6/17/26 at 1:35 PM, Staff F, Certified Medication Assistant (CMA) reported when the pharmacy sent a whole tablet of a controlled substance and the order specified a half tablet, some staff would put the unused half of the tablet back in the card for the next dose. Staff F said when she administered medication, she'd tape the half tablet back in the medication card and put a date and her initials on it. She said some nurses say technically you can't do that and that you should destroy the unused half of the tablet rather than putting it back in the card. She said last night when passing medications to Resident #6 she had to break the Clonazepam tablet in half. She said she taped the unused half of the tablet back into the card. On 6/17/26 at 2:55 PM, Staff G, Registered Nurse (RN) reported she'd heard over the years that you shouldn't put a medication back in the medication card. She said most pharmacies send the correct dosage. She said with Resident #6, staff taped the unused half of the Clonazepam tablet back into the medication card. She said she'd saved half of the tablet to waste and someone told her to tape it back in place as the facility practiced that. On 6/17/26 at 3:43 PM, Staff H, Licensed Practical Nurse (LPN) reported she usually worked nights and didn't administer Resident #6's clonazepam. She said the nurses do have to score it and they put the unused medication back in the medication card. She said when doing narcotic counts, staff find half tablets taped back in the medication card and the narcotic count reflected the half doses. On 6/18/26 at 11:00 AM, the Assistant Director of Nursing (ADON) reported staff should dispose of narcotic medications right away when they are discontinued. She said the narcotic count sheet and medication card should be together when disposing of the medications. She said two nurses must pop out the medication in a cup to verify the correct amount, put the medications in the drug buster, and both sign off on the paperwork verifying the destruction of the medication. The ADON reported CMAs could act as a witness. She said the Pharmacy Consultant reported anyone over the age of 18 could act as a witness and sign off on the medication record. On 6/18/26 at 12:07 PM, the ADON verified the facility discontinued Resident #4's Lorazepam off the MAR in January and Resident #3's Clonazepam upon return from hospitalization in March. On 6/22/26 at 9:25 AM, Staff C reported several narcotics needed destruction as they no longer had active orders. She said she wanted it done before the Department of Inspections, Appeals, and Licensing (DIAL) entered the facility as she didn't want DIAL to find the medications. She said she'd planned to destroy the discontinued narcotic medications with Staff G when she arrived for the third shift. She said she'd reached out to the ADON regarding the medications without active orders and getting rid of them. She said Staff G arrived late for the third shift, a common occurrence. Staff C said she popped out the narcotic medications into separate cups so they could be counted when Staff G got to work. She said she locked the medication cups in a drawer in the medication cart as she needed to check on a resident. Staff C acknowledged she shouldn't have popped out the pills ahead of time. She said when she returned and opened the drawer on the medication cart, she found a knocked-over cup and loose pills inside the drawer. Staff C said she couldn't have loose narcotics in the drawer so she disposed of all the medications into the drug buster. Staff C said she should've had the CMA who worked watch her. She said the drug buster almost overflowed. She said she left the drug buster on the counter and didn't go back into the medication room. Staff C acknowledged she knew some issues would arise from her actions. She said an expectation existed to have a witness when destroying narcotics. When asked which residents' narcotics she destroyed, she said she didn't remember their names but reported several residents. (continued on next page)

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	06/30/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff C said she panicked because Staff G didn't arrive on time. She said she expressed frustration as it happened every time Staff G worked. She said she should've expected Staff G to be late and disposed of the narcotic medications the right way. Staff C said the facility suspended and later terminated her for failing to follow facility protocol. When asked who held responsibility for removing discontinued medications from the medication carts, Staff C reported the facility designated one person to do rounds with the Nurse Practitioner. She said the ADON would do the rounds and then give a list of new orders to the nurses. She said staff didn't always remove the medication card when a medication discontinuation occurred. She said the same thing happened when a psychotropic medication stopped after a certain duration. She said the psychotropic medication would fall off the MAR but remain in the cart. She said medication discontinuations didn't trigger the nurses to pull the card. On 6/24/26 at 9:18 AM, the DON said she received a phone call from Staff G, who reported Staff C's solo destruction of narcotic medications and request for Staff G to sign off. She said Staff G expressed distress. She said Staff G laid everything out to her and identified the involved residents and the number of medications Staff C destroyed for each resident. She said she called the Administrator and started an investigation immediately. She said she called Staff C and learned Staff C wanted to leave and Staff G arrived late for work. She said Staff C admitted to her actions and knew she committed an error. The Discarding and Destroying Medications policy dated June 2025 directed staff to dispose of medications in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste, and controlled substances. The policy instructed that disposal of controlled substances must take place immediately, defined as no longer than three days, after discontinuation of use. The policy directed that the medication disposition record contain the following information:a. The resident's nameb. Date of medication disposalc. The name and strength of the medicationd. The name of the dispensing pharmacye. The quantity of disposalf. Method of dispositiong. Reason for dispositionh. Signature of witnesses

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	06/30/2026

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility didn't clarify and implement an emergency overdose medication order upon admission, failed to maintain an available stock of emergency medication, didn't provide staff with access or training for the automated medication storage system, and failed to accurately measure and administer titrated liquid narcotic doses for 1 of 1 resident reviewed (Resident #1).The State Agency informed the facility of the Immediate Jeopardy (IJ) on [DATE] at 1:45 PM that began as of [DATE]. The Facility Staff removed the IJ on [DATE] through the following actions:-On [DATE] the Director of Nursing (DON) met with each nurse and Certified Medication Aide (CMA) showing the location of the Narcan in each medication cart and how to use it.-On [DATE] the Pharmacy delivered Narcan along with the fact sheet on the usage and a nasal spray of Narcan was placed in both medication carts. The DON met with all nursing staff on the usage of the Narcan spray.-On [DATE] an audit was completed for current Medbank users. Access was granted to Staff A, RN. The facility orientation packet has been updated to include enrolling nursing staff to have Medbank access. The scope lowered from a J to D at the time of the survey after ensuring the facility implemented education and Narcan was available in each medication cart. The facility reported a census of 34 residents.Findings include:Resident #1's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS identified Resident #1 functioned independently with bed mobility, transfers, and ambulation. The MDS included diagnoses of Huntington's disease (progressive brain disorder). The MDS documented Resident #1 received opioid medication during the last 7 days. The Care Plan (CP) with a target date of [DATE] revealed Resident #1 received pain medication therapy related to a disease process and previous injury. The CP documented Resident #1 took Methadone (strong pain reliever), an opioid that came with a black box warning (strict safety warning). The CP and black box warning documented the following directions:Staff must follow residents for signs and symptoms of respiratory depression (slowed breathing) and sedation (severe drowsiness); if the resident appeared visibly sedated, staff must evaluate the cause of the sedation;Must instruct personnel on how to measure and administer the correct dose of Methadone oral solution and use extreme caution when measuring the doseStaff must use a device that can measure and deliver the prescribed dose accuratelyStaff must ensure clear communication of the dose and accurate dispensing because dosing errors can result in accidental overdose or death. A. The Clinical Census revealed Resident #1 entered the facility on [DATE]. The Discharge Summary with a date of service from [DATE] to [DATE] documented Resident #1's principal diagnosis included acute hypoxic and hypercapnic respiratory failure (severe breathing failure with high carbon dioxide levels) secondary to respiratory depression (slowed breathing). The Discharge Summary revealed Resident #1 required intubation (breathing tube insertion) from medication-related side effects during the hospital stay. The After Visit Hospital Summary and Physician orders dated [DATE] documented the following orders:Methadone 10 mg (milligrams) tablets to take 9 tablets (90 mg total) daily for a diagnosis of opioid use disorder (drug addiction) in remissionNarcan (Naloxone) (emergency overdose drug) 0.4 mg/ml (milliliters) to inject 0.25 ml (0.1 mg total) intravenously (IV) (directly into the vein) as needed (PRN) if the patient became unarousable. Review of the [DATE] and [DATE] Medication Administration Records (MAR) revealed the following orders:Methadone 10 mg- give 9 tablets in the morning for pain management related to Huntington's disease with a start date of [DATE] and end date of [DATE].Methadone Hydrochloride (HCL) oral solution 10 mg/5 ml- give 90 mg in the morning with a start date of [DATE] and end date of [DATE]Methadone Oral Concentrate 10 mg/ml- give 9 ml in the morning with a start date of [DATE] and end date of [DATE]. The Clinical Record lacked documentation that staff clarified the Narcan IV order received on admission. Review of the [DATE] and [DATE] MARs lacked documentation of the Narcan order. The Progress Note dated [DATE] (continued on next page)

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	06/30/2026

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	documented a Certified Nursing Assistant (CNA) alerted the nurse that Resident #1 didn't look right. Upon the nurse entering the room, Resident #1 lay in bed and presented as cyanotic (blue skin discoloration) with blue discoloration noted on the face, lips, and lower extremities. Resident #1 showed no verbal response to repeated sternal rubs (chest rubs). Respirations appeared shallow and compromised. The note documented Resident #1's blood pressure measured 78/44, pulse counted at 100, and staff couldn't obtain oxygen saturation. Staff notified Resident #1's family of the condition change, and the family requested a transfer to the emergency room (ER). Staff notified Resident #1's Physician, who gave an order to transfer Resident #1 to the ER and to administer Narcan medication if available. The note documented the facility didn't stock Narcan. Two staff members helped lower Resident #1 to the floor from the bed. At the time of the move, Resident #1 began to regain responsiveness. Resident #1 became increasingly more alert but exhibited disorganized thinking, confusion, and argumentative behavior, refusing to go to the ER. Emergency Medical Services (EMS) arrived and transferred Resident #1 to the ER for further evaluation. The Hospital Discharge Summary revealed Resident #1 stayed in the hospital from [DATE] to [DATE]. The summary documented Resident #1's diagnoses during the hospital stay included acute respiratory failure with hypoxia (severe breathing failure from low oxygen), unresponsiveness, acute respiratory failure with hypercapnia (severe breathing failure from high carbon dioxide), an elevated troponin level (heart damage protein), and opioid intoxication (drug overdose) without complication. The Progress Note dated [DATE] documented Resident #1 re-entered the facility with medication changes to decrease Lyrica (nerve pain medication) to 100 mg three times a day (TID) and to discontinue Zyprexa (antipsychotic medication). Resident #1 needed to continue the Methadone and other medications. A Physician Progress Note dated [DATE] documented a follow-up visit for Resident #1 after the hospital stay. The note documented staff found Resident #1 somnolent (abnormally drowsy) and nearly nonresponsive, and staff eventually administered Narcan despite a significant delay. Resident #1 woke up immediately, expressed anger at the disruption, and initially refused transport but eventually went. The physician decreased his Lyrica, discontinued his Zyprexa, and left his Methadone in place. On [DATE] at 1:20 PM, the Director of Nursing (DON) reported she lacked familiarity with Methadone or Narcan when Resident #1 entered the facility. She said the facility didn't administer IV medications. The DON stated she completed Resident #1's admission and didn't clarify the Narcan IV order or get the order changed. She said she since gained more familiarity with Narcan and Methadone. She said on [DATE] the Emergency Kit (E-kit) contained Narcan under the name Naloxone, but the nurse lacked familiarity with that name. She said staff didn't administer the Narcan on [DATE] because Resident #1 woke up and didn't need it. The DON said the facility Nurse Practitioner (NP) initially refused to admit Resident #1 due to the Methadone therapy. She said the NP eventually agreed after ensuring someone else managed the Methadone. She said Resident #1 took Methadone for a long time without any problems that she knew of. She said the facility since learned that Resident #1 developed some underlying medical conditions. On [DATE] at 4:50 PM, the DON said she placed Narcan nasal spray in each medication cart after the [DATE] incident. She said nursing staff received education on how to use it per the instruction sheets. The DON said Staff A, Registered Nurse (RN) typed the letters NAR into the computer when checking for Narcan in the Medbank or E-kit on [DATE] and didn't try the name Naloxone. The Inventory Snapshot for the Medbank from [DATE] to [DATE] documented that injectable Naloxone 0.4 mg/ml remained available. On [DATE] at 8:20 PM, Staff A reported that the previous shift nurse passed on in report that Resident #1 slept most of the day and responded slowly. She said when she went to check on him, he appeared cyanotic, his oxygen saturation level dropped, and his pulse felt low and thready. She said she performed a sternal rub a couple of times and didn't get a response. She said she turned him onto his side in bed and still didn't get a response. She said she made a couple of phone calls and then transferred him to the floor because she thought she needed to start Cardiopulmonary Resuscitation (CPR). She said as soon as Resident #1 hit the floor, he started to come around. She said she talked to Resident #1's NP 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
	165320	A. Building B. Wing	06/30/2026

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	received instructions to give Narcan if available. She said she knew Resident #1 took Methadone and suspected the symptoms stemmed from that. She said after Resident #1 woke up, he spoke with disorganization and became argumentative. She said Resident #1 normally didn't exhibit such confusion and clearly didn't have his right mind. When asked about the Narcan, she said the medication didn't show as available. Staff A said she checked both medication carts for Narcan and couldn't find it. She said she searched the medication room and refrigerator. She said she checked the E-kit in the refrigerator, but it mostly contained insulins. She said a Medbank stood in the medication room, but very few people held access to it. She said she had no idea how to enter it and lacked a code for it. She said she didn't know if the Medbank contained Narcan and couldn't find a medication list for it. Staff A said during the confusion regarding the Narcan, another nurse told her they could go to the town clinic to get a vial of injectable Narcan if needed. Staff A agreed that traveling to the clinic to get the Narcan would delay administration. She said she believed the clinic stood a couple of blocks away from the facility. When asked if she received any education regarding Narcan, she said she read information online. She said she saw it administered once but never administered it herself. Staff A said she knew that Narcan also goes by the name Naloxone and she looked for both names in the medication carts and medication room. On [DATE] at 9:20 AM, the DON reported that someone always maintained access to the Medbank at the facility. She said medication aides and nurses hold access to it. She said the Pharmacy Representative told her that Narcan listed under Naloxone in the Medbank. She said when Staff A called her, Staff A reported checking the Medbank and typing the letters NAR into the computer without the medication appearing. She said everything occurred in a matter of minutes when Staff A called the NP, checked the Medbank, and then Resident #1 aroused. She said another staff member went to the NP's office in town to obtain Narcan, but they didn't need it because the NP's office stood about a block away. On [DATE] at 9:40 AM, an observation revealed Resident #1 had four vials of injectable or intramuscular (IM) Narcan in a plastic bag in the top drawer of the medication cart. The prescription label directed staff to give 0.4 mg/ml IM as needed and bore the date [DATE]. The [DATE] and [DATE] MARs lacked an order for Narcan IM as needed. On [DATE] at 10:30 AM, the Pharmacist reported the pharmacy sent four vials of IM Narcan on [DATE]. The Pharmacist said he noted that the physician order read IV. He reported he couldn't find a clarification order for the Narcan but confirmed the pharmacy sent the injectable or IM form to the facility. The Pharmacist reported the facility Medbank contents included injectable Narcan. On [DATE] at 10:39 AM, Resident #1's NP reported she lacked awareness of the Narcan IV order on admission. The NP said the facility doesn't maintain the ability to perform IV treatments. She said she didn't check to ensure an order for Narcan accompanied the Methadone, calling it a bad presumption on her part. When asked if she knew Resident #1 didn't receive the Narcan on [DATE], she said she didn't. She said the nurse presented the situation as though staff couldn't find the Narcan, which prompted a facility staff member to travel to her office to obtain it. Review of Google Maps revealed the facility sat 0.4 miles away from the local family practice clinic. On [DATE] at 2:25 PM, Staff A reported she received her code and password early that morning for the Medbank and E-kit. The DON attended the interview and reported that when she requested a list of medications for the Medbank from the pharmacy, she also requested a list of users and didn't realize Staff A didn't appear on the user list. When asked if anyone trained Staff A on how to use the Medbank, Staff A stated she held familiarity with other systems but staff hadn't shown her how to use the Medbank at this facility. Staff A reported she worked as an agency staff member prior to signing on at the facility at the beginning of [DATE]. She said she came to the facility for six to eight months prior as an agency nurse and didn't possess a code or password for the Medbank until that morning. The undated Pharmacy policy titled E-kit Procedures directed staff the following:Contact the prescriber for an order.Prior to calling the prescriber, staff must review the E-kit list to ensure the medication remains prescribed in the E-kit.Staff must contact the prescriber for the orderDocument the order in the resident's chart.To open the E-kitStaff must obtain the unique six-digit code to open the cube from (continued on next page)

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	06/30/2026

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the PharmacistRemove the prescribed medication. B. A Physician order dated [DATE] directed staff to titrate Resident #1's Methadone Oral Concentrate 10 mg/ml according to the following directions:Give 43 mg 2 times a day (BID) until [DATE]Give 42 mg BID until [DATE]Give 41 mg BID until [DATE]Give 40 mg BID until [DATE]. Review of the Controlled Drug Receipt/Record/Disposition form for Resident #1's Methadone Concentrate documented that on [DATE] at 5:00 PM staff administered 4.3 ml of Methadone, leaving 48.6 ml in the bottle. On [DATE] at 6:25 AM the record documented an adjustment to the amount of remaining medication to 39.9 ml. Next to the adjustment, a note documented a discrepancy due to a measuring error related to a lack of a measuring tool. Review of the Controlled Drug Receipt/Record/Disposition form for Resident #1's Methadone Concentrate documented that on [DATE] at 3:36 PM staff administered 4.0 ml instead of the ordered 4.2 ml. Review of the [DATE] MAR revealed an order for Methadone Oral Concentrate 10 mg/ml- give 41 mg two times a day related to opioid dependence (drug addiction) with a start date of [DATE] and an end date of [DATE]. Review of the Controlled Drug Receipt/Record/Disposition form directed staff to give Methadone Concentrate 10 mg/ml take 4.1 ml by mouth every 12 hours for 7 days with a start date of [DATE]. According to the form, staff administered 3.8 ml (38 mg) to Resident #1 twice on [DATE], twice on [DATE], and once on [DATE] instead of 4.1 ml. On [DATE] at 2:50 PM, Staff B, Registered Nurse (RN) explained that staff dosed Resident #1's liquid Methadone using a 10 ml syringe that measured in 0.2 increments. Staff B showed the 10 ml syringe in the medication cart attached to the Methadone bottle in a plastic bag. Staff B reported that sometimes they couldn't measure the medication accurately when the order directed odd dosages like 4.1 ml or 4.3 ml. She said she recorded 39.9 ml on the narcotic record since the level fell just below 40 ml. On [DATE] at 4:50 PM, the DON acknowledged concerns with the Methadone administration and noted that management needed to check the documentation more frequently. The DON said the pharmacy planned to start printing a new narcotic sheet each week when the dosage changes so the information on the form remained correct and matched the MAR. In addition, she said the pharmacy would send new syringes for the Methadone administration to ensure accurate dosing. The undated facility policy titled Administering Medications instructed that staff shall administer medications in a safe and timely manner, and as prescribed. The policy directed that staff must administer medications in accordance with the orders, including any required time frame.