STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165362	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarion Wellness and Rehabilitation Center	110 13th Avenue SW Clarion, IA 50525

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858 Based on clinical record review, facility policy review, residents and staff interviews the facility failed to treat residents with respect and dignity in a manner that promotes maintenance or enhancement of their quality of life for 3 out of 6 residents reviewed. (Residents #1, #2 and #4). The facility identified a census of 66 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating no memory impairments. able to be understood and understand by others, no behaviors and supervision with all activities of daily living (ADL). The MDS included diagnoses of heart failure, diabetes mellitus, anxiety, bipolar and the need for assistance with personal cares. The MDS reflected Resident #1 received an antianxiety medication in the lookback period. The Care Plan Focus initiated 1/1/25 indicated Resident #1 had a potential for a psychosocial well-being problem related to a verbal abuse incident. The Interventions included: *Allow time to answer questions and to verbalize feelings perceptions, and fears. *Increase communication between resident/family/caregivers about care and living environment: explain all procedures and treatments, medications, results of labs/tests, condition, all changes, rules, options. *Provide emotional support as needed *Provide opportunities for family to participate in care. *Social Services to check on resident periodically to see how she is coping and needs any further assistance/follow up. (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	The Incident Note dated 1/1/25 at 4:00 PM reflected Resident #1 stated she put on her call light to have a Certified Nursing Assistant (CNA) staff make bed. A CNA went into Resident #1's room and turned off light stating, she didn't have any time. Resident #1 watched the CNA staff go up and down the hall for the next two hours, without stopping at her room. After about 2 hours, Resident #1 pressed her call light again. The same CNA returned to Resident #1's room and turned off her light yelling I am answering 'fucking' call lights, I don't have time. When leaving the room, Resident #1 stated she wanted the door left open. The CNA instead slammed the door shut. Immediate Intervention: The facility notified the Director of Nursing (DON) immediately and immediately walked the CNA out of facility. The Social Services Note dated 1/2/25 at 10:31 AM indicated a staff member talked with Resident #1 regarding the Incident on 1/1/25 with the CNA she talked to about making her bed. Resident #1 said, I pulled the call light and asked her to make my bed, the CNA stated she would when she finished answering call lights. Resident #1 said, I had my door opened and I kept seeing her go back and forth. I pulled the light again and she came in stating, 'I told you when I have time, I will make your bed' and then she walked out. Resident #1 stated, When I used the call light for a 3rd time, she came in and yelled at me saying, 'she will get to my bed when she can.' I was scared because she was so angry and yelling at me. Resident #1 said she didn't see her for the rest of the night. This staff person asked her about how long she did the call lights to ask for her bed to be made and resident stated at least 45 minutes. Resident #1 said that she never felt this upset with a staff person and she felt safe at the facility, all the girls there are good to me except this time. The Condition Follow-up Note dated 1/3/25 at 2:44 AM, for the condition that started 1/1/25, regarding the abuse allegation by a CNA to Resident #1. Resident #1 rested quietly with no change in mood or sleep pattern, no tearfulness, and no vocalization regarding incident with the CNA. The Condition Follow-up Note dated 1/3/25 at 2:08 PM for the condition that started 1/1/25, regarding the abuse allegation by a CNA to Resident #1. Resident #1 didn't voice any concerns regarding the abuse allegation with the CNA. Resident #1 rested in the recliner with no distress noted. Call light within reach. The Condition Follow-up Note dated 1/3/25 at 10:41 PM, for the condition that started 1/1/25, regarding the abuse allegation by a CNA to Resident #1. Resident #1 didn't voice any concerns regarding abuse allegation with the CNA. Resident #1 rested in bed with no distress noted, with her call light within reach. The Condition Follow-up Note dated 1/4/25 at 5:44 PM, for the condition that started 1/1/25, regarding the abuse allegation by a CNA to Resident #1. Resident #1 voiced no complaints of the current caregivers and reported, I feel better now that she doesn't work down this hall. Interview on 2/10/25 at 5:15 PM, Resident #1 verified Staff A, CNA, didn't treat her very nice being very rude and disrespectful when she only wanted her bed made. Resident #1 stated she hasn't seen Staff A since the incident and she felt safe at the facility. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #2's MDS assessment dated [DATE], identified a BIMS score of 15, indicating intact cognition. The MDS indicated Resident #2 didn't have behaviors. The MDS listed Resident #2 as dependent on staff for toilet use, personal hygiene, and transfers. The MDS included diagnoses of anemia (low blood iron level), hypertension (high blood pressure), diabetes mellitus, arthritis, anxiety, depression, and bipolar. The MDS reflected Resident #2 used antianxiety medication within the lookback period. The Care Plan Focus initiated 1/1/25 identified Resident #2 had a potential for psychosocial well-being problem related to a verbal abuse incident with a CNA. The Interventions include: *Allow time to answer questions and to verbalize feelings perceptions, and fears. *Increase communication between resident/family/caregivers about care and living environment: explain all procedures and treatments, medications, results of labs/tests, condition, all changes, rules, options. *Provide emotional support as needed *Provide opportunities for family to participate in care. *Social services to check on resident periodically to see how she is coping a needs any further assistance/follow up. The Follow-up Condition Note dated 1/1/25 at 8:45 PM, for the condition that started 1/1/25, regarding emesis and the abuse allegation by a CNA to Resident #2. Resident #2 stated her upset stomach went away when she took the as needed Zofran (anti-nausea) medication. Resident #2 verbalized being slightly upset about the CNA staff. The writer made sure to tell Resident #2 she is safe. Resident #2 appeared alert and oriented to person, place, and time with no other concerns or complaints noted. The Incident Note dated 1/1/25 at 10:33 PM, the writer received notification that Resident #2 complained of verbal abuse from a CNA. Resident #2 stated she didn't feel well that morning and throughout the afternoon. She requested to go to bed to a CNA. The CNA yelled at Resident #2 stating nobody told me you didn't feel well, why didn't first shift put you to bed. Resident #2 reported the CNA as very rude to her. The Immediate Intervention indicated the facility notified the DON immediately and management team. The facility walked the CNA out immediately. The Follow-up Condition Note dated 1/2/25 at 5:35 AM, follow-up for the condition that started 1/1/25, regarding emesis and the abuse allegation by a CNA to Resident #2. Resident #2 rested quietly throughout the night with no tearfulness or verbalization regarding the incident the day before. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Social Services Note dated 1/2/25 at 9:36 AM, reflected the writer talked with Resident #2 about the incident on 1/1/2025 with the CNA. Resident #2 stated, I have not been feeling well the last 3-4 days which I know because the last 2 holidays have been hard for me due to the loss of my daughter. I had my bed raised with my 2 pillows next to my head and I laid over the bed with my top half. I had asked to use the bathroom and then go to bed. The CNA told her that she didn't hear that in report and why didn't she tell the staff about being sick. Resident #2 replied it's not my fault if you didn't know. The CNA continued being rude and short tempered with her. A staff person came in and the CNA left, and I didn't see her again. Resident #2 said reported that CNA as the only one that talked to her like that. She gets along with other people there on staff and she felt safe there. The Nursing Note dated 1/5/25 at 8:57 PM, reflected Resident #2 had her call light on. When the agency CNA answered the call light, Resident #2 stated that it's 8:30 PM. The CNA replied yes, it is. Is there something that I can help you with? Resident #2 said I need to be put to bed. Resident #2 was already lying in bed. The same agency staff member stated, you are in bed. Is there a routine you would like me to do? Resident #2 became visibly upset, and repeated Goodnight. Give me my blanket. Goodnight. At the time, the writer helped the roommate in Resident #2's room. The writer nurse stated to agency CNA to reproach at a later time. When Resident #2's light came on again, the writer answered the call light. The writer asked Resident #2 what she could assist her with, and she stated, going to bed. The writer asked her to tell her routine, she became visibly upset again. The writer educated Resident #2 on the importance of communication with staff to ensure the best care. Resident #2 verbalized understanding and had no further complaints that shift. Interview on 2/10/25 at 4:15 PM, Resident #2 reported Staff A as very rude and disrespectful to her. Resident #2 stated the staff treat her with dignity and respect except for Staff A. Since the incident, Resident #2 explained she hasn't seen Staff A at the facility. 3. Resident #4's MDS assessment dated [DATE], identified a BIMS score of 14, indicating intact cognition. The MDS reflected Resident #4 didn't have behaviors. Resident #4 required substantial to maximum assistance with activities of daily living (ADLs). The MDS listed Resident #4 as dependent with transfers. The MDS indicated Resident #4 always had incontinence of bladder and bowel. The MDS included diagnoses of heart failure, depression, muscle weakness, and unsteadiness of gait. The Care Plan Focus initiated 12/4/24, reflected Resident #4 had the potential for a psychosocial well-being problem related to a verbal abuse incident with an agency CNA. The Interventions include: *Allow time to answer questions and to verbalize feelings perceptions, and fears. *Increase communication between resident/family/caregivers about care and living environment: explain all procedures and treatments, medications, results of labs/tests, condition, all changes, rules, options. *Provide emotional support as needed *Provide opportunities for family to participate in care. *Social Services to check on resident periodically to see how he is coping and needs any further assistance/follow up. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Social Services Note dated 12/17/24 at 4:11 PM indicated the write talked with Resident #4 that day. He said he felt safe there and got good care. He voiced no concerns at that time. The clinic record had two progress notes with the same information on 12/19/24 at 10:52 AM one titled Nursing labeled as late entry and one titled Social Services. The notes reflected Resident #4 reported to the staff that morning that during the night, he had an aide larger in size, with dark hair, tall and with glasses come into his room to do care and poked him in the chest. He described the poking as annoying but it didn't really hurt. Resident #4 said he was awake, so he didn't know why she did that. He said, she was frustrated with me because I couldn't roll like she wanted me too. She was rude, and I didn't want her to take care of me again. No noted bruising to his chest noted at that time. Resident #4 verified I like all the caregivers. This one wasn't a regular staff person. The Condition Follow-up Note dated 12/20/24 at 3:48 AM, for the condition that started 12/19/24, regarding an agency CNA verbally aggressive to Resident #4. Resident #4 rested quietly, with no change in mood and sleep pattern. No tearfulness noted. Resident #4 cooperated with positioning changes with some agitation, per his normal. The Condition Follow-up Note dated 12/20/24 at 9:48 PM, for the condition that started 12/19/24, regarding an agency CNA verbally aggressive to Resident #4. Resident #4 reported he is very much over and not bothered any longer about the rude CNA. The Condition Follow-up Note dated 12/21/24 at 5:23 PM, for the condition that started 12/19/24, regarding an agency CNA verbally aggressive to Resident #4 and poked him in the chest. No concerns voiced over reports of CNA being verbally and physically aggressive. The Social Services Note dated 1/9/25 at 8:38 AM indicated the writer visited with Resident #4 that morning and he stated his care has been good, and the staff answer his call light in a timely manner. He added he felt safe there. Interview on 2/10/25 at 2:00 PM, Resident #4 verified that an agency CNA was not happy to do his care, treated him rude, and not with respect. Resident #4 explained the CNA took a finger and poked him in the chest to wake him up, it didn't hurt, it was just annoying because he was already awake. Resident #4 stated he felt safe at the facility. Interview on 2/11/25 at 3:00 PM, the facility administrator and DON, verified they expected all staff to treat residents with dignity and respect per the policy/procedure. The Resident Rights document dated October 2016, instructed as a resident of the nursing facility, they have the right to a dignified existence, self-determination, and communication with access to persons and services inside and outside the facility. They have the right to exercise their rights without interference, coercion, discrimination, or reprisal from the facility as a resident of the facility and as a citizen or resident of the United States. The section regarding Respect and Dignity, indicated they have the right to be treated with respect and dignity.