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	07/09/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, hospital record review, policy review, resident and staff interviews, the facility failed to provide care and services to promote healing of pressure wounds for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 56 residents.Finding include:The Minimum Data Set (MDS) assessment identifies the definition of pressure ulcers:Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is a partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, with slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III is full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue) which may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound.Other staging considerations include:Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent skin. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #1 required substantial/maximal assistance with bed mobility and depended on staff for transfers. Resident #1's MDS included diagnoses of hypertension (high blood pressure), anemia (low blood iron), diabetes mellitus, malnutrition (not enough nutrition), and orthopedic aftercare following surgical amputation. The MDS documented Resident #1 had a risk for developing pressure ulcers/injuries. The MDS identified Resident #1 had 2 venous/arterial ulcers and surgical wounds. The MDS documented Resident #1 received the following skin and ulcer/injury treatments: pressure reducing device to chair/bed, nutrition or hydration interventions to manage skin problems, pressure ulcer/injury care, applications of nonsurgical dressing, and applications of ointment/medications. The Care Plan with a goal date of 4/22/25 documented Resident #1 had a pressure ulcer to the coccyx (area near the buttocks) and right knee related to disease process, history of ulcers, immobility (lack of movement), peripheral vascular disease (impaired blood vessels in the legs and arms) and diabetes mellitus. The care plan directed the following interventions:- Staff to administer medications/treatments as ordered and monitor/document for side effects and effectiveness.- Staff to assess, record, and monitor wound healing including measuring the wound (length, width, depth), status of the wound perimeter (area around the wound) and wound bed. The intervention directed staff to report improvements and declines to the Physician. - Staff to monitor, document, and report to the Physician as needed changes in the skin status including appearance, color, wound healing, wound size, wound stage, signs and symptoms of infection.- Staff complete a weekly head-to-toe skin at risk assessment. The Braden Scale for Predicting Pressure Sore Risk documented the following scores:1/3/25 - 14 - Moderate Risk3/11/25 - 11 - High Risk4/5/25 - 9 - Very High [NAME] Progress Note dated 1/24/25 documented Resident #1 had a new wound to his coccyx. The note documented the area as open and described the skin around the wound as red/purple in color. The note documented the nurse requested a treatment order for Triad paste (treatment used to keep wound bed moist and facilitate autolytic debridement body does the work) to the area and the Physician responded ok. The progress note lacked documentation of measurements, type and staging of the wound.A Progress Note dated 1/31/25 documented Resident #1 received new orders to discontinue the Triad paste and clean the sacral (tailbone) wound with wound cleanser, pat dry, apply skin prep to peri-wound and apply Allevyn sacrum dressing (foam dressing) every 3 days and as needed. A Skin Pressure Ulcer Weekly assessment dated [DATE] documented Resident #1 had a stage 2 pressure wound to his coccyx that measured 1.0 cm (centimeters/length) x 0.7 cm (width). The assessment documented the wound bed had granulation (new tissue and small blood vessels that develop on a wound as it starts to heal) with no drainage or odor present. A Progress Note dated 2/18/25 at 4:07 PM documented Resident #1 left

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interview, facility records review, staff interview, and policy review, the facility failed to provide sufficient staff to meet the needs of residents who resided in the facility (Residents #6 and #7) for 2 of 5 resident reviewed for call lights. The facility reported a census of 56 residents. Findings include: 1. Resident #6's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The Census listed Resident #6 resided in private room [ROOM NUMBER]. On 7/8/25 at 3:23 PM, observed Resident #6's call light on. At 3:50 PM observed someone answer the call light. The observation revealed Resident #6 had his call light on for 27 minutes. On 7/9/25 at 8:36 AM, Resident #6 reported his call lights can be on for half an hour or more. He reported the long call lights happened a lot and was his biggest concern. Resident #6 reported he kept track of the call light times with his phone and his clock. He said he planned ahead and pushed the call light early when he has to go to the bathroom as he knew he would have to wait. He said the facility didn't have a specific shift when the call lights were worse. He reported in general the facility had long call lights. Review of Resident #6's Call Light report for room [ROOM NUMBER] from 7/2/25 to 7/9/25 listed call lights on for 15 minutes or more on the following dates and times:7/2 - 5:19 AM - 16 minutes7/2 - 6:55 AM - 17 minutes7/3 - 12:32 AM - 20 minutes7/3 - 6:50 AM - 16 minutes7/4 - 6:19 AM - 21 minutes7/4 - 8:31 AM - 20 minutes7/4 - 9:24 AM - 16 minutes7/4 - 12:36 PM - 17 minutes7/4 - 1:56 PM - 17 minutes7/5 - 8:55 AM - 24 minutes7/5 - 5:45 PM - 28 minutes7/7 - 10:00 PM - 18 minutes7/8 - 2:51 PM - 27 minutes7/8 - 3:23 PM - 26 minutes and 48 seconds7/8 - 6:16 PM - 17 minutes7/8 - 8:42 PM - 18 minutes2. Resident #7's MDS assessment dated [DATE] identified a BIMS score of 5, indicating severe cognitive impairment. The Census revealed Resident #7 resided in private room [ROOM NUMBER]. On 7/8/25 at 3:17 PM, observed Resident #7's call light on. At 3:49 PM witnessed someone answered their call light. The observation revealed Resident #7 had their call light on for 32 minutes. Review of Resident #7's Call Light report for room [ROOM NUMBER] from 7/2/25 to 7/9/25 reflected they had their call light on 15 minutes or more on the following dates and times:7/2 - 4:42 AM - 16 minutes7/2 - 12:54 PM - 23 minutes7/2 - 7:04 PM - 16 minutes7/3 - 12:04 AM - 40 minutes7/3 - 10:44 PM - 16 minutes7/4 - 1:12 AM - 20 minutes7/4 - 5:22 AM - 25 minutes7/4 - 6:04 AM - 27 minutes7/4 - 5:23 PM - 33 minutes7/4 - 6:50 PM - 16 minutes7/4 - 8:46 PM - 21 minutes7/5 - 2:41 AM - 19 minutes7/5 - 8:47 AM - 45 minutes7/5 - 9:51 AM - 16 minutes7/5 - 12:24 PM - 20 minutes7/5 - 1:30 PM - 36 minutes7/5 - 5:53 PM - 17 minutes7/6 - 3:53 AM - 32 minutes7/6 - 5:35 PM - 18 minutes7/6 - 5:56 PM - 17 minutes7/6 - 6:32 PM - 20 minutes7/7 - 3:44 AM - 31 minutes7/7 - 3:32 PM - 20 minutes7/7 - 5:23 PM - 50 minutes7/7 - 8:52 PM - 22 minutes7/8 - 3:17 PM - 31 minutes7/8 - 5:42 PM - 27 minutes7/8 - 10:08 PM - 31 minutes and 34 seconds7/9 - 5:22 AM - 20 minutesOn 7/9/25 at 9:07 AM, the Administrator reported he expected the staff to answer call lights within 15 minutes. He reported the facility had 2 staff members called in the afternoon of 7/8/25. A facility policy titled Call Light/Bell revised May 2007 directed staff to answer the light/bell within a reasonable time of 10 - 15 minutes.