| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441<br><br>Based on clinical record review, policy review and staff interview, the facility failed to ensure a consistent code status between the Iowa Physician's for Scope of Treatment (IPOST), Care Plan, and the Electronic Health Record (EHR) for 1 of 1 resident reviewed for advanced directives (Resident #16). The facility reported a census of 61 residents.<br><br>Findings include:<br><br>The Care Plan Focus dated [DATE] indicated Resident #16 desired to have cardiopulmonary resuscitation (CPR) per his IPOST. The Goal reflected the staff would honor his advanced directive. The Intervention directed the staff to review the IPOST document with each care conference and update as needed (PRN).<br><br>The Clinical Physician Orders reviewed on [DATE] included an order dated [DATE] for Resident #16 to have cardiopulmonary resuscitation (CPR)/Full Code.<br><br>Resident #16's IPOST dated [DATE] reflected he desired a do not resuscitate (DNR) status.<br><br>The Advanced Directives policy, revised [DATE] instructed changes or revocations of a directive must be submitted to the facility, in writing. The Care Plan team will be informed of such changes and/or revocations so that appropriate changes can be made in the resident assessment, Care Plan, or elsewhere in the clinical record.<br><br>During an interview [DATE] at 1:10 PM the Director of Nursing (DON) acknowledged Resident #16's IPOST didn't match his Care Plan or his orders in the EHR. The DON added they expected the advanced directives match between the IPOST, the Care Plan and the orders in the EHR. |

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 |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49698<br><br>Based on observations, resident interviews, staff interviews, clinical record review, facility investigation, police report, and facility policy, the facility failed to provide a safe environment free from physical, verbal, and psychosocial abuse for 2 of 2 residents reviewed (Residents #47 and #316).<br><br>1. Despite Resident #47 reported alleged physical abuse on 3/20/24, the alleged abuser continued to work until the Director of Nursing (DON) learned of the allegations and started an investigation on 3/26/24. The facility allowed the alleged abuser to return to work on 4/3/24 and he continued to work at the facility. Resident #47 reported the alleged staff member on multiple occasions entered and stayed in her room alone. Resident #47's Care Plan updated on 3/28/24 instructed the alleged staff member to not enter her room alone. Interviews with CNAs revealed the alleged staff member often came in and out of Resident #47's room throughout the day. Observations revealed the alleged staff member entering and exiting Resident #47's room alone. Resident #47 reported while crying about being afraid of the alleged staff member and being afraid to tell anyone about the situation.<br><br>2. A witnessed event on 6/16/24 around 11:30 PM of verbal abuse towards Resident #316 didn't get reported to the DON until 6/20/24 around 3:30 PM. The alleged abuser continued to work with vulnerable residents until the DON learned of the allegations on 6/20/24 around 3:40 PM.<br><br>The facility's lack of action for multiple days, allowing the alleged perpetrators to continue to work with vulnerable residents resulted in an immediate jeopardy situation to the residents.<br><br>The Department notified the facility of the immediate jeopardy (IJ) on 10/16/24 of the IJ that began on 3/20/24. The facility removed the immediacy on 10/16/24 after implementing the following:<br><br>a. The facility educated all staff on 10/16/24 regarding the abuse policy and reporting of alleged abuse to their supervisor immediately. The facility would notify the as needed (PRN) staff prior to them working their next shift.<br><br>b. The facility terminated the employment of the 2 alleged perpetrators.<br><br>The facility lowered the scope and severity from a level K to a G prior to the survey exit after ensuring the facility implemented their removal plan. The facility reported a census of 61 residents.<br><br>Findings include:<br><br>1. Resident #47's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) of 12, indicating moderately impaired cognition. The assessment reflected a Resident Mood Interview (PHQ 9) score of 6, indicating mild depression. The MDS reflected Resident #47 didn't have evidence of acute changes in mental status, indicators of psychosis including hallucinations or delusions, no behaviors such as physical, verbal, wandering or rejection of cares. The MDS included diagnoses of heart failure, diabetes mellitus, and depression. Resident #47 received Hospice services during the lookback period.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The Care Plan Focus dated 3/28/24 indicated Resident #47 had a potential problem with her psychosocial well being problem related to an incident with a staff member. The Intervention dated 6/4/24 directed Staff B, Dietary, not to enter Resident #47's room alone.<br><br>The Care Plan lacked documentation of delusions, hallucinations, or making false statements.<br><br>Review of the facility's investigation reflected Staff C, CNA, completed their employee statement by phone on 3/26/24 at 6:00 PM. Staff C stated she went into Resident #47's room on 3/20/24 with an agency CNA, to put her to bed. While they provided her care, Resident #47 asked them if she told them something, could they promise not to tell anyone? Resident #47 then told them Staff B from dietary brought her meal to her room, visited with her for a little bit, and when he went to leave he kissed her on the neck prior to leaving the room. He also told her his wife didn't understand his sense of humor. Staff C reported she told Resident #47 she needed to tell someone. The facility immediately reeducated Staff C on timely reporting of allegations of abuse and they voiced understanding.<br><br>Interview on 10/16/24 at 11:50 AM, Staff C explained Resident #47 told her Staff B would bring her meals and always tell her it was nice to have her to talk to because his wife didn't understand. On that day after saying that Staff B, bent down and kissed her before leaving the room.<br><br>Review of facility's investigation, statement taken by the Director of Nursing (DON), for Resident #47 dated 3/26/24 at 7:00 PM stated The DON asked Resident #47 if she had any problems with her care or treatment by the staff. Resident #47 paused for approximately 30 seconds and then asked if she meant Staff B from the kitchen? The DON asked her if she could tell her what happened. Resident #47 replied, it's no big deal, she didn't want anyone to get in trouble. The DON reassured her that she just needed Resident #47 to tell her what occurred to ensure she is safe and cared for. Resident #47 responded, Oh she is definitely safe and she isn't afraid of anyone there. Resident #47 then stated, one-night last week they brought her the wrong drinks. Staff B brought her the correct one. He visited with her for a few minutes and kissed her on the cheek when he left. Again, adding it wasn't a big deal. Resident #47 remarked she felt perfectly safe with everyone there and not scared of anyone.<br><br>Review of the facility's investigation statement by Staff B on 3/27/24 reflected he didn't recall the incident with Resident #47. He added he always been nice to her as she reminds him of his grandma. She jokingly called him her boyfriend in front of other staff members a few times that he could recall, while delivering trays. He reported he worked in healthcare for 7 years and never had an accusation such as that. Staff B explained he never kissed a resident even on the cheek and knew it would be inappropriate. He added he tried his best to be nice with all of the residents and go out of his way to help them.<br><br>Review of the Police Department Report dated 3/26/24 at 8:59 PM, indicated Resident #47 appeared of sound mind. The police officers conducted an interview of the suspect. The interview of Staff B, concluded he was simply trying to be nice, he had no sexual intent or intent to harm.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 10/15/24 at 4:33 PM, Resident #47 revealed she did not want to discuss the incident much. If she knew it would have blown up so much she wouldn't have told the girls (Staff C, CNA). Resident #47 reported the police came there, making it a whole big thing. Resident #47 stated after the incident, Staff B, talked to her but not like before, he just said hi. That lasted for a couple weeks, then Staff B came into her room and checking on her often. It started as Staff B, being nice and pushing her in the wheelchair to the dining room. Resident #47 stated Staff B, now came in her room and sits in her recliner uninvited. He came to Resident #47's room [ROOM NUMBER] 8 times a day and it made her uncomfortable. Resident #47 explained a time in the dining room, Staff B sat by her. He started rubbing her arm and back, Resident #47 asked Staff B to stop. Resident #47, repeatedly stated how uncomfortable Staff B made her when he came in her room so often. Resident #47 explained she made up excuses for him to leave, earlier that day (10/15/24) after lunch Staff B, came and sat in her recliner. When Resident #47 told him she was going to nap, Staff B responded with did that mean he had to leave? Resident #47 became tearful and said she couldn't directly tell Staff B that he made her uncomfortable or to tell him to stop coming to her room. Resident #47 hadn't told him the reason she wanted him to leave and just continued to make excuses. While tearful, Resident #47 stated she denied being afraid or uncomfortable with Staff B to the staff for fear of what would happen. Since the last time she had told Staff C what happened and the police showed up. Resident #47 expressed she had fear of the staff and Administration finding out what she said in the interview.<br><br>The Hospice Residential Communication Form completed by the Hospice Social Worker on 6/18/24 indicated Resident #47 reported increased feelings of depression. The Hospice Nurse on 6/24/24 left a note that order sent to the primarcy care provider (PCP) to increase/add an antidepressant.<br><br>The Hospice Physician Orders dated 6/25/24 reflected Resident #47 reported an increase in depression. The Provider replied if history of seizures, begin Wellbutrin XL (antidepressant) 150 MG by mouth everyday for 2 weeks then 300 MG everyday by mouth.<br><br>On 10/16/24 at 8:28 AM, observed Staff B push a cart from the kitchen to Resident #47's room with a room tray. Staff B entered Resident #47's room delivering a breakfast tray.<br><br>Interview on 10/16/24 at 11:30 AM, Staff J, Dietary, reported she often saw Staff B go into Resident #47's room. Staff J stated Staff B is part of the kitchen staff and didn't understand why he needed to go in there so often.<br><br>Interview on 10/16/24 at 11:40 AM, Staff K, CNA, revealed she often saw Staff B go in and out of Resident #47's room.<br><br>Interview on 10/16/24 at 11:58 AM, Staff L, CNA, revealed Staff B went in Resident #47's room a lot. Staff L explained at times, they had to ask Staff B to leave Resident #47's room to provide cares. Staff L, CNA, stated they didn't know Staff B couldn't be in Resident #47's room alone.<br><br>Interview on 10/16/24 at 11:12 AM, Staff I, Human Resources (HR), stated she didn't know of Resident #47 making any allegations towards other residents or staff, other than the investigated incident on 3/26/24. Staff I, also denied any knowledge of Resident #47 having any negative feeling towards Staff B that may have led to a false accusation.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 10/16/24 at 11:15 AM, Staff M, Social Services, stated other than the investigated incident with Resident #47 and Staff B, she didn't know of any other accusations towards staff or residents made by her. Staff M, denied knowing of any ill feelings Resident #47 may have towards Staff B that may have led to a false accusation. Staff M, met with Resident #47 routinely after the incident, Resident #47 didn't communicate to Staff M that she felt uncomfortable around Staff B.<br><br>In an interview on 10/16/24 at 1:55 PM, the DON and Facility Administrator acknowledged the intervention that Staff B was not to enter Resident #47's room alone, on her Care Plan. They stated Resident #47's Care Plan shouldn't have that and they put it there as a precaution.<br><br>In an interview on 10/17/24 at 1:07 PM, Facility Administrator acknowledged they expected residents' Care Plans get updated appropriately, timely, and followed as indicated.<br><br>Review of Comprehensive Person Centered Care Planning Policy revised date December 2023 directed the interdisciplinary team (IDT) shall develop a comprehensive person centered Care Plan for each resident that included measurable objective and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>2. Resident #316's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS included diagnoses of neurocognitive disorder with Lewy bodies (disorder that affects memory), cognitive communication deficit (difficulty talking due to memory), anxiety disorder, abnormalities of gait and mobility, muscle weakness, and need for assistance with personal care. Resident #316 used antipsychotic medication, antianxiety medication, and antidepressant medication within the lookback period.<br><br>The Care Plan Focus dated 6/21/24 indicated Resident #316 had a terminal prognosis related to Lewy body dementia. The Intervention instructed the staff to encourage him to express his feelings and listen with non judgmental acceptance and compassion.<br><br>The Care Plan Focus dated 4/19/24 reflected Resident #16 had a risk for elopement and wandering related to disorientation to place. The Interventions directed the following:<br><br>a. Identify patterns of wandering and intervene as appropriate.<br><br>b. Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes.<br><br>The Change of Condition Note dated 6/16/24 at 6:04 PM indicated Resident #316 received an order to increase his lorazepam (antianxiety medication) due to his increased restlessness and anxiety.<br><br>The Condition Follow-Up Note dated 6/17/24 at 4:25 AM reflected Resident #316 didn't sleep that night, he moved his feet and legs constantly. He attempted to stand by himself, closes his eyes briefly then has an entire body jerk, waking himself. Resident #316 hallucinated and talked to himself. He occasionally answered questions correctly but frequently had word salad (confused nonsensical speech). He scratched his entire body but mostly his arms and legs. He had hydroxyzine without relief. Resident #316 required one-on-one (1:1) assistance for safety. Resident #316 had neurological checks within his normal limits. He received a recent increase in Aricept and Ativan the day before. Difficult to ascertain if restlessness and itching are medication related.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of the facility's investigation, Staff I's, CNA, statement indicated on 6/16/24 they each watched Resident #316 for 30 minutes. Staff I sat with Resident #316 while Staff C sat at the other end of the table. When Staff I returned from break, she started answering call lights. Staff C started yelling and screaming at Staff I for not sitting with Resident #316. Staff I told the nurse that if she screamed at her like that again, she would go home. After that Staff C sat with Resident #316. Staff C talked very mean to Resident #316, and told him, he is going to sit his fucking ass down. Then she asked him where do you think you are going? You are not going anywhere. This went on until Staff I sat with Resident #316 again. The night nurse suggested Staff I take Resident #316 to the back desk and chart to keep things mellow for the night.<br><br>Review of the facility's investigation dated 6/20/24, listed the corrective action as Staff C immediately suspended from working pending investigation.<br><br>Review of time cards dated 6/16/24 to 6/20/24, Staff C continued to work the rest of her overnight shift on 6/16/24 6/17/24 and an overnight shift on 6/19/24 6/20/24.<br><br>On 10/17/24 at 1:07 PM the Administrator stated he expected a staff who witnessed any form of abuse to separate the victim and alleged abuser. They need to make sure the victim is safe and immediately report the incident to the administration staff including himself and the DON.<br><br>Review of facility provided policy Abuse Prevention and Prohibition revised September 2017 indicated that each resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This included but not limited to freedom from corporal punishment, involuntary seclusion, any physical or chemical restraints not required to treat the resident's medical symptoms. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, resident representatives, families, friends or other individuals. The section labeled Prevention indicated all personnel, residents, visitors etc. are encouraged to report incidents and grievances without the fear of retribution. The facility will provide feedback regarding concerns. The facility employees will take action to protect, prevent abuse, and neglect from occurring within the facility by: Staff having knowledge of the individual residents' care needs. Supervision of staff to identify inappropriate behaviors (i.e. derogatory language, rough handling, ignoring residents while giving care etc.). Assess, Care Plan and monitor residents' rooms, self injurious behaviors, communication disorders, totally dependent on staff. Protection If a resident incident is reported, discovered or suspected, where the health, welfare or safety of the residents is involved, the facility will take the following steps to prevent further potential abuse while the investigation is in progress; if the suspected perpetrator is an employee: Remove employee immediately from the care of any resident; Suspend employee during the investigation. Reporting/Response All alleged violations will be reported via phone or in writing within 24 hours to the State Licensing Agency. The facility shall follow up to the State Licensing Agency in writing the findings and results of the completion of the investigation within 5 days. The Facility will report to the State Nurse Aide Registry or Licensing authorities any knowledge it has of any action by a court of law which would indicate an employee is unfit for service. The facility will analyze occurrences and determine what changes are needed, if any, to the policies and procedures to prevent further occurrences. The Administrator/Designee will inform the resident and his/her representative of the results of the investigation and corrective action taken. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49698<br><br>Based on clinical records review, staff interview, facility investigation review, and policy review, the facility failed to notify the Department of Inspections, Appeals, and Licensing (DIAL) of 2 of 2 allegations of physical and verbal abuse within 24-hours of staff learning of the incidents.<br><br>1. On 3/20/24 around 11:30 PM, Resident #47 notified a Certified Nursing Aide (CNA) of alleged physical abuse. On 3/26/24 around 5:50 AM a Dietary Aide learned of Resident #47's allegation of physical abuse by a second CNA. No one reported the allegation of abuse until the Dietary Aide reported it to the Director of Nursing (DON) on 3/26/24 around 6:00 PM. The facility began their investigation of the alleged abuse on 3/26/24 and reported the incident to that evening at 10:08 PM.<br><br>2. On 6/16/24 around 11:30 PM a CNA documented they witnessed alleged verbal abuse towards Resident #316. The CNA reported the alleged verbal abuse to the DON on 6/20/24 around 3:30 PM. The DON called the DIAL abuse hotline on 6/20/24 around 3:40 PM to report the alleged abuse. The facility failed to provide the completed investigation findings and results within 5 days to the DIAL. The Facility filed their Self-Report with the DIAL on 7/1/24 at 9:14 PM.<br><br>The Department notified the facility of the immediate jeopardy (IJ) on 10/16/24 of the IJ that began on 3/20/24. The facility removed the immediacy on 10/16/24 after implementing the following:<br><br>a. The facility educated all staff on 10/16/24 regarding the abuse policy and reporting of alleged abuse to their supervisor immediately. The facility would notify the as needed (PRN) staff prior to them working their next shift.<br><br>b. The facility terminated the employment of the 2 alleged perpetrators.<br><br>The facility lowered the scope and severity from a level K to an E prior to the survey exit. The facility reported a census of 61 residents.<br><br>Findings include:<br><br>1. Resident #47's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) of 12, indicating moderately impaired cognition. The assessment reflected a Resident Mood Interview (PHQ 9) score of 6, indicating mild depression. The MDS reflected Resident #47 didn't have evidence of acute changes in mental status, indicators of psychosis including hallucinations or delusions, no behaviors such as physical, verbal, wandering or rejection of cares. The MDS included diagnoses of heart failure, diabetes mellitus, and depression. Resident #47 received Hospice services during the lookback period.<br><br>The Care Plan Focus dated 3/28/24 indicated Resident #47 had a potential problem with her psychosocial well being problem related to an incident with a staff member. The Intervention dated 6/4/24 directed Staff B, Dietary, not to enter Resident #47's room alone.<br><br>The Care Plan lacked documentation of delusions, hallucinations, or making false statements.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | The Nursing Note dated 3/26/24 at 6:40 PM identified Staff C, CNA, reported Resident #47 told her as she provided care of an incident on 3/20/24 at approximately 11:30 PM. Resident #47 reported that previous to 3/20/24, as Staff B, Dietary, brought a meal to her room, he visited with her for a while, and then kissed her on the neck prior to leaving her room. The Director of Nursing (DON) interviewed Resident #47 immediately, she reported Staff B kissed her on the cheek prior to leaving the room. She didn't remember exactly which day it occurred but stated she knew it happened prior to the day she said something to the girls. She denied feeling unsafe or afraid of Staff B and stated he's a nice man. The DON continued the investigation. Resident #47 had a BIMS score of 13, indicating intact cognition.<br><br>Review of facility Self-Report indicated the incident approximately occurred on 3/20/24 at 11:30 PM. The facility submitted the report on 3/26/24 at 10:08 PM.<br><br>Review of the facility's investigation reflected Staff C, CNA, completed their employee statement by phone on 3/26/24 at 6:00 PM. Staff C stated she went into Resident #47's room on 3/20/24 with an agency CNA, to put her to bed. While they provided her care, Resident #47 asked them if she told them something, could they promise not to tell anyone? Resident #47 then told them Staff B from dietary brought her meal to her room, visited with her for a little bit, and when he went to leave he kissed her on the neck prior to leaving the room. He also told her his wife didn't understand his sense of humor. Staff C reported she told Resident #47 she needed to tell someone. The facility immediately reeducated Staff C on timely reporting of allegations of abuse and they voiced understanding.<br><br>Staff D's, Dietary Aide, statement on 3/26/24 at 6:00 PM, reflected Staff E, CNA, notified her around 5:50 AM that Staff C mentioned Resident #47 let her know when Staff B took her room tray, he set it down on the table, and then gave her a kiss on the neck. No one mention what day it happened.<br><br>In an interview on 10/15/24 at 1:32 PM, Staff D reported on 3/26/24 at 5:50 AM, Staff E told her that Staff C told her about the incident with Resident #47 and Staff B. Staff D stated she reported it to the Administration at approximately 6:00 PM on 3/26/24.<br><br>Review of the facility's investigation dated 3/26/24, listed the facility's corrective action as suspending Staff B pending the outcome of the investigation. The facility re-educated all staff on the current procedure for reporting any suspected adult abuse.<br><br>2. Resident #316's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS included diagnoses of neurocognitive disorder with Lewy bodies (disorder that affects memory), cognitive communication deficit (difficulty talking due to memory), anxiety disorder, abnormalities of gait and mobility, muscle weakness, and need for assistance with personal care. Resident #316 used antipsychotic medication, antianxiety medication, and antidepressant medication within the lookback period.<br><br>The Care Plan Focus dated 6/21/24 indicated Resident #316 had a terminal prognosis related to Lewy body dementia. The Intervention instructed the staff to encourage him to express his feelings and listen with non judgmental acceptance and compassion.<br><br>The Care Plan Focus dated 4/19/24 reflected Resident #16 had a risk for elopement and wandering related to disorientation to place. The Interventions directed the following:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | a. Identify patterns of wandering and intervene as appropriate.<br><br>b. Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes.<br><br>The Change of Condition Note dated 6/16/24 at 6:04 PM indicated Resident #316 received an order to increase his lorazepam (antianxiety medication) due to his increased restlessness and anxiety.<br><br>Review of the facility's Self-Report indicated an allegation of abuse occurred on 6/16/24 at 12:30 AM. The report listed the date knew as 6/20/24, with the Self-Report filed 7/1/14 at 9:14 PM.<br><br>Review of facility's investigation, the DON's statement dated 6/20/24, reflected they received a phone call from Staff I, Human Resources (HR), reporting Staff F, CNA, told her Staff C, CNA, used profanity when caring for Resident #316. The event occurred on 6/16/24 during the graveyard shift and Staff F didn't report it until 6/20/24, her next scheduled day to work.<br><br>Review of the facility's investigation, Staff I's, CNA, statement indicated on 6/16/24 they each watched Resident #316 for 30 minutes. Staff I sat with Resident #316 while Staff C sat at the other end of the table. When Staff I returned from break, she started answering call lights. Staff C started yelling and screaming at Staff I for not sitting with Resident #316. Staff I told the nurse that if she screamed at her like that again, she would go home. After that Staff C sat with Resident #316. Staff C talked very mean to Resident #316, and told him, he is going to sit his fucking ass down. Then she asked him where do you think you are going? You are not going anywhere. This went on until Staff I sat with Resident #316 again. The night nurse suggested Staff I take Resident #316 to the back desk and chart to keep things mellow for the night.<br><br>Review of the facility's investigation dated 6/20/24, listed the corrective action as Staff C immediately suspended from working pending investigation.<br><br>On 10/17/24 at 1:07 PM the Administrator stated they expected any staff who witness any form of abuse is to separate the victim and alleged abuser, making sure the victim is safe. Then immediately report the allegation to administration staff including the Administrator and the DON.<br><br>Review of facility provided policy, Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment revised 11/28/17 indicated in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility will: ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source, and misappropriation of resident property, are reported immediately but not later than 2-hours after the allegation is made if the events that cause the allegation involve abuse or resulted in serious bodily injury. Not later than 24-hours if the events that cause the allegation didn't involve abuse and didn't result in serious bodily injury. Ensure all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of resident property, are reported to the Administrator of the facility, the State Survey Agency, and the Adult Protective Services (as appropriate). Ensure that after receipt of a report of possible abuse, neglect, mistreatment, exploitation, or misappropriation of resident property, steps are immediately taken to protect the identified resident(s).<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of facility provided policy Abuse Prevention and Prohibition revised September 2017 instructed the following:<br><br>a. Training Orientation program will include review of facility's policy on:<br><br>i. What constitutes abuse, neglect, exploitation and misappropriation of resident property.<br><br>ii. Care of the cognitively impaired/appropriate interventions to deal with aggressive and/or catastrophic reactions of resting;<br><br>iii. Dementia Management and Resident Abuse Prevention;<br><br>iv. How staff should report their knowledge related to allegations without fear of reprisal.<br><br>v. How to recognize signs of burnout, frustration and stress that may lead to abuse. The Department of Justice information regarding Your Legal Duty . Reporting Elder and Dependent Adult Abuse. Elder Justice Act Reporting Reporting/Response All alleged violations will be reported via phone or in writing within 24 hours to the State Licensing Agency. The facility shall follow up to the State Licensing Agency in writing the findings and results of the completion of the investigation within 5 days. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49698<br><br>Based on resident's record review, staff interviews, facility investigation review, time card detail, employee files, and policy review, the facility failed to separate staff members accused of alleged physical and verbal abuse from dependent residents in a timely manner for 2 of 2 residents reviewed (Residents #47 and #316).<br><br>1. Resident #47 reported an allegation of physical abuse on 3/20/24 to a Certified Nurse Aide (CNA). The CNA failed to report the allegation to Administration, which allowed the alleged abuser to work multiple days after the allegation. In addition, one dietary staff member learned of the allegation in the morning of 3/26/24, but failed to report the allegation until 5:00 PM that evening. This allowed the staff member to continue to work their entire shift on 3/26/24.<br><br>2. A CNA witnessed another CNA swear at a behavioral resident on 6/16/24. The CNA didn't report the incident to Administration until 6/20/24, their next scheduled day to work. Due to the lack of the CNA reporting the incident to Administration, the alleged abuser continued to work multiple days until 6/20/24.<br><br>The Department notified the facility of the immediate jeopardy (IJ) on 10/16/24 of the IJ that began on 3/20/24. The facility removed the immediacy on 10/16/24 after implementing the following:<br><br>a. The facility educated all staff on 10/16/24 regarding the abuse policy and reporting of alleged abuse to their supervisor immediately. The facility would notify the as needed (PRN) staff prior to them working their next shift.<br><br>b. The facility terminated the employment of the 2 alleged perpetrators.<br><br>The facility lowered the scope and severity from a level K to an E prior to the survey exit after ensuring the facility implemented their removal plan. The facility reported a census of 61 residents.<br><br>Findings include:<br><br>1. Resident #47's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) of 12, indicating moderately impaired cognition. The assessment reflected a Resident Mood Interview (PHQ 9) score of 6, indicating mild depression. The MDS reflected Resident #47 didn't have evidence of acute changes in mental status, indicators of psychosis including hallucinations or delusions, no behaviors such as physical, verbal, wandering or rejection of cares. The MDS included diagnoses of heart failure, diabetes mellitus, and depression. Resident #47 received Hospice services during the lookback period.<br><br>The Care Plan Focus dated 3/28/24 indicated Resident #47 had a potential problem with her psychosocial well being problem related to an incident with a staff member. The Intervention dated 6/4/24 directed Staff B, Dietary, not to enter Resident #47's room alone.<br><br>The Care Plan lacked documentation of delusions, hallucinations, or making false statements.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of the facility's investigation reflected Staff C, CNA, completed their employee statement by phone on 3/26/24 at 6:00 PM. Staff C stated she went into Resident #47's room on 3/20/24 with an agency CNA, to put her to bed. While they provided her care, Resident #47 asked them if she told them something, could they promise not to tell anyone? Resident #47 then told them Staff B from dietary brought her meal to her room, visited with her for a little bit, and when he went to leave he kissed her on the neck prior to leaving the room. He also told her his wife didn't understand his sense of humor. Staff C reported she told Resident #47 she needed to tell someone. The facility immediately reeducated Staff C on timely reporting of allegations of abuse and they voiced understanding.<br><br>Review of the facility's investigation dated 3/26/24, listed the facility's corrective action as suspending Staff B pending the outcome of the investigation. The facility re-educated all staff on the current procedure for reporting any suspected adult abuse.<br><br>Review of Staff B's time cards dated 3/20/24 to 4/10/24, reflected he continued to work on 3/20/24, 3/22/24, 3/23/24, 3/25/24, and 3/26/24 with access to vulnerable residents. The facility placed Staff B, on suspension during the investigation process and allowed him to return to work on 4/4/24.<br><br>On 10/16/24 at 8:28 AM, observed Staff B push a cart from the kitchen to Resident #47's room with a room tray. Staff B entered Resident #47's room delivering a breakfast tray.<br><br>Interview on 10/16/24 at 11:30 AM, Staff J, Dietary, reported she often saw Staff B go into Resident #47's room. Staff J stated Staff B is part of the kitchen staff and didn't understand why he needed to go in there so often.<br><br>Interview on 10/16/24 at 11:40 AM, Staff K, CNA, revealed she often saw Staff B go in and out of Resident #47's room.<br><br>Interview on 10/16/24 at 11:50 AM, Staff C explained Resident #47 told her Staff B would bring her meals and always tell her it was nice to have her to talk to because his wife didn't understand. On that day after saying that Staff B, bent down and kissed her before leaving the room.<br><br>Interview on 10/16/24 at 11:58 AM, Staff L, CNA, revealed Staff B went in Resident #47's room a lot. Staff L explained at times, they had to ask Staff B to leave Resident #47's room to provide cares. Staff L, CNA, stated they didn't know Staff B couldn't be in Resident #47's room alone.<br><br>2. Resident #316's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS included diagnoses of neurocognitive disorder with Lewy bodies (disorder that affects memory), cognitive communication deficit (difficulty talking due to memory), anxiety disorder, abnormalities of gait and mobility, muscle weakness, and need for assistance with personal care. Resident #316 used antipsychotic medication, antianxiety medication, and antidepressant medication within the lookback period.<br><br>The Care Plan Focus dated 6/21/24 indicated Resident #316 had a terminal prognosis related to Lewy body dementia. The Intervention instructed the staff to encourage him to express his feelings and listen with non judgmental acceptance and compassion.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of facility's investigation, the DON's statement dated 6/20/24, reflected they received a phone call from Staff I, Human Resources (HR), reporting Staff F, CNA, told her Staff C, CNA, used profanity when caring for Resident #316. The event occurred on 6/16/24 during the graveyard shift and Staff F didn't report it until 6/20/24, her next scheduled day to work.<br><br>Review of the facility's investigation, Staff I's, CNA, statement indicated on 6/16/24 they each watched Resident #316 for 30 minutes. Staff I sat with Resident #316 while Staff C sat at the other end of the table. When Staff I returned from break, she started answering call lights. Staff C started yelling and screaming at Staff I for not sitting with Resident #316. Staff I told the nurse that if she screamed at her like that again, she would go home. After that Staff C sat with Resident #316. Staff C talked very mean to Resident #316, and told him, he is going to sit his fucking ass down. Then she asked him where do you think you are going? You are not going anywhere. This went on until Staff I sat with Resident #316 again. The night nurse suggested Staff I take Resident #316 to the back desk and chart to keep things mellow for the night.<br><br>Review of the facility's investigation dated 6/20/24, listed the corrective action as Staff C immediately suspended from working pending investigation.<br><br>Review of time cards dated 6/16/24 to 6/20/24, Staff C continued to work the rest of her overnight shift on 6/16/24 6/17/24 and an overnight shift on 6/19/24 6/20/24.<br><br>Review of a disciplinary notice dated 7/2/24 for Staff C identified due to gross misconduct - suspicion of verbal or emotional abuse of a resident. On 6/20/24 a staff member reported that Staff C spoke to Resident #316 on 6/16/24 using profanity. The facility immediately placed Staff C on leave until 7/2/24. Following the completion and outcome of the investigation, the facility terminated Staff C's employment immediately.<br><br>On 10/17/24 at 1:07 PM the Administrator stated they expected any staff who witness any form of abuse is to separate the victim and alleged abuser, making sure the victim is safe. Then immediately report the allegation to administration staff including the Administrator and the DON.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of facility provided policy Abuse Prevention and Prohibition revised September 2017 indicated that each resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This included but not limited to freedom from corporal punishment, involuntary seclusion, any physical or chemical restraints not required to treat the resident's medical symptoms. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, resident representatives, families, friends or other individuals. The section labeled Prevention indicated all personnel, residents, visitors etc. are encouraged to report incidents and grievances without the fear of retribution. The facility will provide feedback regarding concerns. The facility employees will take action to protect, prevent abuse, and neglect from occurring within the facility by: Staff having knowledge of the individual residents' care needs. Supervision of staff to identify inappropriate behaviors (i.e. derogatory language, rough handling, ignoring residents while giving care etc.). Assess, Care Plan and monitor residents' rooms, self injurious behaviors, communication disorders, totally dependent on staff. Protection If a resident incident is reported, discovered or suspected, where the health, welfare or safety of the residents is involved, the facility will take the following steps to prevent further potential abuse while the investigation is in progress; if the suspected perpetrator is an employee: Remove employee immediately from the care of any resident; suspend the employee during the investigation. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875<br><br>Based on clinic record review, staff interviews, resident interview, Nurse Practitioner interview, and policy review, the facility failed to administer medications per physician orders for 2 out of 2 residents reviewed (Resident #25 and #2) for significant medication errors.<br><br>1. The facility failed to provide Resident #25 their ordered Revlimid (anticancer medication that slows the progression of multiple myeloma and various types of cancer) from 4/25/24 to 6/5/24.<br><br>2. Resident #2 received medications not prescribed to her. Resident #2 received her roommates' medications (Resident #10) instead of her own. The facility reported a census of 61 residents.<br><br>The State Agency informed the facility of the Immediate Jeopardy on 10/16/24 at 2:47 PM that began on 4/25/24.<br><br>The facility staff removed the Immediate Jeopardy on 10/16/24 through the following actions:<br><br>a. The facility educated all nurses and certified medication aides (CMAs) on following the physician orders policy on 10/16/24. As needed (PRN) staff members will complete education prior to working the next shift.<br><br>b. The DNS (Director Nursing Services)/designee will audit all missing/omitted MAR (Medication Administration Records) and TAR (Treatment Administration Record) entries daily for the next 4 weeks. They will educate nursing when needed on following physician orders, correct order entry, and the process for medication errors.<br><br>c. Two nurses will double note all orders. This is a permanent systemic change. The DNS/designee will run missing entries report in the electronic medical record (EMR) daily for omissions on the MAR/TAR.<br><br>The scope lowered from a J to a D at the time of the survey after ensuring the facility implemented their removal plan.<br><br>The facility identified a census of 61 residents.<br><br>Findings include:<br><br>1. Resident #25's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMs) score of 15, indicating intact cognition. Resident #25 required partial/moderate assistance with bed mobility, transfers, and toileting. The MDS included diagnoses of cancer, anemia (low blood iron), hypertension (high blood pressure), and renal (kidney) disease.<br><br>The Care Plan Focus dated 2/5/24 reflected Resident #25 had an alteration in hematological (affecting the blood) status related to cancer. Resident #25 received treatments in [NAME] City. The Care Plan directed staff to administer medication as ordered, monitor for side effects, and effectiveness.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A Physician order dated 3/27/24 directed staff to restart Revlimid (Lenalidomide) 5 milligrams (mg) by mouth on days 1-21 every 28 days.<br><br>The Oncology Report dated 3/27/24 indicated Resident #25's care facility wasn't completely sure if he received his Revlimid or not. They believe he last received it February 24 through March 16, which put him due to restart on March 24, 2024. They reported they had a complete cycle worth of Revlimid for him in their facility. Orders placed to restart Revlimid 5 mg that day.<br><br>A Physician order dated 4/10/24 directed staff to administer Revlimid (Lenalidomide) 5 mg by mouth on days 1-21 followed by 7 days off. The order directed to start the Revlimid on 4/25/24 to 5/15/24 with no dose from 5/16/24 to 5/22/24. The Advance Registered Nurse Practitioner (ARNP) signed the order and the facility faxed the order to the pharmacy on 5/8/24.<br><br>The Oncology Report dated 4/10/24 indicated Resident #25's care facility wasn't completely sure if he received his Revlimid or not. They believe he last received it February 24 through March 16, which put him due to restart on March 24, 2024. They reported they had a complete cycle worth of Revlimid for him in their facility. Orders placed to restart Revlimid 5 mg on 3/27/24. Next cycle to start 4/25/24.<br><br>A Physician order dated 6/5/24 directed staff to continue Revlimid 5 mg by mouth on days 1-21, followed by 7 days off. The order directed the staff to start the Revlimid on 6/5/24 to 6/25/24 with no dosing from 6/26/24 to 7/2/24. The order listed the Revlimid order as ongoing.<br><br>The Oncology Report dated 6/5/24 reflcted Resident #25's care facility wasn't completely sure as to whether he received his Revlimid or not, but they believe he last received it February 24 through March 16, which would have put him due to restart on March 24, 2024. Once again, Resident #25 didn't receive Revlimid since April 17th, 2024. The provider contacted the DON of Resident #25's care facility who advised the nurse believed they discontinued Resident #25's medication, so they didn't give Revlimid to the him. The provider provided information on Revlimid dosing and the importance of proper administration. The DON reported they had a complete cycle worth of Revlimid for him in the facility and could restart Revlimid that day.<br><br>Review of the March and April 2024 MAR reflected Resident #25 received Revlimid 5 mg from 3/28/24 to 4/17/24.<br><br>Review of the April, May, and June 2024 MAR lacked documentation of Resident #25 receiving Revlimid as ordered by the physician from 4/25/24 to 5/15/24. In addition, the forms lacked documentation Resident #25 restarted their Revlimid on 5/23/24 as order.<br><br>A Physician Progress note dated 6/5/24 from the cancer center indicated they restarted Resident #25 on Revlimid 5 mg for 21 days every 28 days in the latter part of February 2024. The note identified Resident #25 didn't receive his Revlimid since 4/17/24. The ARNP contacted the Director of Nursing (DON) who advised the nurse believed they discontinued the medication, so they didn't give Resident #25 the Revlimid. The note documented the ARNP provided information on Revlimid dosing and the importance of proper administration. The note documented the facility reported they had a complete cycle worth of Revlimid for Resident #25 in the facility and would restart his Revlimid on 6/5/24.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A Cancer Center note titled Missed Revlimid Cycles dated 6/5/24 documented the facility nurse and the DON reported Resident #25 didn't receive his Revlimid medication since 4/17/24. The note included Resident #25 brought a medication list with him that didn't have Revlimid listed. The note documented Resident #25 missed one complete cycle and a part of the following cycle of the Revlimid medication. The note documented the facility DON verbalized the facility had two cycles of the Revlimid medication on hand. The DON didn't provide an explanation on why Resident #25 didn't receive the Revlimid medication. The note documented written physician orders on 4/10/24 instructed the facility staff to start the next cycle of Revlimid on 4/25/24. The facility didn't administer the medication starting on 5/23/24. The facility received instructions to have Resident #25 start the Revlimid on 6/5/24 for 21 days then off for 7 days per the 28 day cycle and resume next cycle after the 7-day break.<br><br>A graph labeled M Protein IgG Lambda (a type of paraprotein that is produced by myeloma cells) dated 4/1/24 to 10/28/24 documented elevated M Protein IgG Lambda levels in May 2024 when Resident #25 didn't receive their Revlimid medication. The graph documented the M Protein IgG Lambda levels consistently decreased since June 2024.<br><br>Review of the clinical record lacked documentation of the facility notifying Resident #25's Primary Care Physician and/or family regarding Resident #25 not receiving the Revlimid medication per the Physician's order. The facility didn't complete an investigation and medication error form regarding the omission of the Revlimid.<br><br>On 10/14/24 11:40 AM, Resident #25 reported he had his cancer medication screwed up at one time. He stated he thought it happened about a month ago or so. He stated the facility told him about it. When asked if he received the medication now, he reported he didn't know for sure.<br><br>On 10/15/24 at 3:23 PM, The DON acknowledged she couldn't locate documentation that Resident #25 received the Revlimid medication from 4/25/24 to 5/15/24 and restarted the order on 5/23/24. The DON reported she was still looking into it. She thought maybe a nurse didn't know how to transcribe the medication onto the MAR with 21 days on and 7 days off. She stated the Revlimid came from an outside pharmacy set up by the cancer center. The DON stated the cancer center would contact her regarding medication concerns.<br><br>On 10/15/24 at 10:10 AM, the Cancer Center Operation Manager, MSN (Master of Science in Nursing), reported the Cancer Center called the facility regarding concerns with the administration of the Revlimid medication. She stated the cancer center nurse talked to a facility nurse and the DON. She reported Revlimid as a medication used to help control Resident #25's multiple myeloma (cancer). She stated not receiving the medication could contribute to the progression of the multiple myeloma and could be potentially fatal. She stated Resident #25's had an elevation in his lab (M spike) (lab to measure the amount of M protein in the blood) in May. She reported the Cancer Center sent the physician orders for the Revlimid to the specialty pharmacy. She reported she didn't know of any issue with the facility receiving the medication.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 10/16/24 at 12:35 PM, the Cancer Center ARNP reported she had concerns with Resident #25 missing cycles of the Revlimid medication. The ARNP reported Resident #25 restarted the Revlimid in February 2024. She sent specific orders on when to dose the medication and when to stop it. She stated to give the Revlimid for 21 days and then stop for 7 days. She stated the treatment was ongoing. She had concerns for Resident #25's health as multiple myeloma could be a life-threatening illness. She reported the facility didn't have to refill his medication as they had so much on hand. The ARNP reported she called the DON on 6/5/24 as she was concerned Resident #25 could relapse and could die. She stated the DON blamed the problem on a new nurse. She stated the cancer center didn't typically call the facility ahead of time to get the resident's MAR but they did for Resident #25, as they wanted to check to see if he received his Revlimid. She reported they had a hard time getting information from the facility. She stated at the last appointment they requested the MAR ahead of time and didn't get the MAR until he came to the appointment. The ARNP stated not administering the Revlimid to Resident #25 consistently could lead to his demise and he could die. She stated if he didn't get the appropriate treatment it could lead to a relapse. She stated Resident #25 already had 2 stem-cell transplants in the past and she didn't want him to have to go through that again. She described Resident #25 as currently stable, with his lab counts improved.<br><br>On 10/16/24 at 1:04 PM, the DON reported she received a call from a nurse at the Cancer Center at the beginning of the summer. She stated the nurse was checking to ensure Resident #25's Revlimid orders were put in the computer correctly. She stated the cancer center feared Resident #25 missed a cycle of his Revlimid. She stated the Cancer Center ordered to give the Revlimid for 21 days and then off for 7 days. She stated the nurse wanted to make sure they gave it correctly. The DON reported she didn't give the medication, her nurses did.<br><br>On 10/17/24 at 9:15 AM, the Nurse Consultant reported she expected the staff to follow physician orders and the 6 rights of administering medications.<br><br>A facility policy titled Physician Orders revised May 2019 instructed all drugs shall be administered only upon the written order of a person duly licensed and authorized to prescribe such drugs. The policy further documented that the charge nurse or DON shall place the order for all prescribed medications.<br><br>A facility policy titled Medication Errors and Adverse Reactions reviewed May 2023 directed the facility needed to report medication errors and adverse drug reactions the resident's attending physician. The policy directed to complete a medication error form and the nursing service would implement/follow any new physician's orders. The policy instructed to record the resident's condition and response to any ordered treatment.<br><br>2. Resident #2's MDS assessment dated [DATE] identified a BIMs score of 15, indicating intact cognition. Resident #2 required partial/moderate assistance with bed mobility, transfers, and toileting. The MDS included diagnoses of coronary artery disease (impaired blood circulation), hypertension (high blood pressure), hyperlipidemia (elevated cholesterol), thyroid disorder, anxiety disorder, depression, schizophrenia (mental health disorder that can cause hallucinations and delusions), and cognitive communication deficit.<br><br>The clinical census report identified Resident #2 and Resident #10 resided in room [ROOM NUMBER].<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An incident reported titled Medication Error dated 10/13/24 documented a CMA gave Resident #2 Resident #10's medications by accident. The incident report identified Resident #2 received the following unprescribed medications: Oxycodone (opioid) 5 mg (milligrams), Baclofen (muscle relaxer) 10 mg, Gabapentin (anticonvulsant) 100 mg, Lexapro (antidepressant) 10 mg, Melatonin (hormone to help with sleep) 6 mg and Topamax (anticonvulsant) 100 mg. The incident report documented immediate action taken included notifying the Physician, monitoring Resident #2 throughout the night, and reviewing the 6 rights of giving medications with the CMA. The incident report documented the facility notified Resident #10's family of the error.<br><br>On 10/16/24 at 11:52 AM, Staff G, RN (Registered Nurse), verified she worked the evening of 10/13/24. Staff G reported Resident #10 called for a nurse. Staff G reported Resident #10 showed her a cup of pills and stated they weren't hers. Staff G looked at the cups of pills and verified they weren't Resident #10's medications. Staff G stated she took the cup of pills to Staff H, CMA, and asked her whose pills they were. Staff G stated Staff H reported she mixed up the pills and gave Resident #2's pills to Resident #10 and Resident #10 pills to Resident #2. Staff G reported she destroyed the cups of pills that Resident #10 gave her in the drug buster and dispensed the correct medications to Resident #10. Staff G stated she notified the doctor of Resident #2's medication error. She stated she checked on Resident #2 every hour throughout the night to make sure she was alert and would wake up. Staff G stated she educated Staff H on never taking two medication cups in the room at the same time, as she was asking for trouble. Staff G reported she educated Staff H regarding leaving medications in the room unattended. Staff G reported Staff H took both residents' medication cups in the same room at the same time and got them mixed up.<br><br>On 10/17/24 at 9:15 AM, the Nurse Consultant reported she expected the staff to follow the 6 rights of administering medications.<br><br>A facility policy titled Medication Administration reviewed May 2021 instructed to accurately prepare, administer, and document oral medications. The policy directed staff to identify the resident when administering medications by the photo on the MAR or by asking their name. The policy documented they must identify the resident before administering medications. The person administering the medication must remain with the resident until all they swallowed all of their medications. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>48886<br><br>Based on observation and staff interviews, the facility's Dietary Staff failed to perform the proper functions of food and nutrition services for the pureed food process for 3 of 3 residents requiring a pureed diet. The facility reported a census of 61 residents.<br><br>Findings include:<br><br>During an observation 10/16/24 at 11:20 AM, Staff D, Cook, began the puree process for turkey and wild rice casserole for 3 residents on a puree diet. Staff D used the 5 1/3-ounce scoop to scoop out 3 servings of the casserole. Staff D placed the servings in the Robot Coupe (brand name machine used to puree food). Staff D added an unmeasured amount of thickener and chicken broth to the Robot Coupe. Staff D pureed this in the Robot Coupe, and added more unmeasured chicken broth. Without measuring the puree or using the graph to determine what size to use, Staff D placed the total pureed casserole into a container. Staff D used the 5 1/3-ounce scoop to plate the food for the 3 residents with a puree diet.<br><br>During an interview 10/16/24 at 11:35 AM, Staff D stated she pureed the food for approximately a year and had no training on the process. Staff D stated she googled and asked the Dietitian how to puree. She didn't receive training on the texture pureed servings. Some have told her the texture is a little too thick, which she will thin it out. She never received training on the consistency for pureed food. Staff D stated she didn't know how to use the puree graph (on the wall in the kitchen), she stated she never used the graph. Staff D looked at the book and menu from the food distributor for the food served for that day, and used the scoop size listed in the book. Staff D stated she never measured the pureed food after pureeing to determine the scoop size using the graph. She has added thickener and liquid to the mixture, altering the original volume.<br><br>During an interview 10/16/24 at 1:56 PM, the Administrator stated they expected the staff to measure the pureed food after it is pureed and use the graph to determine the scoop size to use. The Administrator stated the facility didn't have a specific puree policy, however the Administrator stated they expected staff to follow the therapeutic diets and use the graph to determine the scoop size for pureed food, to ensure the residents received the appropriate portion size. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>48886<br><br>Based on observation and staff interviews, the facility failed to ensure staff used proper food handling procedures to prevent possible contamination of food during lunch service with food uncovered. The facility reported a census of 61 residents.<br><br>Findings include:<br><br>During an observation on 10/16/24 at 12:30 PM, the facility delivered the room trays to residents in the 100 hallway, 200 hallway, 300 hallway and 400 hallways. The trays contained uncovered food of the desserts on all of the room trays brought to residents, a bowl of chips, and a bowl of crackers.<br><br>During an interview 10/16/24 at 12:50 PM, Staff D, Cook, reported they should cover all food when transported down the hallways. Staff D acknowledged they didn't cover the dessert placed in bowls for residents eating in their rooms, as well as a bowl of chips, and a bowl of crackers. Staff D stated they expected food be covered.<br><br>During an interview 10/16/24 at 2:04 PM, the Administrator stated they expected the staff to cover all food when food is transported in hallways when serving residents their meals, for infection control purposes. The Administrator stated the facility didn't have a policy specific to food service, stated the facility followed professional standards for food service safety and infection control. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875<br><br>Based on observations, clinical record review, staff interviews, and policy review, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 1 of 2 resident reviewed for catheter care (Resident #363). The facility reported a census of 61 residents.<br><br>Findings include:<br><br>Resident #363 lacked a completed Minimum Data Set (MDS) assessment due to recent admission to the facility on [DATE].<br><br>The Care Plan Focus dated 10/2/24 reflected Resident #363 had an indwelling urinary catheter related to urinary retention and benign prostatic hyperplasia (BPH enlarged prostate that blocks the passage of urine). The Care Plan directed staff to position the catheter bag and tubing below the level of the bladder and away from the entrance room door.<br><br>On 10/14/24 at 12:12 PM, observed Resident #363's catheter drainage bag lying on the floor without a privacy cover next to the low bed behind the fall mat. Observed Staff A, CNA (certified nursing assistant), pick up the uncovered catheter bag off the floor and hanged it on the side of the bed, visible from the entrance door of the room.<br><br>On 10/15/24 at 3:31 PM, observed Resident #363's catheter drainage bag with a privacy cover hanging on the side of a trash can containing garbage.<br><br>On 10/16/24 at 8:30 AM, observed Resident #363's catheter drainage bag hanging on the side of a trash can containing garbage.<br><br>On 10/16/24 at 8:55 AM, observed Resident #363's catheter drainage bag continuing to hang on the side of the trash can. The ADON (Assistant Director of Nursing) completed a wound treatment to the right heel and threw garbage in the trash can while the catheter drainage bag hanged on the side.<br><br>On 10/17/24 at 9:15 AM, the Nurse Consultant verified the catheter drainage bag shouldn't hang on the side of a dirty trash can.<br><br>A facility policy titled Indwelling Urinary Catheter revised December 2023 instructed to provide each resident with an indwelling catheter daily and as needed catheter care to prompt hygiene, comfort, and decrease the risk of infection. The policy directed staff to cover the drainage bag with a privacy bag to maintain dignity. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0943<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.<br><br>49698<br><br>Based on review of employee file, facility policy, and staff interview, the facility failed to provide a valid Dependent Adult Abuse Mandatory Reporter Certificate, for the time of an alleged abuse (3/20/24) for Staff C, Certified Nursing Assistant (CNA). The facility reported a census of 61 residents.<br><br>Findings include:<br><br>Review of the facility's abuse investigation dated 3/26/24, identified Resident #47 told Staff C, CNA, of an alleged abuse incident that happened to her. Staff C failed to report this to the Administrative Staff in the facility.<br><br>On 10/15/24, the review of Staff C's employee file included a current completed Dependent Adult Abuse Mandatory Reporter Certificate dated 3/27/24.<br><br>An Email date 10/16/24 at 1:57 PM, Staff I, Human Resources, indicated she couldn't find a Dependent Adult Abuse Mandatory Reporter Certificate with a date prior to 3/27/24.<br><br>On 10/17/24 at 3:15 PM, the Director of Nursing (DON) stated, Staff C was obtaining a copy of this certification and bringing it to the facility.<br><br>The facility failed to provide the document prior to exit of the facility on 10/17/24 at 5:00 PM.<br><br>The Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment policy revised 11/28/17 instructed in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility would ensure all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of resident property, are reported immediately but: not later than 2 hours after the allegation is made if the events that cause the allegation involved abuse or resulted in serious bodily injury. The facility wouldn't report later than 24-hours if the events related to the allegation didn't involve abuse and didn't result in serious bodily injury. The facility would ensure all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of resident property, are reported to the Administrator of the facility, the State Survey Agency, and the Adult Protective Services (as appropriate). The facility would make sure to take immediate steps after receipt of a report of possible abuse, neglect, mistreatment, exploitation, or misappropriation of resident property, to protect the identified resident(s).<br><br>The Abuse Prevention and Prohibition policy revised September 2017 directed the facility to provide a training orientation program. The program would include a review of the facility's policy on:<br><br>a. What constitutes abuse, neglect, exploitation and misappropriation of resident property.<br><br>b. Care of the cognitively impaired/appropriate interventions to deal with aggressive and/or catastrophic reactions of resting.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165362 | A. Building<br>B. Wing | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clarion Wellness and Rehabilitation Center | 110 13th Avenue SW<br>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 0943<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | c. Dementia Management and Resident Abuse Prevention.<br><br>d. How staff should report their knowledge related to allegations without fear of reprisal.<br><br>e. How to recognize signs of burnout, frustration and stress that may lead to abuse.<br><br>f. Department of Justice information regarding Your Legal Duty . Reporting Elder and Dependent Adult Abuse.<br><br>g. Elder Justice Act Reporting Reporting/Response All alleged violations will be reported via phone or in writing within 24-hours to the State Licensing Agency.<br><br>h. The facility shall follow up to the State Licensing Agency in writing the findings and results of the completion of the investigation within 5 days. |