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	08/28/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, staff interviews, and policy review the facility failed to implement care plan interventions to reduce the risk for falls for 1 out of 20 residents reviewed (Resident #19). The facility reported a census of 62 residents.Findings include: Resident #19's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired cognition. Resident #19 required substantial to maximal assistance with bed mobility and all transfers. The MDS included diagnoses of fractures and other multiple traumas, depression, chronic obstructive pulmonary disease (COPD), muscle weakness, wedge compression fracture of the second lumbar vertebrae (a type of spinal fracture where the front portion of the vertebrae in the lumbar area of the spine collapses, creating a wedge shape), COVID-19, cognitive communication deficits, limitation of activities due to disabilities, other reduced mobility and repeated falls.The Care Plan Focus initiated 7/28/25 indicated Resident #19 had an actual fall with no injury. The Intervention created 8/10/25, initiated 8/8/25 directed to put Resident #19's bed a low position.The Nursing Note dated 8/8/25 at 8:38 AM documented 2 Certified Nurse Aides (CNA) summoned the nurse to Resident #19's room. The nurse observed Resident #19 lying on his right side on the floor facing the bed. He had his feet near the dresser next to the bed below the TV. He wore his brief but didn't have on his gown. Resident #19's had his oxygen concentrator on but didn't have the oxygen cannula in place as it laid on the bottom of the bedside table. Resident #19 sustained a skin tear to his right elbow that measured 2.7 centimeters (cm) x 2.7 cm with minimal bleeding. The nurse cleaned the area and applied border gauze (sterile multi-layered absorbent wound dressing). Three staff assisted Resident #19 from sitting position standing position with a gait belt and then into the wheelchair. An additional skin assessment revealed an abrasion to Resident #19's right knee covered with a Mepilex (a padded type dressing). Resident #19 had a small red area to the right shoulder blade. The note indicated Resident #19 could bear his own weight on both lower legs. The staff put oxygen back on Resident #19. The note reflected an immediate nursing intervention have Resident #19's bed in a low position while he's in bed. On 8/25/25 at 2:12 PM, observed Resident #19 lying in bed, not in low position.On 8/27/25 at 1:56 PM, observed Resident #19 lying in bed, not in low position.On 8/27/25 at 3:32 PM, Staff A, CNA reviewed Resident #19's Care Plan and stated it directed the bed be in low position. After going to Resident #19's room, observed him lying supine in bed without the bed low position. Staff A lowered the bed to the lowest position closest to the floor.On 8/27/25 at 4:05 PM, the Director of Nursing (DON) said he expected the staff to follow the Care Plan. On 8/28/25 at 9:00 AM, the Administrator reported the standard of practice is for the staff to follow the Care Plan.The Fall Management policy revised June 2018 directed to provide each resident with an appropriate assessment and intervention to prevent falls and minimize complications if falls occur.

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 B. Wing	08/28/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, hospital record review, and facility policy review, the facility failed to provide adequate nursing supervision to prevent an accident and injuries for 1 of 1 resident reviewed (Resident #23) related to a suicide attempt. Resident #23 voiced he wanted to kill himself and had a plan on 5/17/25 (he attempted to use his fingernails to try to dig out a vein) and 5/18/25 (he placed a pen over his wrist and inner arm bend), the facility sent him to the emergency room (ER) on both dates. Upon return on 5/17/25 the facility implemented temporary one-to-one (1:1) supervision. The facility discontinued the supervision the same day around 9:30 PM without putting any further safety interventions in place. Resident #23 returned to the ER on [DATE] related to suicide ideation and gestures. The facility reported a census of 62 residents. Findings include:Resident #23's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS identified Resident #23 as independent with bed mobility, transfers, and required partial/moderate assistance with ambulation. The MDS included diagnoses of anxiety, depression, and schizophrenia.The Care Plan Focus revised 10/7/24 indicated Resident #23 took psychotropic medications related to the diagnoses of bipolar, schizoaffective disorder, and auditory hallucinations. The Interventions directed the following:a. Staff to monitor, record, and report to the Provider as needed any side effects and adverse reactions of psychoactive medications that included suicidal ideation.b. Staff to notify psychiatric services via telehealth of increased auditory hallucination, statements of voices telling Resident #23 to do inappropriate things or self-harm. The Care Plan lacked information regarding suicide precautions or a prevention plan.The Nursing Note dated 5/16/25 at 5:03 AM reflected Resident #23 stood at the end of the hallway yelling, Give me my fucking water, give me my fucking water now, I'm going to fuck you up. The note documented Resident #23 threatened to hit the staff with his walker. Resident #23 came down the hallway full force with his walker in his hand and knocked the Registered Nurse (RN) to the ground. Resident #23 stood over the RN and stated, give me fucking water now. The note indicated Resident #23 returned to his room, slammed his door shut and started hitting the walls loudly. The note documented facility called the police and ambulance to transfer Resident #23 to the hospital. The Hospital After Visit Summary dated 5/16/25 documented an altered mental status with diagnosis of agitation as the reason for Resident #23's visit. The summary documented a new order to give hydroxyzine (medication used for anxiety) 50 milligrams (mg) every 6 hours as needed for agitation. The Ambulance Service Report dated 5/17/25 documented the Emergency Medical Services (EMS) received a page to the facility for Resident #23 due to statements of him being suicidal and conducting self-harm with his fingernail. The facility staff reported they couldn't control him. The report documented the facility nurse reported Resident #23 told her he was going to commit suicide and was not going to stay at the facility. The facility nurse reported Resident #23 went to the emergency room (ER) within the last 20-hours for the same thing. The note documented EMS transferred Resident #23 to the ER. A Psychiatric Evaluation assessment dated [DATE] at 9:43 PM revealed Resident #23 completed a suicide risk screening and was considered a positive screen. Resident #23 answered yes to the questions of in the past few weeks, have you wished you were dead? Have you ever tried to kill yourself? In addition, when asked Resident #23 how he tried to kill himself, he reported he wanted to leave the nursing home and so he cut himself superficially to be taken seriously and get out. The Psychiatric Evaluation Reassessment dated [DATE] indicated Resident #23 arrived to the emergency department (ED). The facility nurse reported him as delusional and suicidal. On arrival, he reported suicidal ideations and had superficial scratches on his arms. Resident #23 reported he was trying to dig a vein out. The note documented Resident #23 declared he would kill himself if he had to go back to the facility. The note indicated (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 B. Wing	08/28/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #23 didn't have any thoughts of hurting himself during the assessment. The Nursing Note dated 5/17/25 at 10:34 AM documented Resident #23 returned to the facility with a new order to start Geodon (antipsychotic medication) 20 mg 1 tablet at bedtime. The indicated Resident #23 rested in his room with his call light in place. Resident #23's clinical record lacked documentation of implementation a formal suicidal prevention plan, suicide precautions and/or interventions upon his return from the ER. The Condition Follow-Up Note dated 5/18/25 at 4:34 AM indicated Resident #23 told the staff to shut the door when they leave after they open his room door.The Behavior Note dated 5/18/25 at 4:53 PM documented Resident #23 refused all medication during the morning (AM) and evening (PM) pass. The note reflected Resident #23 told staff he was suicidal. When the nurse asked Resident #23 if he had a plan, he slammed the door to his room. When the nurse opened the door to visit with Resident #23 regarding his suicidal intentions, he held a pen on his wrist and then moved the pen to his antecubital area (inner arm bend). Resident #23 informed the nurse he would take his medication. When the nurse informed him, they had to crush his medication due to his history of pocketing, regurgitating, and stockpiling the medication in his room, Resident #23 pushed the nurse with the door and attempted to slam the door on the nurse. The note revealed the nurse called 911 and informed police of Resident #23's behaviors and the police directed to send him to the ER. The Nursing Note dated 5/18/25 at 5:00 PM, documented as the nurse filled out paper work to send Resident #23 to the ER, the police officer called for an ambulance due to him becoming increasingly agitated and restless. A Psychiatric Evaluation assessment dated [DATE] at 9:43 PM reflected Resident #23 completed a suicide risk screen, that resulted in a positive screen. Resident #23 answered yes to the following questions of in the past week, have you been having thoughts about killing yourself? Have you ever tried to kill yourself? In addition, when Resident #23 asked how he tried to kill himself, he replied that he tried to put a pen to his arm.The Psychiatric Evaluation Assessment listed Resident #23's chief complaint as suicide. The note reflected Resident #23 reported if he went back, he would try it again. The impression/risk assessment documented Resident #23 may have decompensated psychiatrically and he required inpatient psychiatric hospitalization for safety, medication management, and discharge planning. The Psychiatric Evaluation Reassessment dated [DATE] at 9:41 AM documented the impression/risk assessment indicated when informing Resident #23 he would be returned back to the long-term care facility, he developed conditional suicidal ideation, stating he would poke himself again if he went back. The reassessment treatment/therapy recommendations directed the long-term care facility to remove all sharp objects including pens and utensils (can have plastic utensils) and Resident #23 should be in line of sight at the care facility.The Nursing Note dated 5/20/25 at 4:53 PM documented Resident #23 returned to the facility accompanied by the Administrator and the Director of Nursing (DON). The note documented the facility received new orders for Resident #23 to have no sharp objects could harm the patient or staff in his room. The note indicated the facility faxed the psychiatric evaluation reassessment to the primary provider. Resident #23's clinical record lacked documentation of the implementation of a formal suicidal prevention plan, suicide precautions and/or interventions after he return from the hospital. The clinical record lacked documentation the facility implemented the order for Resident #23 to have no sharp objects, increased supervision, or had him in line of sight. On 8/26/25 at 3:56 PM, the DON reported he didn't feel Resident #23 acted suicidal, but behavioral. He said he knew Resident #23 and felt he tried to find a way to leave the building. He said he talked with Staff D, Licensed Practical Nurse (LPN), about Resident #23's behaviors. He said Resident #23 didn't harm himself but acted like he would. He said the pen didn't actually touch Resident #23's skin. The DON said he didn't have any concerns and didn't think Resident #23 would actually harm himself. When asked what safety measures, they put in place, the DON responded when Resident #23 returned from the ER on [DATE] he asked Staff E, Certified Medication Aide (CMA), to sit with Resident #23. He reported Resident #23 chased Staff E out of his room and down the hallway. He said he spoke to Resident #23 and didn't think he was a continuous risk. The DON reported he didn't recall any scratch (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 B. Wing	08/28/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	marks. He said it must not have broken the skin and he didn't have a huge concern about the incident. When asked if the facility did any suicide assessments, the DON replied no. On 8/27/25 at 9:42 AM, Staff C, RN, reported when she came on duty that night, Resident #23 already went to the ER on ce. She said later that night Resident #23 walked up to the nurses' station and said he would commit suicide if he couldn't go back to the ER. Staff C reported she asked him if he had a plan and he referred to his fingernails. She said Resident #23 dug into his antecubital and described the area as red with scratches but without blood. She said she told Resident #23 he went to the ER. She said Resident #23 said he would go back to his room and keep working at it. She described him as adamant he needed to go to the ER or he would kill himself. She added Resident #23 stated he had his teeth and she didn't know for sure what he planned to do with his teeth. She said she made the decision, Resident #23 needed evaluated. She called the ER and the DON. She said Resident #23 went to sit in the dining room. She went in and out of the nurses' station and could see where he sat. She said she couldn't say 100% if he continued to scratch at his arms but she didn't see any movement with his hands. When asked if anyone, provided supervision in the dining room, she responded no. She said Resident #23 left the dining room to go back to his room when the police officer showed up and knew him. She said the police officer went back to Resident #23's room and stayed with him until the ambulance came. She said Resident #23 walked out of his room and sat on the cot. She described him as not aggressive. When asked if Resident #23 had any history of suicidal ideation, she replied she didn't recall any, just that one week. She said his behaviors reached an all-time high level. She described Resident #23 saying he wanted to die as different for him. She said Resident #23 had strange quirks but reported that as something different. When asked if the facility had a suicide policy and/or an assessment, she said normally if the staff felt a resident had a potential risk they would remove anything from the room that could be used to harm themselves like sharp objects, call light cords, or shoes laces. She didn't think that happened on her shift unless they did it the next day. She said Resident #23 didn't have a lot of stuff in his room.On 8/27/25 at 10:57 AM, Staff D, LPN, reported Staff E, CMA, tried to give Resident #23 his medications. He refused the medications and told Staff E he wanted to kill himself. She said Staff E told her about it, so she went to his room. She said Resident #23 put a pen to his wrist and moved it to his left antecubital area. Staff D said he didn't push the pen into his skin and she didn't think he had the pen out. She said Resident #23 didn't make any marks on his skin. She said Resident #23's incident happened not long after he had an encounter with another nurse he injured. Staff D said she stood in the doorway and Resident #23 tried to slam the door on her. She described the door as really heavy and Resident #23 really had to push the door. She felt Resident #23 tried to crush her with the door. Staff D said she had concerns about his aggressiveness towards her. She said she called his primary care physician and received an order to send Resident #23 to the ER. She said when the officer arrived and after some time passed Resident #23 started to get aggressive with the officer. When asked if the facility had a policy or protocol regarding suicide, she replied she believed the facility did, but couldn't remember what the policy said. She thought the policy directed 15-minute checks, removing objects that could be sharp or used to harm themselves, and to provide a bell as a call light. When asked if the facility put any safety interventions in place, she responded she didn't know of any interventions and no one passed any information about one in report. She acknowledged she didn't put any interventions in place herself, and didn't know if anyone went through his room to look for harmful objects. She reported she didn't really have concerns about him hurting himself. She said Resident #23 didn't like to be in pain and she didn't think he had the means to hurt himself. She said he didn't have much in his room to begin with. She acknowledged Resident #23 spent a lot of time in his room with the door shut and he ambulated independently. She reported he could have the opportunity to obtain something if he wanted. She reported she didn't know how he got the pen. On 8/27/25 at 2:00 PM, the DON reported on 5/17/25 after Resident #23 returned from the hospital he asked Staff E to provide 1:1 care. He said Staff E was scheduled until 2 PM but agreed to stay over. He said he stopped the 1:1 with Resident #23 after (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 B. Wing	08/28/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff E called him. He said he didn't feel Resident #23's needed the 1:1 as Resident #23 didn't voice any suicidal thoughts. When asked if they put any additional safety precautions in place after they stopped the 1:1, he replied no. The DON and Corporate Nurse verified the facility didn't update the Care Plan regarding Resident #23's suicidal ideation, attempts, and interventions. On 8/27/25 at 2:17 PM, Staff E, CMA reported she worked 6 AM to 2 PM on 5/17/25. Staff E said the facility asked her to stay over to provide 1:1 with Resident #23. She said she started the 1:1 around 2 PM and stopped around 9:30 PM. She called the DON and he gave her the okay to leave since Resident #23 acted like his regular self. She said she didn't know if anyone provided supervision prior to 2 PM or after she left. She sat in his room and then moved out into the hallway for his comfort. On 8/27/25 at 3:54 PM, the DON reported he didn't know about the treatment recommendations from the psychiatric reassessment on 5/20/25. He added they didn't provide Resident #23 supervision to keep him within line of sight. He acknowledged Resident #23 had his room at the end of the hallway and he liked to keep his door closed. The Suicidal Precaution and Prevention policy revised October 2024 directed the staff to:a. Identify residents at risk to self-injury.b. To keep the safety of residents as a priority. When a resident expresses the desire to die or states a plan to kill oneself, all staff begin a Suicide Watch.c. Any staff person hearing a resident express things such as life isn't worth living, wishes for death, or attempts to harm himself will report the information to their supervisor, licensed nurse/charge nurse, or DON. The policy instructed to complete the following:a. Nursing to call a primary care physician, responsible party and/or surrogate decision maker. b. Nursing to monitor, via room every 15 minutes and/or 1:1 interaction depending on resident's verbalization of plans to harm themselves.c. Initiate alert charting including, but not limited to such observations as to the nature of the resident's comments, body language, verbal expression, and mood.d. Include residents and type of comments to the 24-hour report.e. Review medical status and/or condition with a medical provider to rule out medical conditions. Notify the crisis line or send the resident to the ER for evaluation. f. Resident's door to remain open at all times. Staff to pull the privacy curtain when giving care.g. All staff keep sharp objects out of reach of the resident (needles, scissors, pens, mirrors, glass picture frames, cords, jewelry, etc.)h. Dietary to provide all meals/snacks on paper/plastic products. i. Social Services will evaluate resident's psychosocial and mood indicators. They will coordinate and communicate with the mental health clinicians and update the plan of care as needed.

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	08/28/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinic record review, staff interviews, and policy review, the facility failed to administer medications per physician orders for 1 out of 1 resident reviewed (Resident #23) for significant medication errors. The facility reported a census of 62 residents. Findings include: Resident #23's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS listed Resident #23 as independent with bed mobility, transfers. He required partial/moderate assistance with ambulation. The MDS included diagnoses of anxiety, depression, and schizophrenia.The Care Plan Focus revised 10/7/24 reflected Resident #23 took psychotropic medications (antipsychotic medication Haldol and Geodon) related to diagnoses of bipolar (frequent changes in mood), schizoaffective disorder (a mixture of mood and schizophrenic symptoms), and auditory hallucinations (hearing things not there). The Interventions directed staff to administer medications as ordered and give the Haldol Decanoate intramuscular injection (IM) every month as ordered.Resident #23's May 2025 Medication Administration Record included the following orders:a. Started 5/16/24: Fluphenazine HCL (antipsychotic medication) 5 milligrams (mg) administer 1.5 tablets every morning (AM) and at bedtime (HS) related to schizoaffective disorder. The MAR lacked documentation of administration on the following days: i. 5/18 - AM ii. 5/23 - AM, HS iii. 5/24 - AM iv. 5/25 - AM v. 5/27 - AM, HSb. 5/17/25: Geodon - inject 20 mg IM as needed every time Resident #23 refused to take the fluphenazine for 2 weeks related to schizoaffective disorder, bipolar type. The MAR lacked documentation that staff offered and/or Resident #23 received Geodon 20 mg IM on the dates/times he didn't receive or refused his fluphenazine medication. A Physician order dated 6/25/25 directed staff to administer Haldol Decanoate IM - inject 50 mg IM one time every 30 days related to schizoaffective disorder. Resident #23's July 2025 MAR indicated he didn't receive the Haldol Decanoate IM on 7/26/26.The eMAR - Medication Administration Note dated 7/26/25 at 12:58 PM documented Resident #23 refused his medication and care needs. The progress notes lacked documentation staff offered or attempted to give the Haldol Decanoate injection at a later time. The Secure Conversation with the Primary Care Physician Note dated 8/13/25 documented Resident #23 missed his medication. The note identified Resident #23 didn't receive his monthly injection of Haldol on 7/26/25 and was due again on 8/26/25. The Physician directed staff to give the Haldol injection on 8/13/25 or as soon as possible and to complete monthly thereafter. An incident report titled Medication Error dated 8/13/25 documented Resident #23 missed his monthly Haldol injection on 7/26/25. The incident report documented the staff gave the medication and adjusted the MAR. On 8/26/25 at 3:56 PM, the Director of Nursing (DON) acknowledged the facility didn't give Resident #13's Haldol Decanoate IM in July per the Physician order. He said the nurse made an error and identified it. He said the staff gave the Haldol IM when they found the error. On 8/26/25 at 4:21 PM, Staff B, Licensed Practical Nurse (LPN), reported she found the Haldol IM medication error. Staff B said she honestly didn't know how the error occurred. She said Resident #23 had increased behaviors and as she researched his notes/orders, she discovered he didn't receive his Haldol injection in July. She notified the DON and Physician and gave the injection that day she identified the error. On 8/27/25 at 12:04 PM, the DON reported he expected the nursing staff to administer the Haldol Deaconate IM per the Physician's orders. On 8/27/25 at 2:00 PM, the DON acknowledged Resident #23 didn't receive the Geodon IM as ordered by the physician and he expected the staff to follow the order.The Administration of Medications policy dated July 2017 directed to administer medication as prescribed by the resident's physician, nurse practitioner, or physician's assistant. The policy directed staff to administer medication in accordance with the written orders of the attending physician and as recorded on the resident's MAR.

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	08/28/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to have a complete and accurately documented medical record for 1 of 20 residents reviewed (Resident #23). The facility reported a census of 62 residents.Findings include: Resident #23's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS listed Resident #23 as independent with bed mobility, transfers. He required partial/moderate assistance with ambulation. The MDS included diagnoses of anxiety, depression, and schizophrenia.A Physician order dated 4/9/24 directed staff to administer benztropine mesylate (Cogentin, medication to treat side effects of other drugs) 1 milligram (mg) at bedtime related to schizoaffective disorder, bipolar type.The Secured Conversations Note dated 5/10/25 at 8:33 PM indicated the nurse sent a message to the primary care physician (PCP) identified the facility didn't have Resident #23's Cogentin medication in stock since the beginning of the month.Resident #23's May 2025 Medication Administration Record (MAR) documented he received his Cogentin medication from 5/1/25 to 5/5/25 and on 5/9/25. On 8/26/25 at 2:05 PM, the Pharmacist reported the pharmacy sent 27 tablets of Cogentin on April 4th to cover until the end of April. She said the pharmacy didn't send any Cogentin again until May 20th when the facility got the order reinstated. She said the pharmacy didn't send the Cogentin medication at the beginning of May as the prior authorization (PA) ran out and the pharmacy didn't receive a new PA. She said the pharmacy received an order to discontinue the Cogentin medication on 5/12/25. She said the pharmacy sent the PA either to the facility or Provider to complete. She said they sent a notice of noncoverage to the facility initially on 4/17/25. She said the notice of noncoverage, and the PA are two separate things. She said the notice of noncoverage provided a list of different options for the facility. She said the facility had the option to authorize the fill until the approval of the PA, requested an alternative medication from the Provider, or asked the provider to hold the medication until the approval of the PA. She said they sent the notice of noncoverage again to the facility on 5/8/25.On 8/27/25 at 12:04 PM, the Director of Nursing (DON) acknowledged the staff signed off the MAR that they administered the Cogentin medication in May when the facility didn't have the medication. The Administration of Medications policy dated July 2017 directed staff to record all current drugs and dosage schedules on the resident's MAR. In addition, the policy directed the staff must indicate the reason and document the appropriate code they withheld a drug with any follow up documentation as appropriate for the situation.

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	08/28/2025

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on review of the facility's Quality Assurance Performance Improvement (QAPI) plan, the facilities past 2 surveys, and staff interview, the facility failed to correct their own deficiencies for 1 of 1 areas of concern. The facility reported a census of 62 residents. Findings include: The survey identified a concern with infection prevention and control at the current recertification survey and during the last 2 recertification surveys: The undated facility Quality Assurance and Performance Improvement (QAPI) Plan documented the facility will put in place systems to monitor care and services, drawing data from multiple sources. Feedback systems will actively incorporate input from staff, residents, families, and others as appropriate. It will include using performance indicators to monitor a wide range of care processes and outcomes and reviewing findings against benchmarks and/or goals the facility has established for performance. It also included tracking, investigating, and monitoring adverse events every time they occur, and action plans implemented through the plan, do, study, act (PDSA) cycle of improvement to prevent recurrences.During an interview on 8/28/25 at 1:15 PM, the Administrator acknowledged the facility received a deficiency at F880 on the current recertification survey and the previous 2 recertification surveys.

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	08/28/2025

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on facility record review and staff interview, the facility failed to have the minimum required members present at their quarterly Quality Assessment and Performance Improvement (QAPI) meetings as directed by Centers for Medicare and Medicaid Services (CMS). The facility reported a census of 62 residents. Findings include:The facility provide the list of sign-in sheets of the QAPI meetings. The review of the staff sign-in lacked documentation of the Infection Preventionist (IP) presence during the 2/18/25 meeting. An email from the Director of Nursing reflected all people who attended the QAPI meeting, signed the forms the day of the meet.During an interview on 8/28/25 at 9:05 AM the Administrator acknowledged the IP didn't sign the form to indicate attendance on the quarterly February 2025 QAPI meeting as expected. The Administrator added he planned to have QAPI meetings monthly instead of quarterly.

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	08/28/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility failed to provide wound care in a manner to prevent infection for 1 of 3 residents reviewed with wounds (Resident #3). The facility reported a census of 63 residents.Findings include:Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental status (BIMS) score of 13, indicating no cognitive impairment. The MDS included diagnoses of diabetes, chronic obstructive pulmonary (lung) disease, and pressure ulcer of the sacral region.The Care Plan Focus dated 7/9/25 identified Resident #3 had an actual skin impairment of a pressure ulcer to her coccyx. The Care Plan identified Resident #3 had a risk for additional pressure ulcers. The Goals listed his ulcers would remain free from infection. The Care Plan Identified Resident #3 had a diabetic ulcer of the right front leg, with a secondary etiology (cause) of a venous (impaired blood flow of the veins) leg ulcer. The Goals indicated Resident #3 wouldn't have complications from the ulcer through the review date.On 8/25/25 at 11:23 AM watched Staff B, Licensed Practical Nurse (LPN), perform Resident #3's wound care. Staff B placed supplies on Resident #3's table without a barrier. Staff B put on a gown and gloves, then removed a dressing from Resident #3's lower leg. Without hand hygiene, Staff B changed her gloves completed Resident #3's wound care and removed her gloves. Staff B washed hands for a few seconds turned off faucet with her bare hand before she removed paper towels to dry her hands. Staff B put on new gloves. Resident #3 stood, and Staff B removed the dressing to their coccyx (area above the buttock). Without hand hygiene, Staff B changed her gloves, cleansed the area, applied ointment, and covered the ulcer. Staff B then washed her hands in the same manner previously described. On 8/27/25 at 4:05 PM the Infection Preventionist (IP) stated the staff should only take the dressing supplies needed to a resident's room and then put on a barrier. She reported the staff should wash their hands for 20 seconds and use a paper towel to shut off the faucet. She stated staff should complete hand hygiene with sanitizer or washing hands between glove changes. The Hand Hygiene policy revised October 2022 instructed to provide the necessary supplies, education, and oversight to ensure healthcare workers performed hand hygiene based on accepted standards. The policy described hand hygiene as one of the most effective measures to prevent the spread of infection. Studies showed that effective hand decontamination could significantly reduce the rate of healthcare associated infection. All personnel should follow the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents, and visitors. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:a. Before and after coming on dutyb. Before and after direct contact with residentsc. Before donning sterile glovesd. Before handling clean or soiled dressings, gauze pads, etc.e. Before moving from a contaminated body site to a clean body site during resident caref. After contact with a resident's intact sking. After contact with blood or bodily fluids h. After handling used dressings, contaminated equipment, etc.m. After removing gloves i. After removing and disposing of personal protective equipment.The procedure directed to vigorously lather hands with soap, rubbing them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of running water, at a comfortable temperature. The staff should rinse hands thoroughly under running water while holding their hands lower than their wrists without touching their fingertips to the inside of sink. The policy instructed to dry hands thoroughly with paper towels and then turn off the faucets with a clean, dry paper towel.