STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165440	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winslow House Care Center	3456 Indian Creek Road Marion, IA 52302

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, clinical record review, staff interviews and facility policy review the facility failed to utilize Enhanced Barrier Precaution (EBP) for 4 out of 4 encounters with residents (Resident #3 and Resident #32) and their environment, and failed to personal protective equipment (PPE) while handling dirty laundry. The facility reported a census of 48 residents.Findings include: The Minimum Data Set (MDS) assessment for Resident #3 dated 8/1/25, listed diagnoses of pressure ulcer of the left heel, and diabetes mellitus (DM) The MDS listed the Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. The Care Plan for Resident #3 dated 10/3/25 reflected she needed for EBP related to wound care.On 9/22/2025 at 10:25 AM Staff K, Certified Nurse Aide (CNA) reported the EBP sign on the door of Resident #3's room because of her wound.1. On 9/23/2025 at 2:03 PM Staff A, Certified Nurse Aide entered Resident#3's room washed her hands. The Care Coordinator stood back to observe. Staff A applied gloves. Staff B, CNA entered the room, washed her hands, and put gloves on. Staff A and Staff B applied the gait belt and with the slide board, and moved Resident #3 to the bed in a slow smooth motion. Staff A put the resident's feet up on the bed. On 9/23/2025 at 2:10 PM, Resident #3 stated she needed to get back for cake and ice cream activity. Staff A sat her back up on the side of the bed, and both CNA's moved Resident #3 back in the wheelchair (w/c). Both CNAs failed to use EBP. The EBP sign hung on the room door and the supplies hung on the back of the room door.2. On 9/24/2025 at 7:55 AM, Staff B, CNA staff entered Resident #3's room to make her bed, They talked about her leaving at 9:30 for the wound clinic. Staff B reported they needed to get her boot on, they forgot right away this morning. Staff B put the w/c pedals on Resident #3's w/c and put the arms on her w/c. Staff B failed to use any EBP when she made the bed, put the arms, w/c pedals and placed the boot on Resident #3.3. The MDS for Resident #32 dated 8/21/2025 included diagnoses of stroke, hypertension and anxiety. The MDS listed the BIMS score of 15 out of of 15, which indicated intact cognition. The Care Plan for Resident #32 dated 9/17/2025 identified stage II pressure ulcers to her right and left buttocks. The Care Plan directed the resident needed EBP. On 9/24/2025 at 8:07 AM Staff C took Resident #32 into the bathroom. Staff C failed to wear a gown or gloves in the bathroom or as she walked Resident #32 to her recliner. Staff C confirmed she just got Resident #32 up for breakfast. The sign that hung on the room door for Resident #3 and Resident #32 directed stop, Enhanced Barrier Precautions. Everyone Must: clean their hands, including before entering and when they leave the room. Providers and staff must also: Wear gloves and a gown for the following high contact resident care activities. Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding, tube, tracheostomy. Wound Care: any skin opening requiring a dressing. 4. On 9/2/2025 at 10:02 AM, the black water pipe that hung above the hanging clean clothes in the laundry room held 1/2 an inch thick by 2 feet long debris. The 12-inch fan that hung on the wall over the folding table held 4 gray balls 1/2 inch thick of debris.On 9/2/2025 at 10:02 AM, Staff I, Laundry reported she failed to know who cleaned the pipe above the clean hung laundry, and she reported Environmental Supervisor cleaned the fan. Staff I failed to wear an apron while she removed dirty clothes form the basket and placed them in the washer. She reported she needed to wear a gown with isolation items but failed to need other PPE with moving (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dirty laundry. Staff I opened the cabinet and pointed out the PPE for the isolation. On 9/25/2025 at 10:17 AM the Environmental Supervisor reported the gowns, gloves, and goggles were in the cabinet the laundry. She reported the staff in the laundry room needed to use the PPE when isolation is used or if the laundry is really dirty, gloves and gown otherwise glove with dirty laundry out of the tube. She acknowledge the dirty fan on the wall.On 09/25/2025 at 9:43 AM Staff J, Registered Nurse (RN) reported the staff needed to use the EBP for residents with wounds, catheters, colostomy, any tubes from their bodies. She stated the staff are expected to use the EBP when they come in contact with the wounds or tubes. She said the EBP isn't needed to put foot rests in place on the wheelchair (w/c) or adjusting the resident in then w/c, and they didn't need EBP to remake the resident bed. On 9/25/2025 at 12:22 PM the Director if Nursing (DON) reported she expected the staff to use EPB as directed by the signs on their room doors with contact of the residents and their personal items. The DON reported she needed to check the policies for the personal protective equipment (PPE) the staff needed to use with dirty laundry. On 9/25/2025 at 12:51 PM the DON reported the appropriate PPE is an apron with moving dirty laundry from the bin to the washer.The facility provided a policy titled Infection Prevention and Control-Laundry dated 8/1/2017, that directed soiled linen shall be handled as little as possible and with minimum agitation to prevent gross microbial contamination of the air and of the person handling the linen. Staff will wear gloves and other appropriate PPE when handling soiled linen.

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F 0578 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and policy review the facility failed to maintain code status records for 1 of 3 residents reviewed (Resident #21). The facility was unable to locate code status documentation after a resident's return from the hospital. The facility reported a census of 48 residents. Findings include:The Minimum Data Set, dated [DATE] for Resident #21 revealed the resident scored 14 out of 15 on a Brief Interview for Mental Status exam (BIMS), which indicated intact cognition. The MDS further indicated diagnoses of coronary artery disease, mild persistent asthma with acute exacerbation, and obstructive sleep apnea.The resident's Care Plan did not include the resident's preference for Cardiopulmonary Resuscitation (CPR) or Do Not Resuscitate (DNR).The resident's Electronic Health Record (EHR) did not include the resident's preference for CPR or DNR.The resident's paper chart did not include the resident's preference for CPR or DNR.On [DATE] at 3:01 PM Staff H, Licensed Practical Nurse (LPN) confirmed he worked mostly overnight which meant he was the only nurse on duty. He stated code status documents should be in the front of the resident's paper chart. Staff H looked through chart sections more than two times and he was unable to find code status documents. When asked if there was any reason it would be removed, Staff H stated the resident had been to the hospital and indicated the nurse overseeing the resident's return to the facility was supposed to put the documents back in the chart. When asked where else the information might be found, Staff H did not know where else to look and was not able to communicate the resident's code status. When asked if he would do CPR on this resident without the form in the chart, Staff H looked through the chart again and did not answer.On [DATE] at 3:04 PM, the Director of Nursing (DON) confirmed Resident #21 came back from the hospital recently. She stated the care coordinator was in charge of the paperwork that came back and signatures. She contacted him and he did not think he had her code status documentation.During a follow up with the DON on [DATE] at 4:03 PM, she indicated the facility was unable to locate the document and would correct it.On [DATE] at 1:11 PM, the Administrator said that unfortunately the nurse sent the original code status form to the hospital without making a copy for the chart. She confirmed the resident went to the hospital [DATE] and came back [DATE]. A policy titled Cardiopulmonary Resuscitation (CPR) Policy Resuscitation Policy effective [DATE] documented each resident's resuscitation status will be maintained in the clinical record as follows: A signed CPR policy indicating the resident's choice of CPR or do not perform CPR will be placed directly under the front cover of the resident's chart.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code all diagnoses and Preadmission Screening and Resident Review (PASRR) for 1 of 1 resident reviewed for Minimum Data Set (MDS) assessments (Resident #7). The facility reported a census of 48 residents. Findings include: Record review of Resident #7's Notice of PASRR Level II Outcome dated 5/22/2024 revealed the resident had short term approval until 5/22/2025, and determined to be a Level II (a comprehensive, in-depth evaluation for individuals determined to have a Serious Mental Illness (SMI), Intellectual Disability (ID), or related condition that requires specialized services.) The PASRR documented the resident had the diagnosis of schizoaffective disorder, bipolar type (a mental health condition that combines symptoms of schizophrenia and bipolar disorder). The PASRR also included the following direction to the facility: The facility should document yes to the following question on the MDS Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?.The MDS dated [DATE] for Resident #7 documented the following question response was marked no: Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? The MDS also lacked documentation of her diagnosis of schizoaffective disorder, bipolar type.The MDS dated [DATE] for Resident #7 lacked documentation of schizoaffective disorder.During an interview on 9/25/2025 at 12:21 PM with the Director of Nursing (DON) informed Resident #7 MDS's dated 12/30/24 and 6/27/25 should reflect her current PASRR Level II status and her diagnosis of schizoaffective disorder, bipolar type. She also informed she followed the Resident Assessment Instrument (RAI) manual.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and clinical record review, the facility failed to obtain a resident's Level II Preadmission Screen and Resident Review (PASRR), failed to implement Level II requirements, and failed to resubmit the Level I after expiration for one out of one resident reviewed (Resident #7). The facility reported a census of 48 residents. Findings include:The Minimum Data Set assessment for Resident #7 dated [DATE] included diagnoses of Bipolar disorder and cancer. The Brief Interview for Mental Status (BIMS) reflected a score of 11 out of 15, which indicated moderately impaired cognition. Review of Resident #7's Preadmission Screen and Resident Review (PASRR) dated [DATE] reflected following determination: Level 1 positive, No status change, and further documented did not require further PASRR evaluation due to lack of significant change since previous PASRR Level II evaluation. PASARR paperwork revealed the resident's previous summary of findings remained valid for the resident's stay at the nursing facility, should accompany resident if transferred to another nursing facility, and services in previous PASARR remained appropriate and should continue to be delivered. The PASRR directed since was determined resident had a PASRR condition, the facility needed to document the PASRR condition in important Medicaid nursing facility paperwork, and directed the following question should be marked yes on the MDS: Is the resident currently considered by the stated level II PASRR process to have a serious mental illness and/or instinctually disability or a related condition? PASRR paperwork directed that Resident#7's specific PASRR condition should be checked in question A1510, Level II PASRR conditions (on MDS).The PASRR outcome explanation revealed a PASRR Level II evaluation not required as no status change occurred and the current PASRR evaluation remained valid. The Level II PASRR for Resident #7 dated [DATE], obtained by the facility on [DATE], reflected approval for a short term stay that ended on [DATE]. The PASRR Level II reflected mental illness as schizoaffective disorder, bipolar type. The Level II PASRR for Resident #7 directed specialized services for her behavioral health and/or developmental condition were required. The nursing facility was required to Care Plan in a PASRR compliant fashion for all identified services including Specialized Services and Rehabilitative Services.The Care Plan for Resident #7 dated [DATE] failed to address PASRR recommendations. On [DATE] at 7:40 AM, Resident #7 reported she failed to sleep well last night related to bad dreams. On [DATE] at 8:44 AM the Activity Director reported Resident #7 reported yesterday morning she failed to sleep well the night before due to nightmares.On [DATE] at 2:37 PM, the Registered Nurse Consultant (RNC) MDS Coordinator, reported the facility obtained the PASRR Level I and placed in Resident #7's record. She reported the facility failed to obtain a copy of the PASRR Level II and they failed to complete a resubmission due to the short-term approval expired on [DATE]. The RNC reported she expected the facility to obtain the Level II PASRR put the recommendations in the Care Plan and she expected the a new PASRR completed before the expiration of the short-term approval. On [DATE] at 2:52 PM the Director of Nursing (DON) reported she failed to know Resident#7's Level II PASRR existed. She reported she expected the Level II PASRR addressed on the Care Plan. She stated she failed to know of a policy or procedure that addressed PASRR.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, interviews, and policy review the facility failed to provide a resident unable to carry out Activities of Daily Living (ADLs) independently the necessary services to maintain adequate personal hygiene and grooming (Resident #28). The resident was admitted to the facility 9/4/25 and was bathed/showered 1 time between 9/4/25 and 9/25/25. The facility reported a census of 48 residents. Findings include: The Minimum Data Set (MDS) for Resident #28 dated 9/10/25 documented diagnoses of stroke, non-Alzheimer's dementia, and depression. Section GG indicated the resident required supervision or touch assistance with tub/shower transfers and bathing. The resident's Brief Interview for Mental Status score was 2/15 which indicated severe cognitive impairment.The Care Plan for Resident #28 indicated she was at risk for skin breakdown due to incontinence and impaired mobility. It further documented her ability to complete Activities of Daily Living (ADLs) had deteriorated related to dementia and impaired mobility. An intervention dated 9/17/25 indicated the resident should get a whirlpool/shower two times per week. The care plan did not address bathing refusals or interventions.Observation on 9/22/2025 at 11:21 AM revealed the resident in the dining room with her hair up in partial pony tail. The hair in back that remained down appeared matted against the back of her head.On 9/23/2025 at 12:11 PM Resident #28's hair remained pressed against the back of her head and appeared stringy. The small pony tail was still in her hair with portions sticking out and twisted as though slept on.On 9/24/2025 at 8:12 AM the resident was at her table in the dining room. Her hair appeared stringy with strands clumped together around her ears and the back of her head.A final observation on 09/25/2025 at 7:55 AM revealed the resident's hair remained stringy around her ears.On 9/24/2025 at 2:52 PM, bathing sheets requested from the DON (Director of Nursing). She provided a document from the Electronic Health Record (EHR) titled Point of Care Audit Report which indicated the resident had scheduled bathing times on 9/8/25 at 1:59 PM, 9/10/25 at 1:41 PM, 9/16/25 at 1:46 PM, and 9/19/25 at 1:50 PM.An additional record titled Documentation Survey Report revealed that on 9/8/25 the resident received a bath/shower. On 9/10/25, 9/16/25, and 9/19/25 the resident refused.A review of the resident's progress notes revealed that on 9/10/25 at 5:18 PM the resident refused her shower 3 times that day. The progress notes did not include documentation that the resident refused any other days, whether or not she was offered alternate options such as a bed bath, or if any additional interventions were tried during the month. The progress notes did not include documentation that the Provider had been notified of the refusals, or that they had been communicated to the resident's responsible party.During an interview on 9/25/2025 at 8:20 AM Staff F, Certified Nurses Aide (CNA), stated residents who refused a bath or shower were offered a bed bath. Three approaches would be made and then they would usually not get a bath or shower until their next scheduled day.On 9/25/2025 at 12:21 PM Staff G, CNA stated that when a resident resident refused a bath or shower they notified the nurse and documented why the resident refused. She stated they would try the next day if there was time, otherwise the resident would wait until their next scheduled day. Staff G stated she had only gotten Resident #28 in for bathing once. She reported the resident had recently been changed to evening bathing but was not sure if that was working. When asked who completed bathing when she was out of the building, Staff G said it varied and there was not a set plan.On 9/25/2025 at 10:58 AM the Director of Nursing (DON) stated bathing schedules were determined at admission and residents were integrated into the list. Baths were offered Monday, Tuesday, Thursday, and Friday. If a resident refused they were reapproached and it was documented on the Point of Care list she had provided. The DON confirmed she was aware the resident was refusing bathing and thought they were eventually getting her to do it. Documentation lacked this occurred.The Administrator was asked for a bathing policy. On 9/25/2025 at 10:23 AM she provided documents titled Bathing Prompts that listed the steps staff should follow for showers and whirlpool baths. The documents were not specific to Resident #28 and did not include steps to take if a resident refused.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, record review, and staff interviews the facility failed to update as needed and provide current daily staffing information for residents and visitors. The facility reported a census of 48 residents. Findings include: During an observation on 9/22/2025 at 9:17 AM, the facility's staffing posting on the wall at the main facility entrance was observed to be dated 9/19/25. Review of Daily Staff Posting records from September 1 to September 23, 2025 had no edits or changes in staffing for the month. During an interview on 9/24/25 at 2:40 PM Staff D, Registered Nurse (RN) and Staff E, RN informed they did not have anything to do with the Daily Staff Posting and the Director of Nursing (DON) completed them. During an interview on 9/24/25 at 2:45 PM with the DON, informed it was on the night nurses responsibilities to change them over. During a follow up interview on 9/25/25 at 12:20 PM with the DON, informed she was the only one that updated the Daily Staff Posting records. She also revealed she had had new night shift nurses who were supposed to change it over, and thought they had forgot.