STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165446	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westbrook Acres	605 Garfield Street Gladbrook, IA 50635

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 0585 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on document review, policy review, and staff interview, the facility failed to utilize a grievance form to address missing resident items for 1 of 2 residents sampled (Resident #40). The facility reported a census of 44 residents. Findings include: Resident #40's Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition. The MDS documented Resident #40 with adequate vision and hearing and able to understand others and be understood. The 1/23/25 Resident Council Meeting Note detailed Resident #40 missing a Black Iowa Select hooded sweatshirt. The 2/11/25 Resident Council Meeting Note documented Resident #40 continued to be missing a Black hooded Iowa Select sweatshirt. During an interview on 3/4/25 at 1:41 PM the Administrator reported they review for lost items during the Resident Council Meetings, then work with laundry to go through all residents' closets to search for the missing items. She reported Resident #40 sweatshirt had not been found, but Resident #40 has a family member that does take some items home. She reported they had not followed up with the family as they didn't think anyone would want to steal a sweatshirt. On 3/05/25 at 2:05 PM the Administrator responded she had called the family and they could not recall if the sweatshirt had been brought in. They searched the donated clothes, closets, and everywhere and were unable to find it, but Resident #40 is pretty sure she had it at the facility. The Administrator reported they would start using the grievance policy and forms to address any missing laundry items. During an interview on 3/06/25 at 7:45 AM Staff B Licensed Practical Nurse (LPN) recalled Resident #40 had worn a black hooded sweatshirt and reported it missing a few months ago back in January (2025). She had not seen the resident wearing the sweatshirt in a few months. She reported Resident #40 had the black hooded sweatshirt at the facility. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Some	On 3/06/25 at 9:05 AM Resident #40 reported she is still missing the black hooded sweatshirt. It was black with white writing Iowa Select Farms on the front. She had been told by laundry that they had searched every closet. She reported her family does not swap her clothing in and out and no one in the family could wear the sweatshirt. The sweatshirt was not in poor repair or stained. Resident #40 further stated the facility really couldn't replace the items because it was a gift she had been given and it meant something to her. On 3/06/25 at 9:15 PM the Laundry Supervisor reported they did not have a grievance form made out for the loss of Resident #40 sweatshirt. She reported they looked all over the facility for the sweatshirt and it was not found. Staff C, housekeeping stated the resident goes out of the facility a lot and she told the resident that she (resident) may have to search the car or see if the sweatshirt had been left somewhere on one of her outings as they had searched everywhere for it. During an interview on 3/06/25 at 9:25 AM the Administrator reported the facility is so small and up to this point they had always found missing items, so there was no need to have a paper trail on anything. She acknowledged the facility had not completed a grievance form or done any more follow-up after they couldn't locate the missing item. She reported she had talked with Resident #40 right before this interview and the resident said the items could not be replaced as it was a gift unless she wanted to replace it with a facility logo sweatshirt. On 3/06/25 at 10:52 AM the Assistant Director of Nursing (ADON)/Admission Nurse reviewed Resident #40 electronic chat and her paper medical chart. She verbalized she could not find the resident's inventory (belongings) sheet. The 2021 Grievance Policy specified that completed forms could be slid under the office door of the Administrator for anonymity, or could be given to any staff member to be directed to the Administrator. The Administrator would review the Concern Form and forward it to the appropriate department head with a time frame for completion. The completed Concern Form (including response) would be filed in the Administrative Office and kept for no less than one year. No more than 10 business days would pass between the initiation of the form and the return of the completed form, unless there was documented communication with the involved parties. The Policy further specified all complaints will be addressed whether it is through the formal written procedure or merely verbalized complaints.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50874 Based on clinical record review and staff interview the facility failed to inform the Long-Term Care (LTC) Ombudsman office of a resident hospitalized for 2 of 2 residents reviewed (Resident #4 and Resident #46). The facility reported a census of 44 residents. Findings include: 1. Resident #4 Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 indicating moderate cognitive impairment. The MDS listed diagnoses of non-traumatic brain dysfunction (damage to the brain by internal factors), diabetes mellitus, and Non-Alzheimer's Dementia. A review of the Electronic Health Record Census Detail page for Resident #4 revealed Resident #4 had been hospitalized from 12/24/2025 to 12/27/2025 and from 1/31/2025 to 2/6/2025. A Progress Note dated 12/24/2024 a 10:44 PM, documented the hospital called to inform the facility that Resident #4 had been admitted . On 12/27/24 at 3:44 the Progress Notes revealed Resident #4 had been readmitted to the facility. A Progress Note dated 1/31/2025 at 10:40 AM documented Resident #4 had been transferred to the hospital. A Progress Note dated 2/6/2025 at 4:50 PM revealed Resident #4 had been readmitted to the skilled nursing facility. A review of the Notice of Transfer Form to Long Term Care Ombudsman dated December 2024 and January 2025 lacked documentation the LTC Ombudsman Office had been notified of Resident #4 transfers to the hospital. The Notice of Transfer Form for December contained notification of resident transfers from 12/5/24 to 12/29/24. The Notice of Transfer Form for January contained notification of resident transfers from 1/2/25 to 1/30/25. During an interview on 3/4/2025 at 3:38 PM, the Administrator acknowledged Staff A, Assistant Director of Nursing (ADON)/Admission Nurse had been responsible for sending the notifications to the LTC Ombudsman. The Administrator acknowledged notifications to the LTC Ombudsman had not been completed for any hospitalized residents. On 3/6/2024 at 10:46 AM, Staff A, ADON/Admission Nurse acknowledged she failed to submit the required notification to the LTC Ombudsman for all hospitalized residents. The facility failed to provide a policy for the required notification to the LTC Ombudsman for resident transfers and discharges. 42133 (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	2. Resident #46 MDS dated [DATE] showed a BIMS score of 3 out of 15 indicating severe cognitive loss. The MDS listed diagnoses of cancer, urinary tract infection in the past 30 days, Non-Alzheimer's Dementia, and other fracture. A Review of Resident #46 Electronic Medical Record Census documented Resident #46 out to the hospital on 2/21/25 and returned to the facility on [DATE]. A 2/21/25 5:30 PM Progress Note documented the local ambulance arrived at 5:30 PM and transported Resident #46 to a local hospital emergency department. A 2/25/25 Admission Summary Progress Note documented Resident #46 returned to the facility. Review of the February 2025 Notice of Transfer Form to the LTC Ombudsman Form lacked documentation the LTC Ombudsman Office had been notified of Resident #46 transfer to the hospital. The Notice of Transfer Form contained notification of resident transfers from 2/4/25 to 2/26/25.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on clinical record review, Long-Term Care (LTC) Resident Assessment Instrument (RAI) 3.0 User's Manual, Center for Disease Control and Prevention (CDC) 2025 Adult Immunization Vaccination Schedule, and staff interview, the facility failed to ensure the Minimum Data Set (MDS) Assessment accurately reflected the health status of 1 of 5 residents reviewed for pneumococcal immunizations (Resident #31). The facility identified a census of 44 residents. Findings include: Resident #31 Electronic Health Record (HER) Census documented admission to the facility on [DATE]. Resident #31 EHR Immunization Record showed Resident #31 received the pneumococcal polysaccharide (PPSV)23 vaccination on 11/01/21 at the age of 53. The Immunization Record lacked documentation of any other Pneumococcal Vaccination received by the resident. The CDC 2025 Adult Immunization Schedule for Pneumococcal Vaccination for adults age 50 or over directed when PPSV23 is the only pneumococcal vaccination received, then one dose of PCV15, PCV20, or PCV21 should be offered at least 1 year after the last PPSV23 dose. Resident #31 MDS assessment dated [DATE] documented Resident #31 in a persistent vegetative state with a diagnosis of cerebral palsy. The MDS further documented Resident #31 pneumococcal vaccination status as up to date. During an interview on 3/06/25 at 10:35 AM the MDS Coordinator explained she checks the residents EHR immunization record and reviews documentation in the resident's paper chart to see if the resident is up to date on the pneumococcal vaccination before coding the MDS. She voiced she had a call out to Resident #31 prior nursing home to see if they had records of Resident #31 vaccination status prior to coming to their facility. On 3/06/25 at 11:35 AM the MDS Coordinator reported she uses the RAI to code the MDS assessment. The LTC RAI 3.0 User's Manual, Version 1.19.1, October 2024 on Page 1-4 directs the RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that the assessment accurately reflects the resident's status. Page O-17 under Coding Tips defines Up to date means in accordance with current Advisory Committee on Immunization Practices (ACIP) recommendations. The ACIP develops recommendations on how to use vaccines to control disease in the United States and makes recommendations to the CDC Director. The 2025 Adult Immunization Schedule was adopted by the CDC Director on 10/24/24.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 50874 Based on time card review, schedule review, and staff interview, the facility failed to provide a Registered Nurse (RN) in the facility for eight (8) consecutive hours per day as required by the Federal Regulations. The facility reported a census of 44 residents. Finding include: Review of all Nursing Schedules from 7/1/2024 thru 9/30/2024 and Time Card Punches from 7/1/2024 thru 8/18/2024 revealed the facility failed to staff an RN for 8 consecutive hours on the following dates: 7/6/24, 7/7/24, 8/4/24, 8/17/24, and 8/18/24. During an interview on 3/5/25 at 2:47 PM, the Administrator revealed the facility uses an accounting company to submit all Payroll Based Journal staffing data. The accounting company emailed the Administrator a report reflecting the staffing data submitted. A Review of the Payroll Based Journal Quarterly Analysis from the accounting company for the period of 7/1/2024 to 9/30/2024 submitted documented the total number of days with no RN coverage for the quarter to be 5 days. The identified dates are 7/6/2024, 7/7/2024, 8/4/2024, 8/17/2024 and 8/18/2024. On 3/6/25 at 10:50 AM, the administrator acknowledged there were no RN's working in the facility for 8 consecutive hours on the identified dates.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 50874 Based on review of the Center for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report for the quarter of July 1, 2024 - September 30, 2024, facility staffing reports, and staff interviews the facility failed to submit accurate staffing reports for the PBJ Staffing Data Report. The facility reported a census of 44 residents. Findings include: The PBJ Staffing Data Report with a run date of 2/26/25 triggered for excessively low weekend staffing (submitted weekend staffing data is excessively low). A review of the schedules for the months of July 2024, August 2024, and September 2024 revealed nursing shifts covered by facility employee and outside staffing agencies. During an interview on 3/5/24 at 2:47 PM, the Administrator revealed the facility utilized an outside accounting company to submit the PBJ staffing data. The Administrator acknowledged data provided to the accounting company comes from the Administrator and a corporate administrative assistant. The Administrator revealed prior to the accounting company submitting the data, a preliminary report had been provided to the facility. The Administrator had the opportunity to review the report for any discrepancies and correct any discrepancies identified. On 3/6/25 at 10:14 AM the Administrator acknowledged the submitted report did not accurately reflect the facility staffing for quarter 4. The Staffing Data Submission Payroll Based Journal website (https://www.cms.gov/medicare/quality/nursing-home-improvement/staffing-data-submission), provides information on how data is collected and who to contact for questions. The deadlines for reporting staffing data are: Fiscal Quarter Reporting Period Due Date 1 October 1- December 31 February 14 2 January 1 - March 31 May 15 3 April 1 - June 30 August 14 4 July 1 - September 31 November 14 Users are strongly encouraged to take additional steps after uploading their data to ensure a successful submission. Therefore, the following verbiage appears upon uploading data to reflect the recommended next steps: 1. Check the My Submissions page. This feature will show the status of the zip file. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Check CASPER for a system generated PBJ Final File Validation Report (FFVR) within 24 hours. If no FFVR appears, run a PBJ Submitter Final File Validation Report to check your file for errors. 3. Run the PBJ 1702D (by Employer) or 1703D (by Job Type) Reports to verify the quarterly PBJ data reflects your records. 4. For additional assistance contact the Quality Improvement and Evaluation System (QIES) Help desk at iqies@cms.hhs.gov.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on clinical record review, policy review, and staff interview the facility failed to follow the Center for Disease Control and Prevention (CDC) 2025 Adult Immunization Schedule for pneumococcal vaccination for 1 of 5 residents sampled (Resident #31). Findings include: Resident #31 Electronic Healthcare Record (EHR) Census documented admission to the facility on [DATE]. Resident #31 EHR Immunization Record showed Resident #31 received the pneumococcal polysaccharide (PPSV) 23 vaccination on 11/01/21 at the age of 53. A review of the EHR Progress Notes, Miscellaneous documentation and paper medical chart lacked documentation of receiving a pneumococcal conjugate (PCV) 15, 20 or 21 vaccination. A Pneumococcal Vaccine Informed Consent Form signed by Resident #31's family member on 10/25/22 documented consent for the facility to administer a Pneumococcal Conjugate (PCV) 20 vaccination. The CDC 2025 Adult Immunization Schedule for Pneumococcal Vaccination for adults age 50 or over directed when PPSV23 is the only pneumococcal vaccination received, then one dose of PCV15, PCV20, or PCV21 should be offered at least 1 year after the last PPSV23 dose. On 3/05/25 at 4:10 PM the facility provided a undated document titled Pneumococcal Vaccination for Patients 50 to less than [AGE] years of age that had a circle in the category of PCV 13 (at any age) and PPSV23 at less than [AGE] years of age indicating Resident #31 required a PCV in five years from the last pneumococcal vaccination. The Document for PPSV 23 only (at any age) had the recommendation for PCV 20 or PCV 21 to be administered at 1 year or greater after the PPSV 23 vaccination. Interview on 3/06/25 at 7:40 AM with the MDS Coordinator reported she had received the Pneumococcal Vaccination Document from the pharmacy. The pharmacy reported Resident #31 was not due for a PCV vaccination until 2026. She did not know the year or information the recommendation was based on. Interview on 3/06/35 at 7:43 AM the Director of Nursing (DON) reported the facility didn't know if Resident #31 had received the PCV 13 vaccination prior to admission to the facility. Resident #31 admitted from a nursing home in another state and they had asked the family, but the family didn't know her vaccination status. On 3/06/25 at 10:35 AM the Assistant Director of Nursing (ADON) reported they were checking on the resident's pneumococcal status with the prior nursing home which is out of state and hadn't heard anything back yet. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/06/25 at 10:55 AM the ADON reported she reviews the Immunization Registry Information System (the IRIS system is a computerized tracking system of immunizations for adults who are seen in a variety of public and private health care provider sites throughout the state of Iowa), and hospital EHR records for any vaccinations that may have been done at a physicians visit. She had not been aware of the 2025 CDC pneumococcal (vaccination) schedule changes and the facility just ordered the updated consent forms today. She further stated all residents are to be offered the pneumococcal vaccinations. If a resident admits and doesn't have a record of updated pneumococcal vaccinations, they would address that. On 3/06/25 at 11:15 AM the DON voiced she expects the CDC to be followed regarding pneumococcal vaccinations. During an interview on 3/06/25 at 11:40 AM the Administrator voiced if a resident's vaccination status is unknown, then they need to proceed to ensure the correct vaccinations are offered. The Pneumococcal Policy, undated, provided by the facility directed a pneumococcal vaccination and education would be offered on admission, regardless if long or short term stay resident following the current recommendations by the CDC or the Iowa Department of Public Health. The Procedure further outlined as appropriate, residents will be offered the opportunity to receive a one-time dose of vaccine for pneumococcal pneumonia after the age of 65; or per the recommendations by the CDC or Iowa Department of Public Health. Each time the facility offers immunizations they will provide the education regarding the benefits and potential side effects of the immunizations to the resident/legal guardian, whether or not the resident elects to receive the immunization.