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	03/12/2026

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on staff interview, clinical record review and facility policy review, the facility failed to obtain consent to administer psychotropic medications taken by 1 of 5 residents reviewed for unnecessary medications (Resident #9). The facility reported a census of 40 residents. Findings include: Review of the Minimum Data Set (MDS) assessment for Resident #9 dated 12/23/25 revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated moderate cognitive impairment. The list of diagnoses included Alzheimer's Disease, Cerebrovascular Accident (CVA or stroke), seizure disorder, anxiety disorder, and psychotic disorder. Resident #9 used the following high-risk medications: antipsychotic, antianxiety, antidepressant, and anticonvulsant. Review of the Care Plan initiated 3/12/25 revealed a Focus area for psychotropic medication use related to diagnoses of anxiety, dementia, frontal lobe meningioma (brain tumor), and psychotic disorder. The Care Plan indicated that Resident #9 was currently took Buspirone (medication used to treat anxiety disorders). Interventions included, in part: a. Administer meds as per physician orders. Date initiated 3/12/25.b. Abnormal Involuntary Movement Scale (AIMS) test every 6 months. Date initiated: 9/25/25. c. Consult with Pharmacy for medication review as needed. Date initiated 3/12/25. d. Gradual Dose Reduction (GDR) as per physician when deemed appropriate. Date initiated 3/12/25. e. Monitor exacerbation of mood or behavior issues or acute changes and notify physician as needed. Date initiated 3/12/25. f. Monitor for potential significant side effects antianxiety and antipsychotic medications and notify physician of abnormal as needed. Date initiated: 3/12/25. Review of Resident #9's Medication Administration Records (MAR) between the dates of March 2025 and March 2026 revealed the following psychotropic medications and dose changes for the resident's medications: 1. Buspirone (Buspar) tablet 5 milligrams (mg), with instructions to give 1 tablet by mouth three times a day for Generalized Anxiety Disorder. Date initiated: 3/03/25a. Increase in Buspirone to 10 mg, with instructions to give 1 tablet three times a day. Start date: 5/09/25.b. Decrease in Buspirone to 7.5 mg, with instructions to give half a 15 mg tablet (7.5 mg) three times a day. Start date: 12/02/25. 2. Quetiapine (Seroquel) tablet 25 mg, with instructions to give one tablet by mouth at bedtime for dementia. Date initiated: 3/03/25a. Decrease in Quetiapine to 12.5 mg at bedtime, between the dates of 4/08/25 and 4/21/25, then discontinue (stop) medication on 4/22/25. b. Restart Quetiapine 12.5 mg, with instructions to give 12.5 mg daily. Start date: 9/26/25. 3. Citalopram (Celexa) tablet 10 mg, with instructions to give one tablet by mouth daily for anxiety/depression. Date initiated: 7/31/25. a. Increase Citalopram to 20 mg, with instructions to give 20 mg by mouth daily. Start date: 9/16/25. Review of the facility provided document titled Psychotropic Medication Therapy Informed Consent Form revealed the following:1. Resident #9 signed consent on 3/03/25 to receive the antianxiety medication Buspirone 5 mg three times a day for anxiety/irritability. The medical records lacked documentation of consent obtained when dosage was increased to 10 mg three times a day on 5/09/25. 2. Resident #9 signed consent on 3/03/25 to receive the antipsychotic medication Quetiapine 25 mg daily for dementia with behavioral disturbance. The medical records lacked documentation of consent obtained following restarted Quetiapine 12.5 mg daily on 9/26/25.3. Resident #9's medical records lacked documentation of consent obtained for the antidepressant medication Citalopram 10 mg daily, ordered for depression, or consent obtained when Citalopram (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	increased to 20 mg daily. On 3/12/25 at 2:22 PM, the Director of Nursing (DON) stated the normal process for psychotropic medication consents included obtaining consent from a resident or resident representative upon admission, after discussing potential side effects. The DON explained also was done intermittently when there were changes in medication dosage or if side effects were observed. The DON denied having documentation of psychotropic medication consents obtained for Resident #9's Citalopram started, increased Buspirone dosage, or restarted Quetiapine. Review of the facility policy titled Residents' [NAME] of Rights revised 11/2016 revealed the following per Section C. Planning and Implementing Care: The Resident has the right to be informed of, and participate in, his or her treatment, including: (1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. (5) The right to be informed in advance, by the physician or other practitioner, or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility policy review, the facility failed to ensure an as needed psychotropic medication was limited to 14 days unless the prescribing practitioner documented a rationale to extend medication for 1 of 5 residents reviewed for unnecessary medications (Resident #34). The facility reported a census of 40 residents. Findings include: Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated moderate cognitive impairment. Review of the resident's diagnoses per the MDS included cancer, non-Alzheimer's dementia, Cerebrovascular Accident (CVA or stroke), anxiety disorder, and adult failure to thrive. Review of the Care Plan Focus area initiated on 12/30/25 for Resident #34's use of the psychotropic medication revealed the following: The resident used Lorazepam, related to anxiety disorder, with times of yelling out to peers/staff, insomnia, non-sensical speech, and fixation on health. The Care Plan identified the resident currently took Lorazepam 0.5 milligrams (mg) twice per day as needed. Interventions included the following, in part: a. Administer anti-anxiety medications as ordered by physician. Monitor for side effects and effectiveness after given. Date initiated: 1/15/26. b. Abnormal Involuntary Movement Scale (AIMS) test every 6 months. Date initiated: 1/23/26. c. Consult with Hospice as needed. Date initiated: 2/03/26. d. Educate the resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms of Lorazepam. Date initiated: 1/15/26. e. Monitor the resident for significant adverse drug reactions with anti-anxiety medication. Date initiated: 1/15/26. Review of a Nurse's Note dated 12/30/25 at 1:40 PM revealed Resident #34 had agitation and aggression noted and new order received for 0.5 mg of Lorazepam twice a day as needed was processed. The Nurse's Note dated 2/12/26 at 11:13 AM revealed the Hospice nurse visited and the facility received a new order to increase Resident #34's Lorazepam to 0.5 mg every 4 hours as needed for increased unusual behaviors. Review of Resident #34's Medication Administration Record (MAR) dated March 2026 revealed a current order for Lorazepam (Ativan) 0.5 mg, with instructions to give 1 tablet every 4 hours as needed (order dated 2/16/26). Lorazepam 0.5 mg was given multiple times in the month for agitation, anxiety, and restlessness. Review of Resident #34's Electronic Health Record (EHR) lacked documentation of physician rationale to extend the order for Lorazepam 0.5 mg as needed for greater than 14 days. During an interview on 3/12/26 at 1:18 PM, Staff E, Licensed Practical Nurse (LPN) reported Resident #34 started the Lorazepam 0.5 mg on 12/30/25 and was increased by Hospice. Staff E stated the resident's as needed Lorazepam was minimally effective in treating Resident #34's symptoms of anxiety, restlessness, and agitation unless given early or as soon as symptoms started. On 3/12/26 at 3:30 PM, the Facility Administrator denied documentation related to physician indication to continue Resident #34's Lorazepam 0.5 mg as needed past 14 days. The facility policy titled Drug Regimen Review Policy, undated, revealed the objective of the drug regimen review policy was to try to minimize or prevent adverse consequences or to prevent residents from receiving unnecessary drugs.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and policy review the facility failed to complete a comprehensive assessment and evaluation of a resident for readmission to the facility after hospitalization for 1 of 3 residents reviewed for discharge (Resident #48). The facility reported a census of 40 residents.Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #48 revealed the resident admitted to the facility on [DATE]. The MDS assessment dated [DATE] for Resident #48 documented an unplanned discharge to a short term general hospital, with return not anticipated. Diagnoses included urinary tract infection over last 30 days, depression and vascular dementia.A Baseline Care plan initiated 1/9/26 documented Resident #48 admitted from the hospital with the goal to return home after therapy goals were met. Resident #48 was alert and oriented to self, and confused. The discharge goal revealed to remain at Long Term Care (LTC) setting. Resident #48 required assist of one with transfer, bathing, grooming, and locomotion on and off the unit. The resident used a walker. A Physical Therapy Evaluation and Plan of Treatment for Resident #48 beginning 1/9/26 documented the resident was referred by neurologist for skilled therapy after hospitalization for acute cystitis (bladder infection) and weakness. The resident was expected to transition to Long Term Care (LTC) after skilled therapy. Complexities included acute cystitis, legal blindness, heart disease, stroke and vascular dementia. The Transition/Discharge section of the form revealed the resident was to reside in the LTC facility.The admission Summary Note dated 1/9/26 at 12:20 PM revealed the resident admitted to the facility, was alert, and was pleasantly confused. The Nurse's Note dated 1/10/26 at 12:41 AM revealed the Resident #48 was able to make their needs known and denied pain. The Nurse's Note dated 1/10/26 at 12:55 PM revealed the resident required reminders to use call light and to not transfer independently. The Nurse's Note dated 1/10/26 at 3:58 PM revealed the resident's family visited, and the resident rested in a chair. The Nurse's Note dated 1/11/26 at 2:33 AM revealed Resident #48 rested quietly in bed, voiced no complaints, and was able to make their needs known. The Nurse's Note dated 1/11/26 at 9:50 AM revealed the resident required assist of one with cares and required cues and reminders from staff. The Nurse's Note dated 1/12/26 at 4:45 AM documented Resident #48 refused to get up to bathroom, and stated, I dont get up at night. Per the Nurse's Note, incontinence care was provided, and the resident was pleasant and cooperative.The Nurse's Note dated 1/12/26 at 8:00 AM revealed the resident was slightly non-compliant with morning cares and dressing, with assist of two (staff) used. The Nurse's Note further revealed the resident yelled in the main dining room that she did not belong [at facility] and insisted on going home right now. The resident mimicked staff, yelled at staff, and tried to kick and swing at staff. The resident attempted to push their chair into other residents, refused to eat breakfast, and was noncompliant with therapies. The Nurse's Note further revealed the resident was placed in her room and was offered to sit in her recliner. The resident refused, and yelled to get her out of here right now. The resident was left alone to calm, and was checked on frequently from the doorway. The Nurse's Note later in the day at 10:00 AM revealed the resident said no thank you to the offer of her recliner.The Nurse's Note dated 1/12/26 at 1:27 PM revealed the resident had a new order to obtain a urinalysis. Per the Nurse's Note dated 1/13/26 at 1:30 AM, the resident's urine specimen was obtained. The Nurse's Note dated 1/13/26 at 7:45 AM revealed the resident refused medication and spit them out two attempts. The resident demanded to go back to their room.The Nurse's Note dated 1/13/26 at 8:10 AM revealed the resident was observed in their room in their wheelchair with the wheelchair tipped backwards. The handle bars of the wheelchair prevented the resident's head from being on the floor. The Nurse's Note dated 1/13/26 at 8:45 AM revealed the resident wanted to leave, staff tried to talk with her, and the nurse instructed to go ahead and have 911 paged. The Nurse's Note dated 1/13/26 at 9:15 AM revealed notification to the (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's family that facility was sending resident to the hospital for acute behavior changes, and that the facility and would be discharging the resident that day. Per the Nurse's Note, the facility was unable to accommodate a female admission in memory care at that time. A Discharge Summary form for Resident #48 for admission on [DATE] and discharge on [DATE] revealed the resident was discharged related to inappropriate behaviors, and no beds in the memory care unit for a female. Per the form, the resident was discharged to [redacted name] hospital. The Additional Comments section of the form revealed the resident had increased agitation and aggression towards staff, and tossed trays of food. It further revealed the resident refused care, hit, scratched, put their feet on dining room tables, and yelled. The Additional Comments section further noted the resident made unsafe choices as tried to get up and ambulate. The resident was sent to check for acute causes of mental status change. The Additional Comments section further revealed no memory care beds were available for females, and unable to readmit. A Physical Therapy (PT) Discharge Summary for dates of service 1/9/26 to 1/12/26 revealed Resident #48's discharge location was unknown. Per the PT Discharge Summary, the resident was discharged unexpectantly due to noncompliance and insistence on leaving the facility.An Emergency Involuntary Discharge letter dated 1/13/26, signed by the Administrator, was faxed to the hospital. The Emergency Involuntary Discharge letter documented the facility sought to discharge the resident from the facility because her discharge was mandated to protect the health, safety, or well-being of other residents and staff. The Emergency Involuntary Discharge letter revealed Resident #48 was being discharged to [hospital name redacted] Emergency Department (ED) on 1/13/26. On 3/10/26 at 1:48 PM the hospital Social Worker (SW) explained the nursing facility relayed would not accept Resident #48 back to the facility. The SW relayed during hospitalization that Resident #48 did not have such agitation as reported, and further relayed resident was sassy and not trusting. Per the Hospital SW, it would subside and the resident took medication as ordered. The SW relayed the hospital did have to keep the resident longer than required related to obstacles of finding another facility. Resident #48 was treated for respiratory infection and did release to another nursing facility. On 3/12/26 at 10:40 AM the Director of Nursing (DON) revealed Resident #48 admitted from the hospital to the facility, and no behaviors reported. The first few days, the resident ate in her room. The resident did agreed to come to the dining room then yelled, and said didn't belong, take me home. The resident refused the meal. The next day, agreed again to go to the dining room, and became very angry and belligerent. Staff tried change of environment to the memory care unit for increased one to one. The DON recalled on Resident #48's last day at the facility that Staff A, Licensed Practical Nurse (LPN), the DON and the Administrator attempted to calm the resident who stood up and held on the nurse's counter. The resident would not follow direction, held onto staff, did not believe hit staff and did not hit another resident. The DON relayed Resident #48 was very difficult, aggressive, threw her food tray while in her room, and was unwitnessed. The DON reported the Administrator decided to send Resident #48 to the hospital and discharged resident from the facility. On 3/12/26 at 11:00 AM Staff A relayed knew Resident #48 worked with therapy, and recalled a day at breakfast that Resident #48 was upset, agitated, and unable to console. The resident had abruptly stood up from the wheelchair, tried to get her (resident) to sit, would not, and hung on to staff. Per Staff A, got the gait belt on with difficulty, and finally got resident to sit and took back to room. Per Staff A, Resident #48 grabbed staff, did not hit, and just hung on to the nurse's station and the nurses. Staff A agreed sometimes would see similar behaviors with an infection, and thought staff attempted to rule that out. Staff A relayed was able to get Resident #48 to her room to calm her, and attempted with different staff to calm. The Administrator tried to calm than decided to just send her out. On 3/12/26 at 11:10 AM, Staff B, CNA relayed when Resident #48 arrived, the resident was friendly and compliant. Then, within a few days, would yell out. Staff B explained knew the resident was confused, and the resident talked about leaving. Staff B, relayed the day Resident #48 left, she was fine in the morning. The resident was taken to the dining room, got angry, yelled, and kicked at the table. Interview with Staff B revealed the resident did not strike at residents or staff just the (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	table. The resident was loud so took her back to her room to avoid a resident to resident interaction. Per Staff B, made sure she had her food tray, her call light, and left her to calm. Maintenance staff viewed Resident #48 in room and (the resident) had tipped the wheelchair backwards, and she (resident) had flung her tray of food everywhere. The Nurses came to assess, brought the resident to the nurse's station, could not calm her, and resident was sent out to the hospital shortly after. On 3/12/26 at 11:20 AM, Staff C, CNA relayed Resident #48 got dressed for staff, and had no aggression until she came to the dining room. Per Staff C, the resident was aggressive, explained as not towards others, and the resident wanted to leave. Resident #48 pushed at the chairs and table, said didn't belong here, and was loud and disruptive. Other residents were about to eat. Per Staff C, tried to calm (resident)at the table, would not listen to any staff. Resident #48 was taken back to her room with room tray and access to call light. Per Staff C, shortly after was called to the room because resident had thrown ice in the hall, and the tray and food were on the floor. Resident #48 was brought back to dining room, felt calmed a little bit, then was sent to the hospital. On 3/12/26 at 11:32 AM, Staff D, Registered Nurse (RN) relayed first time they met Resident #48 was the day she left. On that morning the resident sat on bedside, and agreed to vitals except refused the blood pressure. Staff D further explained the also refused the standard COVID test for new residents. Per Staff D, let her be, and was aware got a urine sample and had tried to get blood. Staff D explained had wondered if (resident) had a UTI with the confusion. At 7:45 AM Resident #48 was at the breakfast table, agreed to take medications, then spit them out. Resident #48 said someone bumped their foot, not seen that, resident was flexible, and put her leg up on the dining room table. The resident got mad, and demanded (go) back to room. Staff D explained resident was taken back, given a tray of food, and call light. Staff D relayed at 8:10 AM the maintenance staff summoned nurses because Resident #48 tipped the chair over. Food and drink were everywhere, and couldn't say if she (resident) threw the food tray or bumped it over. Per Staff D, tried to assess the resident, and the resident swatted at Staff D. The resident struck out and wanted to be left alone, wouldn't let anyone assess. The resident knew her name, and was confused and wanted her husband who passed. Resident #48 was brought up front for the DON to sit with her. The Administrator and the DON and Nurse, Staff A were there and got a gait belt because resident wanted to walk, which made her more agitated, and was taken back to resident's room. The Administrator directed a nurse to call 911 to send her out because she was so agitated, and had a standing orders to send out. The paramedic came and resident in agreement to a ride. Per Staff D, it was communicated did not have urinalysis results back. Staff D confirmed the facility did have residents with dementia throughout the facility as well as in the memory care unit, and sometimes residents waited in the regular halls and moved back to the unit with availability. On 3/12/26 at 12:25 PM the Administrator relayed felt could not accommodate Resident #48, and felt needed the memory care unit. The Administrator explained the facility did not have an open bed, and due to the behaviors, could not have Resident #48 return. The Administrator acknowledged did not reassess after Resident #48 was sent to the hospital. The Administrator explained the Physician was notified after the resident was transferred. The Facility Assessment updated 2/20/26 documented the facility did accept residents with or that may develop complex care and management. This included residents with psychiatric, mood disorders with common diagnoses of impaired cognition, metal disorders, and behaviors that needed interventions. The Facility Assessment further revealed the average or range of residents with mental health/behavioral health needs equaled 21. Per the assessment, on occasion the facility had residents that required temporary one on one supervision, and at those times, had increased staffing to accommodate.