STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165509	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Alverno Health Care Facility	849 13th Avenue North Clinton, IA 52732

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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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on review of the Centers for Medicare & Medicaid Services Certification and Survey Provider Enhanced Report (CASPER), review of the facility Quality Assurance Performance Improvement (QAPI) plan, and staff interviews the facility failed to implement quality assurance practices to prevent the repeat of citations of deficient practices in the area of infection control and pharmacy services. The facility reported a census of 87 residents. \Findings include: Review of the CASPER revealed the facility had the following repeat deficient practices:F761 - Label/Store Drugs & Biologicals cited during a complaint survey ending on 8/7/25; and the current Recertification survey completed on 2/19/26.F880 - Infection Prevention & Control cited during the Recertification surveys that ended on 5/2/24, 2/6/25 and the most recent one completed on 2/19/26. During an interview on 2/19/26 at 1:30 PM, the Administrator stated the facility has been providing a lot of staff education regarding enhanced barrier precautions, performing staff audits on peri care, and providing one on one education on an as needed basis to staff members on infection control issues.Review of the facility's QAPI plan, dated November 2019, revealed a Statement of Purpose which declared The Mission Driven Quality Assurance and Improvement Plan (QAPI) at.is comprehensive and ongoing. It encompasses the full range of services and is founded in Clinical Care, Quality of Life and Resident Choice. The Mission Driven Quality Assurance and Performance plan section, directed, in part: The Mission Driven Performance Improvement Projects will be based upon input and data from CMS Nursing Home Compare, Resident and Family Satisfaction Surveys, [name of brand name decision making tool redacted], Family and Resident Councils, Annual Surveys, and Colleague feedback.

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	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews and facility policy review, The facility failed to ensure staff followed contact precautions for 1 of 1 residents (Resident #103) on contact precautions, failed to utilize Enhanced Barrier Precautions correctly effecting 2 of 2 residents (Resident #16 and Resident #52), failed to follow infection control practices to minimize the potential to spread COVID in the Memory Care unit, and failed to cover wet laundry during transport to an operational dryer. The facility reported a census of 87 residents.Findings include:1. Review of the Minimum Data Set (MDS) assessment for Resident #16, dated 12/2/25, revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated a severe cognitive impairment. The MDS listed a primary diagnosis of non-traumatic brain dysfunction (dementia). The MDS identified the resident dependent on staff to assist personal hygiene, toileting, showering, oral hygiene and bed mobility. The MDS indicated Resident #16 utilized a urinary catheter and has a pressure ulcer of the right heel. During an observation on 2/16/26 at 11:59 AM, an Enhanced Barrier Precautions sign noted to be posted on the wall by the entrance to the resident's room. During a continuous observation on 2/18/26 that stared at 8:03 AM, with the room to the door shut, Resident #16 heard yelling from his room. Staff D, Certified Nurse's Assistant (CNA) and Staff C, CNA, then exited the resident's room while they wore Personal Protective Equipment (PPE) which included a gown, eye covering an a N95 mask. During an immediate interview, Staff D, CNA stated she and Staff C, CNA had assisted Resident #16 to change an incontinence brief. She explained Resident #16 had fallen, and she and Staff C assisted the resident to get back into bed with a Hoyer lift. At 8:05 AM, without a change in PPE Staff D, CNA entered Resident #52's room. With the door partially left open, Staff D heard asking Resident #52 about their choice of clothing and then raised the resident's bed. At 8:07 AM during an interview, Staff C, CNA, confirmed that she and Staff D, CNA, did not change the PPE worn during personal cares to Resident #16 prior to entering Resident #52's. Staff C explained that Resident #16 did not have COVID, so they did not need to change their PPE. Staff C explained they currently had to wear PPE on the unit (memory care unit) at all times. During an interview at 8:10 AM, Staff D, CNA, reported she provided personal cares to Resident #52 including changing his incontinent brief and helping the resident to dress. During an interview on 2/18/26 at 8:56 AM, the Clinical Resource Manager reported staff should switch out their PPE including gown, mask and gloves before and after providing cares to a resident with EBP. The Clinical Resource Manager reported there was a risk of cross contamination between residents if staff did not change their PPE. 2. Review of the electronic health record (EHR) revealed Resident #103's admitted to the facility on [DATE] with diagnoses that included pneumonia, acute respiratory failure, stage 3 chronic kidney disease, and diarrhea. Review of a Treatment/Order Update/Change in Condition revealed a verbal order, dated 2/16/26, for Contact Precautions by Shift for possible C-DIFF (a bacterial infection which causes severe diarrhea). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/18/2026 at 12:35 PM, PPE supplies with a Contact Precaution signed noted to be present outside of Resident #103 door. A strong odor of bowel present upon entering room. Staff K, Certified Medication Assistant, and Staff L, CNA in room providing cares to Resident #103. Staff K and Staff L each wore gloves, with no other PPE. Staff L, CNA exited Resident #103 rom with a mop and bucket. Staff K, CMA, with a glove on her left hand exited the room while carrying a bag with soiled items. Staff K delivered the bag to the laundry, removed the glove and completed hand hygiene using alcohol-based hand rub. Review of the Treatment/Order Update/Change in Condition, updated 2/18/26, electronically signed by the provider at 10:06 PM revealed the order discontinued due a negative C-DIFF result. During an interview on 2/19/26 at 10:03 AM, the Infection Prevention Nurse stated a resident in contact precaution isolation for CDIFF required all staff entering and caring for the resident to wear the appropriate PPE, which included gown, gloves, and to complete hand hygiene with soap and water. 3. During an observation on 2/18/2026 at 12:22 PM, Staff E, Licensed Practical Nurse (LPN) exited the Memory Care Unit (MCU). Due to positive COVID residents on the MCU, Staff E wore a respirator mask, goggles and gown. Staff E then went to the mediation cart. While at the cart, Staff E obtained insulin pens, and made an entry into a computer. Staff E, without a change in PPE, entered another resident's room. During an observation on 2/19/26 at 11:25 AM, two signs noted to be placed at the entrance to the locked memory care unit. The signs included: a. Droplet Precautions, which directed. Everyone must: clean their hands, including before entering and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry. Remove face protection before room exit. b. A Notification the is experiencing a Covid/respiratory outbreak. And directed.All staff are to wear the proper PPE before entering the unit. Gown, N95 mask, and eye shield. A PPE Station present at the entrance of the unit. The Station included gowns, respirator masks, face shields, and hand sanitizer is provided. On the exit side of the door to the MCU another posted sign directed the how to remove PPE. The directions included: a. Except for respirator (mask), remove PPE at doorway. Remove respirator after leaving patient room and closing door. b. Performing hand hygiene between steps if hands become contaminated and immediately after removing all PPE. During an interview on 2/19/26 at 10:03 AM, the Infection Prevention Nurse stated, isolation for COVID positive residents in the locked memory unit is not ideal. She explained the facility's intervention for infection control is for all staff to wear PPE including a respirator mask, gown, gloves, and goggles at all times. The staff are expected to put on PPE when entering the memory unit and remove when exiting the unit. The Infection Prevention Nurse stated Staff E, LPN should have (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	removed the PPE when exiting the memory unit and before assisting on the another. 4. During an observation on 2/16/26 that started at 12:04 PM, Staff F, Environmental Services Assistant Laundry, delivered residents' clean clothes in an uncovered shopping cart to residents residing on third floor North (memory care unit). A total of 20 residents resided on the unit. At 12:25 PM, Staff F observed on the third floor, with a cart full of uncovered wet blankets and toweling waiting outside the elevator. During an interview, Staff F reported the dryer was not working on the third floor, and she was taking the wet laundry down to the main laundry on the first floor to use the dryer. During an observation on 2/19/26 at 8:14 AM, Staff E, Environmental Services Assistant Laundry, at the second-floor elevator entrance with a laundry cart full of uncovered wet resident clothing and towels. During an interview, Staff E stated she was taking the laundry downstairs. Staff E explained each floor had their own laundry facilities, but there were extra dryers on the first floor. Review a policy manual for Infection Control, dated 11/12/2024 revealed the following: a. Enhanced Barrier Precautions: Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of targeted multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with targeted MDRO as well as those at increased risk of targeted MDRO acquisition (e.g., residents with chronic wounds or indwelling medical devices).Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. The use of gown and gloves for high-contact resident care activities may be indicated, when Contact Precautions do not otherwise apply, for nursing home residents with chronic wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with targeted MDRO infection or colonization according to CDC guidelines. In general, for residents with a targeted MDRO infection or colonization as well as a residents with chronic open wounds or indwelling medical devices (such as central lines, feeding tubes, catheters, tracheostomies, etc.) gown and gloves may be required for high contact care activities such as: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, Wound care: any skin opening requiring a dressing b. Contact Precautions: 1. Hand Hygiene and Gloves: wearing gloves while providing care, when in direct contact with a resident who is infected, change gloves after contact with infective material, avoid contaminating other surfaces with gloved hands, and remove gloves before leaving the resident's room and immediately wash hands with an antimicrobial agent or use of waterless hand sanitizer. 2. Gown: wear gowns when clothing is anticipated to come in contact with the resident, environmental surfaces, or items contaminated with organism. Remove gown before leaving room and immediately perform hand hygiene. c. Droplet Precautions: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Gloves and Hand Hygiene: wear gloves during the course of providing resident care. Change gloves after contact with infective material and when moving form one body site to another or when going from dirty to clean tasks. Remove gloves before leaving the resident's room and immediately perform hand hygiene, using soap and water if hands are visibly soiled. 2. Mask: wear a mask when within three feet of the resident. Remove mask and immediately perform hand hygiene. Avoid touching front of mask during removal as it is considered contaminated. 3. Goggles: wear goggles if likelihood of exposure during care. Removing goggles and immediately perform hand hygiene. Avoid from touching goggles during removal as it is considered contaminated. d. Laundry Services: 1. Transport Clean and Soiled Linen Separately: Cover clean linen for protection from contamination during transport. Store clean linen in a protected area until distributed for resident use. Soiled linen barrels, linen carts, and covers are cleaned when visibly soiled.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on clinical record review, review of facility policy, resident and staff interview, the facility failed to determine if a resident was clinically appropriate to self-administer medications for 1 of 1 residents sampled (Resident #33). The facility reported a census of 87 residents. Findings include:Review of the Minimum Data Set (MDS) assessment for Resident #33, dated 12/26/25, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated a moderate cognitive impairment. The assessment identified diagnoses of renal failure, hip fracture, and chronic obstructive pulmonary disease. Review of the Care Plan for Resident #33, last revised 12/19/25, revealed, in part, a focus area of person centered care and a goal to promote quality of life. The care plan included an intervention for resident exert her individual rights by making her own independent choices, i.e. (for example) refusal of care, treatment and diet. The care plan did not address whether or not the resident had chosen to self-administer medication. Review of Physician Orders revealed an order, dated 12/19/25, for Albuterol inhaler 90 micrograms (mcg)/actuation 2 puffs every 6 hours PRN (as needed). On 2/16/26 at 2:38 PM, observation revealed Resident #33 had an Albuterol inhaler sitting on her bedside table. In an interview during the same observation, Resident #33 reported the Albuterol inhaler was her rescue inhaler and she had always kept this with her. On 2/18/26 at 7:55 AM, during an interview, Resident #33 reported she had the Albuterol inhaler in her pocket. On 2/18/26 at 8:56 AM, during an interview, the Clinical Resource Manager reported if a resident requested to self-administer a medication, nursing staff completed a Self-Administration Evaluation form, notified the physician and got an order approving the resident to self-administer the medication, and added the information to the resident's Care Plan. The Clinical Resource Manager confirmed staff had not completed a Self-Administration Evaluation form for Resident #33 to self administer her Albuterol inhaler. The Clinical Resource Manager reported an inability to find a physician order allowing the resident to self administer Albuterol and could not find information in the Care Plan that addressed the self-administration. On 2/18/26 at 9:13 AM, during an interview, Staff H, Certified Medication Aide (CMA), reported no residents were self medicating to her knowledge and denied any residents had medications in their room. Staff H confirmed Resident #33 was not approved to self-administer any of her medications.On 02/18/2026 12:10 PM, during an interview, the Clinical Resource Manager reported she did find the resident in possession of her Albuterol inhaler. The Clinical Resource Manager reported she had completed the Self-Administration Evaluation form with Resident #33, obtained a physician order and updated the resident's Care Plan. Review of the facility policy, titled Self Administration of Medications, dated 6/1/24, revealed, in part, the facility, in conjunction with the interdisciplinary team, should assess and determine, with respect to each resident, whether self-administration of medications is safe and clinically appropriate .the facility should ensure that orders for self administration list the specific medication(s) the resident may self-administer .the facility should document in the resident's care plan whether the resident or the facility is responsible for the storage of the resident's medications .

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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 clinical record review, review of facility policy, resident and staff interview, the facility failed to maintain clear, concise determination of a resident's advance directive choice related to receiving cardiopulmonary resuscitation for 1 of 1 residents sampled (Resident #33). The facility reported a census of 87 residents. Findings include:Review of the Minimum Data Set (MDS) assessment for Resident #33, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated a moderate cognitive impairment. The assessment identified diagnoses of renal failure, hip fracture, and chronic obstructive pulmonary disease. Review of the Care Plan for Resident #33, last revised [DATE], revealed , in part, a focus area of person centered care and a goal to promote quality of life. The care plan included an intervention for resident exert her individual rights by making her own independent choices, i.e. (for example) refusal of care, treatment and diet. On [DATE], review of the electronic health record (EHR) Advance Directives tab revealed the resident had chosen no CPR (do not resuscitate-DNR). Review of a form scanned into the EHR, titled Emergency Response Directive, dated [DATE], included documentation Resident #33 chose to receive CPR. The form included the resident's signature and physician's signature. Review of the Physician Order Sheet, dated [DATE], revealed an order, dated [DATE], for no CPR. On [DATE] at 12:02 PM, during an interview, Staff H, Certified Medication Aide (CMA), reported she would look in the EHR to determine a resident's code status. Staff H reported she would also look in a hardbacked binder located in the nurses office. Staff H confirmed the EHR identified Resident #33 was no CPR, and the binder located in the nurses office identified Resident #33 had chosen to receive CPR. Observation of the binder in the nurses station during the same interview with Staff H revealed a form, titled Emergency Response Directive, dated [DATE], which identified Resident #33 wanted to receive CPR. On [DATE] at 12:06 PM, during an interview, Staff G, Licensed Practical Nurse (LPN) reported that if she needed to know a resident's advance directive choices, she would look in the EHR, but if it was an emergency, she would go by the information kept in a binder in the nurses office. On [DATE] at 12:10 PM, during an interview with the MDS Nurse and the Clinical Resource Manager, they both reported they would grab the binder in the nurses office to determine the code status of a resident in an emergency situation. The MDS Nurse confirmed the EHR identified Resident #33 had chosen not to receive CPR. On [DATE] at 11:31 AM, during an interview, Resident #33 reported she did want staff to perform CPR on her in the event of an emergency. Review of the facility policy, titled Heartsaver Cardiopulmonary Resuscitation (CPR) and Automatic External Defibrillator (AED), last reviewed 2/2018, revealed, in part, the American Heart Association has established evidenced-based decision making guidelines for the initiation of CPR when cardiac arrest occurs. CPR is initiated unless one of the three following conditions is present: a. A valid DNR (do not resuscitate) order is in place;b. Initiating CPR would cause injury or peril to the rescuer; or,c. In the presence of signs of clinical death Be aware of residents' wishes including: DNR, advance directives, or limited treatment orders before proceeding.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, clinical record review and staff interview the facility failed ensure the secure location of the keys to the double locked compartment to ensure the safety of narcotic medications as required by law to prevent potential loss and/or diversion. The facility reported a census of 87 residents. Review of the facility investigation for the 11/10/25 reported incident regarding a medication discrepancy found on 11/9/25 revealed Staff R, Registered Nurse (RN) was scheduled on first floor. Staff R delivered medications from the pharmacy to the second floor. After delivering medications Staff R, RN proceeded to enter the second floor medication room and was witnessed by at least 3 other employees to be in the medication cart, the nurses office and medication room that she was not assigned to. Staff R, RN reported that she was in the nurse's office and noticed that Staff P, Licensed Practical Nurse (LPN) had left her keys in the narcotic box behind the locked medication room door.During an observation on 02/17/2026 at 1:14 PM, the medication cart on 2 South unit noted to be locked locked. Staff N, Licensed Practical Nurse (LPN) and Staff O, Registered Nurse (RN) completed narcotic count. The keys to the narcotics secured and passed from Staff N to Staff O after the count completed. During an interview on 02/18/2026 at 8:57 AM, Staff P, LPN stated on 11/09/25 while on the 2 South unit she left the narcotic box open with the keys left in it. She explained the keys were in the narcotic box and she had left them in the box because she was running back and forth between the two sides of second floor. Staff P stated at that time a resident had fallen and another had a drop in their oxygen levels and she had forgotten to take the key out of the narcotic box. She stated she had never done that before left narcotic box wide open and the door was not shut on it. She stated she knew to keep the narcotic box locked and was a new nurse and had been overwhelmed. During an observation on 02/19/2026 at 10:11 AM, Staff O, RN dispensed locked medication from cart and relocked the narcotic box and then locked the medication cart During an interview on 02/19/2026 at 10:23 AM Staff O, RN stated the narcotic keys should always be kept on the nurse assigned them and never left in the narcotic box, or the box left open. During an observation on 02/19/2026 at 10:34 AM, the two medication carts on the lower level skilled floor locked with no issues noted. During an interview on 02/19/2026 at 10:36 AM Staff Q, RN stated once the narcotic keys are in your possession they should stay with you. She stated you should never leave the narcotic box open and medication cart should always be locked. During an interview on 02/19/2026 at 11:06 AM, the Administrator explained on 11/09/25 Staff P, LPN worked on the second floor and left the keys in the narcotic box and left it unlocked. The medication room was locked and the narcotic box left inside of it was left open. She stated she would expect the nurses to keep the keys on themselves and the narcotic box should be kept locked. On 02/19/2026 at 1:42 PM, the Administrator revealed the facility did not have a policy on the narcotic keys for the nurses. She stated after the last deficiency their plan of correction included staff education and she had provided individual education to staff.