DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165188	A. BUILDING ______ B. WING ______	01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH WINTERSET	1015 WEST SUMMIT WINTERSET, IA 50273

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date: 2-16-23 The following deficiencies resulted from the facility's annual recertification survey and investigation of complaint #108457-C conducted January 17-19, 2023. Complaint #108457-C was not substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F 578		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Autumn M	Administrator	2/16/23

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.

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F 578	Continued From page 1	F 578		

Continued From page 1

entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview and policy review, the facility failed to document an accurate code status for 1 of 16 residents reviewed (Resident #14) as documented on the Iowa Physician Orders for Scope of Treatment (IPOST). The facility reported a census of 36 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated 12/8/22 documented an admission date of 10/15/19 for Resident #14 and had diagnoses of cerebrovascular accident (stroke) and bipolar disorder. The MDS further revealed Resident #14's cognitive skills for daily living were severely impaired and she never/rarely made decisions.

Review of the care plan for Resident #14 revised 6/1/22 revealed the IPOST would be reviewed quarterly and as needed.

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F 578	Continued From page 2	F 578		
	Review of the IPOST signed 8/3/21 by Resident #14's power of attorney (POA) and signed 8/24/21 by the physician revealed an order for cardiopulmonary resuscitation (CPR). Review of the electronic health record (EHR) revealed an order for do not resuscitate (DNR) effective 4/15/22 for Resident #14. During an interview 1/17/23 at 3:39 PM, Staff B, Licensed Practical Nurse (LPN) reported she located orders for advanced directives in the EHR on the resident's "main page". Review of Resident #14's "main page" revealed the resident had a DNR order. During an interview 1/17/23 at 3:42 PM, Staff C, Certified Medication Aide (CMA) reported she located advanced directives on the resident's Medication Administration Record (MAR) in the EHR. Review of Resident #14's MAR revealed a DNR order. Review of the facility policy titled, Advance Directives, revised December 2016 revealed the director of nursing services or designee will notify the attending physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care. During an interview 1/18/23 at 10:12 AM the Director of Nursing (DON) acknowledged Resident #14 had an order in place for cardiopulmonary resuscitation as noted on the IPOST and she did not have an IPOST with a DNR order.			
F 606 SS=D	Not Employ/Engage Staff w/ Adverse Actions	F 606		

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F 606	Continued From page 3	F 606		

CFR(s): 483.12(a)(3)(4)

§483.12(a) The facility must-

§483.12(a)(3) Not employ or otherwise engage individuals who-
(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;
(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or
(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

§483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.
This REQUIREMENT is not met as evidenced by:
Based on personnel file reviews, facility policy review and staff interview, the facility failed to assure all employees had an Iowa criminal background check and abuse registry check completed prior to working in the facility for 1 of 5 current employees sampled (Staff A). The facility reported a census of 36 residents.

Findings include:

The personnel file for Staff A, Certified Nursing Assistant (CNA), revealed a hire date of 8/1/22. The file failed to contain a criminal background

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F 606 Continued From page 4 — F 606

and abuse registry check prior to hire date. Review of the background check revealed it was complete as of 8/2/22 at 8:37 AM.

Review of employee time card punch detail revealed Staff A worked the following dates and times prior to the background checks being completed:

a) 8/1/22 6:00 AM-2:20 PM
b) 8/2/22 punch detail revealed no hours

The facility's Abuse, Neglect and Exploitation Policy and Procedures revised 4/21 did not directly address Iowa criminal record checks and dependent adult/child abuse registry checks on all prospective employees prior to hire.

During an interview 1/18/23 at 4:30 PM, the Business Office Manager revealed Staff A, CNA was hired on 8/1/22 and did orientation that day. She reported she realized her mistake and ran the background check the next day. She stated it was the expectation to run a background check and ensure they were cleared to work prior to starting an employee.

F 625 SS=D — Notice of Bed Hold Policy Before/Upon Trnsfr
CFR(s): 483.15(d)(1)(2) — F 625

§483.15(d) Notice of bed-hold policy and return-

§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if

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F 625	Continued From page 5 any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and policy review, the facility failed to provide 2 of 2 residents (Resident #33 and #4) with a bed hold policy prior to discharge or within 24 hours of transfer to the hospital on four separate hospital transfers. The facility reported a census of 36 residents. Findings include: 1. Record review of Resident #33's document tiled Clinical Census in the electronic health record (EHR) on 1/19/2023 documented discharges to the hospital 12/12/2022, 12/20/2022 and 1/5/2023. Record reveiw of Resident #33's Progress Notes dated 1/19/2023 lacked documentation of family	F 625		

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F 625	Continued From page 6 or resident notification of a bed hold for hospital transfers 12/12/2022, 12/20/2022 and 1/5/2023. During an interview 1/19/23 at 10:25 AM, Staff D, Registered Nurse (RN) revealed the facility does not have documentation or paperwork for Resident #33's hospital stays on 12/12/2022, 12/20/2022, and 1/5/2023. Record review of facility document titled, Admission Agreement, dated 12/27/2022 for Resident #33 included the facility's procedure regarding a bed hold policy however it lacked direction regarding bed hold notification at the time of transfers out of the facility. 2. The Minimum Data Set dated 12/2/2022 for Resident #4 documented a Brief Interview of Mental Status (BIMS) as 15 indicating no cognitive impairment. Record review of Resident #4, Clinical Census, on 01/19/2023 documented he discharged to the hospital on the following days: a. 11/30/2022 b. 12/06/2022 Record review of resident #4, Progress Notes, on 01/19/2023 lacked documentation the facility notified Resident #4 or his family representative of the facilities bed hold on 11/30/22 and 12/06/22. During an interview on 1/19/23 at 10:25 AM, with Staff D, Registered Nurse (RN), revealed the facility does not have bed holds they provided to him for his hospital stays on 11/30/2022 and 12/06/2022.	F 625		

F 578 Request/ Refuse/ Discontinue Treatment; Formulate Advanced Directives

1. Resident #14 Advance Directive was reviewed, and the electronic health record was updated to reflect updated Advanced Directive on 2/6/23.
2. A review of current residents advance directives was completed on 2.13.23, to ensure current advanced directives are accurately reflected in the electronic health record.
3. Re-education was completed with staff on 2/15/23, related to the advanced directive policy and procedure. DON or designee will complete a review of new admissions, significant changes, or change in advanced directives during stand up.
4. DON or designee will complete an audit of 5 random residents to ensure current advanced directive reflects the electronic health record weekly x 4 weeks, then monthly x 3 months. The DON or designee will bring the findings of the audits to review with the QAPI committee. Any additional audits, education, or systemic changes will be addressed by the QAPI committee.

Corrective action completion date:____________2/16/23________________.

F 606 Not Employ/ Engage Staff w/ Adverse Actions

1. All residents have the potential to be affected.
2. All residents have the potential to be affected.
3. For Staff A the SING background check was completed on 8/2/22 with no concerns noted.

   Re-education was completed with the HR director on 2/15/23 regarding the background check policy and the completion of background checks prior to the hire date of a new employee.

   An audit of current employee files was completed on 2/15/23 to verify completed SING background checks were completed on current employees prior to hire date, with no concerns identified.

4. The Administrator or designee will complete an audit of background checks to ensure the background check was completed and in the employee's file prior to the employee hire date; this audit will be completed weekly x 4 weeks then monthly x 3 months.

   The Administrator or designee will bring the findings of the audits to review with the QAPI committee. Any additional audits, education, or systemic changes will be addressed by the QAPI committee.

Corrective action completion date: ________________2/15/23___________________

F 625 Notice of Bed Hold Policy Before/Upon Transfer

1. The Bed Hold Policy was reviewed with resident # 33 and resident # 4 family member on 2/15/23 with no concerns noted.
2. All residents have the potential to be affected.
3. Re-education was completed with clinical staff regarding the bed hold policy to be reviewed and provided upon transfer out of the facility.
4. DON or designee will audit all transfers out of the facility to ensure that the bed hold policy is completed weekly x 4 weeks and monthly x 3 months.
   DON or designee will bring the findings of the audits to review with the QAPI committee. Any additional audits, education, or systemic changes will be addressed by the QAPI committee.

Corrective action completion date: ____________2/16/23______________.

F 578 Request/ Refuse/ Discontinue Treatment; Formulate Advanced Directives

1. Resident #14 Advance Directive was reviewed, and the electronic health record was updated to reflect updated Advanced Directive on 2/6/23.
2. A review of current residents advance directives was completed on 2.13.23, to ensure current advanced directives are accurately reflected in the electronic health record.
3. Re-education was completed with staff on 2/15/23, related to the advanced directive policy and procedure. DON or designee will complete a review of new admissions, significant changes, or change in advanced directives during stand up.
4. DON or designee will complete an audit of 5 random residents to ensure current advanced directive reflects the electronic health record weekly x 4 weeks, then monthly x 3 months. The DON or designee will bring the findings of the audits to review with the QAPI committee. Any additional audits, education, or systemic changes will be addressed by the QAPI committee.

Corrective action completion date:_____________2/16/23________________.

F 606 Not Employ/ Engage Staff w/ Adverse Actions

1. All residents have the potential to be affected.
2. All residents have the potential to be affected.
3. For Staff A the SING background check was completed on 8/2/22 with no concerns noted.

   Re-education was completed with the HR director on 2/15/23 regarding the background check policy and the completion of background checks prior to the hire date of a new employee.

   An audit of current employee files was completed on 2/15/23 to verify completed SING background checks were completed on current employees prior to hire date, with no concerns identified.

4. The Administrator or designee will complete an audit of background checks to ensure the background check was completed and in the employee's file prior to the employee hire date; this audit will be completed weekly x 4 weeks then monthly x 3 months.

   The Administrator or designee will bring the findings of the audits to review with the QAPI committee. Any additional audits, education, or systemic changes will be addressed by the QAPI committee.

Corrective action completion date: ________________2/15/23__________________

F 625 Notice of Bed Hold Policy Before/Upon Transfer

1. The Bed Hold Policy was reviewed with resident # 33 and resident # 4 family member on 2/15/23 with no concerns noted.
2. All residents have the potential to be affected.
3. Re-education was completed with clinical staff regarding the bed hold policy to be reviewed and provided upon transfer out of the facility.
4. DON or designee will audit all transfers out of the facility to ensure that the bed hold policy is completed weekly x 4 weeks and monthly x 3 months.
   DON or designee will bring the findings of the audits to review with the QAPI committee. Any additional audits, education, or systemic changes will be addressed by the QAPI committee.

Corrective action completion date: ____________2/16/23______________.