STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165320	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Zearing Health Care, LLC	404 East Garfield St Zearing, IA 50278

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview the facility failed to obtain informed consent for psychotropic medications that have black box warnings (the most serious safety warning the Food and Drug Administration (FDA) uses and requires the healthcare provider to have a comprehensive discussion with the resident/representative about the risks, benefits and alternatives for use) for 5 of 5 resident reviewed for psychotropic medications (Resident #1, #2, #3, #4 and #10). The facility reported a census of 31 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. The MDS included diagnoses of depression and cerebral palsy (disorder affecting movement, posture, and coordination due to non-progressive damage to the developing brain). Resident #1 received an antidepressant and benzodiazepine (2 types of psychotropic drugs that are used to manage various mental health conditions by balancing chemical neurotransmitters in the brain, which are then released by nerve cells to transmit signals across tiny gaps to other neurons, muscles, or glands, allowing communication for all functions like thought, movement, mood, and sensation in the brain) medication during the 7-day lookback period. The review of Resident #1's clinical physician orders on 1/21/26 included orders for 2 antidepressant medications (sertraline and mirtazapine) and 1 benzodiazepine medication (clonazepam). The Electronic Health Record (EHR) for Resident #1 lacked documentation related to psychotropic consents. 2. Resident #3's MDS assessment dated [DATE] identified a BIMS score of 15, indicating no cognitive impairment. The MDS included a diagnosis of anxiety. Resident #3 received an antidepressant medication during the 7-day lookback period. The review of Resident #3's clinical physician orders on 1/21/26 revealed orders for an antidepressant medication (Lexapro). The EHR for Resident #3 lacked documentation related to psychotropic medication consents. 3. Resident #2's MDS assessment dated [DATE] identified a staff assessment for mental status indicating they had severely impaired cognitive skills for daily decision making. The MDS included diagnoses of Huntington's disease (HD) (a progressive neurological condition), dementia, and depression. Resident #2 took an antipsychotic and an antianxiety medication in the 7-day lookback period. The Order Summary Report for active orders as of 1/22/26 included orders for clozapine (antipsychotic) for HD and lorazepam (antianxiety) for aggression, restlessness, anxiety and agitation. (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 - Some	The EHR lacked documentation of informed consents for psychotropic drug use. 4. Resident #4's MDS assessment dated [DATE] identified a BIMS score of 14, indicating no cognitive impairment. The MDS included diagnoses of HD, dementia, and anxiety. Resident #4 took an antipsychotic and an antidepressant medication in the 7-day lookback period. The Order Summary Report with active orders as of 1/22/26 included orders for clozapine (antipsychotic) for HD, trazodone (antidepressant) for HD, and Paxil (antidepressant) for sexual aggression. The EHR lacked documentation of informed consents for psychotropic drug use. 5. Resident #10's MDS assessment dated [DATE] identified a staff assessment for mental status indicating they had severely impaired cognitive skills for daily decision making. The MDS included diagnoses of HD, dementia and depression. Resident #10 took an antipsychotic, antidepressant and antianxiety medication in the 7-day lookback period. The Order Summary Report with active orders as of 1/22/26 included orders for risperidone (antipsychotic) for HD, bupropion (antidepressant), and lorazepam (antianxiety) for agitation, anxiety and aggression. The EHR lacked documentation of informed consents for psychotropic drug use. On 1/21/26 at 2:05 PM the Administrator reported all medications are done via telehealth with Iowa City so the family and/or resident received information of the medications. The Director of Nursing stated that she didn't have informed consents for psychotropic medications. The facility lacked a policy related to informed consents for psychotropic drug use.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review the facility failed to develop a comprehensive, person-centered Care Plan for 3 of 4 residents reviewed for falls (Residents #2, #10 and #29). Staff members reported each resident had a history of putting themselves on the floor, but their Care Plans didn't reflect the behavior. The facility reported a census of 31.Findings include: In an interview on 1/21/26 at 3:15 PM with Staff A, Registered Nurse (RN), and the Assistant Director of Nursing (ADON), Staff A stated Resident #2 tries to get out of bed, so they have a mattress and pads on the floor. Staff A added its Care Planned as she is compulsive and gets agitated. She said Resident #10 rolls herself out of bed when she wants up as she does not use the call light. The ADON stated if she rolled out 2-3 times, they would get her up as she probably wanted up. Resident #29 is noncompliant with lots of things and is known to put himself on the floor.In an interview on 1/22/26 at 9:40 AM with the Administrator and the Director of Nursing (DON), the DON stated Resident #2 didn't use the call light and got herself out of bed. They have it Care Planned. They have a mattress and pads on the floor because of the behavior. The DON said Resident #10 rolls herself out of bed and does not use her call light. Resident #29 is known to put himself on the floor and is very noncompliant. The Administrator stated all 3 residents have their behaviors Care Planned.1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE] indicated she made herself understood and usually understood others. The staff assessment for mental status reflected she had severely impaired cognitive skills for daily decision making. She had physical behavioral symptoms director towards others for 1 to 3 days in the lookback period. The MDS included diagnoses of Huntington's Disease (a genetic illness that affects the boy that involves uncontrollable dance-like movements, cognitive, and psychiatric symptoms), progressive neurological conditions, and depression. Resident #10 rejected care daily in the lookback period. She had 2 falls without injury in the lookback period. The Care Plan Focuses initiated 3/26/20 indicated Resident #2 had:Multiple risk factors for falls such as: Dementia, high risk medications, and an unsteady gate.A potential for an alteration in behaviors show by physical and verbal episodes with being uncooperative with care and being resistive with activities of daily living (ADLs).The Care Plan lacked documentation that Resident #2 gets herself out of bed and falls.In an interview on 1/21/26 at 3:20 PM Staff B, LPN stated that Resident #2 rolls herself out of bed and it is care planned. She is impulsive and doesn't use her call light. It is a behavior.2. Resident #10's MDS assessment dated [DATE] indicated she usually made herself understood and usually understood others. The MDS identified the staff assessment for cognitive skills for daily decision making listed her as severely impaired. Resident #10 had physical and verbal behaviors in the lookback period. In addition, she rejected care daily in the lookback period. The MDS included diagnoses of repeated falls, Huntington's Disease, and depression. Resident #10 had 1 fall without injury since admission or the last assessment. The Care Plan Focus revised 4/1/22 indicated Resident #10 had a potential for falls related to choreatic movement. The Intervention reflected she had her bed on the floor without a bed frame. She had a fall mat next to the mattress for her safety. The Care Plan lacked documentation that Resident #10 purposely rolled herself out of bed.In an interview on 1/21/26 at 3:20 PM Staff B, Licensed Practical Nurse (LPN), stated Resident #10 rolls out of bed and the facility has it Care Planned. It is a behavior as she is impulsive.3. Resident #29's MDS assessment dated [DATE] indicated he made himself understood and usually understands others. The MDS identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. He rejected care daily in the lookback period. The MDS included diagnoses of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	progress neurological conditions, non-Alzheimer's dementia, Huntington's disease, and difficulty walking. Resident #29 had 2 falls without injury during the lookback period. On 1/22/26 at 9:05 AM when questioned if he put himself on the floor on purpose, Resident #29 responded yes, then added just kidding when questioned why he does it. When asked if just kidding is why he puts himself on the ground he stated, Yes.In an interview on 1/22/26 at 9:40 AM the Administrator and the DON, the Administrator stated Resident #29 told him that he put himself on the floor because he didn't want to lose Hospice and his massages.The Care Plan Focus revised 10/4/24 reflected Resident #29 needed assistance of 1 staff with ADLs. The Interventions described Resident #29 as very noncompliant with using his call light and getting assistance for care. He attempted to perform his own care and ended up falling. The Care Plan lacked documentation that Resident #29 put himself on the floor on purpose.In an interview on 1/22/26 at 9:40 AM with the Administrator and the DON, the DON stated she expected the staff to document all falls and behaviors with vital signs and an assessment. If the person hit their head or no one witnessed them putting themselves on the floor, she expected them to complete neurological (neuro) checks (a type of assessment to make sure no injury or change in consciousness). She added no one told her that falls are not getting documented. The Administrator added that if a fall is unwitnessed, then it is not a behavior. He brought in the ADON and stated she needed to hear the concerns as all their Care Plans needed reviewed. The ADON stated the residents changed often and she didn't want to be too specific.In a document titled Fall Prevention, Management, and Documentation dated 6/14/25, instructed all falls, whether witnessed or unwitnessed, must be assessed, managed, and documented promptly, accurately and consistently.The facility didn't provide the requested Care Plan policy prior to the exit conference.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on kitchen service observations, interviews and record review, the facility failed to use gloves correctly to prevent cross contamination. The facility's kitchen staff applied gloves and left them on while touching food and nonfood items. The facility reported a census of 31 residents. Findings include:On 1/20/26 at 11:00 PM, observed the staff puree food. The Dietary Manager (DM) donned (applied) gloves to both hands. After donning gloves she touched the ladle, the pan containing the rolls, placed 6, 6-ounce servings of soup in a container. With the same gloves on, she added 6 rolls, then dumped the contents of the container into a food processor and pureed the food. The DM grabbed the package of bread with the same gloved hands, opened it, and grabbed the 3 pieces of bread out. With the same gloved hands, she tore up the bread, placed them in the food processer and pureed the contents more. The DM poured the soup back into the pan and put the pan in the oven to heat up more. Without changing her gloves or completing hand hygiene, the DM grabbed plates and bowls before arranging them while getting ready for service. She continued wearing the same gloves without hand hygiene, pulled the soup out of the oven, moved some rolls around on the pan and then placed them in the oven.At 12:10 PM Staff C, Dietary Aide (DA)/Cook, came into the kitchen, put gloves on her hands and made sandwiches. She touched the outside of the bread package, the bread, the jar of mayonnaise, slices of bologna, the peanut butter jar, and the knife. Staff C grabbed a container of crackers and took the lid off. The DM grabbed the crackers out of the container as she continued to wear the same gloves and put it on plates alongside the bowls of soup. She used the tongs to grab the rolls. After the completion of the lunch service, the DM acknowledged she did everything mentioned. She stated she should have used tongs for the crackers and she should have changed her gloves after touching non-food items. The DM acknowledged Staff C should have done the same thing. She stated they would change the practice right away. On 1/20/26 at approximately 3:00 PM, the Administrator acknowledged the above concerns. An undated Glove Use & Meal Service policy directed in an effort to protect food products from contamination, all products should be served using utensils. The policy instructed the following:Staff must wash their hands often per the Handwashing policy. Their hands should be washed thoroughly between tasks. Employees should use utensils such as spatulas, scoops, forks and tongs to serve food. If an employee handled raw food, leaves and enters the kitchen, touches equipment handles (i.e. refrigerators, trash can lid) or touches any area of their body - they MUST immediately wash their hands.Gloves may be worn during food preparation but only for single task items (i.e. handling raw chicken).