STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165440	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winslow House Care Center	3456 Indian Creek Road Marion, IA 52302

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical review, staff and resident interviews, and facility policy review, the facility failed to complete wound treatment as ordered for 1 of 5 sampled residents (Resident #1). The facility reported a census of 47 residents. The facility corrected the deficient practice though past-noncompliance through the following actions: *All residents with active treatment orders were assessed and treatments confirmed as completed per physician order*Reeducation of all licensed nursing staff on 1/4/26 and 1/5/26*Post correction audits and weekly audits1.Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #1 had diagnoses which included heart failure, diabetes, non-Alzheimer's dementia, vascular disease and a stage 3 pressure ulcer, and received pressure ulcer/injury care. The resident required substantial assistance from staff for toileting, bathing, and partial assistance for ambulation. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated the resident had severe cognitive impairment. Review of the Care Plan revised 1/24/26 revealed Resident #1 had an actual pressure ulcer related to impaired mobility, described as a Stage III (full-thickness skin loss) on the left lateral foot. The Care Plan intervention dated 1/24/26 directed the staff to provide adequate calories and protein for skin healing and integrity, and the interventions dated 9/17/25 revealed to assess the condition of the pressure ulcer and surrounding skin weekly and to complete treatments as ordered. Review of a Progress Note dated 12/16/25 revealed Resident #1 went out to a local [wound provider] appointment on December 16, 2025 and returned without new orders. Review of a progress note from a local [wound provider] dated 12/16/26 indicated the resident's wound appears worse as noted by an increase in dimensions. The diabetic left lateral wound described as clean, painful and fragile and has been present for more than a year. The Physician Order dated 11/17/25 directed the staff to cleanse the foot wound and surrounding skin. Paint callous and wound with betadine, cover with a foam dressing and secure with gauze wrap and tape. The wound care should be completed daily on the evening shift. Review of the Physical Therapy Treatment Encounter Note for date of service 12/18/25 signed by Staff L, Physical Therapy Assistant and Rehabilitation Director revealed, Pt (patient) states wound care was not completed last night. Wound cover is still dated 12/16 from wound Dr. (doctor) appointment. Per this note, the Administrator was notified. The Incident Report dated 12/18/25 for Resident #1 revealed, Administrator informed nurse that therapy aide informed her that the dressing to the residents left foot had a past date on it and had not been changed on the evening shift. The Resident Description section revealed, When day nurse went to change dressing, resident stated that no one has changed dressing for a couple days. The Immediate Action Taken section revealed, Nurse changed dressing ASAP (as soon as possible) after being informed it wasn't changed by 2-10 nurse.Review of Resident #1's December 2025 treatment record revealed Staff K, LPN (Licensed Practical Nurse) signed of the wound treatment which indicated he completed it on 12/15, 12/16 and 12/17/25. Staff K placed his initials with a check mark on the record (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicating the treatment was completed. Interview with Staff K, LPN on 1/28/26 at 8:55 am revealed Staff K forgot to do the dressing change whatever day in December the resident went to the wound clinic. Staff K was uncertain of the day but stated it was around her appointment date. He admitted he just signed it off because the wound clinic did the dressing change that day. Staff K stated he really cannot remember the date, but stated he just signed it off and reported everyone else did it that way on the days a resident goes to the wound clinic. He stated he did not make any progress notes in regards to the wound in the resident's clinical record. He stated he got terminated for just signing off the dressing change without having completed it. During an interview with Staff G, Director of Nursing (DON) on 1/28/26 at 7:30 am, Staff G stated apparently he was not doing the skin treatments as ordered and was just signing it off as completed. She stated they became aware of the situation on 12/18/25 when Resident #1 had a wound dressing dated 12/16/25. Staff G stated Staff E, Assistant Director of Nursing (ADON) handled the investigation. During an interview with Staff E on 1/27/26 at 11:48, the incident was brought to his attention on 12/18/25 from the Administrator who she received a report from the [wound provider] in regards to Resident #1's dressings not being changed as ordered. Staff E stated the resident went to the [wound provider] on 12/16/25 and stated he really cannot remember if the reported date on the dressing was the day before the weekend or the weekend before. He stated he came into the investigation at the end and was told by the Administrator that on 12/18/25 Resident #1 had a dressing dated 12/16/25. During an interview on 1/28/26 at 1:00 pm with Staff I, Registered Nurse (RN), Staff I stated it was brought to her attention on 12/18/25 that Resident #1's pressure sore dressing currently had a date on 12/16/25 on it. She observed this to be true. She completed the scheduled dressing change on her shift as it was apparently not completed on 12/17 as ordered. According to the Medication Administration Policy last revised on 6/30/2023 directed staff to administer medications as prescribed. The procedure for dispensing medications is as follows:Wash hands with soap and water prior to beginning medication pass. Alcohol waterless sanitizer is acceptable between residents.Open medication cart with key held by licensed nurse/OMT/Director of nurses. Medication labels will be checked against current MAR for individual resident's medication pass.Remove medication with labels facing the nurse/certified medication technician. Check labels to medication administration record. Verify resident, drug, strength, dose, route and hours of administration with medication administration record.Follow manufacturer's directions for medication use.Dispense medication into medication cup.Return medications to cart. Close and lock medication cart. Identify the resident. Administer medication. Assure resident has taken the medication. Sign medication on the medication administration record.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, clinical record review, facility policy and staff and resident interviews the facility failed to appropriately transfer a resident from the bed to chair with the use of a mechanical lift in order to prevent a fall with injury for one of three residents reviewed (Resident #4). The full body lift tipped during Resident #4's transfer, and the resident sustained a bruise and skin tear. The facility reported a census of 47 residents.The facility corrected the deficient practice through past-noncompliance through the following actions: *Staff education completed 12/26/25 and 12/29/25 regarding full body lift safety *Removal of the full body mechanical lift pending inspection*Completion of weekly patient lift inspectionFindings include:1.The MDS (Minimum Data Set) dated 10/23/2025 revealed Resident #4 had no cognitive impairment, required substantial/maximum assistance to transfer from one surface to another and had diagnoses including heart failure, diabetes and pressure ulcer left heel.The Care Plan revised on 1/23/2026, identified the resident had a fall risk. It directed staff to use a full body lift and two staff to transfer the resident to the shower chair. The Morse Fall Scale dated 10/23/2025 revealed the resident had a moderate risk for falls. The facility incident report dated 12/26/2025 revealed Staff A, RN (Registered Nurse) found the resident still hooked to the full body lift with the machine on its side when she entered the room. She found the resident laying on the floor on her back with knees bent. Staff commented that they were turning machine when the machine tipped over sideways. Staff lowered the resident while the other staff tried to hold the machine to keep it from falling on the resident. The lift's crossbar hit the resident's right eyebrow and she sustained a bruise, 2.5 cm (centimeters) by 1 cm to the area. The lateral side of the right great toe had a skin tear that measured 1 cm by 0.5 cm., and a small plaque scab from the resident's psoriasis. The resident denied pain, headache or nausea. Staff A assessed the resident's vital signs and three staff assisted the resident back up into the shower chair using a different full body lift. The resident reported the machine tipped over when staff were transferring her.The 72 hour fall follow up progress note dated 12/29/2025 revealed the resident reported no pain or discomfort. Staff noted a light yellow discoloration of bruise above the right eyebrow.On 1/27/2026 at 2:00 pm, observation revealed the resident, alert and oriented, and in bed watching television. She indicated at the time of the incident everything went great and then suddenly things started collapsing. Two staff were present, Staff B, CNA tried to catch the resident from falling. Staff C., CNA ran the lift and it just tipped over. She bumped her forehead but was not really hurt, and she failed to recall the injury to her toe. On 1/27/2026 at 11:15 am, Staff F, Administrator reported Resident #4's fall happened on 12/26/2025. Staff G, DON (Director of Nursing) called her and informed her that Staff B and Staff C, CNA's did a transfer with the resident with a [Brand name full body mechanical lift] lift from her bed to a shower chair. When they went to turn her into the shower chair, the [full body mechanical lift name redacted] tipped over. Staff B was able to get her safely and lowered her without the lift tipping over on her. The bar that attaches the sling did hit her during that incident. Immediately they pulled the [lift] off of the floor until it could be inspected by Staff E, ADON who was on sight and Staff H, Maintenance when he returned from out of town. The facility rented a second [brand name] lift until that one could be cleared. Staff B and Staff C were interviewed and retrained by Staff E on proper lift use. Staff were re-educated and the entire following week they drilled it in at the 2 pm meetings with all staff training. The education was also written in the communication book. The inspection revealed the lift did work, however the last bit of opening takes longer. Staff failed to make sure the legs of the lift were open wider than the resident. They did not wait for the legs to open completely. They followed the policy except (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	for waiting for the legs to open completely. They handled the situation to the best of their ability and the resident sustained minor injury.On 1/27/2026 at 11:50 am, Staff E, ADON reported he learned Resident #4 had a fall on the following Monday. He indicated staff used a [Brand name redacted] lift and failed to completely open the legs on the lift, causing the imbalance and the lift to tip. Two staff, Staff B and Staff C were present and were able to catch the resident to a point and lower her safely and keep them from hitting anything. Staff E provided one to one education and had Staff B and C demonstrate the safe use of the mechanical lifts prior to using the lifts again. The resident had no injury from the fall.On 1/27/2026 at 2:50 p.m., Staff A, RN revealed when Resident #4 had the fall with the lift, staff called for help. She entered the room and found the resident on the floor on her back. Staff B reported he supported her when she went down and the lift had tilted onto its side. Staff C, CNA managed the lift . They determined the legs on the lift did not open and it tipped. The resident had a bruise on her forehead and a small skin tear on her toe that healed within a few days. Staff A explained they had staff write statements, educated staff and completed the incident report and progress notes. On 1/28/2026 at 8:13 am, Staff G, RN, DON (Director of Nursing) went to Resident #4's room when she heard staff needed help. Staff B and Staff C were transferring her with the [Name redacted] lift bed to shower chair. The [lift] when it was being moved to the shower chair, it tipped. She went down assisted, but she did bump her head on the [lift] bar. She had a bump and bruise on the left side of her forehead and a skin tear on her toe. Staff G explained checked afterwards to see if the legs were spread. The legs did spread but not out all the way. Per the DON, brought the lift out afterwards and tested it, and the legs did spread out completely. The DON explained did education that when moving and turning the machine, the legs need to be completely spread out. Per the DON, the reason they think we said the lift was not working properly was because the legs did not spread as they should have. Per the DON, educated at the meeting at 2 p.m. the aides, all of them, and was is in the communication book.On 1/28/2026 at 8:30 am, Staff C, CNA reported when Resident #4 fell, she transferred her along with Staff B. Staff C called Staff B after she got the sling under the resident. They hooked the sling to the lift. Staff C operated the lift, got the lift up and pressed the button to separate both legs. The grinding noise had stopped and she assumed the legs had fully spread out. Staff C backed up from the bed, and when she went to turn the lift, it began to lean left. She reached out with her left hand in order to grab it and keep it from tipping, but it was too strong for her to stop it. The weight was stronger than her and they started going to the floor. The wheels capsized and lifted into the air. Staff C slid down as gently as she could and Staff B grabbed the resident in order to start steering her into the chair. Staff C's right foot slid and ended up underneath the [brand name lift] wheels. Staff B slid the resident to the ground. Once it started coming down, the whole thing came down. Thankfully, it was a padded lift. The crossbar hit the resident on the left side of the eyebrow and it bruised her. She also had a skin tear on her toe. Staff C believed the DON documented the lift malfunctioned. Staff C did training with Staff E, and she had to demonstrate using the lift. In the end, they determined the [brand name] lift did work correctly. They took that particular [brand name] lift off the floor, somebody checked it out and said it worked correctly. For some reason the legs did not spread out fully. Typically, when she heard a grinding noise it fully opened. The battery was fine so she assumed the legs were spread out. She received coaching and had to demonstrate the procedure. On 1/27/2026 at 4:05 pm, Staff B reported he had just finished across the hall and Staff C said she needed help with Resident #4. Staff C had the [brand name lift] controls and Staff B had the shower chair. Staff C raised the sling up from the bed. Staff B thought the [brand name lift] legs were not open as they should have, the [brand (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	name lift] tipped and the resident hit her head on top of the lift. Staff B had a hold of the sling and tried to lower the resident. Staff B went to get the nurse, she assessed the resident and they got her up off the floor. After the incident he and Staff C were educated regarding safety issues, including the need to make sure the Hoyer legs are open all the way. The also had to demonstrate the procedure.The facility Full Body Lift policy included the following steps:a. Explain procedure to resident, provide privacy b. Appropriate sling size selected c. Two staff members present for transfer d. Sling placed correctly e. Sling correctly attached to the lift f. Resident instructed to cross arms g. One staff manages the lift while the second staff guides the resident, providing support as needed h. Resident positioned for comfort i. Sling removed. Sling may remain under resident in chair if addressed in resident care plan

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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 staff interview and Centers for Medicare and Medicaid Services (CMS) 2567 review, the facility failed to ensure an effective Quality Assurance Performance Improvement (QAPI) process to identify previously identified deficiencies, resulting in a repeated deficiency cited on the current survey and cited in the previous survey. The facility reported a census of 47 residents. Findings include: The Centers for Medicare and Medicaid Services (CMS) 2567 form dated 9/25/2025, reflected a deficiency identified for staff failure to use Enhanced Barrier Precautions while doing resident cares for those identified as a risk. During the current complaint survey and facility reported incident survey dated 1/28/26, the team identified the same deficiency, Infection Control (F880).During an interview with the Administrator on 1/28/26 at 2:30 pm she reported she monitors and audits the effectiveness of the QAPI process and confirmed the concern related to the pattern of a deficiency at F880.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical review, staff interviews and facility policy review, the facility failed to utilize Enhanced Barrier Precaution (EBP) for 1 of 3 sampled residents reviewed (Resident #1). The facility reported a census of 47 residents.Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #1 had diagnoses which included heart failure, diabetes, non-Alzheimer's dementia, vascular disease and a stage 3 pressure ulcer (full thickness skin loss), and received pressure ulcer/injury care. The resident required substantial assistance from staff for toileting, bathing, and partial assistance for ambulation. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated the resident had severe cognitive impairment. Review of the Care Plan dated 9/8/25 indicated the resident needed Enhanced Barrier precautions due to a wound. The Goal section informed staff the precautions would reduce the spread of infectious agents and minimize the transmission of infection. The Care Plan interventions dated 9/8/25 directed the staff to wear a gown and gloves for high contact activities and to have personal protective equipment (PPE) available for staff near the entrance of the resident's room. Additional interventions dated 9/8/25 directed staff to maintain signage on the outside of the resident's door regarding the precautions needed, required PPE, and high contact resident care activities, and to practice good hand hygiene.Observations on 1/27/26 at 1:50 pm revealed the resident's bedroom door did not have a PPE sign hanging on it and the room did not have PPE available for staff use. Staff J, Registered Nurse (RN) entered the resident's room to complete her daily dressing change. Staff J failed to put on a disposable gown as she assembled the needed supplies. Staff elevated the resident's foot and removed the soiled dressing which appeared to have a dark substance on it and then proceeded to perform wound measurements and completed the wound treatment. Staff J re-dressed the resident's wound and cleaned up the room. Staff J completed all of these tasks without having on a disposable gown as directed by the EBP requirements. During an interview with Staff J, RN on 1/27/26 at 4:00 pm, the RN stated she did not wear a disposable gown per policy while completing the wound treatment earlier today at 1:50 pm. She stated she forgot to put it on because the resident's room did not have a sign on the door indicating a need for PPE and the resident recently had a room change. During an interview with Staff E, Assistant Director of Nursing on 1/28/26 at 2:30 pm, Staff E was informed about Staff J not wearing a gown when completing the wound dressing change yesterday for Resident #1. Staff E stated he re-educated her after the last survey regarding this issue. Staff E stated the resident recently changed rooms and the staff must not have not brought the sign and PPE with her.Review of the policy for Transmission Based Precautions updated on 4/1/24 informed the staff Enhanced Barrier Precautions (EBP) referred to an infection control intervention designed to reduce the transmission of multi-drug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. The policy directed the staff to use personal protective equipment such as gloves and gowns. The staff should don the protective equipment prior to high-contact care activities. The policy identified high-contact activities: wound care: any skin opening requiring a dressing.