STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165167	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Village	1203 North E Street Indianola, IA 50125

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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 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. 49990 Based on direct observation, staff interview, facility documentation, and facility policy review, the facility failed to implement measures to ensure safety for each resident identified at risk of injury to themselves for 1 of 4 residents reviewed. The facility reported a census of 49. Findings include: The Quarterly Minimum Data Set (MDS) for Resident#26, dated 10/02/24, documented relevant diagnoses of heart failure, hypertension, history of fractures, Non-Alzheimer's Dementia, seizure disorder, depression, and a history of falling. It documented her brief interview for mental status (BIMS) score as 03, which indicated severely impaired cognition. It further documented a need for a wheelchair or walker for supportive items, and functional ability to walk score of 03, indicating the resident required moderate assistance to walk. The Care plan, last revised on 10/04/24, recorded the resident used a front wheeled walker in her room and a wheelchair for mobility that required longer distances. It documented the resident required an assist of one for ambulation, with the use of a gait belt and front wheeled walker and the resident was an assist of one for wheelchair mobility. It also recorded the resident was an assist of one for transfers. Additionally, it documented fall prevention interventions for Resident #26 included her bed being placed in the standing position, not the low position, to assist the resident in standing from her bed, as well as her wheelchair placed at the foot of her bed to allow her to use it. Review of nursing progress notes dated 08/05/24 revealed Resident #26 fell during the overnight shift at approximately 12:20 am attempting to self-ambulate. She was found by Staff K, Certified Nurse's Aide (CNA), and assessed by Staff L, Registered Nurse (RN). The resident required transportation to the hospital where she was diagnosed with a fractured right wrist. The nursing progress notes do not detail the position of the resident's bed or location of her wheelchair at the time of the incident. Further review of nursing progress notes dated from 07/01/24 until 11/14/24 documented Resident #26 had fallen on at least four documented occasions during the lookback period with the most recent fall having occurred on 10/09/24. Review of hospital discharge records, dated 08/05/24 , confirm Resident #26 sustained a right wrist fracture. (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 0689 Level of Harm - Actual harm Residents Affected - Few	During a direct observation on 11/14/24 at 08:32 AM with Staff J, Certified Medication Aide (CMA), Resident #26 was seen sitting in her bed. Her bed was in the low position, as confirmed by Staff J, and her wheelchair was placed in her bathroom behind a closed door. Staff J acknowledged to the surveyor at this time the bed was in the wrong position and that the wheelchair needed to be at the foot of her bed, not in the bathroom. In an interview on 11/14/24 at 09:09 AM with Staff K, CNA he noted he found Resident #26 shortly after midnight on 08/05/24. He was unable to recall what specific care plan interventions the resident had in place to prevent falls, and did not recall the location of her wheelchair at the time of the incident. In an interview on 11/14/24 at 09:50 with Staff L, Registered Nurse she stated she believed the resident was trying to walk to her recliner or the bathroom at the time of the fall. She stated she had been summoned to Resident #26's room shortly after midnight on 08/05/24 by Staff K, who had found her on the floor with an obvious bend in her wrist. She stated she believed the bed was in the low position and the resident's wheelchair was across the room from her bed, placed near the recliner the resident appeared to be attempting to ambulate to. She assessed Resident #26 and found the resident was unable to move the fingers on her right hand, and the resident was complaining of pain in that arm. There was also a clear bend in the arm near her right wrist that led Staff L to believe she had broken her arm. She contacted the Director of Nursing (DON) after having called for an ambulance transport to the emergency room . She could not recall what interventions Resident #26 had in place to prevent falls. In an interview on 11/14/24 at 01:05 PM with Staff I, CNA, she stated she knows the expectation is to follow the documented interventions in the electronic health record (EHR) for all residents. She stated she knows Resident #26 is prone to falling if her care planned interventions aren't followed, and was able to list the care planned interventions from memory. She stated she had seen prior times in the morning when she noted the care planned interventions for Resident #26 had not been followed, though she could not offer exact dates. In an interview on 11/14/24 at 01:14 PM with Staff H, CNA, she was able to accurately state the care planned interventions for Resident #26. She noted Resident #26 is prone to falls and at risk for injury if her care planned interventions are not in place, as she is non-compliant with things like the call lights system, and she has been harmed in the past falling. In an interview on 11/14/24 at 01:32 PM with the Director of Nursing, she stated it was her expectation that staff follow care planned interventions to enhance resident safety. She agreed that not implementing care planned interventions can lead to harm and injury for residents, and she agreed that not following the care planned interventions on the evening of 08/05/24 could have contributed to Resident #26's fracture. In an interview on 11/14/24 at 10:12 AM with the Advanced Registered Nurse Practitioner (ARNP), she stated that while she believes the residents dementia and poor physical condition were the primary factors in the 08/05/24 fracture, she agreed not following care planned interventions could have contributed to her injury. Review of the facility provided document titled CNA Orientation Checklist directs facility staff members to use the Kardex/Care Plan to guide care for residents identified as at risk for falls.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on observations, staff interview, and policy review, the facility failed to label and store food items in order to maintain food quality and reduce the risk of contamination and food-borne illness. The facility reported a census of 49 residents. Findings include: Initial tour of the main kitchen on 11/12/24 at 10:00 AM revealed the following concerns: a. Unidentified meat wrapped in plastic wrap found in the walk-in cooler without a label or date and stored below a sheet pan of uncooked meat loaf and beef patties b. Plastic storage containers located on a top shelf in dry storage found without a label to identify the product or a date to show when transferred from the original packaging c. Packages of used dry pasta, secured with a knot to close, found without a date to indicate when opened d. Plastic storage container of dry pasta found without a label or date e. Plastic storage container of popcorn kernels found without a label or date; Lid to the container not completely secured f. Used container of popcorn oil observed in the plastic storage bin of popcorn kernels In an interview on 11/12/24 at 2:30 PM, the Director of Food and Beverage acknowledged the presence of the unlabeled meat in the walk-in cooler and the unlabeled plastic storage bins of food and dry pasta in dry storage. All food should have been labeled appropriately. The policy Label & Dating Policy last revised 11/2024, outlines bulk items that have been removed from their original packaging will include the following on the label: a. Food item name b. Date made/prepared or opened c. Use by date-reference [NAME] Life ' s Life of Food Storage and Handling policy d. Food handler's initial

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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** 50500 Based on record review, observations, staff interviews, and policy review, the facility failed to implement Enhanced Barrier Protection (EBP) practices for residents with indwelling medical devices and wounds for 4 of 4 residents reviewed (Resident #3, Resident #21, Resident #39, and Resident #109) reviewed for infection control. The facility failed to sanitize a multi-resident use mechanical lift in-between use for 2 of 3 households (Juniper and Magnolia) observed for equipment sanitation. The facility failed to provide infection prevention practices during urinary catheter cares for 1 of 2 residents (Resident #21) observed for catheter cares. The facility reported a census of 49. Findings include: 1. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #21 had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. Documented diagnoses include neurogenic bladder, obstructive uropathy, and paraplegia. The MDS indicated the presence of an indwelling catheter. The Care Plan with a targeted date of 1/14/25 revealed Resident #21 with an activities of daily living (ADL) performance deficit with total dependence on staff for use of wheelchair. The resident utilizes a mechanical lift for all transfers and relies on at least one staff member for personal cares. An indwelling catheter is present related to the diagnosis of neuromuscular dysfunction of bladder. The Care Plan lacked directives for staff to use EBP but noted the resident declines use of EBP (initiation date of 4/30/24). During observations on 11/12/24 at 12:05 PM, Staff A, Certified Nursing Assistant (CNA), and Staff B, CNA, both donned on a pair of gloves prior to initiating cares. Staff B proceeded to empty Resident #21's urinary catheter bag. A graduate was placed on the floor without a barrier. Staff B cleansed the catheter port with an alcohol swab and emptied the bag. Due to the Resident #21's shared bathroom being occupied by the roommate, the graduate full of urine could not be emptied at that time. Staff B placed the graduate on the floor next to the bed, without a barrier. No hand hygiene or glove change observed from Staff B when transitioned from catheter cares to pericares. Staff A and Staff B both completed pericares, which included the handling of the urinary catheter. After all resident cares finished, Staff B completed hand hygiene and glove change and emptied the graduate in the toilet. The graduate was placed in a plastic bag for storage without rinsing. Staff A and Staff B completed hand hygiene when exited the room. Neither staff member wore gowns while the catheter was cared for and handled. The resident's room lacked signage to indicate the use of EBP or the required Personal Protective Equipment (PPE). During an interview on 11/13/24 at 3:50 PM, the Director of Nursing (DON) acknowledged the lack of EBP throughout the facility. The DON reported the facility's Medical Director uses an algorithm to determine if a resident needs to be placed on EBP. The resident has to be colonized multi-drug resistant organism (MDRO) or have an infection to meet this criteria. A Resident Choices and Mitigating Risk Assessment completed if a resident does not want staff to utilize EBP. (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 interview on 11/14/24 at 09:50 AM, Staff C, CNA explained resident-specific information is available to staff. For those residents with EBP, Staff C reported gown and gloves are to be worn when touching or doing anything with a catheter or if a resident has a wound. Staff C acknowledged training was provided a while ago but have not used gowns. Staff C confirmed the facility has adequate personal protective equipment (PPE) available for staff use. The policy Enhanced Barrier Precaution revised 4/2024 revealed Enhanced Barrier Precautions are a method for reducing the spread of MDROs by using a gown and gloves to prevent contamination of healthcare personnel hands and clothing during the activities that have demonstrated the highest risk for transfer of MDROs to the hands and clothing of healthcare personnel. Enhanced barrier precautions may be used for residents that have any of the following: a. Infection or colonization with an MDRO when Contact Precautions do not otherwise apply b. Wounds and/or indwelling medical devices including: indwelling urinary catheters and chronic wounds including, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Enhanced Barrier Precautions includes the use of gown and gloves for the specific residents during high contact care activities including changing a brief or assisting with toileting, direct care of an indwelling device (such as urinary catheter), performing wound care on a direct opening to the body that requires a dressing, changing linen, or providing personal cares. The policy Catheter-Emptying a Urinary Drainage Bag revised 07/2016 directs staff to: a. Place the graduate cylinder in a plastic basin (or on a plastic bag) under the collection bag's drainage port. The graduate cylinder should not touch the floor and the drainage port should not touch the graduate cylinder b. Fill a disposable cup with tap water, then pour into the graduate cylinder to rinse; empty water into toilet and repeat until the graduated cylinder is thoroughly rinsed c. Place paper towels in graduate to soak up any remaining water. 34817 2. The MDS assessment dated [DATE] revealed Resident # 39 had diagnoses of obstructive uropathy (a condition in which the flow of urine is blocked). The MDS indicated the resident had an indwelling catheter, and had dependence on staff for toileting hygiene, dressing, bed mobility, and transfers. The Care Plan revised 11/3/24 revealed the resident had an Activities of Daily Living (ADL) self-care deficit related to limited mobility, and had an indwelling catheter. The Care Plan directed staff to provide assistance of one with bed mobility and catheter care, use a mechanical lift and assistance of two for transfers, and provide pericare. Resident #39's electronic health record (EHR) lacked a Resident Choices and Mitigating Risk Assessment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observations on 11/13/24 at 11:12 AM, Staff C, Certified Nursing Assistant (CNA), and Staff D, CNA, washed hands and donned gloves, then transferred Resident #39 from the broda chair to the bed using a mechanical lift. Staff D took disposable wipes and cleansed the periarea and catheter tubing from the entry site toward the bag. Staff D changed gloves, took disposable wipes and cleansed the buttocks area front to back, then placed a clean brief under the resident. Staff C and Staff D changed gloves. At 11:20 AM, Staff C donned a pair of gloves and emptied the resident's catheter contents into a graduate container. Staff C took an alcohol swab and cleansed the port on the catheter bag. Staff C emptied the graduate into the toilet, took a disposable wipe and wiped the inside of the graduate, then placed the graduate into a plastic bag and placed the graduate inside a cabinet. Staff C removed her gloves and washed her hands. The resident's room had no EBP signage or the required PPE. Staff C and Staff D did not wear a gown when they transferred the resident, when performed pericare, or when handled the catheter and performed catheter care. Observation on 11/14/24 at 9:45 AM revealed a plastic bin with drawers containing Personal Protective Equipment (PPE) (gowns and gloves) observed inside the resident's room. During an interview on 11/14/24 at 9:50 AM, Staff C, CNA, reported she looked at her phone to get information about what cares a resident needed done. Staff C reported staff were supposed to wear a gown and gloves for EBP anytime staff touched or did anything with a catheter or if a resident had a wound. Staff C reported the facility staff provided staff training about EBP's a while ago but they haven't used gowns during encounters with residents who had a catheter or a wound. 3. The Clinical Medical Diagnosis List documented Resident #109 had diagnoses of a diabetic foot ulcer, infection to the right ankle and foot, and urinary retention. The Care Plan initiated on 11/8/24 revealed the resident had a risk for pressure injuries and impaired skin related to diabetes and impaired mobility. The resident had a diabetic ulcer on his right heel. The Care Plan directed staff to follow facility protocols for treatment. The CarePplan also documented the resident had an indwelling catheter related to urinary retention. Resident #109's EHR lacked a Resident Choices and Mitigating Risk Assessment. Progress Notes revealed the following: a. On 11/12/24 at 10:03 AM revealed an order to apply betadine soaked gauze to the resident's right heel twice a day (BID), and administer bactrim DS (antibiotic) BID for seven days. b. On 11/13/24 at 1:10 AM, resident on skilled level of care for a diabetic ulcer to his right foot and receiving bactrim as ordered for a foot wound. Dressing in place to the wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observations on 11/13/24 at 9:10 AM, Staff E, Registered Nurse (RN), gathered supplies, placed the supplies on an overbed table, washed her hands and donned a pair of gloves. Staff E removed a soiled dressing over the resident's right foot, changed her gloves and sanitized her hands, then cleansed the right foot wound with wound cleanser and gauze. Staff E changed her gloves, applied a betadine gauze and kerlix dressing to the right lateral foot wound, and removed her gloves. The resident's room had no EBP signage or the required PPE, and Staff E did not wear a gown when she performed the wound care and dressing change. Observation on 11/14/24 at 10:40 AM, revelaed a plastic bin with drawers sat outside the resident's room with PPE inside. During an interview on 11/13/24 at 3:50 PM, the DON reported Resident #109 had a diabetic foot ulcer and Resident #39 had a catheter. The Medical Director used an algorithm to determine if a resident needed to be on EBP. The resident had to have a colonized MDRO or have an infection to meet the criteria. Staff filled out a Resident Choices and Mitigating Risk Assessment if the resident did not want staff to use EBP's. 49990 4. The Significant Change Minimum Data Set (MDS) for Resident #3, dated 07/25/24, revealed the resident had a relevant diagnosis of pressure ulcer, hypertension, renal insufficiency, Non-Alzheimer's Dementia, Malnutrition, Anxiety disorder, and depression. It documented a brief interview for mental status (BIMS) score of 05, indicating severe cognitive impairment. The Care Plan for Resident #3, last revised on 11/11/24, documented a stage II medial foot pressure ulcer and advised staff members to administer treatments as directed. It did not document a need for enhanced barrier precautions. In a direct observation on 11/13/24 at 03:38 PM with Staff G, LPN, she applied a barrier treatment to the stage II medial foot pressure ulcer, but did not utilize enhanced barrier precautions. When asked if she believed she was required to use enhanced barrier precautions during wound treatment she indicated she did not believe it was required for Resident #3. In an interview on 11/14/24 at 08:37 AM with the Director of Nursing (DON), she confirmed Resident #3 did require enhanced barrier precautions during wound care. She admitted she had struggled with enhanced barrier precaution and their application. 49698 5. Observations on 11/14/24 revealed the following: 7:55 AM, Staff F, CNA pushed mechanical lift out of a resident ' s room, parking mechanical light in hallway outside of the room then returned to resident ' s room 8:15 AM Staff F, CNA, exited a resident ' s room, crossed the hall, and entered another resident room. Staff C, CNA excited the same resident ' s room pushing the mechanical lift and followed Staff F, CNA into the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8:35 AM Staff F, CNA, observed pushing the mechanical lift out of the resident's room and parking the mechanical lift in the hallway of the unit. During an interview on 11/14/24 at 8:43 AM, Staff C, CNA stated the mechanical lifts are cleaned and sanitized when it appears to be dirt. Staff C, CNA thought the mechanical lifts might be cleaned on the overnight shift or during the weekly cleaning, but did not know for sure. During an interview on 11/14/24 at 12:47 PM, DON, stated the mechanical lifts are to be cleaned after each resident's use. Review of facility provided Infection Control Manual: Nursing Weekly Cleaning Tasks, effective date 8/1/2019, stated multiple use items will be cleaned and disinfected between each resident use. Such as: Shower Chairs, Tubs, Bedside Scales, Mechanical Lifts, Commodes, IV or Tube Feedling- Poles/pumps.