| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165209 | A. Building<br>B. Wing | 05/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Southridge Specialty Care | 309 West Merle Hibbs Boulevard<br>Marshalltown, IA 50158 |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907<br><br>Based on observations, interviews and record review, the facility failed to notify 1 resident's family after a fall (Resident #8). The facility reported a census of 71 residents.<br><br>The facility took corrective action on the day following the fall by providing education to the nurses regarding notifying the family the day that a resident has fallen.<br><br>Findings include:<br><br>Resident #8's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognitive functioning. Resident #8 required substantial/maximal assistance for upper body dressing and bathing. The MDS listed her as dependent on staff for lower body dressing, putting on, and taking off footwear. The MDS included diagnoses of non Alzheimer's disease, anxiety, and depression.<br><br>The Care Plan Focus initiated 3/8/24 indicated Resident #8 had a safety concern. The Goal listed she would remain safe in her environment.<br><br>The Care Plan Focus revised 4/17/25 reflected Resident #8 had a risk for falls. The Goal directed Resident #8 wouldn't experience any major injuries related to falls.<br><br>The Care Plan Focus initiated 3/5/25 identified Resident #8 had open areas on her arms and face from picking her skin. The Interventions directed to complete a full skin assessment each week with Resident #8's bath and/or shower.<br><br>(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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Incident, Accident, Unusual Occurrence Progress Note dated 3/17/25 at 7:10 PM, documented a Certified Medication Aide (CMA) requested Staff E, Licensed Practical Nurse (LPN), go to Resident #8's bathroom. Upon entering the bathroom, they noted Resident #8 lying on the floor with the lower left extremity by the foot riser and her right knee bent and lower extremity by the base of the toilet. In addition, Staff E found Resident #8 lying on the wheelchair cushion with a disposable incontinence pad under her head and back. When asked Resident #8 what happened, she couldn't reply due to her increased confusion. At the time, Resident #8 didn't wear any non skid socks. Three staff members assisted Resident #8 to her feet with the use of a gait belt. Resident #8 stood up by the hand rail while the nurse did a head-to-toe assessment, that revealed no bruising or injuries. The staff then assisted Resident #8 to sit on the toilet. Resident #8 complained of right hip pain and bilateral knee pain. The assessment showed no redness or any swelling to her extremities. Resident #8 stood without any complaints of pain. A staff member transferred Resident #8 off of the toilet to her wheelchair then transferred her to the recliner. Resident #8 voiced no complaints of pain at that time. The nurse-initiated neuro (neurological) checks and measured within normal limits. Resident #8 had equal and strong grips with symmetrical legs.<br><br>On 5/15/25 at 8:57 AM, Resident #8's Daughter reported her mother fell on [DATE]. She added the facility didn't notify her of her mother's fall until the next day at 3:45 PM. Resident #8's Daughter said Staff E called her the following day. Staff E told her daughter, her mother fell late at night the night before and she didn't want to call her. Resident #8 fell around 7:10 PM.<br><br>On 5/15/25 at 10:42 AM, the Assistant Director of Nursing (ADON), reported the nurse didn't notify Resident #8's family after she fall on 3/17/25. The ADON said they found out the next morning the staff didn't notify the family. They educated the nurses that very day they needed to notify a family after a fall.<br><br>The Accidents and Incidents Investigating and Reporting policy revised July 2017, directed to document the date/time when the staff notified the injured person's family and by whom. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513<br><br>Based on clinical record review, staff interviews, policy and Preadmission Screening and Resident Review (PASARR) the facility failed submit a status change in mental health PASRR when 1 of 2 residents (Resident #19) received new mental health diagnoses. The facility reported a census of 71 residents.<br><br>Findings include:<br><br>Resident #19's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. The MDS included diagnoses of psychiatric/mood disorders, anxiety, depression and bipolar. The MDS listed Resident #19 took antipsychotic, antianxiety, and antidepressant medications during the lookback period. The Physician documented a gradual dose reduction as clinically contraindicated on 2/10/25.<br><br>The Care Plan Focus initiated 3/6/21 indicated Resident #19 took antidepressants related to major depression.<br><br>The Care Plan focus initiated 3/22/24 documented Resident #19 took psychotropic medications due to diagnoses of bipolar and paranoid disorder. Resident #19 experienced tactile hallucinations (feeling things that aren't actually happening).<br><br>The Notice of PASRR Level I Screen Outcome dated 3/4/21 documented Resident #19 had suspected depression, with a diagnosis of major depressive disorder. The PASRR listed Resident #19 didn't have known recent or current mental health symptoms and didn't receive any mental health services. The form reflected she received Risperdal (antipsychotropic medication) and Zoloft (antidepressant).<br><br>Resident #19's May 2025 Medication Administration Record (MAR) included the following psychotropic/anti psychotic medications:<br><br>a. Sertraline, 25 milligrams (mg) tablet by mouth one time a day related to major depressive disorder.<br><br>b. Buspirone, 5 mg tablet by mouth two times a day related to generalized anxiety disorder<br><br>c. Olanzapine 5 mg tablet by mouth two times a day related to generalized anxiety disorder<br><br>The Electronic Health Record, report titled Medical Diagnosis revealed mental health diagnosis included:<br><br>a. Major depressive disorder, single episode, unspecified created 3/5/21<br><br>b. Unspecified dementia, moderate without behavior al disturbance, psychotic disturbance, mood disturbance and anxiety created 10/25/22<br><br>(continued on next page) |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | c. Bipolar disorder, unspecified created 6/7/24<br><br>d. Paranoid personality disorder created 6/7/24<br><br>During an interview on 5/15/25 at 1:51 PM Staff D, Social Services, reported the staff informed her of new diagnosis and resident changes at the Quality Assurance (QA) meetings if attended. Staff D didn't know for sure when Resident #19 received the new diagnosis in addition relayed PASRR's management is new for Staff D, was aware that an update is the expectation with new mental health diagnoses.<br><br>During an interview on 5/15/25 at 2:00 PM the Administrator agreed the staff should have updated the PASRR.<br><br>The facilities Policy titled Antipsychotic Medication Use revised December 2016 instructed to evaluate residents admitted who received antipsychotic medications for the appropriateness and indications for use, to complete a PASRR screening, preadmission screening for mentally ill and intellectually disabled individuals. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500<br><br>Based on clinical record review, facility policy review, staff and resident interviews the facility failed follow a physician's order when the failed to arrange a dermatology appointment within a reasonable timeframe for 1 of 2 residents reviewed for wounds (Resident #64). The facility reported a census of 71.<br><br>Findings include:<br><br>Resident #64's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Review for Mental Status (BIMS) score of 14, indicating intact cognition.<br><br>The Care Plan Focus updated 5/14/25, listed Resident #64 had an open lesion on their left cheek. The lesion was biopsied with results of basal cell carcinoma (skin cancer).<br><br>The Physician's Order, dated 2/14/25 at 3:58 PM, via telephone instructed to get Resident #64 a dermatology referral due to an unhealable lesion of the left side of her face. The scanned copy of the order revealed nursing staff signed off the order on 2/14/25.<br><br>The Order Note dated 2/14/25 at 4:10 PM documented the nurse notified the Physician due to Resident #64's lesion on the left side of her face. The staff notified Resident #64 and her family of the order for a dermatology referral.<br><br>The Appointment/Visit Note dated 4/14/25 at 3:16 PM documented Resident #64 had a dermatology appointment on 4/17/25 at 9:30 AM.<br><br>Resident #64's clinical record lacked documentation of attempts to make a dermatology appointment or rationale for the two month gap between the order for the referral and the actual appointment.<br><br>During an interview on 5/15/25 at 9:10 AM, Staff C, Assistant Director of Nursing, explained the facility sent a dermatology referral on 2/14/25. They added the specialty clinics typically review resident records as well as insurance coverage before proceeding with an appointment. At an unknown point in time, Staff C questioned if Resident #64 had the dermatology referral completed. Upon further review, they learned the insurance denied the initial referral and They didn't schedule an appointment. Staff C didn't know if the dermatology office called Resident #64 or her family directly to inform of the denial or if they called the facility. Once Staff C knew Resident #64 didn't have an appointment made, they sent out a second dermatology referral. Resident #64's clinical record didn't have a timeframe provided when they made the second referral.<br><br>During an interview on 5/15/25 at 10:30 AM, Resident #64 acknowledged she had a personal cell phone. Resident #64 didn't know of any calls from a dermatology office.<br><br>During a phone interview on 5/15/25 at 11:10 AM, Resident #64's Daughter denied receiving a call from the dermatology office.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Medication and Treatment Orders policy, revised July 2016, instructed to have consistent orders for medications and treatments, with principles of safe and effective order writing. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907<br><br>Based on observation, interviews, and record review, the facility failed to identify, assess, and put interventions in place for 1 of 1 resident reviewed for undocumented bruises on her body (Resident #8). The facility reported a census of 71 residents.<br><br>Findings include:<br><br>Resident #8's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognitive functioning. Resident #8 required substantial/maximal assistance for upper body dressing and bathing. The MDS listed her as dependent on staff for lower body dressing, putting on, and taking off footwear. The MDS included diagnoses of non Alzheimer's disease, anxiety, and depression.<br><br>The Care Plan Focus initiated 3/8/24 indicated Resident #8 had a safety concern. The Goal listed she would remain safe in her environment.<br><br>The Care Plan Focus revised 4/17/25 reflected Resident #8 had a risk for falls. The Goal directed Resident #8 wouldn't experience any major injuries related to falls.<br><br>The Care Plan Focus initiated 3/5/25 identified Resident #8 had open areas on her arms and face from picking her skin. The Interventions directed to complete a full skin assessment each week with Resident #8's bath and/or shower.<br><br>The Incident, Accident, Unusual Occurrence Progress Note dated 3/8/25 at 6:10 PM, documented that someone called for help and on arrival, they found Resident #8 lying on her right side on the floor in front of her recliner next to her wheelchair. Resident #8 wore socks and shoes on her feet. Resident #8 didn't have a call light on. The nurse completed a head-to-toe assessment. The assessment revealed a hematoma (bruise) on her right forehead. She had normal range of motion for her. The nurse started Neuro checks (assessments to monitor neurological status). Two staff assisted Resident #8 to her recliner. The nurse called the on call provider due to her hitting her head and notified her family.<br><br>Resident #8 had pictures that revealed the following bruising:<br><br>a. 3/15/25 at 10:33 AM, bruise on forehead over right eye.<br><br>b. 3/16/25 at 5:04 PM, faint bruising on right and left knees.<br><br>c. 3/17/25 at 8:16 AM, bruising on right lateral lower buttocks.<br><br>An NSG(nursing):Weekly Skin Observation Tool V2 documented that Resident #8 had no new skin issues on 3/3/25, 3/10/25, and 3/17/25.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/20/25 at 3:28 PM, the Nurse Consultant acknowledged the bruises in the pictures. The Nurse Consultant stated she couldn't find any documentation of bruising on Resident #8's legs or knees. When the surveyor showed the Nurse Consultant The NSG: Skin Observation Tool V 2 indicated the Certified Nurse Aide (CNA) marked no new skin issues for the dates of 3/3/25, 3/10/25 and 3/17/25. The Nurse Consultant stated they started the form for the CNAs to alert the nurses when they find a new skin concern. When they mark yes, the nurses become aware. They need to go and assess the new skin area. She stated what happened is that the CNAs felt the nurses already assessed the resident after a fall, therefore they knew about the skin area. The Nurse Consultant stated that after a fall, bruising may not show up right away, therefore the nurse would not see an area during their initial assessment. She stated they would provide education on that matter.<br><br>A Skin Tears Abrasions and Minor Breaks policy revised September 2013, defined the purpose of the procedure is to guide the prevention and treatment of abrasions, skin tears, and minor breaks in the skin. Preparation:<br><br>a. Obtain a physician's order as needed. Document physician notification in medical record.<br><br>b. Review the resident's Care Plan, current orders, and diagnoses to determine resident needs.<br><br>c. Check the treatment record.<br><br>d. Generate Non Pressure form and complete.<br><br>e. Assemble the equipment and supplies as needed.<br><br>Documentation - Record the following information in the resident's medical record:<br><br>a. Complete in house investigation of causation.<br><br>b. Generate Non Pressure form.<br><br>c. Document physician and family notification, and resident education (if completed) in medical record.<br><br>d. How the resident tolerated the procedure.<br><br>e. Any problems or resident complaints related to the procedure.<br><br>f. Any complications related to the abrasion (e.g., pain, redness, drainage, swelling, bleeding, decreased movement).<br><br>g. Interventions implemented or modified to prevent additional abrasions (e.g., clothes that cover arms and legs).<br><br>h. When an abrasion/skin tear/bruise is discovered, complete a Report of Incident/ Accident. |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907<br><br>Based on observation, interviews and record review, the facility failed to provide the correct diet for 1 resident during a meal service (Resident #39). Resident #1 received a regular textured diet during the meal service. This resident's diet order was for a mechanically soft textured diet. The facility reported a census of 71.<br><br>Findings include:<br><br>Resident #39's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS reflected Resident #39 ate independently. The MDS included a diagnosis of a seizure disorder. The MDS listed Resident #39 received a mechanically altered diet which required a change in texture of food or liquids.<br><br>A Physician's Order dated 12/10/24 documented Resident #39 had a mechanical soft textured diet.<br><br>The facility received an order to discontinued the diet on 5/14/25 at 1:08 PM.<br><br>A Physician's Order dated 5/14/25 at 1:51 PM, directed to start Resident #39 on a regular texture diet.<br><br>A Dietary Progress Note dated 5/14/25 at 12:26 PM, documented the Dietitian visited with Resident #39. Resident #39 reported she had a good appetite and ate 3 meals daily although she reported she didn't care for the mechanical soft meat. She described her weight loss as not intentional but also reported she had a goal to weigh 170 pounds. Resident #39 stated she felt better after she lost the weight. The Dietitian encouraged her to have adequate meal intakes and gradual weight loss as desired.<br><br>On 5/14/25 starting at 12:13 PM, observed the lunch meal service. Witnessed Resident #39 receive a large lettuce salad with ham rolled up on it. The Licensed Nursing Home Administrator (LNHA) stated she had an order stating she could have a more relaxed diet and ham is one of the foods she could choose to eat.<br><br>On 5/14/25 at 1:09 PM, the LNHA stated he would look into this more and find the order. During the service watched Resident #39 as she sat just outside the doorway in the dining room. She had no difficulties with eating the salad with ham.<br><br>On 5/14/25 at 1:36 PM, the LNHA and the Assistant Director of Nursing (ADON), stated no one put Resident #39's order of a regular diet as ordered in her clinical record. The LNHA stated Resident #39 had difficulty with dental problems but they problem had healed. They had an order that directed to advanced back to a general diet. The ADON stated she obtained an order for a regular diet. When asked if she obtained the order for the regular diet after the observation today during lunch hour, she responded yes. When asked if they could show documentation somewhere that the doctor wanted her to be on a regular textured diet, they stated they would look into it further.<br><br>(continued on next page) |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/14/25 at 2:00 PM, the Nurse Consultant and the LNHA acknowledged the concern of serving the incorrect diet. They stated they would look for more documentation.<br><br>At the time of survey, the facility couldn't provide further documentation.<br><br>A Therapeutic Diets policy revised October 2017, directed the attending physician to prescribe therapeutic diets to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. Policy Interpretation and Implementation a. Diet will be determined in accordance with the resident's informed choices, preferences, treatment goals and wishes. Diagnosis alone will not determine whether the resident is prescribed a therapeutic diet.<br><br>b. If a mechanically altered diet is ordered, the provider will specify the texture modification.<br><br>c. The resident has the right to not comply with therapeutic diets.<br><br>d. The Dietitian, nursing staff, and attending physician will regularly review the need for, and resident's acceptance of, prescribed therapeutic diets.<br><br>e. The dietitian and nursing staff will document significant information relating to the resident's response to his/her therapeutic diet in the resident's medical record. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907<br><br>Based on observations, interviews, and record review, the facility failed to follow infection control guidelines for 3 of 3 residents (Residents #24, #45, and #68).<br><br>1. During an observation of Staff A, Licensed Practical Nurse (LPN), providing tracheostomy (a hole that surgeons make through the front of the neck and into the windpipe, also known as the trachea) care to Resident #45, after she finished the tracheostomy (trach) care, while wearing the same gloves and without completing hand hygiene, she pulled off the dressing over their resident's gastrostomy (surgical hole in the abdomen in which a feeding tube is inserted). Staff A left Resident #45's room with a gown, walked down the hall and returned to the room with tape while still wearing the gown.<br><br>2. Witnessed Staff A provided a wound dressing change on Resident #68. She failed to complete hand hygiene between removing the old dressing and applying new gloves.<br><br>3. Watched a Certified Nurse Aide (CNA) drain Resident #24's catheter bag without following enhanced barrier precautions (EBP) by failing to wearing a gown. The facility reported a census of 71.<br><br>Findings include:<br><br>1. Resident #45's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) didn't occur as they rarely or never understood. The MDS included diagnoses of stroke, quadriplegia (extreme weakness to allow 4 extremities), and respiratory failure (poor lung function). Resident #4 had a feeding tube and required tracheostomy care.<br><br>A Doctor's Order dated 1/6/25, directed the licensed staff to replace Resident #45's dressing every shift and clean around their trach with normal saline every shift.<br><br>A Doctor's Order dated 1/6/25, directed staff to clean the gastrostomy tube area with soap and water, then change the split gauze dressing twice a day (BID) and as needed (PRN). Monitor for signs and symptoms of infection every shift.<br><br>On 5/14/25 at 9:41 AM, watched Staff A put on gloves and gown. Staff A cleaned the area between the trach appliance and the tracheostomy with sterile water-soaked gauze and then sterile water-soaked swab. Resident #45 coughed up thick mucus from his trach. Staff A removed the inner cannula from the outer trach appliance and threw it in the garbage. Staff A placed a new inner cannula into the outer cannula. Without changing gloves or completing hand hygiene, Staff A removed a dressing around Resident #45's gastrostomy tube site. She cleaned around the gastrostomy then applied a clean dressing. Staff A stated she needed to go grab some tape. She removed her gloves, kept her gown on, and left the room. Staff A returned to the room wearing the same gown. She applied new gloves and taped the open end of the dressing closed.<br><br>Directly after the observation Staff A stated, she didn't know about leaving the room with her gown on, but thought maybe she shouldn't have done that. She explained should remove her gloves, sanitize her hands, then place new gloves on between trach care and gastrostomy care.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165209 | A. Building<br>B. Wing | 05/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Southridge Specialty Care | 309 West Merle Hibbs Boulevard<br>Marshalltown, IA 50158 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Directly after the above conversation, the Director of Nursing (DON) stated Staff A should have removed the gown prior to leaving the room, and put a new one back on upon reentering the room to finish Resident #45's care. She stated Staff A should have removed her gloves, sanitized her hands, and applied new gloves between the trach care and gastrostomy care.<br><br>50500<br><br>2. Resident #68's MDS assessment dated [DATE] identified a BIMS score of 13, indicating intact cognition. The MDS listed Resident #68 as dependent on staff for lower body dressing (below the waist). The MDS included diagnoses of cancer and coronary artery disease (impaired blood vessels of the heart). This MDS documented Resident #68 had 2 Stage II Pressure Ulcers.<br><br>A Doctor's Order dated 5/9/25, directed to clean the right buttock wound with normal saline, pat dry, apply hydrogel (wound healing gel) to wound bed, and cover wound with a dressing every day shift for wound care.<br><br>On 5/14/25 at 2:09 PM, watched Staff A sanitize her hands and apply gloves. She removed Resident #68's dressing from their right buttock and threw the dressing away. Staff A applied new gloves and cleaned the wound. Staff A grabbed a pen out of her pocket and wrote that day's date on the new dressing with her initials, then applied the dressing. Staff A removed her gloves and threw them away, then sanitized her hands. This LPN then laughed, shook her head and said that she just realized she didn't sanitize her hands between glove change after removing the old dressing and applying the new gloves. Resident #68 didn't have an EBP sign outside her door.<br><br>On 5/15/25 at 3:28 PM, the Nurse Consultant and the Licensed Nursing Home Administrator (LNHA), acknowledged the concern of Staff A not sanitizing her hands between removal of dirty gloves and application of new gloves.<br><br>3. Resident #24's MDS assessment dated [DATE] listed Resident #24 had an indwelling urinary catheter. The MDS included diagnoses of cerebrovascular accident (stroke), hemiplegia (paralysis or weakness on one side of the body), and seizure disorder.<br><br>The Care Plan Focus revised 5/13/25, indicated Resident #24 had a urinary catheter. The Interventions directed to provide catheter care every shift and use EBP.<br><br>Resident #24's Kardex, obtained 5/14/25, alerted staff to use EBP when performing high contact care activities.<br><br>On 5/14/25 at 1:35 PM, observed Staff B, CNA, provide Resident #24's catheter care. As Staff B provided Resident #24's catheter care, they failed to wear a gown.<br><br>Resident #24's room had a sign outside the room which alerted staff to use EPB and the need for additional personal protective equipment (PPE). Resident #24's room had gowns for staff use inside the doorway.<br><br>During an interview on 5/14/25 at 1:50 PM, Staff B stated they wore a gown sometimes when completing catheter care. Staff B added they need to wear gowns when a resident has an infection, such as a urinary tract infection.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/15/25 at 3:15 PM, the Administrator acknowledged Staff B should have wore a gown during Resident #24's catheter care per EBP.<br><br>The policy Enhanced Barrier Precautions, revised 3/28/24, directed to initiate EBP for residents with pressure ulcers and indwelling medical devices, such as feeding tubes, tracheostomies, and urinary catheters. PPE is necessary when performing high contact care activities such as device care or use.<br><br>The policy Enteral Tube Feeding via Gravity Bag, revised November 2018, outlined aseptic technique used when preparing or administrating enteral feedings. The policy instructed staff to wash and dry their hands thoroughly and wear clean gloves.<br><br>The policy Tracheostomy Care, revised August 2013, outlined aseptic (clean) technique used during all dressing changes, tracheostomy tube changes, and cleaning/sterilization (cleanliness by removal of bacteria) of reusable tracheostomy tubes. Glove use on both hands during any or all manipulation of the tracheostomy. Sterile gloves must be worn during aseptic procedures.<br><br>The policy Wound Care, revised October 2010, directed the staff:<br><br>a. Put on exam gloves, loose tape, and remove the wound dressing<br><br>b. Pull the glove over the dressing and discard. Staff must wash and dry hands thoroughly<br><br>c. Put on gloves and continue wound treatment as ordered |