

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165255	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/28/2024
NAME OF PROVIDER OR SUPPLIER  Via of Carlisle		STREET ADDRESS, CITY, STATE, ZIP CODE  680 Cole Street Carlisle, IA 50047	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48004</b></p> <p>Based on document review, observations, resident interview, and staff interview the facility failed to provide dignity by leaving a catheter bag uncovered for 1 of 8 residents reviewed (Resident #2). The facility reported a census of 71 residents.</p> <p>Findings include:</p> <p>Review of Resident #2's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 11 indicating moderate cognitive impairment. The MDS further revealed diagnosis of paraplegia, and chronic obstructive pulmonary disease.</p> <p>Observation 8/25/24 at 1:42 PM Resident #2's Catheter bag was noted to not have a privacy cover.</p> <p>Interview 8/25/24 at 1:42 PM Resident #2 revealed the facility never puts a cover on the drainage bag.</p> <p>During a follow up observation 8/26/24 at 2:07 PM Resident #2's catheter bag was observed with no dignity cover.</p> <p>During a follow up interview 8/26/24 at 2:10 PM Resident #2 revealed that the urinary drainage bag had a cover, but it went missing a long time ago. Resident #2 further revealed the facility did not put a cover on the drainage bag anymore.</p> <p>Interviews 8/26/24 at 2:14 PM Staff A Certified Nursing Assistant (CNA) and Staff B Certified Medication Aide (CMA) revealed that Urinary drainage bags should have dignity covers.</p> <p>Interview 8/26/24 at 4:44 PM with the Director of Nursing (DON) revealed her expectation would be for dignity bags to be on urinary drainage bags for the residents dignity.</p> <p>Interview 8/28/24 at 8:17 AM with the Administrator revealed that the facility does not have a policy for dignity bags as the facility follows standards of care.</p>

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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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47673</p> <p>Based on Electronic Health Records (EHR), resident interview, resident council documentation, and observations the facility failed to provide nursing staff to assure residents safety by not responding to call lights in a timely manner for 4 of 18 residents reviewed (Resident #2, #35, #38, and #41). The facility reported a census of 71 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) dated [DATE] for Resident #35 documented a Brief Interview for Mental Status (BIMS) of 15 which indicated no cognitive impairment. The MDS documented the resident required partial/moderate assistance with toileting hygiene.</p> <p>On 8/25/24 at 2:04 PM Resident #35 stated it takes a while for staff to answer her call light. Resident #35 stated she had turned the call light on while in the bathroom and had to wait for longer than a half an hour. Resident #35 stated at that time she just did the best she could and completed the peri care herself and transferred herself back to the wheelchair.</p> <p>2. The Minimum Data Set (MDS) dated [DATE] for Resident #38 documented a Brief Interview for Mental Status (BIMS) of 15 which indicated no cognitive impairment.</p> <p>On 8/26/24 at 8:13 AM Resident #38 stated it had taken longer than 15 minutes in the last week once or twice for staff to answer his call light. Resident #38 stated it usually takes less than a half hour but longer than 15 minutes for staff to answer his call light. Resident #38 stated he could tell the time with the clock and his phone.</p> <p>On 8/26/24 at 1:12 PM observation of a resident council meeting revealed consistent complaints by all residents attending the council meeting about the lengths of time it took staff to answer their call lights. All residents reporting call lights answering times longer than 15 minutes and up to an hour.</p> <p>On 8/26/24 at 4:38 PM the Director of Nursing (DON) stated one of her jobs as the MDS Coordinator was to complete call light audits. The DON stated she was transferred to the DON and the audits were completed by another nurse. The DON stated that nurses' positions changed so call light audits had not been completed in the last 2 months. The DON stated the facility's expectation was that call lights would be answered in no longer than 15 minutes.</p> <p>48004</p> <p>3. Review of Resident #2's MDS dated [DATE] revealed a BIMS score of 11 which indicated moderate cognitive impairment. The MDS documented the resident had impairment to both lower extremities, and was dependent on staff for toileting hygiene, and dressing for both upper and lower body.</p> <p>Interview 8/25/24 at 1:39 PM with Resident #2 revealed call lights can take forever. Resident #2 further revealed the longest call light time for her was almost 2 hours.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Review of Resident #41's MDS dated [DATE] revealed a BIMS score of 15 which indicated intact cognition. The MDS documented the resident used a walker for mobility.</p> <p>Interview 8/26/24 at 7:55 AM with Resident #41 revealed call lights can take over 15 minutes, and often 30 minutes or longer.</p> <p>During continuous observation 8/26/24 from 1:40 PM until 1:59 PM in Hall 200 revealed a call light on during this time observed. A family member of a Resident in this hall revealed this call light had been on for 20 minutes at this time. This family member further revealed that call lights are rarely answered in 15 minutes or less.</p>		