

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  03/03/2025
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>35434</p> <p>Based on clinical record review, policy review, and staff interview, the facility failed to ensure staff treated residents with dignity and respect for 3 of 7 residents reviewed for resident rights (Resident #2, #7 and Resident #8). The facility reported a census of 75 residents.</p> <p>Findings include:</p> <p>1. The Significant Change Minimum Data Set (MDS) assessment tool, dated 12/29/24, listed diagnoses for Resident #2 which included paraplegia (paralysis in the lower portion of the body), anxiety, and depression, and stated the resident was dependent on staff for bathing. The MDS listed her Brief Interview for Mental Status (BIMS) score as 15 out of 15, which indicated intact cognition.</p> <p>A Care Plan entry, dated 12/2/24, stated the resident had a history of a traumatic life event and directed staff to provide a calming environment through country music, pet visits, and TV.</p> <p>An untitled, undated facility investigation stated on 2/16/25, Resident #2 reported that Staff C Certified Nursing Assistant (CNA) accidentally hurt her arm by lifting it too high to wash under her arms and Staff C called her whiny related to the pain.</p> <p>2. The Quarterly MDS assessment tool, dated 1/13/25, listed diagnoses for Resident #7 which included heart failure, depression, and psychotic disorder. The MDS listed the resident's BIMS score as 9 out of 15, which indicated moderately impaired cognition.</p> <p>Care Plan entries, dated 1/19/19, stated the resident required assistance with activities of daily living such as dressing, showering, and toilet use.</p> <p>3. The Significant Change Quarterly Minimum Data Set (MDS) assessment tool, dated 2/18/25, listed diagnoses for Resident #8 which included diabetes, Parkinson's (a disease which causes tremors and affected mobility), and anxiety.</p> <p>The MDS stated she required partial to moderate assistance with toilet transfers and toileting hygiene and listed her Brief Interview for Mental Status (BIMS) score as 15 out of 15, which indicated intact cognition.</p> <p>(continued on next page)</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/3/25 at 10:46 a.m., Staff D Certified Nursing Assistance(CNA) stated Resident #8 informed her that she told Staff E CNA she needed to go to the bathroom and Staff E told her to urinate in her brief and she would change her. Staff D stated she wrote a statement and turned it into the Director of Nursing (DON). Staff D stated she did not know exactly when this was but was sometime in 2025.</p> <p>An 8/23/24 Care Plan entry stated the resident required the assistance of 1 staff for transfers</p> <p>The facility policy Promoting/Maintaining Resident Dignity, revised 1/30/24, stated the facility would protect and promote resident rights and treat each resident with respect and dignity.</p> <p>On 2/26/25 at 2:19 p.m., Staff B, Registered Nurse (RN) stated there was a situation where Staff C, CNA called Resident #2 whiny. She stated she didn't witness it but she had the CNA's write out statements regarding this and informed the Director of Nursing (DON). Staff B stated last weekend she had another situation where she heard Staff C tell Resident #7 she was done and she was not helping her any more. Staff B stated she talked to Staff C about this and told her she could not tell a dependent adult she would not help them. Staff B stated as soon as Staff C saw her(Staff B) she went back in and helped the resident. Staff B stated she informed the DON about this.</p> <p>On 3/3/35 at 11:19 a.m. Staff C stated she tried to wash under Resident #2's armpit and when she did this, the resident's demeanor changed and Staff C told her she didn't mean to hurt her and she apologized to the resident. Staff C stated she told the resident she was being whiny. She stated she did not tell Resident #7 she did not want to help them. She stated Resident #7 cursed her and she told her she would reapproach her later.</p> <p>On 3/3/25 at 1:56 p.m., the DON stated she wanted staff to treat residents like their own family members. She stated no one reported anything to her about staff telling them to urinate in their briefs.</p> <p>On 3/3/25 at 2:22 p.m., the Administrator stated she expected staff to treat residents with dignity and respect.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>35434</p> <p>Based on clinical record review, policy review, and staff interview, the facility failed to carry out a medication intervention for 1 of 3 residents reviewed for a change in condition (Resident #1). The facility reported a census of 75 residents.</p> <p>Findings includes:</p> <p>The Minimum Data Set (MDS) assessment tool, dated 1/6/25, listed diagnoses for Resident #1 which included hemiplegia (one-sided weakness), diabetes, and anxiety. The MDS listed her cognition as severely impaired.</p> <p>The facility policy Medications Ordering and Receiving from Pharmacy, revised January 2018, did not address how staff should obtain medications needed for new orders.</p> <p>A 4/15/24 Care Plan entry directed staff to administer psychotropic medications as ordered by the physician.</p> <p>The February 2025 Treatment Administration Record (TAR) listed a 2/21/25 6:00 p.m. order for lorazepam(a medication used for anxiety) 2 milligrams (mg)/milliliter (ml) oral concentrate, give 0.25 ml every 6 hours for anxiety/agitation. The 6:00 p.m. dose on 2/21/25 and the 12:00 a.m. dose on 2/22/25 lacked checks to indicate staff administered the medication and referred to the progress notes.</p> <p>A 2/21/25 7:49 p.m. Orders-Administration Note stated the facility awaited pharmacy delivery.</p> <p>A 2/22/25 12:18 a.m. Orders-Administration Note stated NA.</p> <p>A 2/22/25 9:35 a.m. Health Status Note stated the resident's respirations were 36 and appeared labored. The staff was unable to administer lorazepam because the medication did not arrive from the pharmacy and was not available in the emergency kit. The family requested the facility send the resident to the emergency room .</p> <p>A 2/22/25 10:35 a.m. Health Status Note stated the pharmacy delivered the resident's lorazepam at the same time emergency services arrived and the resident received her first dose.</p> <p>On 3/3/25 at 8:12 a.m. via email the Director of Nursing (DON) stated with regard to a pharmacy policy, the facility followed standards of care.</p> <p>On 3/3/25 at 2:43 p.m., the DON stated if the pharmacy did not deliver an ordered medication, she would want the nurses to special order it and call the pharmacy for the estimated time of delivery.</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>35434</p> <p>Based on observations, clinical record review, policy review, and staff interviews, the facility failed to prevent the development and worsening of a facility acquired pressure ulcer for 3 of 3 residents reviewed with pressure ulcers(Residents #1, #3, and #4). The facility reported a census of 75 residents.</p> <p>Findings include:</p> <p>The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers:</p> <p>Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.</p> <p>Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister.</p> <p>Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.</p> <p>Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar.</p> <p>Unstageable Ulcer: inability to see the wound bed.</p> <p>Other staging considerations include:</p> <p>Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface.</p> <p>1. The Annual Minimum Data Set (MDS) assessment tool, dated 8/12/24, listed diagnoses for Resident #1 which included Alzheimer's, non-Alzheimer's dementia, and anxiety. The MDS stated the resident required partial to moderate staff assistance for transfers and to roll left and right. The MDS stated the resident was at risk for developing pressure ulcers but had no unhealed pressure ulcers. The MDS listed her cognition as severely impaired.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy Skin Management Protocol, dated 5/16/23, stated the facility would notify the wound nurse of a new skin alteration or skin ulcer and directed staff to follow wound care guidelines or physician orders.</p> <p>A 10/25/24 at 2:21 p.m. Health Status Note documented the resident had a new open area on her gluteal (pertaining to the buttocks) fold which measured 0.5 centimeters (cm) x 0.3 cm x 0.3 cm (length x width x depth) and stated staff sent an assessment to the physician to review and respond.</p> <p>A 10/25/24 Physician Encounter Note did not mention the resident's new skin area and stated the resident had no lesions or ulcers.</p> <p>An 11/1/24 Nurse Practitioner (NP) Encounter Note stated the resident had an open area to the buttocks, not able to visualize this day, and would request the wound NP to follow.</p> <p>An 11/4/24 Order Note stated the wound NP would see the resident for the area to the buttocks.</p> <p>An 11/5/24 Nurse Practitioner (NP) Wound Treatment Plan stated the resident had a new Stage 3 wound on her sacrum (pertaining to the back wall of the pelvis) which measured 3.0 cm x 1.4 cm x 0.2 cm. The plan directed staff to start wound cleanser to the sacrum, cover with foam border dressing, and change 3 times per week and as needed(prn). The plan directed staff to obtain and Equagel cushion (a cushion containing gel used to reduce pressure) or equivalent for her wheelchair.</p> <p>The facility lacked a treatment order prior to 11/5/24.</p> <p>An 11/10/24 Care Plan entry stated the resident had a Stage 3 sacral ulcer and directed staff to carry out treatments as ordered.</p> <p>An 11/19/24 Skin/Wound Note stated the resident continued with an open area to the top of the coccyx. The area had a strong odor with drainage noted.</p> <p>An 11/19/24 NP Wound Treatment Plan stated the resident's wound measured 3.3 cm x 2.0 cm x 0.5 cm and listed the wound status as deteriorated. The plan stated staff noted an odor yesterday. The plan directed staff to discontinue the current treatment and start to cleanse with quarter strength Dakins' (a diluted bleach solution used to treat and prevent infections in wounds) solution, Flagyl (used to treat infections) sprinkles (crushed Flagyl tablets sprinkled on wounds to treat infections and odors into the wound bed), apply calcium alginate (absorbent wound dressings made from alginate, a natural product extracted from seaweed) over the Flagyl, and cover with silicone super absorbent dressing, and change daily and prn. The plan directed staff to place an Equagel cushion or equivalent in her wheelchair.</p> <p>The October and November 2024 Treatment Administration Records (TARS) listed a 10/24/19 order for house barrier to the coccyx for prevention. The TARS lacked an additional treatment carried out from the discovery of the wound on 10/25/24 until 11/19/24.</p> <p>The TARS lacked documentation of implementation of the 11/5/24 order for the foam border dressing and lacked documentation the 11/19/24 order for Dakins', Flagyl, and calcium alginate was completed on 11/20/24 and 11/21/24. The TARS lacked documentation of an Equagel cushion implemented prior to 11/19/24.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An 11/19/24 Order Note stated the Flagyl and calcium alginate were unavailable.</p> <p>An 11/20/24 Health Status Note stated the Flagyl and calcium alginate were not available for the treatment at this time and the wound had a mild odor.</p> <p>An 11/21/24 Skin/Wound Note stated the facility waited for the pharmacy to deliver wound supplies.</p> <p>A Care Plan entry, initiated 12/30/24, stated the resident had an Equagel cushion in her wheelchair.</p> <p>On 2/27/25 at 8:51 a.m., the Director of Nursing (DON) stated she was unable to find anything additional regarding treatments for Resident #1 (prior to 11/22/24). She stated the first time the resident saw the wound nurse was 11/5/24.</p> <p>2. The Quarterly MDS assessment tool, dated 11/11/24, listed diagnoses for Resident #3 which included pressure ulcer to the sacral region, dementia, and depression. The MDS stated the resident was at risk for developing pressure ulcers but had no unhealed pressure ulcers. The MDS listed her BIMS score as 7 out of 15, which indicated severely impaired cognition.</p> <p>An 11/6/24 Care Plan entry stated the resident had a Stage 3 ulcer to the right buttock and directed staff to complete treatments as ordered.</p> <p>A 12/3/24 Wound Treatment Plan stated the resident had a foam cushion in her recliner with a chuck (disposable pad) over it. The plan stated the resident's Stage 3 pressure ulcer of the right buttock was healed and directed staff to obtain a roho (a cushion which is constructed of air filled cells) or Equagel (gel cushion) for her chair and to not utilize a foam cushion or a small pillow.</p> <p>Ulcer Skin Assessments stated the resident had a Stage 3 pressure ulcer to the right buttock, first observed 12/10/24. The assessments included the following measurements:</p> <p>12/10/24 1.0 x 2.5 x 0.3</p> <p>12/17/24 0.8 x 2.3 x 0.3</p> <p>12/24/24 0.7 x 2.2 x 0.3</p> <p>12/31/24 0.6 x 2.1 x 0.3</p> <p>1/7/25 0.5 x 2.5 x 0.3</p> <p>1/14/25 2.5 x 0.8 x 0.3</p> <p>A 12/13/24 Skin/Wound Note stated the resident had an open area to the right gluteal fold.</p> <p>A 1/21/25 Wound Treatment Plan stated the resident had a completely flat foam cushion in her chair and directed staff to obtain an Equagel cushion for her chair. The plan stated the resident had a new Stage 3 pressure ulcer to the right buttock which measured 1.9 x 0.6 x 0.3.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A 2/4/25 Wound Treatment Plan stated the resident had an Equagel in her recliner.</p> <p>On 2/27/25 at 11:00 a.m. Staff F Quality Assurance (QA) Nurse measured a red open wound on the resident's right buttock as 2.0 x 0.5 x 0.3.</p> <p>On 3/3/25 at 8:45 a.m., the DON stated Resident #3 had a gel cushion for a long period of time but thought staff moved it out of her recliner into the wheelchair. She stated the facility discussed getting two cushions.</p> <p>3. The Quarterly MDS assessment tool, dated 2/3/25, listed diagnoses for Resident #4 which included Stage 3 pressure ulcer of the sacral region, Alzheimer's disease, and depression. The assessment stated the resident was at risk for developing pressure ulcers but had no unhealed pressure ulcers. The MDS listed her cognition as severely impaired.</p> <p>A 2/11/25 Wound Treatment Plan stated the resident had a new Stage 3 pressure ulcer to the left gluteal cleft(referring to a part of the buttocks) which measured 1.9 cm x 2.0 cm x 0.2 cm. The plan directed staff to start cleansing with wound cleanser and cover with a border dressing.</p> <p>The February 2025 TAR listed a 2/18/25 order for the left gluteal fold: cleanse with wound cleanser, cover with foam border dressing, change three times per week and prn. The TAR lacked documentation of a treatment started prior to 2/18/25.</p> <p>A 2/11/25 Care Plan entry stated the resident had a Stage 3 pressure ulcer to the left gluteal cleft.</p> <p>Observation on 2/27/25 at 1:45 p.m. revealed the resident lying on back in bed.</p> <p>On 3/3/25 at 3:43 p.m. via email, the DON stated she did not have any further documentation related to the completion of a dressing between 2/11/25 and 2/18/25.</p> <p>On 2/26/25 at 11:44 a.m., Staff A, wound NP stated usually they implemented some type of dressing to a new open area within 12-24 hours. She stated if the facility discovered a new open area, she assumed they addressed it with someone.</p> <p>On 2/26/25 at 2:29 a.m., the DON stated if they discovered a new open area she would want a treatment started by the next shift. She stated she was not sure about which treatments she was on but would check into it.</p> <p>On 3/3/25 at 8:45 a.m., the DON state she would want the wound NP's recommendations carried out.</p>