STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Via of Carlisle	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47079 Based on observation, record review, staff interview, and policy review, the facility failed to provide the necessary services to maintain personal cares of oral hygiene for 1 of 3 residents reviewed (#11). The facility reported a census of 75 residents. Findings include: On 3/31/25 at 1:42 PM, Resident #11 was observed reclined in a Geri chair (large, padded chair for individuals with limited mobility) in the television area. He was breathing through his mouth and his lips were noted to be chapped and peeling. The Quarterly Minimum Data Set (MDS) for Resident #11 dated 2/03/25 indicated a Brief Interview for Mental Status (BIMS) score of 04 out of 15 which indicated severely impaired cognition. It included diagnoses of anemia, seizure disorder, quadriplegia, a Cerebral Vascular Accident (CVA - stroke), and severe protein-calorie malnutrition. It also indicated the resident was dependent with all Activities of Daily Living (ADLs). The MDS documented that the Resident had a feeding tube for nutitional approaches for both total calories, and fluid intake. The Electronic Health Record (EHR) included a physician order dated 2/20/25 for Aquaphor Lip Repair External Stick (Skin Protectants, Misc.), apply to lips topically as needed for dry chapped lips. The Medication Administration Records (MARs) for March and April 2025 indicated the Aquaphor had not been applied to the resident's lips within the previous 30 days. The Care Plan dated 5/20/24 included an intervention for oral hygiene: assist x1 (offer every 2 hours while awake). A Care Conference Note dated 2/19/25 revealed the resident's brother voiced concerns regarding the resident's dry, chapped lips. A Progress Note dated 2/28/25 indicated dry lips improving this shift with no complaints of discomfort. Treatment with Aquaphor lip repair continues. No subsequent progress notes regarding the resident's lip repair or Aquaphor were available. At 2:20 pm, the resident's lips were noted to still be chapped and peeling. (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

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 04/03/2025
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 2:22 PM, the Oral Hygiene task indicated the resident received oral hygiene at 10:18 AM. On 4/03/25 at 10:35 AM, Staff G, Certified Nurse Aide (CNA) stated documentation of the oral hygiene indicates it was performed. She also stated the resident's lips are checked during oral hygiene and staff apply chap stick if needed. She stated she notifies the nurse if his lips are chapped but was not sure if staff notification was required. At 10:41 AM, Staff H, CNA stated CNA's check the resident's lips when oral hygiene is performed. She also stated if the resident's lips are chapped, they tell the nurse per policy. On 4/03/25 at 10:59 AM, Staff A, Licensed Practical Nurse (LPN) stated she was not notified of Resident #11's chapped lips on 3/31/25. She also stated the CNA's usually apply chap stick when his lips are chapped and she applies Aquaphor if needed. On 4/03/25 at 12:15 PM, the Administrator emailed the facility followed standards of care and did not have a policy specific for ADL's. On 4/03/25 at 1:38 PM, the Director of Nursing (DON) stated staff should have notified the nurse to apply Aquaphor to the resident's lips.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 47079 Based on observations, clinical record review, staff interview, and policy review, the facility failed to provide treatment and services to prevent the development of a pressure ulcer for 2 of 3 residents reviewed (#4 & #11). The facility reported a census of 75 residents. Findings include: The Minimum Data Set (MDS) assessment identifies the definition of pressure ulcers: Stage I is 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. 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. Stage III is 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. 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. Unstageable Ulcer: inability to see the wound bed. Other staging considerations include: 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 junction. 1. On 3/31/25 at 1:42 PM, Resident #11 was observed in a Geri chair (large, padded chair for individuals with limited mobility) in the television area wearing gray socks. He did not have pressure reducing devices on his feet. On 3/31/25 at 1:58 PM, a review of his Electronic Health Record (EHR) revealed a Physician's order dated 3/04/25 for Prevalon boots (cushioned bottom boot that floats the heel to reduce pressure) on at all times, except during transfers. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/31/25 at 2:08 PM, the resident's Prevalon boots were observed stored in the top of a large, gray bin in the resident's room. On 3/31/25 at 3:20 PM, the resident was observed still in the Geri chair in the television area without his Prevalon boots. The Minimum Data Set (MDS) for Resident #11 dated 2/03/25 indicated a Brief Interview for Mental Status (BIMS) score of 04 out of 15 which indicated severely impaired cognition. It included diagnoses of anemia, seizure disorder, quadriplegia, a Cerebral Vascular Accident (CVA - stroke), and severe protein-calorie malnutrition. It revealed the resident was at risk of developing a pressure ulcer and had pressure-reducing devices for his bed and chair. It also revealed the resident was dependent with all activities of daily living (ADLs). The Braden Scale (a scale used to predict pressure sore risk) dated 3/20/25 identified the resident was high risk of developing a pressure ulcer. The Treatment Administration Record (TAR) for March 2025 included Prevalon boots on at all times, except during transfers. Every day and night shift. It was initialed by Staff A, Licensed Practical Nurse (LPN). The Care Plan dated 3/04/25 included an intervention for Prevalon boots on at all times, except during transfers. It included the resident refused to be covered with blankets but no other refusals were included in the Care Plan. The Progress Notes did not include documentation the resident refused to wear the Prevalon boots. On 4/01/25 at 10:45 AM, Staff B, Certified Nurse Aide (CNA) stated Resident #11's Bunny Boots (nickname for Prevalon boots) are used to prevent pressure sores on the resident. She stated he was to have them on while in and out of bed. On 4/01/25 at 12:02 PM, Staff A, LPN stated she was not aware the resident's Prevalon boots were not on Resident #11 while he was in the television room on 3/31/25. She also stated no one told her the resident was in pain but added the order did not allow for his boots to be removed due to pain. On 4/01/25 at 12:40 PM, Staff C, Certified Nurse Aide (CNA) stated she transported Resident #11 to the television room on 3/31/25 and forgot to put his boots on his feet once he was in the television area. 2. On 4/01/25 at 12:25 PM, Resident #4 was observed in the dining room in her wheelchair with a partially contracted (shortened or tightened muscle, tendon, or joint that causes limited movement) right leg and no pressure relieving devices on her feet. A review of Resident #4's EHR revealed a Physician's Order dated 3/04/25 for Prevalon boots on at all times, except during transfers. It also included an order dated 3/04/25 to ensure knee wedge is in place due to contractures for skin protection every shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly Minimum Data Set (MDS) for Resident #4 dated 2/03/25 indicated a Brief Interview for Mental Status (BIMS) was not completed due to the resident was rarely/never understood. It included diagnoses of Alzheimer's Disease, seizure disorder, joint contracture, and depression. It revealed the resident was at risk of developing a pressure ulcer, had a Stage 3 sacral pressure ulcer, and had pressure-reducing devices for her bed and chair. It also revealed the resident was dependent with all activities of daily living (ADLs). The Braden Scale (a scale used to predict pressure sore risk) dated 3/28/25 identified the resident was high risk of developing a pressure ulcer. The Treatment Administration Record (TAR) for April 2025 included Prevalon boots on at all times, except during transfers. Every day and night shift. It also included ensure knee wedge is in place due to contractures for skin protection every shift. Every day and night shift for skin protection. Both were initialed by Staff A. The Care Plan dated 4/03/19 directed staff to attempt Prevalon boots while in bed as resident will allow. It also included an intervention dated 3/04/25 that indicated the resident has wedge between knees due to contracture. Resident to use knee wedge as allows. The Progress Notes did not include documentation the resident refused the wedge or Prevalon boots. The Tasks list did not include pressure relieving devices other than a wheelchair cushion for CNAs to document. On 4/01/25 at 12:54 PM - Staff D, CNA and Staff E, CNA assisted Resident #4 back to bed from her wheelchair after lunch. An observation revealed Resident #4 did not have her Pravelon boots or knee wedge in place. Staff E stated she wasn't sure if the resident was to have the boots on just while in bed or if while she's in the wheelchair too. Staff D concurred. At 1:53 PM, Staff E, CNA stated the resident's Prevalon boots were for pressure ulcer prevention. She stated the resident was only to use them in her bed and not in her chair per her care plan. On 4/02/25 at 2:42 pm, the Director of Nursing (DON) stated staff should be using the pressure-ulcer prevention equipment. If they're unsure, they should verify with the nurse and not assume they don't need to be used. A document titled Pressure Injury Prevention Guidelines revised 2/2025 indicated interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them.

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F 0688

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47079

Based on observations, clinical record review, staff interview, and policy review, the facility failed to use ordered Durable Medical Equipment (DME) to prevent a further decrease in Range-of-Motion (ROM) for 2 of 3 residents reviewed. (provide treatment and services to prevent the development of a pressure ulcer for 2 of 3 residents reviewed (#4 & #11). The facility reported a census of 75 residents.

Findings include:

1. On 3/31/25 at 1:42 PM, Resident #11 was observed in a Geri chair (large, padded chair for individuals with limited mobility) in the television area without any DME. His hands were noted to be limited in range-of-motion.

At 1:58 PM, a review of his Electronic Health Record (EHR) revealed a physician's order dated 3/01/25 for resident to wear palm [NAME] (DME used to prevent contractures <shortened or tightened muscle, tendon, or joint that causes limited movement> and protect skin for people with limited ROM) at all times. [NAME] may be removed if resident complains of (c/o) pain. May remove for hygiene and skin checks. It was ordered for day or night shift for contractures.

At 3:20 PM, the resident was observed still in the Geri chair in the television area without wearing his DME.

The Quarterly Minimum Data Set (MDS) for Resident #11 dated 2/03/25 indicated a Brief Interview for Mental Status (BIMS) score of 04 out of 15 which indicated severely impaired cognition. It included diagnoses of anemia, seizure disorder, quadriplegia, a Cerebral Vascular Accident (CVA - stroke), and severe protein-calorie malnutrition. It also indicated he had bilateral ROM impairment in his upper and lower extremities. It further revealed the resident was dependent with all activities of daily living (ADLs).

The Restorative Splint or Brace Task in the facility Electronic Health Record Point of Care computer documentation revealed the resident was provided 5 minutes of splint or brace assistance on 3/13/25, 3/31/25, and 4/01/25. The record lacked any other splint or brace assistance documented within the previous 30 days.

The Treatment Administration Record (TAR) for April 2025 included resident to wear palm [NAME] at all times. [NAME] may be removed if resident c/o pain. May remove for hygiene and skin checks. It was ordered for every day and night shift for contracture and was initialed by Staff A, Licensed Practical Nurse (LPN).

The Care Plan dated 3/04/25 included palm blaster on at all times. May remove for 2 hours/day. No other palm [NAME] interventions were noted on the resident's Care Plan.

(continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/01/25 at 10:45 AM, Staff B, Certified Nurse Aide (CNA) stated Resident #11's bilateral palm [NAME] was used to keep his hands open to prevent contractures. She stated he was to have them on while in and out of bed. On 4/01/25 at 12:02 PM, Staff A, LPN stated she was not aware the palm [NAME] was not on Resident #11 while he was in the television room on 3/31/25. She also stated it could be removed if the resident complained of pain but added no one told her the resident was in pain. She stated pain would be documented in the progress notes. The Progress Notes did not include any documented complaints of pain. On 4/01/25 at 12:40 PM, Staff C, Certified Nurse Aide (CNA) stated she transported Resident #11 to the television room on 3/31/25 and forgot to apply his palm [NAME]. On 4/02/25 at 2:29 PM, Staff F, LPN stated the palm [NAME] for Resident #11 was to prevent his hand from contracting. 2. On 4/01/25 at 12:25 PM, Resident #4's contracted right wrist was observed outside of her blanket while she was in the dining room in her wheelchair. A review of Resident #4's EHR revealed a Physician's Order dated 3/04/25 to ensure bilateral hand splint are on every shift due to contractures. Remove splints for 2 hours/day. Assess skin for any signs or symptoms (s/s) of breakdown prior to placing splints and removing. The Minimum Data Set (MDS) for Resident #4 dated 2/03/25 indicated a Brief Interview for Mental Status (BIMS) was not completed due to the resident was rarely/never understood. It included diagnoses of Alzheimer's Disease, seizure disorder, joint contracture, and depression. It also indicated she had bilateral ROM impairment in her upper and lower extremities. It revealed the resident was dependent with all activities of daily living (ADLs). The Restorative Splint or Brace Task in the facility Electronic Health Record Point of Care computer documentation revealed the resident was provided 5 minutes of splint or brace assistance on 3/06/25 and 10 minutes of splint or brace assistance on 3/05/25, 3/17/25, and 3/25/25. The residents record lacked any other splint or brace assistance documented within the previous 30 days. The Treatment Administration Record (TAR) for April 2025 included ensure bilateral hand splint are on every shift due to contractures. Remove splints for 2 hours/day. Assess skin for any s/s of breakdown prior to placing splints and removing. Every day and night shift for hand splints. It was initialed by Staff A. The Care Plan dated 3/08/24 directed staff to please don BUE (bilateral upper extremity) hand splints for both day and night wear. Doff for 2 hours during day. (AT anytime). The Progress Notes lacked documentation the resident refused the bilateral wrist splints. On 4/01/25 at 12:54 PM, the resident was observed without wearing her bilateral wrist splints. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:58 PM, Staff E, CNA stated the resident had her wrist splints on before she was showered at 10:30 AM. The order indicated the resident can have them off for 2 hours/day. The splints were noted to be off for 2 hours and 24 minutes. On 4/02/25 at 2:29 PM, Staff F, LPN stated the hand splint for Resident #4 were to keep space in her palms to prevent further contracture and to protect the skin. A document titled Restorative Program Process indicated the licensed nurse will develop a restorative nursing program with individualized interventions and goals which may include recommendations for strategy and adaptive equipment from therapy. It also indicated the licensed nurse will monitor staff and resident(s) to ensure compliance with the restorative nurse program. On 4/03/25 at 1:35 PM, the Director of Nursing (DON) staff should've applied the splints or checked with the nurse to determine if they were off for a reason.

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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 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** 47079 Based on observations, clinical record review, staff interview, and policy review, the facility failed to don appropriate Personal Protective Equipment (PPE) when providing direct resident care for 2 of 2 residents who were on Enhanced Barrier Precautions (EBP) (#11 & #15). The facility reported a census of 75 residents. Findings include: 1. On 4/01/25 at 7:28 AM, Staff D, Certified Nurse Aide (CNA), Staff E, CNA, and Staff G, CNA entered Resident #15's room without any PPE. An Enhanced Barrier Precaution sign was observed attached to the resident's door in both English and Spanish. The sign indicated staff were to wear gloves and a gown for the following activities: a) Dressing b) bathing/showering c) transferring d) changing linens e) providing hygiene f) changing briefs or assisting with toileting g) device care use: central line, urinary catheter, feeding tube, tracheostomy h) wound care: any skin opening requiring a dressing The Significant Change Minimum Data Set (MDS) dated [DATE] for Resident #15 revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition. It included diagnoses of quadriplegia, seizure disorder, and a left buttock pressure ulcer. It indicated the resident was dependent with all areas of Activities of Daily Living (ADLs). The Electronic Health Record (EHR) included an order dated 2/25/25 for Enhanced Barrier Precautions (EBP). The Care Plan included a focus of the resident is at risk of Multidrug Resistant Organism (MDRO) related to wound and directed Enhanced Barrier Precautions. On 4/01/25 at 11:07 AM, Staff G, CNA stated she believed Resident #15 was on EBP. She stated she was not sure what all it entailed for EBP. She clarified she meant she wasn't sure what she was supposed to put on. She confirmed she received infection control education upon hire and it included isolation precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:14 AM, Staff E, CNA stated she didn't know if the EBP was for Resident #15 or her roommate but thought it was for Resident #15. She stated the use of PPE just flew over her head. 2. The Quarterly Minimum Data Set (MDS) for Resident #11 dated 2/03/25 indicated a Brief Interview for Mental Status (BIMS) score of 04 out of 15 which indicated severely impaired cognition. It included diagnoses of anemia, seizure disorder, quadriplegia, a Cerebral Vascular Accident (CVA - stroke), and severe protein-calorie malnutrition. It also indicated he had bilateral ROM impairment in his upper and lower extremities. It further revealed the resident had a feeding tube and was dependent with all activities of daily living (ADLs). The Electronic Health Record (EHR) included an order dated 2/25/25 for Enhanced Barrier Precautions (EBP). The Care Plan dated 10/31/24 included a focus of the resident is at risk of colonization (organism present but not causing signs or symptoms of infection) with MDRO related to Percutaneous Endoscopic Gastrostomy (PEG) tube (tube used for feeding residents who have difficulty swallowing) and directed Enhanced Barrier Precautions. On 4/01/25 at 9:00 AM, Staff G, CNA entered room [ROOM NUMBER] to assist Resident #11 get dressed and changed without donning any PPE. There was an EBP sign attached to the door. At 9:07 AM, Staff G exited the resident's room and put a bag of soiled linen in the soiled linen bin. At 9:10 AM, Staff G stated she didn't know that much about it but wasn't sure if she is supposed to gown when she's just dressing or changing him. She stated there were gloves inside every room. On 4/2/25 at 2:42 PM, the Director of Nursing (DON) stated staff should ask her or double check the EBP sign for determining what is needed when entering the EBP room. A policy titled Enhanced Barrier Precautions updated 5/06/24 defined Enhanced Barrier Precautions as an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. It indicated high-contact resident care activities include: a) Dressing b) Bathing c) Transferring d) Providing hygiene e) Changing linens f) Changing briefs or assisting with toileting (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g) Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes h) Wound care: any skin opening requiring a dressing (excluding shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid(R)) or similar dressing).