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	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Via of Carlisle	680 Cole Street Carlisle, IA 50047

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48004 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. Findings include: 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. Observation 8/25/24 at 1:42 PM Resident #2's Catheter bag was noted to not have a privacy cover. Interview 8/25/24 at 1:42 PM Resident #2 revealed the facility never puts a cover on the drainage bag. During a follow up observation 8/26/24 at 2:07 PM Resident #2's catheter bag was observed with no dignity cover. 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. 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. 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. 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.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on Medication Administration Record (MAR)- Treatment Administration Record (TAR), resident interview and staff interviews the facility failed to represent an accurate assessment of the resident's status during the observation period of the MDS by not accurately assessing need for restrains and utilization of catheter for 2 of 18 residents reviewed (Resident #2 and #38). The facility reported a census of 71 residents. Finding include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #38 documented a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. On 8/26/24 at 8:11 AM Resident #38 stated he had not had a catheter in about 2 years and had not had a catheter at this facility. Review of Resident #38's MDS dated [DATE] documented indwelling catheter present. Review of Resident #38's MAR-TAR documented no physician's order for catheter. Review of Resident #38's care plan documented no care plan for indwelling catheter. On 8/27/24 at 4:59 PM the DON stated Resident #38 never had a catheter since living at the facility. The DON stated the MDS assessment was incorrect and that was a coding mistake. The DON stated the facility's expectation was that the MDS assessment would be completed accurately and coded correctly. 48004 2. Review of Resident #2's MDS dated [DATE] revealed a BIMS score of 11 which indicated moderate cognitive impairment. The MDS further revealed that Resident #2 utilized bed rails daily and is considered a restraint. Review of the Electronic Health Record assessment title, new side rail use assessment, dated 6/7/24 revealed that Resident #2 utilizes bed rails for positioning purposes. During an interview 8/27/24 at 5:05 PM with the Director of Nursing (DON) revealed that Her expectation is for MDS assessments to be completed correctly as well as to be coded correctly. 08/28/24 at 8:19 AM Review of the facility policy for MDS accuracy revealed there is no policy. Administrator revealed that the facility follows the regulations.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on electronic record review (EHR), staff interviews, and policy review the facility failed to implement a comprehensive care plan when staff left a resident that had a care plan of supervision with meals unsupervised during meals for 1 of 5 residents reviewed (Resident #60). The facility reported a census of 71 residents. Finding include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #60 documented a Brief Interview for Mental Status (BIMS) of 9 which indicated moderate cognitive impairment. Review of Resident #60's Care Plans documented an intervention that Resident #60 could eat independently in the dining room with supervision, after setup. Observation on 8/25/24 at 1:30 PM of Staff G, Certified Nursing Assistant (CNA) delivered Resident #60's lunch tray into her room, opened the styrofoam tray, removed plastic wrap from drinks, and handed Resident #60 utensils. Staff G left the room and closed Resident #60's door. Resident #60 began to eat her pie. On 8/26/24 at 1:45 PM Staff F, CNA stated she dropped off the Covid trays to the Covid positive residents on 8/26/24 at the lunch meal. Staff F stated she dropped off Resident #60's lunch meal. Staff F stated she knocked on Resident #60's door, donned personal protective equipment (PPE), opened Resident #60's styrofoam tray, handed Resident #60 her silverware and drinks. Staff F stated she doffed PPE and completed hand hygiene. Staff F stated she had not sat with Resident #60 through the meal. Staff F stated she shut the door when exiting the room with Resident #60 in the room. Staff F stated she did not know what Resident #60's level of supervision was during meals. Staff F stated she returned to Resident #60's room about 30 minutes later to retrieve the lunch meal tray. On 8/26/24 at 5:30 PM the Director of Nursing (DON) acknowledged Resident #60 had a Care Plan that documented she could eat independently in the dining room with supervision, after setup. The DON stated the facility's expectation was during isolation Resident #60 should have had supervision during her meals. On 8/28/24 at 10:20 AM the Administrator stated the facility does not have a policy on following care plans that was a standard of care.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48004 Based on observation, staff interview, and policy review the facility failed to implement policies and procedures regarding the technical aspect of feeding tubes by not verifying gastrostomy tube (feeding tube) is functioning properly before beginning a feeding for 1 of 1 residents (Resident #7) reviewed. The facility reported a census of 71 residents. Findings include: Review of Resident #7's Minimum Data Set (MDS) dated [DATE] revealed diagnosis of traumatic brain dysfunction, pneumonia, malnutrition, and artificial openings of the gastrointestinal tract. Review of Resident #7's Electronic Health Record (EHR) page titled, Physician's Orders, revealed a physician order dated 1/30/24 documenting to check placement and residual prior to administering medications via Percutaneous Endoscopic Gastrostomy (PEG) tube. Observation 8/27/24 at 12:24 PM Staff C Licensed Practical Nurse (LPN) proceeded to access Resident #7's PEG tube to administer medications. Staff C then administered a flush and medications without checking placement and obtained no residual. Interview 8/27/24 at 12:45 PM Staff C LPN revealed a residual should have been completed. Interview 8/27/24 at 5:04 PM with the Director of Nursing (DON) revealed that her expectation is for residual checks to be completed as ordered, as well as placement to be checked. Review of a facility policy related to enteral feedings revealed there was no policy to review.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 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. Findings include: 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. 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. 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. 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. 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. 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. 48004 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. 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. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 48004 Based on document review, and staff interview the facility failed to ensure a Registered Nurse (RN) was in the facility for eight (8) consecutive hours for 9 of 32 days reviewed (July 28th through August 28th 2024). The facility reported a census of 71 residents. Findings include: Review of untitled documents of the facility's daily staffing schedule provided by the facility revealed there was no RN coverage 7/30/24, 7/31/24, 8/5/24, 8/12/24, 8/14/24, and 8/15/24. These documents further revealed there was only 4 hours of RN coverage 8/19/24, 8/20/24, and 8/21/24. During an interview 8/28/24 at 9:02 AM with Staff A Certified Nurse Aide (CNA) revealed that the facility did not have 8 hour RN coverage every day. Staff A further revealed they cannot count management towards the 8 hours RN coverage, and that the facility did not have enough RN coverage for the schedule. During an interview 8/28/24 at 9:06 AM with the Administrator revealed that the facility did not have 8 hour RN coverage for the days reviewed. The administrator further revealed that the facility does not have a policy for RN staffing 8 hours a day, but the facility does follow the regulations.

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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** 48004 Based on observation, Staff interview, and infection control policy the facility failed to use universal infection control measures and Enhanced Barrier Precautions (EBP) during cares for 2 of 3 residents reviewed for infection control (Residents # 2, and #7). The facility further failed to properly wear proper personal protective equipment (PPE) while caring for 2 of 2 Residents reviewed with a positive Covid diagnosis. (Resident #49 and #60) The facility reported a census of 71 residents. Findings include: 1. 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. Review of Resident#2's Electronic Health Record (EHR) document titled, Physician's orders, revealed a physician order dated 5/29/24 documenting EBP every day and night shift related to risk for Multi-Drug Resistant Organisms (MDRO). Resident#2's Care Plan documented a focus area with initiated date of 8/26/24 as follows; Resident is at risk of MDRO related to catheter and wound, with the intervention for staff to use EBP's. Observation 8/27/24 at 11:24 AM Staff A Certified Nursing Assistant (CNA) completed hand hygiene, and donned gloves. No gown was donned for catheter care. Staff A was observed to not have a gown worn for the entirety of catheter care. 2. Review of Resident #7's Minimum Data Set (MDS) dated [DATE] revealed diagnosis of traumatic brain dysfunction, pneumonia, malnutrition, and artificial openings of the gastrointestinal tract. Review of Resident #7's Electronic Health Record (EHR) page titled, Physician's Orders, revealed a physician order dated 3/29/24 documenting EBP every day and night shift. Observation 8/27/24 at 9:28 AM Staff D Licensed Practical Nurse (LPN) washed hands and donned gloves to place Resident #7's enteral feeding on hold and disconnected the enteral feeding tube. No gown was donned at this time. Staff A CNA and Staff E CNA completed hand hygiene and donned gloves while completing incontinence cares. No gowns were donned by Staff A or Staff E for the entirety of the incontinence cares. Observation 8/27/24 at 12:24 PM Staff C LPN completed hand hygiene and donned gloves to provide enteral medications to Resident #7. No gown was donned for the entirety of the enteral medications. Interview 8/27/24 at 12:45 PM Staff C revealed She should have worn a gown during manipulation of Resident #7's enteral tube. Staff C further revealed her expectation would be for EBP to be completed while incontinence cares, and catheter cares are completed. Interview 8/27/24 at 5:04 PM with the Director of Nursing (DON) revealed that staff should be utilizing gowns as part of the enhanced barrier precautions for residents with caths, and feeding tubes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility provided policy titled, Enhanced Barrier Precautions with an updated date of 5/6/24 documented: a. Enhanced barrier precautions should be worn while completing high-contact resident care activities i.e changing briefs, and device care such as enteral (feeding) tubes. Centers for Disease Control and Prevention website titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), visited 5/28/24 and updated 7/12/22 revealed recent changes included, additional rationale for the use of Enhanced Barrier Precautions (EBP) in nursing homes, including the high prevalence of multidrug-resistant organism (MDRO) colonization among residents in this setting. Expanded residents for whom EBP applies to include any resident with an indwelling medical device or wound (regardless of MDRO colonization or infection status). Expanded MDROs for which EBP applies. Clarified that, in the majority of situations, EBP are to be continued for the duration of a resident's admission. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status and Infection or colonization with an MDRO. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care. 47673 3. The Minimum Data Set (MDS) dated [DATE] for Resident #49 documented a Brief Interview for Mental Status (BIMS) of 12 which indicated moderate cognitive impairment. Review of Resident #49's electronic health records revealed Resident #49 tested positive for Covid 19 on 8/21/24 and started isolation in her room. Review of electronic health records revealed Resident #49 resided in room [ROOM NUMBER]. 4. The Minimum Data Set (MDS) dated [DATE] for Resident #60 documented a Brief Interview for Mental Status (BIMS) of 9 which indicated moderate cognitive impairment. Review of Resident #60's electronic health records revealed Resident #60 tested positive for Covid 19 on 8/21/24 and started isolation in her room. Review of electronic health records revealed Resident #60 resided in room [ROOM NUMBER]. Observation on 8/27/24 at 1:00 PM revealed Staff F, Certified Nursing Assistant (CNA) donned gown, gloves, and mask but no eye protection / face shield. Staff F entered room [ROOM NUMBER] Resident #60s room to supervise the lunch meal. Staff F left room [ROOM NUMBER] at 1:05 PM with PPE on walked down the hall to the shower room, entered the shower room, obtained towels from the shower room, entered room [ROOM NUMBER] Resident #49's room, and left the towels. Staff F then left room [ROOM NUMBER] and returned to room [ROOM NUMBER] and remained in the same PPE throughout this process. On 8/27/24 at 3:00 PM the Director of Nursing (DON) stated she would expect eye protection to be worn when required with transmission based precautions. The DON acknowledged that both Resident #49 and Resident #60 were in isolation at that time related to a positive Covid diagnosis.