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	07/31/2025

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and the Resident Assessment Instrument (RAI) Manual the facility failed to accurately complete a Minimum Data Set (MDS) assessment for four of twenty-three residents reviewed (Residents #1, #3, #6 and #32). The facility reported a census of 70 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #3 had a diagnosis of coronary artery disease. The MDS documented the resident took an anticoagulant. The Electronic Health Record (EHR)revealed that Resident #3 had diagnoses of Aortocoronary bypass graft (heart arteries blocked or narrowed) and old myocardial infarction (heart attack). The Care Plan revised 4/12/24 revealed Resident #3 had a risk of abnormal bleeding related to routine use of hematological agents (drugs used to treat disorders of the blood). The Care Plan directed staff to administer medications as ordered and monitor for side effects. The EHR revealed Clopidogrel Bisulfate (Plavix) (an antiplatelet) 75 MG (milligrams) one time a day for an old myocardial infarction (heart attack) and presence of aortocoronary bypass graft (CABG) started on 1/13/21. The EHR lacked documentation that the resident had taken an anticoagulant medication. 2. The Quarterly MDS assessment dated [DATE] revealed that Resident #6 had a diagnosis of viral hepatitis. The MDS documented that this was an active diagnosis in the last 7 days. The Annual MDS dated [DATE] indicated that Resident #6 had diagnoses of anxiety, depression, bipolar disorder and schizophrenia in the last 7 days. It also indicated that there was not a Level II PASRR (Pre-admission Screening and Record Review) in place. The Electronic Medical Diagnosis List revealed that Resident #6 had a diagnosis of acute hepatitis without hepatic coma dated 1/19/23. It also indicated a Level I PASRR on 5/9/23 with a Level II PASRR approval for nursing level of care. Finally, it indicated a Level I positive indicating no status change and that the previous Level II PASRR findings remains valid. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The MDS assessment dated [DATE] revealed Resident #1 had diagnoses of a fracture. The MDS documented the resident took an anticoagulant (AC). The Care Plan revised 4/11/25 revealed Resident #1 had altered cardiovascular (heart and blood vessels) status and had a risk of abnormal bleeding related to routine use of hematological agents. The Care Plan directed staff to administer medications as ordered and monitor for side effects. The Electronic Physician’s Orders revealed Clopidogrel Bisulfate (Plavix) (an antiplatelet) 75 MG once a day for a blood thinner related to hypertension (high blood pressure). The Physician's Orders lacked documentation that the resident had taken an anticoagulant medication. 4. The MDS assessment dated [DATE] revealed Resident #32 had diagnoses of cerebrovascular accident (CVA) (stroke), quadriplegia, coronary artery disease, and viral hepatitis. The MDS documented the resident took an AC. The Care Plan revised 12/16/24 revealed Resident #32 had a risk of abnormal bleeding related to routine use of hematological agents. The Care Plan directed staff to administer medications as ordered and monitor for side effects. The Electronic Physician’s Orders revealed Clopidogrel Bisulfate 75 MG once a day for cerebral infarction (death of brain tissue) started on 11/12/24. the Physician's Orders lacked documentation that the resident took an anti-coagulant. The EHR Medical Diagnoses List revealed the resident had a diagnosis of chronic viral hepatitis C was added on 11/11/24. In an interview on 7/31/25 at 2:20 PM, Staff J, MDS Coordinator, reported she had worked in the MDS role since 12/1/24. She used the RAI Manual to reference how to fill out the resident’s MDS assessment. She did a look-back of 7 days and reviewed the resident's records, looked at the staff’s coding for section GG, and talked to the staff to gather information for completion of MDS assessments. Staff J reported she also used a “cheat sheet” for completion of the MDS. Staff J reported she looked at the order summary to see if a resident received medication such as an AC. Staff J stated that Plavix would be coded as an AC but aspirin would not be coded as an AC because aspirin was an antiplatelet. At the time, Staff J looked up a list of medications and the drug classification and reported Plavix was listed as an antiplatelet. Staff J acknowledged she did not know this. Staff J also responded she did not know the answer to when viral hepatitis would be marked under the diagnoses section. She presumed if the diagnoses was within 3 months, she would mark the viral hepatitis diagnosis under the diagnoses section. Staff J reported she looked at the current PASRR to determine if a resident had a Level II condition. She marked yes in the section about PASRR if the resident’s PASRR had listed a Level II condition. A medication drug classification list revealed Clopidogrel was a antiplatelet. The RAI Manual version 3.0 revealed there are two look-back periods for Section I, diagnosis list. Viral hepatitis would be coded as an active diagnoses if there was a physician-documenteddiagnoses in the last 60 days that had a direct relationship to the resident’s current functional status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Code antiplatelet medication such as clopidogrel if the resident took the medication at any time during the 7-day observation period.

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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** Based on clinical record review, staff interview, and policy review the facility failed to develop a comprehensive care plan that included focus, goals, or interventions for 2 out 5 residents reviewed (Resident #5, #23). The facility reported a census of 70 residents. Findings include: 1. Review of Resident #5's Quarterly Minimum Data Set (MDS) dated [DATE] documented an admission date to the facility of 9/5/13. The MDS also documented a Brief Interview for Mental Status (BIMS) of 03 which indicated severe cognitive impairment. The MDS listed a diagnosis of Non-Alzheimer's dementia. Review of Resident #5's Electronic Health Record (EHR) document titled Care Plan last review completed date of 6/27/25 revealed no documentation of dementia diagnosis with a focus area, goals, or interventions. 2. Review of Resident #23's Quarterly MDS dated [DATE] documented an admission date to the facility of 6/8/23. The MDS listed active diagnoses of Urinary Tract Infection (UTI) (last 30 days). Review of Resident #23's Electronic Health Record (EHR) document titled Care Plan last reviewed date of 6/27/25 revealed no documentation of UTI diagnosis with a focus area, goals, or interventions. A review of the EHR revealed Resident #23's physician visited on 7/25/25 and documented a history of repeated UTIs as a present illness. The Progress Notes for Resident #23 documented Nurse's note on 6/20/25 physician ordered Cephalexin 500 milligrams by mouth twice a day for 7 days (antibiotic). The Progress Notes for Resident #23 documented a recent history of UTIs on 4/14/25 and 2/25/25 with a course of antibiotics each occurrence. In an interview on 07/31/2025 at 2:06 pm the Director of Nursing (DON) stated her expectations for the Care Plan to be accurate, reflect health conditions and to include diagnosis of dementia for Resident #5 and UTI for Resident #23 and interventions.The facility provided policy titled Comprehensive Care Plans updated April 2025 documented: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives andtimeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professionalstandards of quality.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, observation, staff interview, and policy review, the facility failed to ensure staff appropriately completed a resident assessment and provide timely intervention for two residents. One resident with Lower Extremity (LE) wraps for 1 of 1 resident reviewed for edema (Resident #55) and one resident with Chronic Obstructive Pulmonary Disease (COPD) for 1 of 2 residents reviewed for oxygen (Resident #62). The facility reported a census of 70.Findings include:1. The Quarterly Minimum Data Set (MDS) for resident #55, dated 7/24/25, indicated diagnoses of hypertension, diabetes mellitus, and cerebral vascular accident.The Electronic Health Record (EHR) indicated that resident additional diagnoses of chronic peripheral venous insufficiency, localized edema and lymphedema.The EHR indicated and an active order from the primary physician for Lymphedema wraps to be worn 24 hours a day/seven days a week (24/7) and therapy to change starting 4/7/2025. The EHR also indicated that this order was discontinued 7/31/25 with a new order for compression stocking on in the morning and off at bedtime. May use ace wraps until ordered compression stocking arrive.The EHR lacked documentation of wraps being on or off from discharge from therapy 7/11/25 until 7/29/2025. The EHR also lacks notification of therapy about concerns with wraps being off with active order for wraps 24/7.The Care Plan for Resident #55, initiated on 3/25/25, indicated to follow Medical Doctor (MD) orders for compression wraps. It also indicated on 6/27/25 that Resident #55 is Non-Compliant with lymphedema wear as he removes the wraps on his own. The Care Plan lacks interventions and directions for noncompliance.In an observation 07/28/2025 at 2:36 PM, Resident #55 was noted to have bilateral swollen Lower Extremities (LE). There were 2 signs on the wall in the room, on said keep wraps on for 24 hours and to cover them when he gets his showers. The other sign said to please put ted hose on every morning. No wraps or ted hose noted to bilateral lower extremities. Right foot elevated on stool while left leg resting on the floor.In an observation 07/29/2025 at 10:49 AM, Resident #55 was resting in his chair with cover over his head. Had right foot elevated on stool but left remained on the floor. No wraps or [NAME] Hose were on lower extremities.In an observation 07/29/2025 at 3:34 PM, Resident #55 was sitting in his chair with both legs on the ground and no wraps noted to bilateral LE.In an observation 07/31/2025 at 8:08 AM, Resident #55 was sitting in his chair without wraps to bilateral LE.In an interview 07/29/2025 at 1:00 PM, Staff A, Registered Nurse (RN) stated wraps for Resident #55 done by Staff C, Occupational Therapist (OT) 2-3 times weekly. Sometimes she takes off and leaves off for a while but currently supposed to be on 24/7. Not sure of where documentation is kept about putting on wraps. States Resident #55 takes off sometimes. If he does, they put in the hot chart notes and notify therapy. Did not know where ted hose documentation was kept prior to the wraps. Staff A, RN then checked Resident #55 in the dining room noting lack of wraps. Stated he was going to notify therapy and the DON.In an interview 07/29/2025 at1:23 PM, Staff A, RN stated that OT here Tuesdays and Fridays but has not seen her today. Stated the Director of Nursing (DON) was texting Staff B, OT to see when Staff C, OT will be here next. Added that both can do the wraps.In an interview 07/29/2025 at 3:35 PM, Staff A, RN stated he did not here back from OT or the DON.In an interview 07/30/2025 at 1:00 PM, Staff C, OT stated she discharged Resident #55 on 7/11/25 with recommendation for compression socks 24/7 size 4XLg with 10-30 millimeters of mercury (mmHg). Stated she is no longer wrapping his legs. States she was not contacted on 7/29/25 about wraps not being put on but maybe they talked to the manager. Stated that about 2 weeks ago she saw that he was not wearing his socks and she could not find them. Maybe they were in the laundry. Stated when Resident #55 was getting wraps he would take them off until she educated him and then he kept then off until she discharged him. Stated it is her fault as she did not put in a note to the nursing staff. Stated she could order new compression socks but has concerns that the size would be different now. States would probably readmit and wrap for a while again before going back to compression socks. Stated is aware edema is back up.In an interview 07/30/2025 at 2:00 PM, Staff F, Certified Nurses Aid (CNA) stated she is not aware of the wraps and to speak with Staff C, OT. Stated pocket care plan still says lymphedema wraps and she reports to the nurse when they are not on.In an interview 07/30/2025 at 2:23 PM, Staff A, RN stated that after talking with the DON 7/29/25, he took down the sign about ted hose. When questioned about what the DON stated on 7/29/25 Staff A, RN stated the DON stated she is aware that he is noncompliant but would contact therapy. He stated he was not aware that Resident #55 was discharged from therapy with compression socks. Stated that maybe they didn't get a communication about it.In an interview 07/30/2025 at 2:37 PM, with the DON and Staff G, Regional Corporate Nurse, the DON stated that the process for therapy recommendations is

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on clinical record review, resident and staff interviews, and policy review, the facility failed to perform proper transfer method as outlined in the Care Plan which contributed to a femur fracture which resulted in the need for surgical intervention for 1 of 4 residents reviewed for transfers (Resident #45). The facility reported a census of 70. Findings include: The Quarterly Minimum Data Set (MDS) Assessment completed on 6/12/25 revealed Resident #45 with a Brief Interview Mental Status score of 14, which indicated intact cognition. Diagnoses listed on the MDS include paraplegia, anxiety disorder, diabetes, and orthostatic hypotension (low blood pressure). The MDS noted the presence of a urinary catheter and a colostomy. Resident #45 is dependent on staff for chair/bed-to-chair transfers, toilet transfers, and tub/shower transfers. The Care Plan with initiated date of 6/20/24 identified Resident #45 with an Activities of Daily Living self-care performance deficit related to paraplegia, limited mobility, limited range of motion (ROM), and pain. Interventions include the use of a mechanical lift with an assist of 2 staff members for transfers. The Restorative Nursing Program sheet for Resident #45, dated 1/23/25 and created by the attending Physical Therapist, outlined staff assistance of 1-2 for bed mobility and the use of a mechanical lift (Hoyer) for transfers with an assist of 2 staff members. The late entry Progress Note dated 7/8/25, created on 7/17/25, revealed Staff E, Licensed Practical Nurse, was notified by the Restorative Aide (RA) staff that Resident #45 had bumped their foot while RA staff had the resident in the shower chair. Staff E assessed and noted scabbing to both of Resident #45's feet. One toe on the right foot had a scab that had partially been removed and was no longer intact. One of the RAs had cleansed the toe and the scab came off. No open areas noted to toes or injuries to report The Progress Noted dated 7/15/25 at 2:54 PM documented a phone order from the Nurse Practitioner (ARNP) for right hip x-rays.The Progress Noted dated 7/15/25 at 5:34 PM documented x-ray results received and the Primary Care Provider was called. Orders received to send Resident #45 to the emergency room for a broken right femur (thigh bone). The Progress Note/Incident Note dated 7/17/25 at 1:14 PM documented Staff E was alerted by another nurse and RA staff that Resident #45's right leg was bending in a weird spot while performing ROM exercises. Staff E and the Director of Nursing (DON) both assess the resident. It was noted the right knee cap was turned inward when raised and there was a slight bend to the mid-thigh. Staff E called the doctor and a stat portable x-ray order was obtained. The facility document titled Self-Report revealed Staff K, RA, and Staff L, Certified Nurses Aide (CNA), had performed a stand-pivot transfer (way of moving from one surface to another by bearing weight on legs, standing up, turning, and then sitting down on a different surface) with Resident #45 in the shower room on 7/8/25. The DON and Facility Administrator interviewed Staff K who acknowledged the stand-pivot transfer from the wheelchair to the shower bench as Resident #45 had agreed. Staff K noted Resident #45 did not injure their right lower leg and appeared anxious due to left toe bleeding and not liking the shower bench. Staff K reported the stand-pivot transfer was utilized instead of the mechanical lift as they believed as RAs had leeway and could transfer residents during restorative tasks which were not in line with the Care Plan. The Self Report document also noted an interview with Staff L, CNA who acknowledged the completion of the stand-pivot transfer from a wheelchair to the shower bench and then again from the shower bench to a wheelchair. Staff L noted a scab on Resident #45's left toe had reopened further during the transfer. A facility fax received on 7/17/25, the Nurse Practitioner documented the following: Resident #45's x-ray indicated osteoporosis which increases the risk of fractureFractures did not appear spontaneous or pathologic purely due to osteoporosisA mild twisting of joints or other trauma could have resulted in these fracturesOriginal trauma unknown to this Nurse Practitioner The facility document titled Staff Interview Questions were completed by various staff and revealed the following: Staff O, Certified Medication Aide (CMA) reported they had not observed Resident #45 hitting their leg on a mechanical lift (Hoyer) or side table or rolling onto objectsStaff P, CNA, reported they had not observed Resident #45 hitting their leg on a mechanical lift (Hoyer) or side table or rolling onto objectsStaff Q, CNA, reported Resident #45 told them the RAs transferred and scratched her right footStaff R, CNA, reported Resident #45 told them they were hurt during a pivot transfer provided by the RA staffStaff S, CNA, reported they had not observed Resident #45 hitting their leg on a mechanical lift (Hoyer) or side table or rolling onto objectsDuring an interview on 7/28/25 at 11:30 AM, Resident #45 acknowledged the stand-pivot transfer performed on 7/8/25. Resident #45 reported they typically take bed baths but due to an outside appointment that day, agreed to a shower. Resident #45 explained the RA staff used a mechanical lift to transfer them from the bed to a wheelchair. Once in the

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff interview, and policy review, the facility failed to ensure staff secured and placed a resident's catheter bag below the level of the bladder to minimize the risk of cross-contamination and the risk of acquiring a urinary tract infection for one of two residents observed with a catheter (Residents #1). The facility reported a census of 70 residents.Findings include: The Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had diagnoses of renal (kidney) insufficiency, obstructive uropathy (obstructed urine flow), and diabetes. The MDS indicated the resident had an indwelling catheter. The Care Plan revised 5/21/25 revealed Resident #1 had a suprapubic catheter and at risk for a MDRO (multi-drug resistant organism). The Care Plan directed staff to position the catheter bag and tubing below the level of the bladder. Observations revealed the following: a. On 7/28/25 at 11:30 AM, Resident #1 sat in a wheelchair with a catheter bag lying on the floor under the wheelchair. The catheter bag had yellow urine in the bag. At the time, Resident #1 reported she had a UTI (urinary tract infection) in the past. b. On 7/28/25 at 11:50 AM, Resident #1 hollered out as the surveyor walked by her room. Resident #1 reported she was trying to get to her call light so she could turn it on but she kept running over her catheter with the wheelchair. Resident #1 stated she didn't want to pull the catheter out.c. On 7/29/25 at 10:40 AM, Resident #1 [NAME] in bed on her back. The catheter bag hung on a storage bin near the bed above the level of the resident's bladder. The catheter bag had no urine inside. In an interview 7/31/25 at 10:50 AM, the Director of Nursing reported the urinary catheter should be hung and positioned below the level of the bladder in order for the urine to drain properly. The Facility's Catheter Competency updated 5/11/21 revealed the urine collection bag must be kept below the level of the bladder at all times.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff interview, manufacturer's instructions, and competency review the facility failed to administer insulin according to the physician's orders and per manufacturer instructions to ensure the proper amount of insulin administered for one of two residents observed who received insulin during medication pass (Resident #1). The facility reported a census of 70 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had diagnosis of diabetes and diabetic neuropathy (nerve damage caused by diabetes, often affecting the legs and feet due to high blood sugar level). The MDS documented the resident took insulin 7 of 7 days during the look-back period.The Care Plan initiated 5/3/24 revealed Resident #1 at risk for altered blood glucose levels related to diabetes and took insulin. The Care Plan directed staff to administer medications as ordered. The Medication Administration Record for Resident # 1 listed Novolog insulin flexpen 3 units subcutaneously (SQ) administered on 7/29/25 for the mid-morning dose by Staff E, Licensed Practical Nurse (LPN). During observation on 7/29/25 at 11:54 AM, Staff E, LPN, reported she had to use a new insulin pen for Resident #1. Staff E labeled and dated the Novolog insulin flexpen. Staff E attached a needle on the end of the insulin pen and turned the dial on the pen to 2. Staff E held the pen horizontally and pushed the button on the end of the pen. Staff E then turned the dial to 3. Staff E donned a pair of gloves. Staff E then inserted the needle into the resident's left lower abdomen, pushed the button on the end of the insulin flexpen and removed the needle/pen from the injection site within 1-2 seconds. Staff E removed and discarded the needle, then removed her gloves. In a facility's Competency for Insulin Pen Use updated 11/23/21 revealed to prime the insulin pen and waste 2 units prior to each use. Clean the injection site and administer the insulin by pressing injection and slowly counting to 10. According to the Novolog Manufacturer instructions revised 2/2023 revealed the following procedural steps for Novolog insulin injection 100 units/ ml flexpen: a. Attach the needle onto the pen. b. Pull off the outer needle cap. c. Turn the dose selector to 2 units. d. Hold the pen with the needle pointing up. Tap the top of the pen gently a few times to let air bubbles rise to the top. e. Press and hold the dose button in until the dose counter shows 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure up to 6 times. It is important to prime the pen before each injection to avoid injecting air and to ensure proper dosing of insulin administered. If you do not prime before each injection, you may get too much or too little insulin. f. Turn the dose selector to the number of units needed for injection. To give the injection: a. Insert the needle into the skin. b. Press the push button all the way in until the dose counter shows 0. c. Keep the needle in the skin for at least 6 seconds and keep the push button pressed all of the way in until the needle has been pulled out from the skin to ensure the full dose given. In an interview 7/31/25 at 10:50 AM, the Director of Nursing (DON) reported the manner of how to utilize an insulin pen. The DON reported attach the needle onto the insulin pen, turn the dial to 2 to prime the needle, then set the dial to the desired dose to administer the insulin. The DON stated the reason the insulin pen needed to be primed was to make sure the full dose got administered.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on the Center for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report (January 1st to March 31st) review, facility staffing reports review, and staff interviews, the facility failed to submit accurate staff reports for the PBJ Staffing Data Report. The facility reported a census of 70 residents.Findings include:The PBJ Staffing Data Report run date of 724/25 triggered for excessively low weekend staffing for the fiscal year 2nd quarter, January 1st to March 31st, 2025. In an interview with the Administrator on 7/30/25 at 8:30 am she stated the facility was not understaffed on weekends and the PBJ data submission did not include staffing agency staff that worked on weekends. The Regional Director on 7/31/25 at 1:15 pm submitted a PBJ report via email displaying the report showed no concerns. He was advised to call the help line to correct the issue with the CMS's PBJ reporting excessively low weekend staffing for the fiscal year 2nd quarter.

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	07/31/2025

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 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** Based on record review, observation, staff interview, and policy review the facility failed to ensure staff properly disinfected resident care devices such as a glucometer machine and a stethoscope after resident use for 1 of 2 residents observed for a blood sugar check (Resident #40) and 1 of 2 residents observed for a gastrostomy (g-tube) tube (Resident #7). The facility staff also failed to follow infection control practices in order to prevent and control the onset and spread of infection within the facility by not removing soiled gloves for 1 of 2 units. The facility reported a census of 70 residents.Findings include:1.The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had diagnoses of pneumonia. The MDS indicated the resident took an antibiotic. The Care Plan revised 2/19/25 revealed the resident had a tube feeding related to swallowing problem and at risk for MDRO related to an indwelling PEG (gastrostomy) (a tube in the stomach) tube. The Care Plan directed staff to use enhanced barrier precautions. During observation on 7/29/25 at 11:05 AM, Staff E, Licensed Practical Nurse (LPN) donned a yellow gown and gloves. Staff E used a stethoscope to check placement of Resident #7's g-tube (gastrostomy). Staff E laid the stethoscope on top of the blanket covering the resident in the bed. Staff E then administered water flushes and medication through the resident's g-tube. At 11:14 AM, Staff E changed her gloves, then picked the stethoscope up off the bed and draped the stethoscope over the back of her neck and against her uniform. Staff E bagged up the trash in the room, opened the door to the room with her gloved hand, and took the bag of trash to a red barrel in the hallway. Staff I, Registered Nurse (RN) stood in the room and observed Staff E with the surveyor in the room. In an interview 7/31/25 at 11:50 AM, the Director of Nursing (DON) reported she expected staff changed gloves whenever they went from a dirty to a clean area and in-between hand hygiene. A facility's Equipment Cleaning/Disinfecting updated 11/13/24 revealed multiple use items cleaned and disinfected between each resident use. 2.During observation on 7/30/25 at 7:28 AM, Staff J, Registered Nurse (RN) checked resident #40's blood sugar. Staff J took an alcohol swab and cleansed the surface of the blood sugar machine for less than 5 seconds, and placed the machine in the top drawer of the medication cart.In an interview 7/31/25 at 10:50 AM, the DON reported the glucometer machine was used on multiple residents. The DON stated she expected staff to disinfect the glucometer machine with the purple disinfectant wipes after each use. A facility's Competency for Cleaning of Glucometers updated 5/11/21 revealed the glucometer disinfected with a sanitizing wipe per the manufacturer's recommended cleaning and drying time. The purple top (Super Sani-cloth) disinfectant wipes revealed the environmental surface or equipment needs to remain wet for 2 minutes for proper disinfection.