STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165270	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stratford Specialty Care	1200 Highway 175 East Stratford, IA 50249

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review, staff interviews and review of Medicare guidelines, the facility failed to provide a Skilled Nursing Facility Advance Beneficiary Notice of Non Coverage (SNFABN) form for 2 of 2 residents (Resident #33 and #27) whose skilled stay ended and they continued to reside in the facility. The facility reported a census of 36 residents. Findings include: 1. Resident #33's Minimum Data Set `MDS` assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 00, which indicated severely impaired cognition. The MDS included diagnoses of hypertension, cerebrovascular accident (CVA), aphasia (difficulty speaking) and dysphagia (difficulty swallowing). The MDS documented Resident #33 used a feeding tube while a resident in the last 7 days. The Clinical Census revealed Resident #33 was admitted to the facility for a Medicare Part A skilled stay on 10/4/24, was discharged from Medicare on 1/6/25 and remained in the facility private pay. The Clinical record lacked documentation a SNFABN form was given to Resident #33 or a resident representative when Resident #33 was discharged from Medicare Part A to private pay. 2. Resident #27's Minimum Data Set `MDS` assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 5, which indicated severely impaired cognition. The MDS included diagnoses of pneumonia, urinary tract infection, depression, coronary artery disease and hypertension. The Clinical Census revealed Resident #29 was admitted to the facility for a Medicare Part A skilled stay on 3/7/25, was discharged from Medicare on 4/3/25 and remained in the facility private pay. The Clinical record lacked documentation a SNFABN form was given to Resident #33 or a resident representative when Resident #27 was discharged from Medicare Part A to private pay. On 5/19/25 at 12:59 PM, the Administrator reported she could not locate a SNF ABN Form CMS 1055 for Resident #33 or Resident #27 when they were discharged from Medicare Part A and remained in the facility. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/25 at 2:22 PM, the Administrator reported it was an expectation for the SNF ABN Form CMS 105 to be completed when a resident was discharged from Medicare Part A and remained in the facility. The facility policy titled Medicare Advanced Beneficiary Notice dated April 221 documented it was the facility policy to inform residents in advance when changes will occur to their bills. The policy directed that if the admission coordinator or business office manager believed that Medicare would not pay for an otherwise covered skilled service, the resident or representative would be notified in writing why the service may not be covered and the resident's potential liability for payment of the non covered service. The facility issues the Skilled Nursing Facility Advance Beneficiary Notice of Non Coverage CMS 105 to the resident prior to providing care that Medicare usually covers, but may not pay for because the care was considered not medically reasonable and necessary, or custodial. The resident or representative may choose to continue receiving the skilled services that may not be covered, and assume financial responsibility.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on observation, clinical record review, staff interviews and policy review, the facility failed to complete and document appropriate assessments and interventions for the necessary care and services, to maintain the residents' highest practical physical well being for 1 of 1 residents reviewed (Resident #13). The facility failed to immediately assess Resident #13 after she was lowered to the floor and scraped her back on the wheelchair. Findings include: Resident #13's Minimum Data Set `MDS` assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS indicated Resident #13 required substantial/maximal assistance with bed mobility, transfers and ambulation. The MDS included diagnoses of hypertension (high blood pressure), viral hepatitis (infection affection the liver), diabetes mellitus, bipolar disorder and anxiety disorder. The MDS revealed Resident #13 had 2 or more falls without injury since the last assessment. On 5/18/25 at 2:43 PM, Resident #13 reported she fell all the time. She said her legs didn't work and she kept trying. She reported she last fell about a week ago. She said 2 staff members need to help her transfer and she only had 1 staff member. She reported the staff member dropped her. She added she wouldn't fall if the staff member had more help. She explained she scratched her back on the wheelchair, but the scratch didn't hurt. The Incident Report (IR) dated 5/15/25 at 8:10 PM documented a staff member was assisting Resident #13 with peri care after toileting and asked Resident #13 to sit back down so she could get assistance to help with the transfer. The IR documented Resident #13 was impatient and attempted to transfer herself back into the wheelchair, misjudged the distance and staff had to assist Resident #13 to the floor to prevent falling. The IR documented an injury post incident that included an abrasion of the vertebrae. A Progress Note dated 5/16/25 at 5:48 AM revealed Resident #13 was assisted to the floor to prevent falling. The progress note documented Resident #13 was assessed but the note lacked any documentation or an assessment regarding an abrasion to Resident #13's back. A facility form titled Wound Evaluation dated 5/16/25 at 10:15 PM documented Resident #13 had an abrasion to the spine that measured 6 cm (centimeters)(width) x 18.39 cm (length). The form documented that the area occurred on 5/15/25. A Progress Note titled Communication with Physician dated 5/17/25 at 2:39 AM documented on 5/16/25 nurse was notified that Resident #13 received skin area to back during the 5/15/25 incident. The note documented the nurse assessment skin head to toe and noted an abrasion/scratch and bruise to Resident #13's back. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/25 at 10:28 AM, Staff A, CNA (Certified Nursing Assistant) reported she was going down the hallway and Resident #13 roommate came out of the room without her pants on and told her that Resident #13 needed help. She said she went into the room and Resident #13 had transferred herself onto the toilet. She said there was bowel movement (BM) everywhere on the floor all the way to the bathroom. She reported she cleaned up the floor and then proceed to help Resident #13. Staff A said Resident #13 reported she had transferred herself from the wheelchair to the toilet but she thought Resident #13 may have ambulated to the toilet because of all the BM on the floor. She said she put a gait belt on Resident #13 and stood her up to clean up her bottom and then had her sit back down on the toilet. She said Resident #13 required assistance of 2 for transfers so she stepped out of the bathroom, went to check the room number on the outside door and walkie for assistance. She said she was gone maybe a minute and when she went back into the room, she saw Resident #13 was already transferring herself from the toilet and her knees were buckling. She said the gait belt was still in place and she tried to assist Resident #13 but could not get her back into the wheelchair so she lowered her to the floor. She said Resident #13 had scraped her back on the wheelchair and there were two small skin tears that were bleeding a little bit so she knew the nurse would need to take pictures. She said she found the nurse passing medications in the center hall. She said the nurse did not come to Resident #13's room for at least 30-40 minutes. She said the nurse finished passing medications in the center hallway and the right hall before she came to assess Resident #13. Staff A reported she kept trying to walkie for the nurse but the nurse's walkie talkie was dead. She said after waiting 15-20 minutes for the nurse to come and assess Resident #13 and she did not come so herself and two other aides got Resident #13 off the floor and into her wheelchair. She said one staff member stayed with Resident #13 until the nurse came and the other two staff members went to lay other residents down. When asked how she knew how long it took for the nurse to come she said she knew it was a long time as the staff was able to lay down several residents while waiting for the nurse to come. She said after the nurse came and assessed Resident #13, she left her in the wheelchair and did not tell the staff and Resident #13 tried to self-transfer again. She reported she had tried to call the DON (Director of Nursing) regarding the nurse but the DON did not answer. On 5/20/25 at 3:45 PM, Staff B, CNA reported Resident #13's call light had been on and she had transferred herself to the toilet and then was lowered to the floor. She said the aide who lowered her to the floor used the walkie talkie for help. She said the nurse's walkie was on but was not sure where the walkie was located. She said she did not know if the walkie talkie was with the nurse or at the nurses' station. She said the staff used the walkie talkie multiple times asking the nurse to come and also went in person and told the nurse Resident #13 was on the floor. Staff B reported the nurse said she was coming. She said the nurse was at the table in the living room with her lap tap. She said they waited about 10 minutes before herself and two other aides got Resident #13 off the floor. She said she was not going to leave Resident #13 sitting on the floor. She said they lifted her with a gait belt into the wheelchair. She said they left Resident #13 in her wheelchair for a while for the nurse to check her out. She said they put Resident #13 to bed right before 10 PM and that she was the last one to go to bed. She said she did not witness the nurse going into the room. She said the nurse could have and she was not aware of it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/25 at 9:57 PM, Staff C, RN (Registered Nurse) reported on the evening of 5/15/25, she was down the center hall passing medications. She said Staff A, CNA approached her and told her that Resident #13 had taken herself to the BR, had a BM and Staff A had cleaned her up on the toilet. Staff C said Staff A told her that she had gone to check the room number and call for assistance. She said in the meantime Resident #13 decided to self-transfer from the toilet to the wheelchair and Staff A saw that Resident #13 was not going to make it so she assisted Resident #13 by lowering her to the floor to prevent a fall. Staff C reported she was in the middle of passing medication along with giving insulin and she did not want to make a medication error so she finished up with that resident before going to Resident #13's room. She acknowledged and reported that there was a delay in response. She said she made the decision based on the facts that she knew Resident #13 was lowered to the floor, did not actually fall and had not hit her head. She reported when she completed the medications for the one resident, she secured her lap top and med cart and went to Resident #13's room. She said by then there was a 2nd staff member present (Staff B) and the staff had gotten Resident #13 up off the floor and into the wheelchair. She verified Resident #13 had not been assessed before she was moved off the floor. When asked how much time had passed from when she was first told Resident #13 was on the floor by the time she got to the room, she said she did not feel like it was longer than 10 minutes. She said she assessed Resident #13 which included her vital signs and range of motion. She reported she had been notified Resident #13 had an injury on her back. She said she did not look at her lower back at that time. She said she was going to go back when Resident #13 was in bed to look at her back and she did not. She stated she had forgotten and got busy. She said the next day the day shift nurse evaluated Resident #13's back. On 5/21/25 at 11:15 AM, the DON reported she would expect the nurse to complete a nursing assessment before the resident was assisted off the floor. In addition, the DON reported she would expect the nurse to assess Resident #13 back after the fall. The DON said she had identified Resident #13 did not have an assessment completed of her back until the following day. She acknowledged when a staff member lowers a resident to the floor that it was still considered fall and the staff would complete the required fall documentation. The DON reported she was aware and acknowledged there had been a delay in the nurse assessing Resident #13 after a fall. She said she expected the nurse to stop the medication pass and assess the resident after the fall. She said she was in the process of completing a write up for the nurse and would provide the surveyor with a copy. A facility form titled Corrective Action Form dated 5/21/25 documented Resident #13 had a witnessed fall on 5/15/25 in which she was lowered to the floor by Staff A. The form documented that it was reported Staff C did not respond to the fall to complete an assessment timely on 5/20/25 to the DON. The form documented Resident #13 was found to have an abrasion to her spine on 5/16/25 by the day shift nurse. The form revealed the corrective action documented, it was an expectation that Staff C do a full head to toe assessment including skin checks and vital on any resident that has a fall prior to the resident being moved from the position they are in. In addition, if Staff C was completing the medication pass, it was an expectation that Staff C stop what she was doing and attend to the resident. The facility policy titled Change of Condition/Hot Chart Protocol dated January 2015 documented the purpose of the policy was to provide care to residents through nursing assessment, interventions and appropriate follow up. The policy documented a change in condition was an alteration from normal status with could include but not limited to an accident, incidents with or without injury, and skin changes.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on observations, interviews, facility policy review, and record review, the facility failed to ensure the safety of 2 residents reviewed (Residents #13 and #14) for safety and nursing supervision. After Resident #13 took themselves to the bathroom, the staff failed to use the required staff to assisted them after they found them on the toilet. In addition, the staff member left Resident #13 in the bathroom alone. This allowed Resident #13 to get up from the toilet to attempt to self-transfer. The staff member intercepted Resident #13 and lowered her to the floor as her knees gave out. With Resident #14, when they fell the facility failed to put an intervention in place to prevent future falls. The facility reported a census of 36 residents. Findings include: Resident #13's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS indicated Resident #13 required substantial/maximal assistance with bed mobility, transfers and ambulation. The MDS included diagnoses of hypertension (high blood pressure), viral hepatitis (infection affection the liver), diabetes mellitus, bipolar disorder and anxiety disorder. The MDS revealed Resident #13 had 2 or more falls without injury since the last assessment. On 5/18/25 at 2:43 PM, Resident #13 reported she fell all the time. She said her legs didn't work and she kept trying. She reported she last fell about a week ago. She said 2 staff members need to help her transfer and she only had 1 staff member. She reported the staff member dropped her. She added she wouldn't fall if the staff member had more help. She explained she scratched her back on the wheelchair, but the scratch didn't hurt. The Incident Report (IR) dated 5/15/25 at 8:10 PM documented a staff member assisted Resident #13 with peri-care after helping her with using the toilet. The staff member asked Resident #13 to sit back down so she could get assistance to help her transfer. The IR documented Resident #13 as impatient and she attempted to transfer herself back into the wheelchair, misjudged the distance, and the staff member assisted Resident #13 to the floor to prevent falling. The IR documented an injury post incident included an abrasion of the vertebrae. The Incident, Accident, Unusual Occurrence Note dated 5/16/25 at 5:48 AM indicated the staff member provided care to Resident #13, then had her sit on the toilet. After she sat on the toilet, the staff member went to get help to transfer her. While the staff member remained out of the bathroom, Resident #13 became impatient and attempted to transfer self-back into her wheelchair (w/c), she misjudged the distance, and the staff assist her to the floor to prevent her falling. Resident #13 reported she had to go to the bathroom and didn't want to poop her pants. The COMMUNICATION with Physician Note dated 5/17/25 at 2:39 AM reflected on 5/16/25 the staff notified the nurse that Resident #13 received skin area to her back during the incident on 5/15/25. The Fall Risk Evaluation completed on 5/15/25 identified a score of 13, a total score of 10 or above represented a high risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The CNA Kardex reviewed 5/20/25 at 9:01 AM indicated Resident #13 required 2 staff and a standing mechanical lift for all transfers, toilet use, and listed as non-ambulatory. The Kardex included the following safety interventions: a. She had a one way slide in her wheelchair. b. Resident #13 had a sign on her refrigerator to call for assistance when she wanted a snack. c. Place body pillow next to Resident #13 after assisting her to bed for boundary identification. d. Sign in room to call for assistance to get out of bed. e. Staff to stay with Resident #13 while in the restroom. f. She had a bolster mattress on her bed to assist me with boundary identification. g. Resident #13 had T bars (a bar used for bed mobility) placed on bilateral sides of bed to assist with mobility. h. Place Resident #13's bed in lowest position while in bed. The Care Plan Focus revised 3/17/25 identified Resident #13 had actual falls. The Interventions dated 5/16/25 included Resident #13 had a one way slide in her wheelchair. The Care Plan Focus dated 8/15/24 reflected Resident #13's activities of daily living (ADL's). The Interventions directed the following: a. Revised 1/31/25: Ambulation/Mobility - Resident #13 required assistance of 2 staff with a front wheeled walker (FWW) with a wheelchair to follow. She sometimes used a wheelchair for long distances, encourage her to walk. - Updated 5/19/25: Resident #13 required the assistance of 2 staff and the standing mechanical lift for all transfers, as she didn't walk. b. Revised 11/25/24: Toileting - Resident #13 needed 2 staff assistance and had incontinence. - Updated 5/19/25: Resident #13 needed 2 staff assistance with a standing mechanical lift. c. Revised 11/25/24: Transfer - Resident #13 needed 2 staff for assistance with all transfers. She used a FWW. - Updated 5/19/25: Resident #13 needed 2 staff for assistance with the standing mechanical lift for all transfers The Root Cause Analysis (RCA) effective 5/16/25 identified Resident #13 as impatient and attempted to self-transfer to her wheelchair from the toilet, after she self-transferred to the toilet. The note listed an Intervention as a one-way slide in her wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Staff Statement for Staff A, Certified Nurse Aide (CNA), completed by Staff C, Registered Nurse (RN), on 5/16/25 reflected she walked into Resident #13's room to answer her call light. She saw Resident #13 transferred herself to the toilet. Staff A cleaned her up and asked her to sit back down so she could ask for transfer assistance. Resident #13 self-transferred and tried to put herself in the wheelchair. Staff A had to lower Resident #13 to the floor. On 5/20/25 at 10:28 AM, Staff A reported as she went down the hallway, Resident #13's roommate came out of the room without her pants on and told her Resident #13 needed help. She went into the room and noted Resident #13 transferred herself on to the toilet. She said the room had bowel movement (BM) everywhere on the floor all the way to the bathroom. She reported she cleaned up the floor and then proceed to help Resident #13. Staff A said Resident #13 reported she transferred herself from the wheelchair to the toilet but she thought Resident #13 may have ambulated to the toilet because of all the BM on the floor. She said she put a gait belt on Resident #13 and stood her up to clean up her bottom, then had her sit back down on the toilet. She said Resident #13 required assistance of 2 for transfers so she stepped out of the bathroom, went to check the room number on the outside door, and used the walkie for assistance. She reported being gone maybe a minute and when she went back into the room, she saw Resident #13 already transferring herself from the toilet and saw her knees buckling. She said Resident #13 had the gait belt still in place and she tried to assist her but couldn't get her back into the wheelchair so she lowered her to the floor. She said Resident #13 scraped her back on the wheelchair and had 2 small skin tears that bled a little bit so she knew the nurse needed to take pictures. She said she found the nurse passing medications in the center hall. She said the nurse didn't come to Resident #13's room for at least 30-40 minutes. She explained the nurse finished passing medications in the center hallway and the right hall before she came to assess Resident #13. Staff A reported she kept trying to walkie for the nurse but the nurse's walkie talkie was dead. She said after she waited 15-20 minutes for the nurse to come and assess Resident #13, when she didn't come herself and two other aides got Resident #13 off the floor and into her wheelchair. She said one staff member stayed with Resident #13 until the nurse came and the other 2 staff members went to lay other residents down. When asked how she knew how long it took for the nurse to come she said she knew it was a long time as the staff was able to lay down several residents while waiting for the nurse to come. She said after the nurse came and assessed Resident #13, she left her in the wheelchair. The nurse didn't tell the staff and Resident #13 tried to self-transfer again. She reported she tried to call the DON (Director of Nursing) regarding the nurse but they didn't answer. When asked about standing Resident #13 up to do peri care by herself, she said she was told that she could stand Resident #13 up and clean her but could not transfer her alone. She reported she tried to call the DON regarding the nurse but the DON did not answer. When asked if she left a message or sent a text message, she said no. When asked if she came to the facility to talk with the DON, she said no. She said she didn't work since then. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/25 at 3:45 PM, Staff B, CNA, reported Resident #13 had her call light on and she transferred herself to the toilet, then she got lowered to the floor. She said the aide who lowered her to the floor used the walkie talkie for help. She reported the nurse had their walkie talkie on but Staff B didn't know where the nurse had the walkie talkie. She didn't know if the nurse had the walkie talkie or if stayed at the nurses' station. She said the staff used the walkie talkie multiple times asking the nurse to come, and also went in person to tell the nurse about Resident #13 being on the floor. Staff B reported the nurse said she was coming. She said the nurse she saw the nurse at the table in the living room with her laptop. She said they waited about 10 minutes before herself and 2 other aides got Resident #13 off the floor. She said she wasn't going to leave Resident #13 sitting on the floor. She said they lifted her with a gait belt into the wheelchair. She said they left Resident #13 in her wheelchair for a while for the nurse to check her out. They put Resident #13 to bed right before 10:00 PM and added she went to bed last. She said she didn't witness the nurse going into Resident #13's room. She added the nurse could have, but she didn't know about her going into the room. She said they had made sure Resident #13 was okay and comfortable. When asked if she had told any administrative staff about the concerns with the nurse, she said no. She said the aide who lowered her to the floor was going to report it. On 5/20/25 at 3:37 PM, Staff I, Nurse Aide (NA), reported she worked at the facility for about 2 weeks as a noncertified nurse aide. She reported things went well. She said she knew about Resident #13 getting lowered to the floor due to her trying to self-transfer. She said Resident #13 scraped her back. She reported herself, Staff A, and Staff B, CNA, assisted Resident #13 off the floor. She said they had an aide under each arm, one in front, and her chair behind her. On 5/20/25 at 10:48 AM, the Administrator reported the facility scheduled each shift 7 days per week: a. CNAs: First shift 3-4, second shift 3-4, and third shift 2-3. b. Nurses: Day shift 1 nurse and 1 nurse or 1 med aide; Night shift 1 nurse On 5/20/25 at 12:45 PM, the DON reported she completed a corrective action form for Staff A related to Resident #13's fall on 5/16/25. She said Staff A didn't work since the fall so she hadn't reviewed or gave them the corrective action form yet. She said she expected Staff A to use assist of two with all transfers which included standing Resident #13 from the toilet to complete care. The DON reported she didn't know Staff A left Resident #13 unattended in the bathroom. She acknowledged her root cause analysis as not thorough. She reported she expected staff to follow the Care Plan. The DON reported they changed Resident #13 use an standing mechanical lift for transfers on 5/19/25 due to the weakness in her legs. She said Resident #13 wanted to walk and will ask the staff to take her. (continued on next page)

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Stratford Specialty Care	1200 Highway 175 East Stratford, IA 50249

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/25 at 9:57 PM, Staff C reported on the evening of 5/15/25, she was down the center hall passing medications. She said Staff A approached her to tell her Resident #13 took herself to the BR and had a BM. Staff A cleaned her up on the toilet. Staff C said Staff A told her she went to check the room number and call for assistance. She said in the meantime Resident #13 decided to self-transfer from the toilet to the wheelchair and Staff A saw Resident #13 wouldn't make it so she lowered her to the floor to prevent a fall. Staff C reported being in the middle of passing medications and giving insulin. She didn't want to make a medication error so she finished up helping that resident before she went to Resident #13's room. She acknowledged a delay in response. She said she made the decision based on the facts she knew the CNA lowered Resident #13 to the floor, as she didn't actually fall, and she didn't hit her head. She reported when she completed the medications for the one resident, she secured her laptop and med cart, then she went to Resident #13's room. She said by then Resident #13 had a second staff member present (Staff B). The staff got Resident #13 off the floor and into the wheelchair. She verified no one assessed Resident #13 before they moved her off the floor. When asked how much time passed from when the staff first told her about Resident #13 on the floor by the time she got to the room, she said she didn't feel like it was longer than 10 minutes. She said she assessed Resident #13, including her vital signs and range of motion. She reported the staff told her Resident #13 had an injury on her back. She said she didn't look at her lower back at that time. She said she planned to go back when Resident #13 was in bed, to look at her back and she didn't. She explained she forgot and got busy. She said the next day the day shift nurse evaluated Resident #13's back. When asked if she had concerns with Staff A standing Resident #13 up on her own and providing incontinence care, she said yes as Staff A knew Resident #13 needed 2 staff for assistance. Staff C acknowledged Staff A didn't follow the Care Plan and if she did, it may have prevented the fall. On 5/21/25 at 11:15 AM, the DON reported she expected the nurse to complete a nursing assessment before staff assisted the resident off the floor. In addition, the DON reported she expected the nurse to assess Resident #13's back after she fell . The DON said she identified Resident #13 didn't have an assessment completed of her back until the following day. She acknowledged when a staff member lowered a resident to the floor, they still considered it a fall and the staff would complete the required fall documentation. The DON reported she knew and acknowledged Resident #13 had a delay in the nurse's assessment after the fall. She said she expected the nurse to stop the medication pass and assess the resident after they fell . She said she was in the process of completing a write up for the nurse and would provide the surveyor with a copy. 49056 2. Resident #14's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. The MDS listed Resident #14 as independent with rolling left and right, sitting to lying, lying to sitting on the side of bed, and sitting to standing. The MDS listed Resident #14 as partial/moderate assistance with chair/bed to chair transfers and toilet transfers. The MDS described Resident #14 as frequently incontinent of urine. Resident #18's MDS included diagnoses of Alzheimer's disease, non Alzheimer's dementia, anxiety and depression. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Incident Report dated 8/26/24 at 4:34 PM indicated a peer reported to the nursing staff Resident #14 fell on the floor. The nursing staff proceeded to check rooms and found Resident #14 lying on the floor on his left side. Resident #14 stated as he came back from the bathroom and attempted to go from the wheelchair to bed, he got dizzy and fell down. He added he bumped his head on the side of the bed. Two staff assisted Resident #14 to a standing position with a gait belt. The Care Plan with an initiated date of 4/4/17 lacked an intervention for the fall on 8/26/24. On 5/20/25 at 2:15 PM the Director of Nursing (DON) stated that she didn't work at the facility during that time, but acknowledged she couldn't find an intervention for the fall on 8/26/24. The DON stated she expected an intervention put in place at the time of the fall. The policy named QA & A Falls Protocol dated January 2015 instructed the facility would investigate all falls to identify possible causative factors and interventions for prevention. The medical record would reflect the occurrence, findings, action taken, and outcome as appropriate. The charge nurse is responsible for the following interventions at the time of the fall. The nurse must immediately evaluate the resident for injury, complete head-to-toe assessment with vital signs, neurological checks, and orthostatic blood pressures. The charge nurse should provide emergency first aid, document in the clinical record, notify the physician, and the family. In addition, the charge nurse should complete the incident form, when they have completed all areas, place the form in the DON's mailbox. The DON had the responsibility for conducting further investigation and reviewing data, including interviews with staff or others knowledgeable about the event. The DON would review the information to determine if major injury occurred and if they needed to file a self-report. The Care Plan will be reviewed and revised with recommended actions, then communicated to direct care staff.

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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** 46875 Based on observations, interviews, policy review, and clinical record review, the facility failed to have orders for verifying the amount of water to flush the feeding tube when administering medications for 1 of 1 residents reviewed (Resident #35). The facility reported a census of 36 residents. Findings include: Resident #35's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) was not able to be completed. A Staff Assessment for Mental Status indicated Resident #35 had severely impaired decision making. The MDS identified Resident #35 was dependent on staff for bed mobility and transfers Resident #35's MDS included diagnoses of traumatic brain injury, traumatic subdural hemorrhage (bleeding in the brain), altered mental status, persistent vegetative state (inability to move or talk), and dysphasia (difficulty speaking). The MDS documented Resident #35 used a feeding tube while a resident in the last 7 days. The Care Plan Focus revised 2/6/25 indicated Resident #35 had a tube feeding of osmolyte. The Interventions directed to check for tube placement and gastric contents/residual volume per facility protocol and record. On 5/18/25 at 9:37 AM Staff J, Registered Nurse (RN) reported Resident #35 received a bolus of feeding and medications through his tube. She report he could have some liquids as needed like chocolate milk and water. She said he didn't get any food due to possible pocketing and aspiration. On 5/19/25 at 6:50 PM, Staff D, Licensed Practical Nurse (LPN), reported she already gave Resident #35 his medications via his feeding tube (g tube) that morning. She reported if he didn't drink his formula when he got up, she would give him it as a bolus through the tube and let the surveyor know for observations. Resident #35's Medication Administration Record (MAR) listed his diet order as a regular, no added salt diet of a full liquid texture. He could drink fluids of choice. The MAR included the following orders: a. 2/25/25: Enteral tube feeding bolus of Osmolyte 1.5 calorie (cal). Give bolus of 240 milliliters (ML) every four hours followed by 150 ML of water. He could drink his feeding bolus if he desired. If he couldn't drink the bolus give per his feeding tube. The Order Note dated 2/24/25 at 3:33 PM reflected Resident #35 received a new order to discontinue duloxetine (antidepressant) and start venlafaxine (antidepressant) twice a daily via g-tube. The Communication - with Physician Note dated 2/24/25 at 2:37 PM the doctor saw Resident #35 at the facility that day who gave new orders to: a. Keep nothing by mouth (NPO) with sips of water and ice chips (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Continue oral care c. If Resident #35's family opted to continue oral intakes, discuss risks and benefits with them and let them know aspiration could occur. He wouldn't be sent to the ER for further evaluation unless the family wants him sent d. Continue Hospice consultation as ordered the Dietitian to review his diet to ensure adequacy. The facility clarified orders verbally with the doctor and replied okay to keep NPO for food intake and may drink fluids as desired, give all medications via g tube, change divalproex to valproic acid liquid form. The doctor would review his order for duloxetine and change later that day to liquid form. Spoke with wife [NAME] and she is in agreement with diet change and new orders at this time. On 5/19/25 at 8:55 AM, Staff D reported Resident #35 normally drinks his osmolyte mixed with chocolate milk during the day while awake and up in his chair every four hours at 8AM, Noon and 4PM. She reported he gets his bolus feedings via g tube at night while in bed. She reported he drinks his water when sitting at the dining room table. She reported she checks for tube placement prior to medication administration per standard of practice. She reported she does not check for residual. She reported Resident #35 has tolerated his feedings without any problems. On 5/19/25 at 3:27 PM, watched Staff D complete Resident #35 administration of medications. She crushed 2 medications (Seroquel and docusate sodium) and put each crushed medication in a separate plastic cup. She measured 30 ML of water and added the water to each cup to dissolve the medication. She explained she used 30 ML of water was per the facility protocol. She entered Resident #35's room carrying a barrier, 2 cups of dissolved medications, and a cup of plain water. She sat the barrier down on the bed side table, placed the medications, and water on top of the barrier. She put on a gown, sanitized her hands, and got the syringe out of the closet. The syringe had a date of 5/19/25. She put on gloves and checked placement by checking for residual and then reinserted the stomach contents (small amount noted in syringe approximately 10 ML). She reported she normally checked placement with air but the facility added residual checks to the MAR that day after the surveyor asked about residual checks. She then flushed the tube with 60 ML of water, gave 1 medication, flushed with 15 ML of water, gave the second medication, and then flushed tube with 15 ML of water. She said she followed the policy regarding how much water to give before, in between and after the medication. After she finished, she rinsed the syringe, put it back in the bag for storage. She removed her gloves, gown, and sanitized her hands. The facility policy titled Feeding Tube Residual Check Policy dated December 2011 described the purpose of the policy as to check tube placement, patency, and/or residual from the tube feeding. The policy instructed that checking for residual helped minimize risk of overfeeding and helped evaluate how the resident tolerated the feeding. - Use 30-60 ML of syringe to slowly withdraw stomach contents. Check and record amount and appearance of residual in the nurse's notes. - Inject residual back into feeding tube, unless residual is very large. Check physician orders for specific guidelines for reinserting residuals. - After re injecting the residual, flush the tube with 20 30 ML of water. Flushing the tube helps prevent clogging. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy titled Medication Administration through a Feeding Tube dated December 2011 - Crush all tablets. Mix powder with 15 30 ML of water depending on tube diameter - Verify tube placement - Check for gastric residual - Flush tube with 15 30 ML of water before administering medications - Administer each medication separately and flush the feeding tube with 5-10 ML of water between the administration of each medication. - Flush the feeding tube with at least 15 30 ML of water after the completion of the medication administration On 5/20/25 at 12:45 PM, the DON reported she expected staff to follow the facility policy regarding checking placement, residuals, and water flushes with medication administration. The Corporate Nurse reported all homes in the Corporation she went to used the same policies. The Corporate Nurse reported checking placement/residual was not a requirement anymore. The DON reported when Resident #35 first admitted the Physician said they didn't require residual checks but she didn't have documentation to prove that. On 5/20/25 at 2:58 PM, the DON reported the staff received verbal education regarding feeding tubes when Resident #35 first came to the facility but she didn't think she documented anything. When asked if the nurses had access to the feeding tube policies, the DON reported they used to have a folder at the nurses' station with the policies but the staff couldn't find it yesterday when they looked for it. When asked if the medication cart had policies for the nurses to follow, she said no.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on observations, record review, staff interviews, resident interview and policy review, the facility failed to change nebulizer tubing for 1 of 1 resident reviewed (Resident #33) for respiratory services. The facility reported a census of 36 residents. Findings Include: The Minimum Data Set (MDS) assessment for Resident #33 dated 4/3/25 identified a Brief Interview for Mental Status (BIMS) score of 00, which indicated severely impaired cognition. The MDS included diagnoses of hypertension, cerebrovascular accident (CVA), aphasia (difficulty speaking) and dysphagia (difficulty swallowing). The MDS documented Resident #33 used a feeding tube while a resident in the last 7 days. On 5/18/25 at 9:24 AM, observed Resident #33's nebulizer machine sitting on the bed side table with the tubing connected to the machine and mask/chamber sitting behind the machine on the table. The nebulizer mask/chamber was marked/dated 10/14/24. The nebulizer mask was dirty with dust particles and had dried liquid spots on it. Review of Resident #33's May 2025 Medication Administration Record (MAR) revealed there were no current orders for nebulizer treatments. Review of the clinical record revealed Resident #33 was admitted on [DATE] with an order to administer albuterol sulfate nebulization 3 ml (milliliters) every 4 hours as needed. A Progress Note dated 2/28/25 documented the albuterol nebulizer solution was discontinued due to non use. Review of the clinical record and the January 2025 MAR revealed Resident #33 had received three nebulizer treatments on 1/6, 1/10 and 1/11. On 5/20/25 at 8AM, observed Resident #33's nebulizer machine with mask/tubing dated 10/14/24 remained at the bed side. On 5/20/25 at 8:05 AM, the ADON went to Resident #33 ' s room with the surveyor. The ADON acknowledged the date on the nebulizer mask/chamber was dated 10/14/24 and the mask was dirty with dust particle/dried spots. The ADON threw the tubing, mask/chamber in the garbage and removed the nebulizer machine from Resident #33's room. The ADON reported she would sanitize the machine. She said she thought the machine was being rented. The ADON reported the expectation was to change the nebulizer tubing and masks weekly on Sunday and document either on the MAR or TAR. A facility policy titled Inhalation Treatment with Machine dated January 2015 documented to replace the tubing apparatus weekly. In addition, the policy documented nightly cleaning consisted of cleaning the equipment per manufacturer's instructions, label, date and bag after cleaning.

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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** 46875 Based on clinical record review, Payroll Based Journal (PBJ) data, staff, and resident interviews, the facility failed to provide enough staff to care for residents in a timely manner. The facility reported a census of 36 residents. Findings include: 1. Resident #9 Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. On 5/18/25 at 11:29 AM, Resident #9 reported staff could take 30 to 45 minutes and sometimes longer to answer his call light because the facility being short staffed. He reported staff will either quit or have gotten fired. Resident #9 reported he used the clock on the wall to know the length of time of the call light response. Resident #9 said sometimes staff came in, shut off the call light, say they will be back, and then forget to come back. He said the staff run around like their heads are cut off trying to take care of the people. The PBJ Fiscal Year Quarter 1 2025 (October 1 - December 31) date reflected excessively low weekend staffing. A facility form titled Grievance/Concern Investigation dated 2/5/25 documented Resident Council reported call light times between 15 - 30 minutes. The form documented the action and follow up as to continue to audit times and educate on times. The Administrator reviewed the form on 2/5/25. 2. On 5/20/25 at 9:28 AM, Resident #19 reported the facility had more staff than they normally had related to the annual survey and surveyors being present in the building. On 5/20/25 at 10:28 AM, Staff A, CNA (Certified Nursing Assistant), reported the facility was very short staffed and the management staff did not help out. She said there have been times when there was 1 Nurse and 1 CNA for almost 40 residents. She said the facility had a lot of bullying and finger pointing between the staff without any consequences, because of this the staff leave. She said some of her co workers struggled with the DON (Director of Nursing). She said the DON would be on call and when no one shows up or calls in, she would tell the staff to figure it out. She said the DON told the staff they have to find their own replacements. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/20/25 at 3:45 PM, Staff B, CNA, reported being mentally and physically exhausted due to the lack of staff on the evening shift. She reported the facility had a lot of times with only 2 aides between 2:00 PM - 4:00 PM and after supper in the main area. She said she tried to get baths done from 2:00 PM - 4:00 PM but that it was very difficult at times. She reported having the memory care unit open made staffing more difficult. She said it could get stressful at bed time as they had a lot of call lights on and residents wanting to go to bed. She said some of the residents exhibited behaviors and yelled at her. Staff B described the shift as overwhelming and overstimulating because of everything going on. She reported she talked to the DON about the staffing and the DON responded all shifts hurt for help. She said the facility hired staff but some of them don't stay and then others are not reliable. She reported she thought the facility's location made it difficult to find staff. She said on weekends it could be worse when the management staff are not there. She said the staff are more likely to call in on the weekends because they can get away with it. She said it is left up to the nurses to find replacements when the facility had call ins and at times the nurse can't find replacements. She said some staff will come in an hour early. On 5/20/25 at 9:57 PM, Staff C, RN (Registered Nurse),, reported usually on the evening shift there are 2.5 CNAs in the main area and once in a while if they are lucky they will have 3 CNAs. She reported staffing was challenging at times. She reported sometimes it can be hard to get to the call lights in a timely manner. She said she tried to respond and help as much as possible but if the resident required the assistance of 2 people she couldn't do it by herself. When asked if any residents had complaints regarding long call lights, she said, I'm sure we do. On 5/21/25 at 11:15 AM, the DON reported they expected the staff to answer call lights within 15 minutes per the policy. She reported when the facility had a call-in during business hours, the ADON and herself help find replacements. She said on the schedules they have a designated staff member scheduled stay over 4 hours if the facility had a call in on the next shift. The DON gave an example: if they have a call in on the 2 - 10 shift, a designated day shift aide would have to stay over until 6 PM. She reported staff members who call in are to try to find their own replacement but it didn't always happen. When asked about after hours or on the weekend, she said the nurses are to attempt to try to find replacements and if they're not able, then they must notify the on call nurse. When asked about the expectation of the on-call nurse, she said it depended on the staffing situation at the time. She said if the facility had 2 or less CNAs, then they expect the on call nurse to come in. She reported 1 nurse and 2 CNAs in the main area was not ideal but manageable. She said she has worked the shift herself and it was doable. When asked about getting baths done with 2 CNAs, she said they usually only have 4 - 5 baths scheduled. She said if they have a call in on the evening shift then the day shift would try to help out to get the baths done. She said her ideal staffing pattern is 3 CNAs in the main area with 1 CNA in the unit on the day and evening shift. For the overnight shift, 2 CNAs in the main area and 1 CNA in the unit. The facility policy titled Answering the Call Light revised March 2021 documented the purpose of the policy as to ensure timely responses to the resident's requests and needs.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 49056 Based on review of the facility's Quality Assurance Performance Improvement (QAPI) plan, the facility's past surveys, and staff interview, the facility failed to correct their own deficiencies for 1 of concern. The facility reported a census of 36 residents. Findings include: The Quality Assurance and Performance Improvement (QAPI) Program revised March 2020 is overseen and implemented by the QAPI committee, which reports its findings, actions and results to the Administrator and governing body. The Administrator, whether a member of the QAPI Committee or not, is ultimately responsible for the QAPI program and for interpreting its results and findings to the governing body. The governing body is responsible for ensuring that the QAPI program is implemented and maintained to address identified priorities; is sustained through transitions of leadership and staffing; is adequately resourced and funded, including the provision of money, time, equipment, training and staff coverage sufficient to conduct the activities of the program; is based on data, resident and staff input and other information that measures performance and focuses on problems and opportunities that reflect processes, functions and services provided to the residents The facility had the following concerns identified at the current survey, previously cited at surveys in the past year: a. Sufficient Nursing Staff On 5/21/25 at 1:22 PM the Administrator reported they did interviews with the residents. The Administrator stated that we all have community connections and the residents didn't tell the staff their concerns with the call lights. The Administrator explained the residents tell the surveyors their concerns. Even if they had one time six months ago the staff didn't get to their call light soon enough, some residents didn't forget. The Administrator verbalized the one thing that residents don't bring up anymore is call lights. The Administrator stated regarding staff, she felt they would never say they had enough help. The more you have, didn't necessarily mean the work got done faster or more efficiently, and the staff have proved that. The Administrator stated she did call light audits within the last year. The Administrator stated any deficiency they received for staffing, resulted because of resident's interviews and not observation.

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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** 46875 Based on observations, clinical record review, staff interviews, and policy review, the facility failed to provide a safe and sanitary environment to prevent the development and transmission of communicable diseases and infections for 1 of 1 resident (Resident #35) with a feeding-tube. In addition, the facility failed to complete adequate hand hygiene and gloving for 2 of 8 residents reviewed (Residents #29 and #21) during medication administration. The facility reported a census of 36 residents. Findings include: 1. Resident #35's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) was not able to be completed. A Staff Assessment for Mental Status indicated Resident #35 had severely impaired decision making. The MDS identified Resident #35 was dependent on staff for bed mobility and transfers Resident #35's MDS included diagnoses of traumatic brain injury, traumatic subdural hemorrhage (bleeding in the brain), altered mental status, persistent vegetative state (inability to move or talk), and dysphasia (difficulty speaking). The MDS documented Resident #35 used a feeding-tube while a resident in the last 7 days. The Care Plan Focus revised 2/6/25 indicated Resident #35 had a feeding-tube. The Interventions directed the following: a. Use enhanced barrier precautions (EBP). b. Provide local care to the g-tube site (gastrostomy tube) (medical device used to deliver nutrition directly to the stomach or small intestine when a person is unable to eat or drink normally) as ordered. c. Monitor for signs and symptoms of infection. A Physician order dated 11/5/24 directed staff to cleanse the g-tube site and apply bacitracin ointment to the site twice a day. A Physician order dated 11/5/24 directed staff to complete EBP due to tube feeding status. A Physician order dated 3/24/25 directed staff to cleanse Resident #35's g-tube site with soap and water or wound cleanser and apply a split sponge and secure with tape every day and as needed. On 5/18/25 at 9:37 AM observed an EPB sign posted on Resident #35 door. The sign directed everyone must clean their hands, including before entering and when leaving the room. The sign directed providers and staff to wear gloves and a gown following high contact resident care activities which included device care or use of a feeding-tube. (continued on next page)

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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	On 5/19/25 at 10:05 AM observed Staff D, LPN (Licensed Practical Nursing), complete a dressing change to Resident #35's g-tube site. Staff D pushed the treatment cart into Resident #35's room. She put a barrier on the top of the treatment cart, without sanitizing the top of the treatment cart. Staff D washed her hands at the sink, got supplies out of the treatment cart, and placed them on the barrier. Staff D applied gloves and sprayed wound cleanser onto the gauze pad. Staff D removed the old dressing from the peg-tube site with her gloves hands and cleansed the g-tube site with the wet gauze pad. With the same pair of gloves, Staff D opened the bacitracin packet, put the bacitracin ointment on the split gauze pad, she spread the ointment around on the gauze pad using the packet and then applied the split gauze with the ointment to the g-tube site. With the same pair of gloves, Staff D applied tape to the dressing. After securing the dressing, Staff D removed their gloves, used hand sanitizer, and dated the dressing. She then applied gloves, discarded the supplies, and put away the wound cleanser in the bottom drawer. For the entire treatment, Staff D didn't wear a gown. On 5/19/25 at 3:45 PM, Staff D acknowledged she didn't wear a gown when performing Resident #35's dressing change to their g-tube site. She reported she remembered after she finished the treatment. She reported she had training on EPB and knew she should wear the gown. In addition, Staff D verified she used the same pair of gloves during the dressing change procedure. Staff D acknowledged she needed to change her gloves and complete hand hygiene between dirty and clean tasks. On 5/20/25 at 12:45 PM, the Director of Nursing (DON) reported she expected the staff to follow EBP and wear a gown when performing a dressing change to a g-tube site. In addition, the DON reported she expected the staff to change gloves and complete hand hygiene between dirty and clean procedures. A facility policy titled Enhance Barrier Precautions dated 3/28/24 indicated the facility needed to implement enhanced barrier precautions for the prevention of transmission of multidrug resistant organisms (MDRO). The policy defined EBP as an infection control intervention designed to reduce transmission of MDROs the staff employ targeted gown and gloves usage during high contact resident care activities. The policy documented to initiate an order for EBP for residents with any indwelling medical devices, including feeding-tubes even if the resident didn't have a known infection or colonization of a MDRO. The policy indicated high contact resident care activities included device care or use with feeding-tubes. A facility policy titled Dressing Change Clean dated January 2015 documented the purpose of the policy as the following: a. To protect wound and enhanced healing process b. To prevent irritation c. To prevent infection d. To prevent the spread of infection if present. The policy documented the following guidelines: a. Wash hands. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165270	A. Building B. Wing	05/21/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Gather equipment and take it to the bedside. c. Set up a clean area for dressing materials. Open dressing pack. Cut tape with scissors pre-sanitized with alcohol. d. Put on gloves. e. Remove soiled dressing and discard. f. Remove gloves and discard. g. Wash hands or use sanitizer. Put on clean gloves and cleanse the wound with prescribed solution if ordered. h. Remove gloves and discard. i. Wash hands or use sanitizer. Put on clean gloves. j. Apply prescribed medications as ordered. k. Apply dressing and secure with tape. l. Remove gloves and wash hands. 2. On 5/19/25 at 10:00 AM, observed Staff E, CMA (Certified Medication Aide), sanitize her hands using hand sanitizer at the medication cart. She then took a pair of gloves, a tissue, and the eye drop box from the medication cart then went to Resident #29's room. She handed Resident #29 the tissue, then applied the pair of gloves, took the eye drop bottle out of the box, and sat it on Resident #29's beside table without a barrier. Staff E administered one eye drop in each eye and then placed the eye drop bottle in the box. Staff E removed their gloves while leaving the room, then carried the gloves to the medication cart, and threw them away. After removing their gloves and without completing hand hygiene, Staff E proceeded to unlock the medication cart. She put the eye drop box back in the medication cart and then took out a box of nebulizer solution from the medication cart for Resident #21. She took a nebulizer vial out of the box then put the box back in the medication cart and locked the cart. Staff E went down the hallway to Resident #21's room and applied a pair of gloves from the box in the resident's room without completing hand hygiene prior. Staff E put the nebulizer medication into the nebulizer chamber and handed it to Resident #21. Staff E then removed gloves and left the room without completing hand hygiene. Staff E acknowledged the infection control concerns with hand hygiene, gloving, and placing the eye drop box on the table without a barrier. On 5/20/25 at 12:40 PM, the DON reported she expected staff to complete hand hygiene when removing gloves, between residents, and when entering a resident room. A facility policy titled Handwashing revised 3/9/20 defined handwashing as a way to prevent contagion and protect residents from nosocomial infections. The policy directed the frequency as before and after resident care. In addition, the policy documented the recommendation for handwashing per the CDC guidelines (Centers for Disease Control and Prevention) as the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Contact with patient's intact skin - Contact with environmental surfaces in the immediate vicinity of patients - After glove removal. A facility policy titled Gloves dated April 2018 instructed handwashing as necessary even if using gloves were used.