STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165305	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chariton Specialty Care	1214 North Seventh Street Chariton, IA 50049

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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. 46873 Based on clinical record review, staff interview, and instructions of CMS form 10123-NOMNC, the facility failed to appropriately provide a Notice of Medicare Non Coverage (NOMNC) to 2 of 3 (Resident #35 and #36) residents reviewed for Beneficiary Notification. The facility reported a census of 32 residents. Findings include: 1. The census portion of the Electronic Health Record (EHR) of Resident #35 revealed the resident began receiving skilled care under Medicare A payer source on 9/9/24 and Medicare continued to pay for her stay through 11/22/24. The facility was unable to provide documentation of Resident #35 receiving a Notice of Medicare Non Coverage (NOMNC) form. 2. The census portion of the EHR of Resident #36 revealed the resident began receiving skilled care under Medicare A payer source on 7/26/24 and Medicare paid for his stay through 9/11/24. The facility did provide Resident #36 a NOMNC form on 9/10/24, one day prior to his Medicare services ending. The document titled Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 directed: A Medicare provider or health plan (Medicare Advantage plans and cost plans, collectively referred to as plans) must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services. The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. On 1/27/25 at 1:01 pm via email, the Administrator stated the facility could not locate a NOMNC for Resident #35. On 1/29/24 at 3:23 pm, the Administrator stated her expectation is for NOMNCs to be issued at least 2 days prior to Medicare discharge.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 46873 Based on clinical record review, staff interview, guidance from the 2024 Resident Assessment Instrument (RAI) Manual, and facility policy review, the facility failed to complete a Significant Change Minimum Data Set (MDS) Assessments following a significant change within federal guidelines for 1 of 5 residents (Res #4) reviewed for significant change. The facility reported a census of 32 residents. Findings include: The Census Line portion of the Electronic Health Record (EHR) of Resident #4 documented the resident enrolled in hospice care on 9/12/24. The Significant Change MDS of Resident #4 documented an Assessment Reference Date (ARD) of 10/3/24. Page 58 of the MDS documented the MDS was signed as Assessment Completion on 10/8/24 which is 26 days following hospice admission. According to the 2024 RAI, a Significant Change (comprehensive) assessment, the ARD must be no later than the 14th calendar day after determination that a significant change in the resident's status occurred. The RAI stated a Significant Change MDS is required to be performed when a terminally ill resident enrolls in a hospice program. On 1/28/25 at 10:59 am, the MDS Coordinator stated she was on vacation during the time frame that Resident #4 enrolled in hospice care. She stated when she returned and was notified of her hospice enrollment, she then set up and completed the Significant Change MDS. On 1/29/25 at 3:23 pm, the Administrator stated the Corporation that owns the facility has a traveling Regional MDS Coordinator. She stated anytime the facility MDS Coordinator is not in house, the facility will notify the Regional Coordinator to ensure assessments are completed timely. The facility policy titled Resident Assessments documented the following: Point 3: A Significant Change in Status Assessment (SCSA) is completed within 14 days of the interdisciplinary team determining that the resident meets the guidelines for major improvement or decline. Point 4: A SCSA cannot be completed until after a comprehensive Admission Assessment is submitted. Point 5: A SCSA is required when a resident: a. Enrolls in a hospice program; b. Changes hospice providers and remains in the facility; c. Discontinues hospice services; or d. Experiences a consistent pattern of changes with two or more areas of decline from baseline.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47079 Based on record review, staff interviews, and policy review, the facility failed to develop a personalized Care Plan for 4 of 12 residents (#2, #7, #16, and #24) reviewed for Care Plans. The facility reported a census of 32 residents. Findings include: 1. On 1/27/25, a record review of Resident #2's Electronic Health Record (EHR) revealed she received antipsychotic and antidepressant medications. The Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of End-Stage Renal Disease (ESRD), Diabetes Mellitus (DM), Non-Alzheimer's Dementia, Bipolar Disorder, and depression. It also revealed the resident received antipsychotic (AP) and antidepressant (AD) medications during the last 7 days. The EHR included a physician's order for an antipsychotic medication, Quetiapine fumarate 100 milligrams (mg) by mouth at bedtime for Bipolar Disorder and an antidepressant medication, Trazadone hydrochloride (HCL) 125 mg by mouth one time per day for depression. It also included a physician's order to monitor target behaviors and side effects every shift and identified the target behaviors as Codes: 0=No Behaviors, 1= (tearful), 2=(self-isolation), 3=(agitation), 4=other (see progress notes). The Progress Notes included two (2) monitored target behavior entries dated 2/20/24 and 1/17/25. The Care Plan revised 11/28/24 included the resident's antipsychotic and antidepressant medication use but did not include the associated target behaviors for staff to monitor. 2. On 1/27/25, a record review of Resident #7's Electronic Health Record (EHR) revealed he received antianxiety, antipsychotic, and antidepressant medications. The Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of Heart Failure (HF), Diabetes Mellitus (DM), Alzheimer's Disease, Schizoaffective Disorder, and depression. It also revealed the resident received antianxiety (AA), antipsychotic (AP) and antidepressant (AD) medications during the last 7 days. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The EHR included a physician's order for two (2) antianxiety medications, Buspirone hydrochloride (HCL) 7.5 mg by mouth two (2) times per day related to Schizoaffective Disorder and lorazepam 0.5 mg by mouth two (2) times per day related to Schizoaffective Disorder, an antipsychotic medication, Quetiapine fumarate 100 milligrams (mg) by mouth two (2) times per day related to Schizoaffective Disorder, depressive type, and two (2) antidepressant medications, citalopram hydrobromide 20 mg by mouth in the morning related to Major Depressive Disorder, and Trazadone hydrochloride (HCL) 50 mg by mouth at bedtime for Major Depressive Disorder. It also included a physician's order to monitor target behaviors and side effects every shift and identified the target behaviors as Codes 0=No Behaviors, 1=yelling, 2=(aggression), 3= (pacing), 4=other (see progress notes). The Progress Notes included four (4) monitored target behavior entries dated 3/04/24, 8/10/24, 12/22/24, and 1/10/25. The Care Plan revised 11/15/24 included the resident's antianxiety, antipsychotic, and antidepressant medication use but did not include the associated target behaviors for staff to monitor. 3. On 1/27/25, a record review of Resident #16's Electronic Health Record (EHR) revealed he received antianxiety and antidepressant medications. The Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of Heart Failure, anxiety, depression, and psychotic disorder. It also revealed the resident received antianxiety (AA) and antidepressant (AD) medications during the last 7 days. The EHR included a physician's order for an antianxiety medication, Buspirone hydrochloride (HCL) 10 mg by mouth two (2) times per day related to anxiety disorder and three (3) antidepressant medications, Duloxetine HCL 30 mg by mouth one (1) time per day related to Major Depressive Disorder, Trazadone hydrochloride (HCL) 150 mg by mouth one time per day related to Major Depressive Disorder, and Bupropion HCL 100 mg by mouth one (1) time per day related to Major Depressive Disorder. It also included a physician's order to monitor target behaviors and side effects every shift and identified the target behaviors as Codes: 0=No Behaviors, 1=tearfulness, 2=refusal of cares, 3=suicidal ideations, 4=other (see progress notes). The Progress Notes included four (4) monitored target behavior entries dated 5/09/24, two times on 11/12/24, and 12/24/24. The Care Plan revised 11/15/24 included the resident's antianxiety and antidepressant medication use but did not include the associated target behaviors for staff to monitor. 4. On 1/27/25, a record review of Resident #24's Electronic Health Record (EHR) revealed he received antipsychotic and antidepressant medications. The Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated moderately impaired cognition. It included diagnoses of Diabetes Mellitus (DM), Non-Alzheimer's Dementia, Alzheimer's Disease, adjustment disorder anxiety, and depression. It also revealed the resident received antipsychotic (AP) and antidepressant (AD) medications during the last 7 days. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The EHR included a physician's order for an antipsychotic medication, Quetiapine fumarate 50 milligrams (mg) by mouth one (1) time per day related to dementia with mood disturbance and an antidepressant medication, sertraline HCL 100 mg by mouth two (2) times per day related to depression. It also included a physician's order to monitor target behaviors and side effects every shift and identified the target behaviors as Codes: 0=No Behaviors, 1=agitation, 2=combativeness, 3=tearfulness, 4=other (see progress notes). The Progress Notes included fourteen (14) monitored target behavior entries between 11/06/24 and 1/13/25. The Care Plan revised 11/30/24 included the resident's antipsychotic and antidepressant medication use but did not include the associated target behaviors for staff to monitor. On 1/29/25 at 3:35 PM, the Assistant Director of Nursing (ADON) stated Care Plans should include target behaviors with each medication class (category). A policy titled Care Plans, Comprehensive Person-Centered revised 12/2016 indicated assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observation, resident and staff interviews, and clinical record review, the facility failed to follow the physician's orders for 1 of 12 residents (Resident #7) reviewed. The facility reported a census of 32 residents. Findings include: On 1/27/25 at 9:42 AM, Resident #7 was observed lying in his room. The bottom half of the resident's legs were uncovered and noted to be discolored. The resident stated he was supposed to have tubigrips (a tubular bandage that provides support for sprains, strains, swelling, and other injuries) on the lower half of both legs. He stated they were to be applied in the morning and removed at night. The Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of Heart Failure (HF), Diabetes Mellitus (DM), Alzheimer's Disease, Schizoaffective Disorder, depression, left lower limb cellulitis, and erythematous condition (redness of the skin typically caused by inflammation). It also revealed the resident required moderate assistance with bathing and was independent with all other aspects of Activities of Daily Living (ADLs) and mobility and received application of nonsurgical dressings (with or without topical medications) other than to feet. The Electronic Health Record (EHR) included a physician's order dated 2/21/24 for tubigrips to bilateral lower extremities (BLE) two (2) times per day for edema; on in AM and off at hour of sleep (HS - bedtime). The Care Plan, revised 3/04/24, indicated the resident wore tubi-grips on in AM and off at HS. On 1/28/25 at 1:30 PM, Resident #7 was observed sitting on the side of his bed not wearing his tubigrips. The tubigrips were observed lying on a stack of newspapers on his 4-wheeled walker. The resident stated he had not removed the tubigrips because the staff never applied them in the AM. At 1:33 PM, Staff C, Registered Nurse (RN) confirmed Resident #7 was supposed to have the tubigrips on but stated she hadn't put them on yet. She also stated the resident hadn't refused to wear the tubigrips that morning. The Progress Notes did not include documentation on 1/27/25 or 1/28/25 regarding the tubigrips not being placed on the resident. The Treatment Administration Record (TAR) revealed the resident did not refuse the tubigrips on 1/27/25 or 1/28/25. On 1/29/25 at 3:35, the Assistant Director of Nursing (ADON) stated staff should have followed the physician's orders and put the tubigrips on the resident in the AM. The facility did not have a policy specifically regarding following physician's orders.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 46873 Based on observation, facility menu review, and staff interviews, the facility failed to follow the posted menu and serve the appropriate portions for 3 of 3 residents who received pureed diets (Resident #9, #23, #29). Findings include: The facility's menu for lunch on 1/29/25 included the following items to be served to the residents. 2 oz of pulled pork 1 slice of bread 1/2 cup of broccoli 1 slice banana cream pie Continuous observation of lunch service began on 1/29/25 at 11:30 am. The Dietary Services Manager (DSM) stated she would first puree the broccoli for the puree diet residents. She used a #8 (4 oz) scoop and placed four servings of broccoli into a blender cup. She stated the facility had three residents who received pureed diets but she always made one extra serving. She then placed an unmeasured amount of chicken broth into the blender cup and blended the food to an appropriate texture. She transferred the broccoli into a steam pan with no measurement of the total volume (Measuring the volume of the entire product and dividing by the number of servings calculates the appropriate serving size for each person, as adding extra liquid and other ingredients to puree will increase the total volume of the pureed food). The DSM next obtained the food processor bowl and used a two ounce scoop and placed four 2 oz servings of pulled pork into the food processor bowl. She added an unmeasured amount of barbeque sauce and hot water, along with two slices of bread and added this to the pork. She then blended this mixture to an appropriate texture and used a silicone spatula to transfer the pork to a steam pan with no measurement of total volume performed. The DSM then obtained three slices of banana cream pie and placed them into a blender cup. She added an unmeasured amount of milk and a carton of ready to eat vanilla pudding and blended the mixture to an appropriate texture. She used a silicone spatula to transfer the mixture into 3 bowls. She did not measure the total volume to assure each resident got an equal serving. On 1/29/25 at 12:10 pm, the DSM began making plates for each resident and placing the plates on serving carts. As she completed each cart, she rolled the cart to the dining room for other staff to distribute to the residents. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The final three plates made during lunch service were the pureed diet plates. Each plate consisted of a two ounce portion of the mixture of pureed pulled pork, bread and barbeque sauce and a four ounce scoop of the pureed broccoli along with the pureed banana cream pie. The DSM verified these plates were for Resident #9, #23 and #29. On 1/29/25 at 12:43 pm, the DSM stated she had completed lunch service after all meals were completed and sent to the dining room. On 1/29/25 at 12:50 pm, the DSM stated she had never been taught about the volume method or seen the chart for volume method for the puree process until one day prior, on 1/28/25 when the Registered Dietitian (RD) was in the building. She said the RD had explained the volume method on 1/28/25 but the DSM explained she did not feel confident that she understood it. She verified the menu was for one slice of bread and for four servings of pureed pork, she had only used two slices of bread instead of four. On 1/29/25 at 3:25 pm, the Administrator stated her expectation is for the dietary staff to use the volume method for puree foods and to serve the posted menu.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46873 Based on observation, staff interview, guidance from the 2022 US Food and Drug Administration (FDA) Food Code, and facility policy review, the facility failed to use proper sanitation and glove use during lunch service. The facility reported a census of 32 residents. Findings include: The facility's posted menu for lunch on 1/29/25 identified the menu to be: Pulled pork sandwich Broccoli Banana Cream Pie Continuous observation of lunch service began on 1/29/25 at 11:30 am. The Dietary Services Manager (DSM) first prepared pureed broccoli for the residents who required a pureed diet. After this task, the then stated she would puree the pulled pork. The DSM placed gloves on her hands. She picked up the food processor bowl and carried it to the counter. She placed four servings of pulled pork into the food processor bowl. She then obtained a measuring cup and added some barbeque sauce to it. She walked to the coffee maker and obtained hot water from the coffee maker and added it to the cup, still wearing the same gloves. After adding the water and sauce mixture to the pork, she picked up two slices of bread with her gloved hand and added it to the pork mixture to puree the pork. Following the puree process, the DSM then opened a kitchen drawer and obtained a silicone spatula to transfer the pork to a steam pan and then placed the steam pan in the oven to keep warm. The DSM then removed her gloves, pureed the dessert and continued to prepare for lunch service. On 1/29/25 at 11:58 am, the DSM took a gallon size container of barbeque sauce and poured a small amount into a squeeze container for serving. She then stated she was going to make two grilled cheese sandwiches for residents who had requested an alternate meal. The DSM obtained a bagged loaf of bread, a container of butter and a container of cheese and placed all on a clean surface. She placed gloves on her hands with no hand hygiene prior to placing the gloves. She removed the lid off of the container holding the cheese, and picked up one slice of bread and placed it into the palm of her gloved hand. She picked up the container of butter and opened the container, then obtained a spatula and spread the butter on the slice of bread. She repeated this for a second slice of bread and placed both slices into a skillet on the stove to grill the bread. She obtained cheese with the same gloved hands and placed the cheese on the bread. After making the first grilled cheese sandwich, she repeated this for a second sandwich. She then transferred both sandwiches using a spatula to a steam pan. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/29/25 at 12:07 pm, the DSM removed her gloves, performed hand hygiene, and then set up serving utensils on the steam table to begin lunch service. She then entered the walk in cooler and returned with a wheeled cart holding multiple slices of banana cream pie on individual plates. The pie slices were open to air and not covered. On 1/29/25 at 12:10 pm, the DSM performed hand hygiene and placed new gloves on her hands. After placing the gloves on her hands, she walked to the plate warmer, opened the lid, and obtained a stack of plates and placed them in the steam table area. She then picked up a stack of plate covers and placed them near the plates. Still wearing her gloves, she pulled a tray cart closer to her, then turned and obtained a box of plastic wrap. She pulled out a portion of the plastic wrap to cover a slice of pie, then placed the pie plate on a tray. She then returned to the steam table area, picked up a sandwich bun with her gloved hand, and placed it on a plate. She placed a scoop of pork on the bottom bun, picked up the squeeze bottle of barbeque sauce, applied sauce to the pork, then picked up the top bun and covered the pork to form a sandwich. She then used the serving scoop to place broccoli on the plate, carried the plate to the serving cart and placed it on the tray, and covered the plate with plate cover. This process was repeated for each tray, making each pork sandwich with her gloved hands, touching plates, serving utensils, tray covers, plates of pie, and plastic wrap for each tray on the first cart. When the first side of the cart was full, still wearing the same gloves, she turned the cart 180 degrees to fill up the second side of the cart. When the cart was full, the dietary aide added drinks to the cart and then took the cart to the dining room. The DSM then brought the second tray cart over to the steam table area. She removed her soiled gloves and placed new gloves on her hands without washing her hands. She opened the plate warmer, obtained another stack of plates and placed them at the steam table area. She adjusted the tray cart and then placed a plate of pie on each tray on the cart. She then plated the meals for this cart following the same process as the first cart, touching the plates, the plate covers, the serving utensils, the barbeque sauce and the sandwich buns all with her gloved hands. On 1/29/25 at 12:32 pm, she pushed the second tray cart out to the dining room. She then returned, removed her gloves and discarded them, and placed new gloves on her hands. She then pushed the third tray cart to the steam table area and the process was repeated for the last cart. The final three plates to be served were the plates for the pureed diet residents. After making their plates, she walked to the walk-in cooler, still wearing gloves, and obtained the pureed banana cream pie and then returned and placed these bowls on the trays. She then pushed the final cart to the dining room for staff to distribute the meals. When the DSM returned to the serving area, she removed her gloves, and placed a new set of gloves on her hands. She again walked to the walk-in cooler and returned a moment later. She was then wearing one glove and had the other glove in the palm of her hand along with a raw onion. She placed the second glove back on her hand, and obtained a cutting board and a knife and sliced the onion. She picked up a portion of the sliced onion with her gloved hand and placed it in a bowl and covered the bowl with a lid. She carried it to the dining room and gave it to a staff member for a resident who had requested some onion for her sandwich. On 1/29/25 at 12:43 pm, the DSM stated she had completed lunch service. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/29/25 at 12:50 pm, the State Surveyor asked the DSM if, when wearing gloves, then touching plates and plate covers and serving utensils and multiple other surfaces, would the DSM still consider those gloves to be clean. The DSM stated no, the gloves would no longer be clean. She stated she was unsure of what she should have done differently, however. She stated she had not thought to use tongs to pick up the bread or buns. Chapter 3 of the 2022 FDA Food Code documented the following: 3-304.15 Gloves, Use Limitation. (A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. The facility policy dated April 2019 and titled, Food Preparation and Service, identified a Policy Statement of Food and nutrition services employees prepare and serve food in a manner that complies with safe food handling practices. Food Preparation Area, Point 5: Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of food-borne illness. Food Service/Distribution, Point 6: Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single-use items and are discarded after each use.

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	165305	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chariton Specialty Care	1214 North Seventh Street Chariton, IA 50049

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** 47079 Based on observations, resident and staff interviews, clinical record review, and policy review, the facility failed to implement infection control practices to prevent urinary tract infection (UTI) for 2 of 2 residents (Resident #26 and #21) reviewed. The facility reported a census of 32. Findings include: 1. On 1/28/25 at 9:20 AM, observed Resident #26 to have an indwelling urinary catheter. The Minimum Data Set (MDS) dated [DATE] revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition. It included diagnoses of Non-Alzheimer's Dementia, benign prostatic hyperplasia with lower urinary tract symptoms (enlarged prostate that affects urination), and age-related macular degeneration (eye condition that affects central vision). It also revealed he was independent with eating, required setup assistance with oral and toileting hygiene, moderate assistance with dressing and personal hygiene, and maximum assistance with bathing. It did not include an indwelling catheter. The Progress Notes indicated the resident's indwelling catheter was inserted 1/12/25 due to urine retention. The Care Plan revised 1/26/25 included the resident's indwelling catheter and directed staff to use Enhance Barrier Precautions (use of PPE) when performing high-contact care activities. On 1/28/25 at 1:45 PM, Staff D, Certified Nurse Aide (CNA) entered Resident #26's room and prepared to perform the resident's catheter and perineal care. The Interim Director of Nursing (IDON) accompanied Staff D for observation. Staff D performed hand hygiene and donned the Personal Protective Equipment (PPE - gown and gloves). She then reached in a cabinet, grabbed the periwipe package, entered the bathroom and obtained a clear, plastic garbage bag. She reached into her right pocket then her left pocket and pulled out alcohol wipe packets. She placed the alcohol wipes, the clear plastic bag, and the periwipe package on the resident's bedside table. She opened the periwipe package and removed, expanded, and placed each individual periwipe into the clear plastic bag. She did not perform hand hygiene nor change gloves between touching items in the resident's environment and manipulating the wipes. She grabbed her walkie-talkie and asked for assistance to perform the resident's full perineal care. At 1:51 PM, Staff E, Licensed Practical Nurse (LPN) entered the resident's room, performed hand hygiene and donned PPE. At 1:53 PM, Staff D stated she and Staff E would be performing the resident's catheter and perineal care using the normal process. She placed her left gloved hand on the resident's walker and assisted the resident in removing his briefs. Staff D did not change gloves or perform hand hygiene at this point in the process. Staff D grabbed one periwipe from Staff E and wiped the resident's penis tip three (3) times from a top-to-bottom motion using the same periwipe and threw it in the clear plastic garbage bag she placed on the resident's bed. She used a second periwipe and wiped the bottom of the resident's penis and threw the periwipe in the clear plastic garbage bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:56 PM, Staff D got an alcohol swab and cleaned the catheter tubing in a distal motion (moving away from the resident's penis). She removed her PPE, placed it in the clear plastic garbage bag, and exited the room. At 1:57 PM, Staff D returned to Resident #26's room with a box of gloves. She performed hand hygiene, donned PPE, grabbed the clear plastic garbage bag with her right gloved hand and used her left gloved hand to push the bag's contents further into the bag. She moved the bag further away from the resident, turned back around toward the resident, grabbed the urine drainage bag, opened the drainage spigot and emptied the urine into a graduated cylinder. No hand hygiene or glove change was performed between touching the contaminated bag contents and manipulating the resident's urinary catheter drainage bag and spigot. At 2:09 PM, Staff D stated she felt she performed the process correctly and did not identify any missed hand hygiene or glove changing opportunities. She stated she received Infection Prevention training and verbalized hand hygiene should be performed when moving from a dirty area to a clean area when providing resident care. When asked, she confirmed the bag on the bed was considered contaminated and stated she should have performed hand hygiene and changed her gloves prior to manipulating the resident's drainage bag and spigot. On 1/29/25 at 3:35 PM, the Assistant Director of Nursing (ADON) stated staff should have performed hand hygiene between handling the trash and the resident's catheter. A policy titled Handwashing/Hand Hygiene revised 8/2019 directed staff to use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: a. Before and after coming on duty; b. Before and after direct contact with residents; c. Before preparing or handling medications; d. Before performing any non-surgical invasive procedures; e. Before and after handling an invasive device (e.g., urinary catheters, IV access sites); f. Before donning sterile gloves; g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident's intact skin; j. After contact with blood or bodily fluids; k. After handling used dressings, contaminated equipment, etc.; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; m. After removing gloves; n. Before and after entering isolation precaution settings; o. Before and after eating or handling food; p. Before and after assisting a resident with meals; and q. After personal use of the toilet or conducting your personal hygiene. 46873 2. The Minimum Data Set (MDS) of Resident #21, dated 11/28/24 identified a Brief Interview for Mental Status (BIMS) score of 15 which indicated cognition intact. The MDS documented the resident used a wheelchair for mobility independently with no assistance from staff. The MDS coded the presence of a urinary catheter. The Care Plan of Resident #21 identified a Focus Area of Risk for Urinary Tract Infection (UTI), revision date 12/5/24. The Care Plan documented the resident to be at risk of UTI due to a suprapubic catheter related to neuromuscular dysfunction and history of UTI. It directed staff to follow enhanced barrier precautions when performing high-contact care activities. On 1/27/25 at 7:52 am, Resident #21 was observed propelling herself across the dining room in her wheelchair with her catheter tubing dragging the floor. On 1/27/25 at 10:16 am, Resident #21 was observed self propelling in the hallway toward her room. Her urinary bag attached to her catheter was secured to the bottom of her wheelchair, and the tubing was dragging on the floor as she propelled down the hallway. On 1/28/25 at 8:06 am, Resident #21 was observed sitting in the dining room eating breakfast. Her catheter tubing was on the floor and her foot was sitting on top of the tubing as she sat at the table. On 1/28/25 at 1:56 pm, observation was completed of catheter cares for Resident #21 by Staff F, Certified Nurse Aide (CNA). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #21 was in her room, and privacy was provided. Staff F washed his hands and donned Personal Protective Equipment (PPE). Rather than a single use disposable isolation gown, Staff F donned a cloth hospital gown over his clothing. After donning the PPE in the resident bathroom, Staff F brought paper towels, a graduated cylinder in a plastic bag and alcohol swabs to the resident who was sitting in her wheelchair. He placed the paper towels on the floor, then the graduated cylinder in the plastic bag on top of the towels. He removed the drain from the bag, cleansed the outlet of the drain with alcohol then drained the urine into the graduated cylinder. When the urine bag was empty, with a clean alcohol swab he again cleansed the outlet before closing it and securing it to the bag. He carried the graduated cylinder to the toilet and dumped the urine. He rinsed the cylinder and dumped the rinse water in the toilet and placed the cylinder in a clean plastic bag. He removed his PPE, disposing of his gloves and turning the gown inside out as he removed it, rolled it up and placed it in a plastic bag. He washed his hands and then exited the room and took the bagged soiled gown to the laundry. On 1/28/25 at 2:10 pm, the Interim Director of Nursing stated the facility only had disposable isolation gowns and no cloth gowns. She stated the white cloth gowns are hospital gowns, not isolation gowns. On 1/28/25 at 2:12 pm, the Regional Director of Clinical Services stated Staff F wears a hospital gown over his scrubs to protect his clothing when he gives residents showers. She stated she would provide education on this. On 1/28/25 at 3:21 pm, the Assistance Director of Nursing stated Staff F was unaware he was not to use a hospital gown for catheter cares and had received education and will wear a disposable isolation gown in the future. On 1/29/25 at 3:23 pm, the Administrator stated her expectation for residents with catheters is for any excess tubing to be tucked into a catheter dignity bag on a wheelchair or otherwise clamped up to stay off of the floor.