STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165373	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Longview	1010 Longview Road Missouri Valley, IA 51555

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on clincal record review, resident interview, staff interview, and policy review the facility failed to make prompt efforts to resolve grievances the resident may have for 1 of 1 residents reviewed (Resident #52). The facility reported a census of 65 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. On 7/15/24 at 1:17 PM Resident #52 stated she reported to Staff O, Social Service Designee and Staff P, Business Office Manager that she was missing $5.00 worth of change, $100.00 in $20 bills, $50.00 in $1 bills, and a couple [NAME] tickets that were no good. Resident #52 stated nothing was done about it. Resident #52 stated she was told by Staff P that she shouldn't have had that much money laying around. Resident #52 stated the facility did not replace the money. Resident #52 stated this happened a couple months ago. On 7/16/24 at 11:42 AM Staff O, Social Service Designee stated that she had heard nothing of Resident #52 missing $165.00. Staff O stated when she reviewed the grievance book there was no grievance filled out related to the missing money for Resident #52. Staff O stated the process should have been that the staff that were notified should go and look through the room and then the police would be notified. Staff O stated the staff that was notified should have filled out a grievance for the Resident #52. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/24 at 11:42 AM Staff P, Business Office Manager stated Resident #52 did mention missing money. Staff P stated she talked about the missing money during stand up or stand down meeting the day she was told by Resident #52. Staff P stated Resident #52 did not say how much money was missing, but Resident #52 did mention the money was missing. Staff P stated it was hard to say who was present during the stand up or the stand down that day she did not remember. Staff P stated she had mentioned it in the meeting but thought that someone else was going to fill out the grievance but from now on she will do it herself. Staff P stated she thought that Staff O was going to fill out the grievance but if she was not present then thought the Administrator or Staff N would have filled out the grievance. Staff P stated when a resident reported missing items this concern would be discussed in stand up, a grievance would be filled out, and then would be assigned to a staff to investigate the concern. Staff P stated that person was then expected to write up an investigation about the concern. Staff P stated this occurred 4 - 6 months ago. On 7/16/24 at 11:55 AM the Administrator stated she was not aware of the incident. The Administrator stated she spoke to Resident #52 and the resident reported that there was $170.00 missing. The Administrator stated the facility would be replacing the money. The Administrator stated Resident #52 only wanted $7.00 replaced. The Administrator stated the facility would be replacing the full amount. The Administrator stated when the resident reports a missing item, the staff should notify management. The Administrator stated she would expect the staff that was notified of the concern would fill out a grievance form. The Administrator stated then she would follow up with the POA or guardian for resolution. On 7/16/24 at 1:00 PM the Administrator stated $300.00 was found in the residents room when searching for missing money. Stated Resident #52 was offered a lock box but refused. Review of policy titled, Grievances with reviewed date of 5/23 documented the staff member who receives a grievance (whether in person or by telephone) that is not immediately resolved as described above, completes the Grievance Report Form with assistance and input from the complaining person. The Form should be signed by the individual filing the Grievance. If a written Grievance is received, it is attached to the Form. The completed Form is provided to the Director of Social Services, or designee, either in person, or if the Director or designee is not immediately available in person, by placing the completed form in a sealed envelope and placing it either in the Director of Social Services mailbox or under his/her door. If the Director of Social Services is unavailable for an extended period of time, the Form should be provided to the Administrator or Manager on Duty.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on clinical record review, staff interview, and policy review the facility failed to complete a Pre-Admission Screening and Resident Review (PASRR) for 1 of 1 residents (Resident #25), who was diagnosed with new mental disorder diagnoses since admission to the facility. The facility reported a census of 65 residents. Findings include: Review of Resident #25's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive deficit. The MDS further revealed diagnoses of anxiety disorder, depression, and post traumatic stress disorder (PTSD). Review of a facility provided document titled, PASRR Notice of Nursing Facility Approval, dated 10/11/22 revealed a summary of findings indicating that Resident #25 that did not show evidence of a serious mental illness or an intellectual or developmental disability (IDD) that appears to require PASRR intervention. The document further revealed the screen remained valid for the stay at the nursing facility. The document revealed the diagnosis of major depression and medication of Escitalopram 10 mg/day. The Electronic Health Record Review (EHR) revealed Resident #25 admitted to the facility on [DATE] from another facility. The EHR review of medical diagnoses for Resident #25 revealed generalized anxiety disorder diagnosed [DATE], PTSD 10/24/23, Insomnia, and major depressive disorder, recurrent, mild. Clinical Physician Orders documented the following orders: Escitalopram Oxalate oral tablet 15 MG one time a day for depression and Melatonin Oral Tablet 10 MG one time a day for sleep aid. During an interview on 7/17/24 at 11:41 AM PM Staff O, Social Service Designee, stated the new diagnoses had been missed and a new PASRR had not been completed. The staff confirmed Resident #18 did not have a PASRR newer than 6/3/21. Staff O indicated that the resident should have had a new PASRR completed with the new mental health diagnoses. On 7/17/24 at 3:21 PM Staff Q, Administrator, stated during an audit 6-9 months ago the facility discovered there was a need for 25-30 PASRR updates due to a provider adding diagnoses for residents and not notifying the facility. The facility missed updating Resident #25's PASRR with the new diagnoses. The facility did not have a policy regarding residents requiring a new PASRR when they were current residents in the facility and had an addition of a mental health diagnosis.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observations, staff interviews, resident interview and clinical record review the facility failed to implement interventions to prevent the worsening of pressure sores for 2 of 3 residents reviewed. While Resident #16 was a resident at the facility, she developed on a pressure sore on her heel. Staff failed to implement orders in a timely manner, failed to use the recommended pressure relieving boots, and failed to apply the treatment properly. Resident #17 had a chronic pressure area on his buttocks and staff failed to use the protective barrier creams as recommended. The facility reported a census of 65 residents. Findings include: The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. 1) According to the MDS assessment dated [DATE], Resident #16 had a Brief Interview for Mental Status (BIMS) score of 12 (moderate cognitive deficit). She was totally dependent on staff for dressing, hygiene, toileting and transfers. She was always in continent of urine and bowel. Diagnosis included atrial fibrillation, heart failure, renal insufficiency, chronic pain and morbid obesity. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Care Plan dated 12/12/23, showed that Resident #16 was at risk for impaired skin integrity due to limited mobility and cardiovascular disease. Staff were directed to observe for signs and symptoms of worsening and to encourage the resident to shift weight evaluate [NAME] integrity, utilize pressure relieving devices on appropriate surfaces. The Care Plan for Resident #16, updated on 3/22/24, showed that the resident had developed a foot ulcer on her right heel that was surgically debrided. She was non-weight bearing and staff were to ensure that her right heel was off-loaded at all times, and that she had Prevalon boots (protective boots with a cushioned bottom that help reduce the risk of bedsores by keeping the heel floated, relieving pressure) to bilateral heels. According to a Comprehensive Skin Evaluation, dated 3/5/24 at 10:34 AM, Resident #16 did not have any identified skin concerns on her heels. A New Skin Alteration Evaluation dated 3/19/24 at 10:56 PM, showed that she had a right heel sore, Stage 2, with a scant amount of serous drainage that measured 2 centimeters (cm) x 3 cm x 0.1 cm. The physician was notified. A Physician's Order was entered on 3/23/24 at 7:00 AM, to clean the heel wound with wound cleanser, pat day and apply collagen pad to the heel. Cover area with Allevyn (foam wound dressing) until healed. The Treatment Administration Record (TAR) showed that the first treatment for the developing wound was on 3/23/24, four days after it was first discovered. On 3/25/24 an order was entered for a specialize wound care service to evaluate and treat. A Wound Care Visit Detail Report, (WCVDR) dated 3/26/24, showed that Resident #16 had been seen on that date and reported that she did not have much feeling in her feet so, initially, she was unaware she had a wound on her heel. She was found to have a Deep Tissue Injury (DTI) that most likely started with a small area. The resident was a sit to stand for all transfers and spent a majority of time in her recliner. She was to continue to wear the Prevalon boots at all times. Orders at this visit included; cleanse the wound with soap and water, pat dry, scrub the wound bed to mechanically debride. Apply skin prep to the entire heel, and change the dressing daily and as needed for soiling. Keep the right foot in Prevalon boot or heels floated at all times. The electronic Physician Order Set showed that the wound order had not been entered until 4/3/24 at 11:30 AM and indicated that the dressings were to be changed every 3 days and as needed if dressing soiled. A WCVDR, dated 4/9/24 showed that while cleansing the wound, the resident indicated it being very sore. There was maceration (lighter in color, wrinkly, soft or soggy, occurs when skin is in contact with moisture too long) in surrounding peri wound. Orders include an addition of calcium alginate to dressing due to drainage and slough. The wound specialist stated that she preferred the Prevalon boot applied going forward as it covers more proximity of the right lower extremity, and was better for off-loading the heels. The ulcer was consistent with pressure as the primary etiology. The heel laid on the foot rests of recliner, very heavy legs with chronic lymphedema. Wound drainage and peri-wound status deteriorated compared to the conclusion of the previous visit. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Change dressing every three days and as needed for soiling. The order was to cleanse the wound, scrub the wound bed and apply Fibracol Collagen/Alginate (103 sq. cm or less) and cover with bordered gauze (103 sq. cm or less) and change the dressing every three days and as needed. Keep the right foot in Prevalon boot or heel floated at all times. The orders entered into the electronic chart on 4/10/24 at 6:15 PM, failed to include the measurement of the Alginate medication. The WCVDR dated 4/16/24, showed that the patient was complaining of more pain to the right heel in last few days. Wound assessment revealed a change in status with increase in length and width, and an odor with increased slough. The area was debrided (procedure to remove infected/dead tissue). Notes included direction to staff to ensure that they cut the calcium alginate to borders of wound, today it was extending over all the maceration of the wound borders, which encouraged the spread of bacteria. The resident asked why the wound was worsening and the Nurse Practitioner (NP) answered that she suspected it was because of non application of Prevalon boots as ordered. Staff were aware and were coming up with a plan to ensure staff was placing the boots on as directed. Staff were also educated to ensure that the nurses understood that primary wound dressing needed to fit within the borders of wound. Frequency of dressing change every other day and as needed for soiling, saturation or unscheduled removal. Odor improved post debridement. Order entered into the electronic chart included instructions to ensure Alginate was cut to size, but indicated dressing changes every 3 days rather than every other day. The WCVDR dated 4/23/24, showed that the wound appeared smaller, but was more concerning for infection. There was an odor that was not eliminate after cleaning. The NP decided to start an antibiotic, and to change treatment. She was unable to clear slough from wound base due to patients pain and increased drainage. Stage 3 full thickness tissue loss subcutaneous fat may be visible but bone tendon or muscle is not exposed. A nursing note dated 4/24/24 at 9:43 PM showed that earlier in the day, Resident #16 had been anxious, crying and feeling like she was going to die. She was sent to the emergency room where they determined she had fluid overload and was being transferred to a different hospital to deal with the infection in her right foot. According to the hospital report dated 4/24/24, the chief complaint was shortness of breath but the doctor was concerned about the necrotic skin on her right heel due to a pressure ulcer with a foul smell. She was given an antibiotic and transfer to hospital at 5:12 PM. According to the Hospital Encounter Summery dated 4/30/24, upon admission on 4/24/24, the patient had a stage 3 pressure ulcer on the right heel. She was referred to surgery for irrigation and debridement right heel ulcer and went to the operating room on 4/27/24. A nursing note dated 4/30/24 at 8:34 PM showed that she was readmitted to the nursing home on that date with surgical wound with 5 staples. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 7/17/24 at 10:56 AM, the Wound Care Nurse Practitioner (WCNP) said that she first saw Resident #16 on 3/26/24, and the resident had a Deep Tissue Injury (DTI). The WCNP recommended that Prevalon Boots be used at all times. She saw the resident again on 4/2/24, at that time, the wound was partially open, so she added an order for Collagen/Allginate. On the 4/9 visit, the heel was macerated with sloth and the resident reported more pain. At that visit, the resident was wearing blue heeled booties for protection, and the staff said that they didn't have the Prevalon boots, so the WCNP recommended that they should at least try to float the heels. On the 4/16 visit, when she took that dressing off to look at the wound, there was a distinct odor with increased sloth, and was determined to be a Stage 3 pressure. The WCNP said that the Alginate had been cut bigger than the open wound so she educated the staff on ensuring that that fabric was cut to the size of the wound because when it was bigger, bacteria tends to spread. Again, the resident was not wearing the Prevalon boots at this visit. On 4/23 the resident was in a lot of pain, the wound was odorous and she could smell it as soon as she walked in the room. She did some debriding, but was unable to continue due to the resident's pain. The WCNP started the resident on an antibiotic and ordered labs. She said that she would have wanted a phone call sooner, when the odor and infection had gotten worse through the week. She said that the wound had a very rapid deterioration and quick intervention was the key. If they could have gotten an antibiotic sooner, it may have changed the outcome. The resident was unable to lift her legs and the boots that they were using did not provide adequate support to her heel as the Prevalon boots could. On 7/17/24 at 9:39 AM Staff C Licensed Practical Nurse (LPN) said that she had changed the residents bandage on her heel several times. She did not remember the dates, but did remember that there was an odor at one point. She reported to the next shift and knew that the resident would be seen by wound care. On 7/17/24 at 12:33 PM Staff D, Certified Nurse Aide (CNA) said that she did work with Resident #16 during the time that the spot on her heel was getting bad. She said that she told at least two nurses that there was increased in odor, and she thought that they had assessed it, but she wasn't sure. Staff D said that she noticed the odor about a week or 2 before the resident went to the hospital. On 7/18/24 at 9:17 AM Staff A, CNA said that she had worked with Resident #16 quite a bit during the time the ulcer was developing on her heel. She said they were using the small blue boots for protection, and they didn't fit her very well, I just used what they gave me to use. She thought they had used them for about a month. Staff A had given the resident bed baths during that time, and she was told not to unwrap the bandage on the heel, so she hadn't seen the wound. On 7/17/24 at 3:25 PM Staff G, CAN, remembered when the blister started on the heel of Resident #16. Staff G said that the resident had a lot of swelling in her feet and legs, and the protective boots that they put on her for support were too small. On 7/17/24 at 12:49 PM, Staff J, Assistant Director of Nursing (ADON), and wound care nurse said that he had no knowledge of signs of infection in the heel wound, and none of the staff reported an odor. He said that he would have contacted the Primary Care Physician (PCP) or the wound care services, but there was no report of odor or worsening of the ulcer. He maintained that the heel was getting better. According to the WCVDR notes, Staff J was present for the wound care visit on 4/16/24 and on 4/23/24 when there was mention of an odor. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 7/18/24 at 9:10 AM Staff J, and Staff Z, Nurse Consultant, said that there was just one time when the wound nurse came and the resident was not wearing the Prevalon boots and that was because they were soiled, and in the laundry. They maintained that the heels were always floated. On 7/18/24 at 11:00 AM, Staff J and Staff Z said that while doing rounds, they found that they needed to do some education with staff because some pressure prevention interventions were not being implemented. They had the in-service on 4/18/24 and educated the nurses on how to apply the Calcium/Alginate treatments. 2) According to the MDS assessment dated [DATE], Resident #17 had a BIMS score of 15 (intact cognitive ability). He was totally dependent on staff for dressing, and toileting hygiene. He was frequently incontinent of urine and always incontinent of bowel. His diagnosis included; anemia, benign prostatic hyperplasia, neurogenic bladder, wound infection, paraplegia, anxiety disorder, and unspecified intellectual disability. The Care Plan revised on 5/29/24 showed that he had urinary incontinence related to a neurogenic bladder and spinal cord injury. Staff were directed to apply barrier cream to peri area after each incontinent episode, to monitor for incontinence episodes and to keep the skin clean and dry. On 7/15/24 at 1:03 PM, Resident #17 said that he had a pressure area to his bottom and it hurt sometimes. According to a Comprehensive Skin Evaluation dated 7/14/24 at 12:15 AM the resident did not have any skin concerns and they were applying barrier cream as preventative measure. On 7/15/24 at 1:07 PM, Staff A CNA, and Staff B CNA transferred Resident #17 to his bed and provided incontinence cares. When they removed his brief and cleaned his buttocks, it was revealed that the resident had three reddened spots on the upper right thigh and a small open area. They asked him if he wanted lotion or house powder. The resident replied you tell me. They then said that they would have the nurse come in later and proceeded to apply a clean brief without barrier cream on his sores. A nursing note dated 7/15/24 at 4:00 PM showed that the resident had a fluid filled blister on the right thigh measuring 1.5 cm x 1.0 cm. On 7/17/24 at 1:10 PM, the Director of Nursing (DON) said that she would expect staff to apply a barrier cream after every incontinence episode. On 7/18/24 at 11:47 AM, Staff J said that the resident had a heavy cream that was used three times a day on the resident's buttocks and thighs. He said it was very thick and stayed on between incontinence episodes, so there was no need to use a barrier cream unless the resident was getting a bath. When pointed out that there was no cream on the resident at the time of observation, he said he couldn't speak to that, and the aides should have gotten the nurse to put on the cream. According to a facility policy titled: Prevention of Pressure Injuries, revised in 2020, the prevention of pressure injury included cleaning promptly after episodes of incontinence. Use a barrier product to protect skin from moisture. Staff were to select appropriate support surfaces based on the residents risk factors.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on clinical record review, staff interviews, provider interview and policy review the facility failed to provide a professional standard of quality of care by not following physician orders and failing to maintain continence for 2 of 4 residents reviewed (Resident #61, #17). The facility reported a census of 65 residents. Findings include: 1. Review of Resident #61's MDS assessment dated [DATE] indicated no bladder or bowel appliances, and occasional incontinence. The resident required partial to moderate assistance for toileting transfers and dependence for toileting hygiene. Review of Resident #61's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive deficit. The MDS further revealed diagnoses of urinary tract infection (UTI), and septicemia. The resident had an indwelling catheter and urinary continence was not rated. Resident #61's Care Plan revealed a focus area of bladder incontinence related to confusion, impaired mobility, inability to communicate needs, hypoxia with exertion, urinary retention on tamsulosin, and saw gynecology related to a pelvic mass - initiated on 11/7/23 and revised on 6/27/28. Interventions for staff included the following: -Use of disposable briefs/pull up briefs, -Monitoring and documentation of signs/symptoms (s/sx) for UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns with initiation date of 11/07/2023. -Staff were to monitor/document/report to the provider as necessary possible medical causes of incontinence: bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, and medication side effects with date initiated of 11/07/2023. -Staff were to check for incontinence episodes often, assist to wash, rinse and dry the perineum and change clothing after incontinence episodes as needed with the initiation date of 11/07/2023. An additional focus area of risk for dehydration or potential fluid deficit related to sepsis, recurring UTI's, and respiratory infections was initiated on 7/1/24. Interventions for staff included monitoring/documenting, reporting s/sx of dehydration. Review of Resident 61's electronic health record (EHR) Progress Notes provided the following: (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 6/10/24 to 6/16/24 revealed no complaints of pain, decreased fluid intake or increased confusion. On 6/16/24 at 2:55 PM Resident #61's daughter contacted the facility with a request for a urinary analysis (UA) due to concerns the resident had a urinary tract infection (UTI) as the resident was complaining of pain and had increased confusion. The nurse faxed a request for a UA with culture and sensitivity (C&S) if indicated. On 6/17/24 at 11:30 AM the document titled, eINTERACT SBAR, indicated the resident's temperature was 98.0, resident had an increase in morphine, no changes in mental status evaluation, was alert and oriented, had no tremors, and lung sounds were diminished. The provider's response to the document was a fax was sent for order dated 6/16/24. On 6/18/24 at 12:52 PM the record indicated a one time UA with C&S was ordered. On 6/19/24 at 8:18 AM it was documented the resident was lying in bed with her head hanging over the bed touching the floor and complained of pain in the left side that made her jump. On 6/19/24 at 7:15 PM Resident #61 was found to be lethargic and weak, and was transferred to the emergency room . The resident was admitted to the hospital for Acute Kidney Injury, Pneumonia, and UTI. On 6/20/24 at 8:11 PM the facility received the results from the UA and faxed the results to the provider. On 6/21/24 at 9:10 the results of the C&S were received and faxed to the provider. On 6/24/24 Resident #61 readmitted to the facility with diagnoses of Sepsis and UTI, and antibiotics of Doxycycline and Metronidazole. The EHR indicated a prescriber written order entered on 6/18/24 for a one time UA with C&S with a start date of 6/18/24 at 1:00 PM and end date of 6/19/24 at 12:59 PM. The Hospital Discharge Record dated 6/24/24 revealed the principal problem for Resident #61 was Sepsis due to UTI and active problems of acute metabolic encephalopathy and anemia requiring transfusions. The document revealed there was a component of polypharmacy to her mentation, although the UTI was the main reason for encephalopathy at presentation. Resident #61 had a urinary Foley catheter placed during the hospitalization with a voiding trial in 1 week. Resident's hemoglobin was stable at discharge, mentation had improved to baseline, and acute kidney injury was improving. The resident received Cefepime and Rocephin IV as well as Flagyl orally during hospitalization . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 7/17/24 at 9:40 AM the Advanced Registered Nurse Practitioner (ARNP) stated there were multiple missed opportunities for prevention of Resident #61's hospitalization . The ARNP stated the family called the facility on the morning of 6/16/24 indicating Resident #61 complained of back pain and decreased mental abilities, which were signs of the resident developing a UTI. The facility nurse proceeded to send a fax requesting a UA rather than calling the on-call provider and getting a verbal order due to a change in condition. The ARNP indicated on 6/17/24 she signed the order for the UA and faxed it back to the facility. On 6/18/24 the provider completed rounds at the facility and was notified the UA had not been completed. The facility stated they had not received an order for the UA. The ARNP stated she provided the order for completion on 6/18/24. On 6/19/24 the provider received a notification in the morning that the resident had fallen in her room and hit her head. At the time of the fall the ARNP stated the UA had not yet been completed. The ARNP received a call later in the evening indicating the resident had a further decline in mental status. The provider ordered Resident #61 be sent to the emergency room by 911. The provider believed had the staff called with the initial change in status on 6/16/24 the outcome of falling and hospitalization would have been prevented. The provider expected that the facility would notify the provider by phone with any change in status, especially with changes of mental/cognition and shortness of breath. The provider stated there was always a staff on call for notification of change in status, including after hours and weekends. The expectation with UA orders would be to complete with a straight catheterization if the resident is unable to move or complete toileting and correctly utilize a hat for urine capture. The ARNP stated since this incident communication has improved with the facility and had no further concerns. On 7/17/24 at 2:09 PM Staff K, Director of Nursing, Registered Nurse, indicated the order for the UA was faxed as the request for it was on the weekend. The staff indicated another request for a UA was obtained as she was unsure if the first order got passed along. Staff K stated a nurse's response if there was a change in condition would be to complete a full change of condition assessment, call the physician, and carry out the orders. The staff expected orders would be carried out within an hour or 2, write a hard note, place it in Point Click Care (PCC) and note the order. If the order involved medications a call would be placed to the pharmacy, especially if it was a new medication or change in medication. On 7/17/24 at 3:21 PM Staff Q, the Administrator, stated orders should be followed as urgent as needed based on the severity and diagnosis. With regards to Resident #61 the staff indicated there had been a break in communication, obtaining and completing the orders for the UA. The facility met with the Provider on 6/20/24 and a plan was put into place for prevention of further breakdown including training nurses and auditing of orders. On 07/18/24 at 10:48 AM Staff L, LPN, stated nurses should be calling the on call provider on the weekend with any changes in conditions noted to residents. Orders frequently were faxed over the weekend as no one is in the providers' office. Staff L stated there was an in-service on this incident where all the nurses participated in an in-service and signed the education. On 7/18/24 at 10:50 AM Staff M, RN, indicated had just started working in the facility on this date. Staff stated if a physician was needed on the weekend, would check the profile page for the on-call doctor. On 07/18/24 at 11:12 AM Staff N, Assistant Administrator / Certified Nursing Assistant (CNA)/Certified Medication Aide (CMA) stated the staff should be calling physicians with any changes in conditions and not faxing. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	The unnamed facility training form revealed faxes come through the main fax. The DON or designee M-F during normal business hours will hand the orders to the day shift nurses. Weekends, nights, holiday's and outside normal business hours it is the nurses responsibility to check the fax machine for any new orders. It further revealed obtaining orders for physicians whether it is a telephone order, verbal order, or written order. (if need for order on the weekend occurs, contact the on call physician. The on-call physician list is at each nurses station and above the fax machine). Place order into Point Click Care. Complete the order - If it is a medication order, fax and call pharmacy to get the medication sent to facility. If it is a lab order, collect the blood draw or urine sample as soon as possible. If it is an x-ray order, go onto trident care and place order for x-ray, then print requisition off to fax to physician to sign and send back. Once a lab specimen is collected, the specimen needs to be taken down to the lab. Document that the lab specimen was obtained and who took the lab specimen down to lab. Once lab results are obtained, call the physician for further orders. (if it is the weekend, call the on-call physician). Ensuring that the nurse is using the SBAR note for communicating with the physician. 41785 2. According to the MDS assessment dated [DATE], Resident #17 had a BIMS score of 15 (intact cognitive ability). He was totally dependent on staff for dressing, toileting hygiene. He was frequently incontinent of urine and always incontinent of bowel. His diagnosis included; anemia, benign prostatic hyperplasia, neurogenic bladder, wound infection, paraplegia, anxiety disorder, and unspecified intellectual disability. The Care Plan revised on 5/29/24 showed that Resident #17 had urinary incontinence related to a neurogenic bladder and spinal cord injury. Staff were directed to apply barrier cream to peri area after each incontinent episode, to monitor for incontinence episodes and to keep the skin clean and dry. On 7/15/24 at 1:03 PM, Resident #17 said that he had a pressure to his bottom and it hurts sometimes. On 7/15/24 at 1:07 PM, Staff A CNA, and Staff B CNA transferred Resident #17 to his bed and provided incontinence cares. They transferred the resident with the use of the Mechanical Lift and as they lifted him from the wheelchair, it was revealed that there was a protective pad in the wheelchair soaked with urine and his shorts were soiled. They asked him what time he had gotten up that morning and he said he had been in his chair since after his bath at 8:30 AM. On 7/17/24 at 10:07 AM, Staff X CNA said that at one time, Resident #17 would use his urinal more throughout the day and would ask for help, but recently he hadn't been asking and so he was usually incontinent, and he needed help with the urinal. On 7/17/24 at 10:08 AM, Staff Y CNA said that in the past, Resident #17 would ask for help with the urinal or he would tell staff when he needed to use the toilet. But most recently, he didn't ask, and he would be in his wheelchair all day. Because he had a large belly, it was difficult for him to use the urinal while sitting in his chair so he mostly was incontinent throughout the day and used the urinal at night. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 7/17/24 at 1:10 PM, the Director of Nursing (DON) said that she would expect staff to offer to toilet the resident at least every 2 hours. According to the facility policy dated August 2022 titled: Continence and Incontinence - Assessment and Management. The physician and staff would provide appropriate services and treatment to help residents improve bladder function and prevent urinary tract infections. Staff and physicians will evaluate the effectiveness of interventions and implement additional pertinent interventions as indicated.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on observations, resident interviews, staff interviews, resident council notes, and policy review the facility failed to provide food at an appetizing temperature to 4 of 20 residents reviewed (Resident #25, #52, #59, and #61). The facility reported a census of 65 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. On 7/15/24 at 1:13 PM Resident #52 stated the food is cold half the time when it should be warm. 2. The Minimum Data Set (MDS) dated [DATE] revealed Resident #59 had a Brief Interview for Mental Status (BIMS) score of 13 indicating no cognitive impairment. On 7/15/24 at 10:56 AM Resident #59 stated the corn dogs were served cold a couple nights ago. Resident #59 stated the manager in the kitchen will not listen to the residents about the food. Resident #59 stated when she first came to the facility she told the kitchen manager the food was slop and was cold. Resident #59 stated the food is frequently cold. Resident #59 stated the food had been served cold in the last week. Resident #59 stated the facility had a resident meeting once a month. Resident #59 stated a lot of people complain about the food at these meetings. On 7/15/24 at 12:06 PM an observation revealed a room tray being delivered from the dietary cart by Staff I. Request for remake of the tray and temperature check of food on the plate. Temperature check completed revealed temperature of 132 degree for beef stroganoff and temperature of 111 degrees for brussels sprouts. On 7/17/24 at 1:17 PM Staff H, [NAME] stated he had worked at the facility for [AGE] years. Staff H stated he did not remember any complaints from residents at the facility about the food being served cold. Staff H stated he would expect the brussels sprouts would have been warmer than 111 and that the dietary cart was gone for 20 minutes prior to the plate returning to the kitchen for temperature check. On 7/17/24 at 1:20 PM Staff I, Dietary Aide stated the dietary cart had been out of the kitchen for about 20 minutes when the tray was obtained for temperature check. Staff I stated it was his intention to deliver the tray to Resident #59 when asked to obtain a temperature and remake the plate. Staff I stated the plate was taken directly to the kitchen to obtain a new plate and test the temperature. Review of document titled, Resident Council Concerns 4-1-24 documented that residents expressed concerns that the hamburgers are often over cooked, dry, and cold. Also eggs and oatmeal are often cold when served. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/16/24 at 12:32 PM the Administrator stated ideally the tray would go right to the residents room. The Administrator stated obviously the temperature would decrease with any length of delivery hold up. The Administrator stated the facility's expectation was the brussels sprouts would have been delivered to the room at a higher temperature than 111 degree. Review of document titled, Food Preparation and Service revised 4/19 documented that proper hot and cold temperatures are maintained during food service. 49628 3. Review of Resident #25's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive deficit. The resident required setup for meals. On 7/15/24 at 11:50 AM Resident #25 stated she always consumes her meals in her room. The food is often cold and pasta is mushy. At 1:03 PM the resident stated the pasta was sort of warm and she did not eat the vegetable as it was not part of her diet. 4. Review of Resident #61's MDS assessment dated [DATE] revealed a BIMS score of 15 indicating no cognitive deficit. On 7/15/24 at 11:20 AM Resident #61 stated she ate the majority of her meals in her room and they were not always hot. At 1:12 PM the resident had left the majority of her food on her plate and indicated she had not wanted to eat the meal. Resident #61 stated the meal was warm but not really hot. On 7/16/24 at 10:46 AM Staff H, AM Cook, stated the kitchen started using hot plates to assist with maintaining temperatures on the room trays/delivery of meals due to concerns with food temperatures from the previous day. During continuous observation on 7/16/24 at 11:30 AM of the kitchen service of room trays, Staff H removed the heated hot plates from the steam oven, placed a single plate on each tray, placed the plate with food on the heated plate, covered it with an insulated warmer, and Staff R, cook, placed the tray in the delivery cart. On 7/17/24 at 12:35 PM Staff S, Dietary Manager I, stated foods should be served at the appropriate temperatures and the kitchen had implemented a new process for delivery of trays including the use of heated plates to maintain the temperature of the food. The facility policy, Food Preparation and Service revised 4/19, indicated proper hot and cold temperatures were maintained during food service.

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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. 49628 Based on observations, staff interviews, and policy review the facility failed to follow proper sanitation, food safety and food handling practices in accordance with professional standards. The facility reported a census of 65 residents. Findings include: Observation on 7/15/24 at 9:30 AM noted Staff H, cook, to have facial hair but not a facial covering. Continuous observation on 7/15/24 at 10:38 AM noted Staff H, cook, to have facial hair and no covering, Staff I, Dietary Aide, observed to have facial hair and no facial covering, and Staff U, Dietary Aide, to have facial hair and no facial covering. Continued continuous observations revealed the following: Staff H, served food items from the steam table using gloves and scoops and placed the plates on the trays with insulated covers. Staff S, cook, took the tray with hot food, added uncovered cold beverages and uncovered desserts to the trays, and placed the trays in the transportation carts for delivery to Memory Care, assisted living which resides on the bottom floor of the building and room tray delivery. Staff S wore gloves during handling of the trays, dessert plates, and cups. A total of 48 trays were delivered without dessert covering or cold beverage coverings. Staff S was observed to remove gloves, leave the kitchen area, return, and don gloves without hand hygiene following glove removal, re-entry into the kitchen or donning gloves. Staff I was observed to enter the kitchen several times following delivery of meal carts and proceed to load/unload the dishwasher, manage clean plates without hand hygiene. Observed the staff touch face and hair multiple times and continued with kitchen tasks without hand hygiene. Staff W, Dietary Aide, left the kitchen, returned, donned gloves, and proceeded with drink management without hand hygiene. Staff W utilized individual glasses to scoop ice and fill with beverages. Staff W did not utilize a scoop for adding ice to cups. On 7/17/24 at 12:35 PM Staff S, Dietary Manager I, stated staff should be completing hand hygiene upon entering the kitchen, before, after and with glove changes. The kitchen did have 2 sinks for hand hygiene. One sink was located by the dishwasher and one by the food preparation area. Staff S indicated staff with facial hair must wear coverings or shave. The staff provided personal hygiene education to the staff regarding facial hair and hands. Staff S stated staff must use a scoop for placing ice in glasses and not use the glass itself. Food and drink items placed on trays for room or wing delivery must have coverings over them before placement in the tray carts. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy, Food Preparation and Service revised 4/19, revealed staff must perform hand hygiene before serving food to residents, after collecting soiled plates and food waste prior to handling food trays. Staff must wear hair restraints including hair and beard restraints. It further revealed staff should adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. The facility policy, Handwashing/Hand Hygiene Revised 8/19, revealed hand hygiene should be performed before applying gloves and upon removal of gloves.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on resident interview, staff interview, electronic health records (EHR) review, and policy review the facility failed to maintain medical records on each resident that were complete and accurate by not signing medication administration records when the enteral feeding was given for 1 of 2 residents reviewed (Resident #52). The facility reported a census of 65 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 had a Brief Interview for Mental Status (BIMS) score of 13 indicating no cognitive impairment. The MDS also revealed Resident #15 required use of an enteral feeding tube for nutritional intake. On 7/15/24 at 3:09 PM Resident #15 stated the evening nurse forgets to turn the pump on sometimes and the am nurse finds it in the morning. Resident #15 stated she did not miss any feedings. On 7/17/24 at 9:00 AM Resident #15 stated when the enteral feedings were not started on time she would notify the nurse and the feeding would be started or sometimes she would fall asleep and not notice and the am shift nurse would ask her in the morning and feedings would be started then. Review of Resident #15's Medication Administration Records (MAR) and Treatment Administration Records (TAR) documented for the month of February 2024 enteral feedings were not signed off on the 8th, 20th, 22nd, 27th, and 29th. For the month of March 2024 enteral feeding were not signed off on the 6th, 14th, 20th, 21st, 25th, 27th, and 28th. For the month of April 2024 enteral feeding were not signed off on the 1st, 3rd, 11th, 16th, 21st, 25th, and 30th. For the month of May 1st, 2nd, 9th, 14th, 16th, 23rd, 29th, and 30th. On 7/17/24 at 6:04 AM Staff T, Licensed Practical Nurse (LPN) stated she works overnight and took care of Resident #15 last night. Staff T stated Resident #15's enteral feedings were ordered to be started at 6 pm. Staff T stated for the most part she starts the enteral feedings on time. Staff T stated the morning shift unusually shuts the feeding off. Staff T stated Resident #15 had never missed a feeding that she had heard of or knew of. On 7/17/24 at 9:38 AM Staff C, Licensed Practical Nurse (LPN) stated she worked 6 am - 6 pm. Staff C stated Resident #15's enteral feedings used to be started on the am shift. Staff C stated she never started Resident #15's enteral feedings on the am shift because Resident #15 was usually at supper or not in bed yet. Staff C stated she thought if she did not sign the MAR that it would be left open for the PM shift to sign and would leave the MAR pink. Staff C stated she never missed starting any of the feedings. Staff C stated she would occasionally chart in PCC that the feeding had not started because the resident was unavailable. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24 at 10:19 AM Staff V, Registered Nurse (RN) stated she worked the hall that Resident #15's room was on all the time. Staff V stated she worked 6 pm - 6 am. Staff V stated Resident #15's enteral feedings were usually around 7 pm unless Resident #15 was in the dining room late. Staff V stated Resident #15's enteral feeding times were moved but the enteral feedings were never set up when she arrived. Staff V stated Resident #15 stated she didn't like the feeding being set up late. Staff V stated Resident #15 never missed a feeding. Staff V stated the way the MAR was set up she would only see the 6 pm orders. Staff V stated she would start Resident #15's enteral feedings every night she worked but did not always sign the feedings off if it was set to be signed prior to 6 pm. Staff V stated she always started Resident #15's enteral feeding every night that she worked just after narcotic count. Staff V stated Resident #15 never missed a feeding. Staff V stated she may have not signed the MAR off appropriately every time. On 7/17/24 at 10:56 AM the DON stated Resident #15 had not reported that her enteral feeding was being started late. The DON stated the facility's expectation was that the nurse that started the feeding would have documented in the MAR - TAR. The DON stated the facility's expectation was that a progress note would have been entered if the enteral feeding was not started or not started on time. Review of policy titled, Administering Medications revised 4/19 documented when administering medication it was required that the individual administering the medication must sign the MAR with signature and title.

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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** 41785 Based on observations, staff interviews, clinical record review and facility policy review the facility failed to provide adequate hand hygiene and Enhanced Barrier Precautions (EBP) for 3 of 9 residents reviewed for precaution. Staff failed to change gloves during incontinence cares for Resident #17, and failed to use proper Personal Protective Equipment (PPE) during catheter cares for Residents #25 and #21. The facility reported a census of 65 resident. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #17 had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive ability). He was totally dependent on staff for dressing, and toileting hygiene. He was frequently incontinent of urine and always incontinent of bowel. His diagnosis included; anemia, benign prostatic hyperplasia, neurogenic bladder, wound infection, paraplegia, anxiety disorder, and unspecified intellectual disability. The Care Plan revised on 5/29/24 showed that he had urinary incontinence related to a neurogenic bladder and spinal cord injury. Staff were directed to apply barrier cream to peri area after each incontinent episode, to monitor for incontinence episodes and to keep the skin clean and dry. On 7/15/24 at 1:07 PM, Staff A CNA, and Staff B CNA transferred Resident #17 to his bed and provided incontinence cares. They transferred the resident with the use of the Mechanical Lift and as they lifted him from the wheelchair, it was revealed that there was a protective pad in the wheelchair soaked with urine and his shorts were soiled. With gloved hands, they removed his soiled brief and Staff B wiped the feces from his buttocks. With the same gloves, she then held onto the resident's hip area to roll him over. On 7/17/24 at 1:10 PM the Director of Nursing (DON) said that she would expect staff to change gloves after wiping resident and before touching other surfaces. 49628 2. Review of Resident #25's Minimum Data Set (MDS) dated [DATE] revealed a BIMS score of 15 indicating no cognitive deficit. The MDS revealed diagnoses of renal insufficiency, renal failure or end stage renal disease, multidrug-resistant organism (MDRO) and dependence on renal dialysis. Resident #25's Care Plan revealed a focus area related to dialysis with a failed arteriovenous (AV) fistula in the left forearm and a permacath placed 6/22/23 in the chest. Interventions for staff included the following: Nurse completion of pre and post dialysis assessments and report abnormalities. (continued on next page)

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Azria Health Longview	1010 Longview Road Missouri Valley, IA 51555

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	Additional focus area revealed the resident required Enhanced Barrier Precautions (EBP) related to MDRO - extended-spectrum beta-lactamase (ESBL - producing Enterobacterales) with an initiation date on 4/25/24 and revision on 7/15/24. A goal included the resident remaining on EBP through the next review with date initiated 4/25/24 and target date of 9/1/24. Interventions for staff included: Use appropriate personal protective equipment (PPE), and maintain EBP in accordance with Centers for Disease Control (CDC) guidelines On 7/17/24 at 10:36 AM Staff J, Licensed Practical Nurse (LPN) Assistant Director of Nursing/Wound Nurse, entered Resident #25 to complete the post dialysis assessment. Staff J entered the resident's bathroom and completed hand hygiene. The staff proceeded to ask the resident questions regarding breakfast, snacks, and transportation while entering the information into a laptop computer. Staff J proceeded to take the resident's temperature, blood pressure using a manual cuff and stethoscope, pulse, listen to the resident's heart, and respirations. Staff J placed the blood pressure cuff around his neck and continued with the assessment. The staff and resident discussed the resident's pain (location, intensity, and medications). Staff J utilized hand sanitizer and proceeded to assess the resident's AV fistula and permacath site. Throughout the assessment the staff did not utilize any PPE. The Administrator, on 7/17/24 at 3:30 PM stated staff were to follow EBP as required. The Director of Nursing (DON), stated when completing a post dialysis assessment the nurse should utilize EBP including gown, gloves, and mask. The DON stated EBP with Resident #25 were especially important as the resident had a perma-cath and increased risk for infection. The facility policy, Enhanced Barrier Precautions 8/22, indicated targeted gown and glove use during high contact resident care activities. Gloves and gown are applied prior to performing high contact resident care activity and face protection may be used. EBP were indicated for residents with indwelling medical devices regardless of MDRO colonization and remained in place until discontinuation of the indwelling medical device. 47673 3. The MDS assessment dated [DATE] revealed Resident #21 had a BIMS score of 10 indicating moderate cognitive impairment. The MDS documented use of an indwelling catheter. An observation on 7/16/24 at 1:38 PM of Resident #21's catheter cares completed by Staff B, CNA with Staff J, LPN, ADON, Wound Nurse present revealed hand hygiene was completed by both staff and gloves were applied. Staff B utilized clean warm wash cloths to provide catheter care. Staff B completed catheter cares and removed gloves and completed hand hygiene. Staff B did not apply a gown when completing catheter cares on Resident #21. Review of Resident #21's electronic health records (EHR) titled, Care Plan documented Resident #21 requires Enhanced Barrier Precautions related to: Indwelling Medical Device (Indwelling Catheter). Review of ERH titled, Medication Administration Record and Treatment Administration Record documented a physician's order for a Foley catheter. On 7/16/24 at 1:46 PM Staff J stated enhanced barrier precautions (EBP) should have been followed. Staff J stated a gown should have been donned when catheter cares were completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/24 at 4:44 PM the DON stated with enhanced barrier precautions there should be gowns and gloves worn. The DON stated a gown should have been worn by Staff B when completing catheter cares on Resident #21. Review of document titled, Enhanced Barrier Precautions (EBP) revised 8/22 documented EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. Centers for Disease Control and Prevention website titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), visited 7/11/24 and updated 7/12/22 revealed recent changes included, additional rationale for the use of Enhanced Barrier Precautions (EBP) in nursing homes, including the high prevalence of multidrug-resistant organism (MDRO) colonization among residents in this setting. Expanded residents for whom EBP applies to include any resident with an indwelling medical device or wound (regardless of MDRO colonization or infection status). Expanded MDROs for which EBP applies. Clarified that, in the majority of situations, EBP are to be continued for the duration of a resident's admission. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status and Infection or colonization with an MDRO. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care.