STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165383	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Rehabilitation & Health Care Center	615 SE Kent Street Greenfield, IA 50849

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 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. (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 3Number of residents cited: 1Based on staff interviews, Electronic Health Record (EHR) review, policy review and document review, the facility failed to provide the estimated cost of service with the end of a Medicare part A stay or when all of part B therapies were ending to 1 of 3 resident representatives (Resident #6). The facility reported a census of 43 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #6's Brief Interview for Mental Status (BIMS) documented Resident #6 was rarely / never understood. Review of the document dated 5/28/25 titled, Declaration Relating to Life-sustaining Procedures (Living Will) and Durable Power of Attorney For Health Care Decisions (Medical Power of Attorney) documented Resident #6's daughter as power of attorney for health care decisions. Review of Resident #6's EHR titled, Profile documented Resident #6's daughter as the responsible party.Review of document titled, Notice of Medicare Non-Coverage for Resident #6 documented no signature of date from Resident #6 or Resident #6's representative.Review of document with mailed date of 5-30-25 titled, Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage for Resident #6 did not document the estimated cost of the services per day/item or service. The document also contained no signature of patient or authorized representative. Review of email dated 6/27/25 from Resident #6's daughter documented on the notice of non-coverage, the estimated cost was not included. Can her secondary insurance cover some of that cost? If physical therapy will help her build strength and rehabilitate after the trauma, Resident #6's daughter explained she would like to review the costs and logistics of providing Resident #6 that care.Review of email response dated 6/27/25 to Resident #6's daughter from Staff L, Licensed Practical Nurse (LPN) / Social Services Department Staff documented, Let's talk about this. Review of email response dated 6/27/25 to Resident #6's daughter from Staff M, MDS Coordinator / Assistant Director of Nursing (ADON) documented Therapy cannot work with Resident #6 as she is unable to follow directions. Medicare will not pay for therapy if there is no progress. If you would like to pay privately for therapy you may. Review of email response dated 7/15/25 to Resident #6's daughter from Staff L documented a forward of the email that Staff M sent on 6/27/25. Email documented a request after reading let the facility know if there are any further questions. Email explained Staff L emailed form, Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage and requested the form signed and returned.Review of email response dated 7/15/25 from Resident #6's daughter to Staff L documented the form Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage was not attached. Resident #6's daughter explained in the email she did not necessarily need the form as she had been carrying the one she received in the mail with her awaiting a response to her questions. Resident #6's daughter explained in the email she had not received an answer to her question about the secondary insurance covering physical therapy. Resident #6's daughter explained further she had asked about an estimated cost for the physical therapy. Resident #6's daughter explained in the email the estimated cost was left blank on the form that was sent and the form came with option 3 already checked as if it was already chosen by the facility without giving her the information for the other options. Resident #6's daughter continued to explain she did not feel comfortable signing and mailing back until she received the answers to the questions she had posted on 6/27/25.On 7/16/2025 at 3:40 PM Staff L, stated she was unable to determine the cost of therapy services. Staff L stated she had a resident that was private pay and could not determine the breakdown of cost when requested. Staff L stated she did not complete the NOMNC / CMS 10123. Staff L stated she spoke with the Administrator about the estimated cost of services and the Administrator discussed it with therapy as well. Staff L stated eventually she did get an estimated cost of services.On 7/16/2025 at 4:21 PM the Administrator stated Resident #6's daughter came into the facility and paid for her mothers stay and the form titled, Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage was not brought up to Resident #6's daughter's attention then. The Administrator acknowledged the estimated cost was not on CMS-10055 form. The Administrator explained the beneficiary notice should have been followed up on once Resident #6's daughter had requested the information. On 7/16/2025 at 4:28 PM Staff M stated Resident #6's daughter was emailed the form Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage and it that she had been given the 48 hour notice. Staff M stated Resident #6 had met her potential and because of her dementia she could not remember her education after it was provided. Staff M stated Resident #6's daughter accepted taking Resident #6 off the skilled services. Staff M acknowledged she was the staff that

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Number of residents sampled: 11Number of residents cited: 8Based on clinical record review, staff interview and guidance from the 2024 Resident Assessment Instrument (RAI) Manual, the facility failed to complete and transmit Comprehensive Minimum Data Set (MDS) Assessments within federal guidelines for 6 of 11 residents (#1, #2, #4, #6, #8, #18) reviewed for MDS Assessments. The facility reported a census of 43 residents.Findings include:1. The admission (Comprehensive) Minimum Data Set (MDS) of Resident #1 documented an Assessment Reference Date (ARD) of 3/18/25. The MDS recorded the resident had an admission date to the facility of 3/12/25. Page 58 of the MDS recorded a completion date of 4/2/25, day 22 of the resident's stay.2. The admission (Comprehensive) MDS of Resident #2 documented an ARD date of 1/15/25. The MDS recorded the resident had an admission date to the facility of 1/3/25. Page 58 of the MDS recorded a completion date of 1/28/25, day 26 of the resident's stay.3. The admission (Comprehensive) MDS of Resident #4 documented an ARD date of 8/2/24. The MDS recorded the resident had an admission date to the facility of 7/26/24. Page 58 of the MDS recorded a completion date of 8/16/25, day 22 of the resident's stay.4. The admission (Comprehensive) MDS of Resident #6 documented an ARD date of 5/22/25. The MDS recorded the resident had an admission date to the facility of 5/7/25. Page 58 of the MDS recorded a completion date of 5/22/25, day 16 of the resident's stay.5. The admission (Comprehensive) MDS of Resident #8 documented an ARD date of 6/19/25. The MDS recorded the resident had an admission date to the facility of 6/6/25. Page 58 of the MDS recorded a completion date of 6/27/25, day 22 of the resident's stay.6. The admission (Comprehensive) MDS of Resident #18 documented an ARD date of 1/10/25. The MDS recorded the resident had an admission date to the facility of 12/30/24. Page 58 of the MDS recorded a completion date of 5/22/25, day 16 of the resident's stay.According to the 2024 RAI, for an admission (comprehensive) assessment, the MDS Completion Date (Item ZO500B) must be no later than the 14th calendar day of the resident's admission (admission date + 13 calendar days). On 7/16/25 at 12:30 pm, the Director of Nursing stated she signs the MDS Assessments as complete due to the MDS Coordinator being an LPN (Licensed Practical Nurse) rather than an RN (Registered Nurse) and the MDS requires an RN to sign the assessments as complete. She stated she does not really have any MDS knowledge of the regulations. She stated the MDS Coordinator normally tells her verbally when she needs assessments signed or may email her or leave a note on her desk. She stated she normally will sign them on the same day she is told they are ready to be signed and does not delay signing them. On 7/16/25 at 2:15 pm, the Administrator of the facility stated the facility does not have a policy regarding MDS Assessments and they follow the guidelines of the RAI Manual.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 3Number of residents cited: 1Based on clinical record review, staff interview and guidance from the 2024 Resident Assessment Instrument (RAI) Manual, the facility failed to complete Quarterly Minimum Data Set (MDS) Assessments within federal guidelines for 1 of 3 (Resident #39) residents reviewed. The facility reported a census of 43 residents. Findings include: The MDS portion of the Electronic Health Record (EHR) of Resident #39 recorded the resident's admission MDS was dated 11/28/24 with a Quarterly MDS dated [DATE]. The Resident then had a discharge MDS dated [DATE] with a re-entry dated 5/14/25. Per the MDS tracker built into the software, the next quarterly MDS was due 5/23/25. Upon review on 7/15/25 at 11:45 am, no further Quarterly assessments had been scheduled or completed. A Medicare - 5 day MDS dated [DATE] was the last MDS scheduled or completed. Page 2-35 of the 2024 RAI Manual documented a Quarterly Assessment must be within 92 days of the Previous OBRA assessment which includes Quarterly, Admission, Annual, SCSA (Significant Change in Status Assessment), SCPA or SCQA (Significant Correction to Prior Annual or Prior Quarterly). OBRA Assessments are assessments mandated by the Omnibus Budget Reconciliation Act of 1987. OBRA assessments are standardized assessments used in nursing facilities to evaluate the needs of the residents.On 7/15/25 at 1:29 pm, the MDS Coordinator stated she had completed a five day assessment (a payment assessment that is not part of the OBRA assessment schedule) and did not realize she had to complete the quarterly assessment as well.On 7/16/25 at 2:15 pm, the Administrator of the facility stated the facility does not have a policy regarding MDS Assessments and they follow the guidelines of the RAI Manual.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Number of residents sampled: 13Number of residents cited: 2Based on clinical record review, staff interviews, information from a drug manufacturer and guidance from the 2024 Resident Assessment Instrument (RAI) Manual, the facility failed to accurately reflect the status of 2 of 13 residents in the Minimum Data Set (MDS) Assessments (Resident #2, Resident #6). The facility reported a census of 43 residents. Findings include: 1. The MDS of Resident #2 dated 4/10/25 identified a Brief Interview for Mental Status Score of 14 which indicated cognition intact. The MDS coded the resident had a start date for Speech therapy as 3/18/25. The MDS recorded the resident had zero minutes of speech therapy during the seven day lookback period of April 4/4/25 - 4/10/25. The MDS coded the resident had a start date for Occupational Therapy of 3/18/25 and also recorded zero minutes of Occupational Therapy during the same seven day lookback period. The MDS coded the resident had a start date for Physical Therapy of 3/19/25, also with zero minutes of therapy recorded. On 7/14/25 at 3:02 pm, Resident #2 stated she had recently completed therapy and had been improving her balance during therapy sessions. On 7/15/25, a member of the facility's therapy team ran a report for the therapy minutes during the seven day lookback period. The therapy minutes stated Resident #2 received 145 minutes of Speech Therapy, 135 minutes of Occupational Therapy and 93 minutes of Physical Therapy during this time period. On 7/15/25 at 1:11 pm, the MDS Coordinator stated that therapy minutes are normally pulled automatically onto the assessment. She explained that at times, the minutes did not carry over as expected, and in those instances, she would request a therapy minutes report from the therapy department. She also stated there had recently been a software change which had caused some glitches. She acknowledged it was her error in missing the therapy minutes not being recorded on the MDS Assessment. The 2024 RAI Manual directs for Speech-Language Pathology and Audiology Services and Occupational and Physical Therapies to enter the total number of minutes of therapy that were provided on an individual basis in the last seven days, as well as minutes provided as concurrent minutes, group minutes and co-treatment minutes and to enter the number of days therapy services were provided in the last seven days. 2. The MDS of Resident #6 dated 5/13/25 documented diagnoses that included diabetes Mellitus. The MDS recorded Resident #6 was administered insulin injections on one of the last seven days of the look-back period. The Medication Administration Record (MAR) for May of 2025 failed to reflect the resident had received any insulin during the month. On 7/15/2025 at 1:29 pm, the MDS Coordinator stated she had recorded an insulin injection due to the Resident receiving Ozempic once a week. She stated she was unaware Ozempic was not an insulin. The Ozempic Clinical Overview by the manufacturer of the medication documented Ozempic is a GLP-1 RA (a glucagon-like peptide-1 receptor agonist (a class of medications that mimic the effects of the GLP-1 hormone, which helps regulate blood sugar levels and reduce appetite). On 7/16/25 at 2:15 pm, the Administrator of the facility stated the facility does not have a policy regarding MDS Assessments and they follow the guidelines of the RAI Manual.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Number of residents sampled: 13Number of residents cited: 1Based on clinical record review and staff interviews, the facility failed to implement a Baseline Care Plan within 48 hours of admission for 1 of 13 residents reviewed (Resident #2). The facility reported a census of 43 residents. Findings include: The Census Line portion of the Electronic Health Record (EHR) of Resident #2 recorded the resident had moved from the facility's Assisted Living into the Long Term Care portion of the facility on 1/3/25. The Minimum Data Set (MDS) Assessment of Resident #2, dated 1/3/25, additionally recorded an admission date of 1/3/25. The Care Plan Section of Resident #2 EHR identified her most recent Care Plan had been initiated on 1/15/25. The prior Care Plan had an initiation date of 11/22/2022. When reviewed on 7/15/25, the Care Plan reflected initiation dates that varied by focus area. The earliest initiation date was documented as 1/20/25, which was five days after the Care Plan was noted as initiated and 17 days after the resident was admitted to the Long Term Care portion of the facility. On 7/15/25 at 3:53 pm, the Director of Nursing (DON) stated Resident #2 had not had a Baseline Care Plan done. She stated no Care Plan was initiated until 1/15/25. She voiced she had not identified any reason why it was not done. On 7/16/25 at 12:30 pm, the DON stated she had spoken to the MDS Coordinator the prior evening. She stated the MDS Coordinator told her that when Resident #2 moved from the Assisted Living area into the Long Term Care area, her Assisted Living Care Plan came through with her on the EHR. She stated the MDS Coordinator failed to close that Care Plan and initiate a current one for Long Term Care. She said the MDS Coordinator had caught the error on 1/15/25 and that is when she started her current Comprehensive Care Plan. On 7/16/25 at 1:44 pm, the MDS Coordinator stated when she initiates a new care plan she normally will complete the Focus Areas of Falls, Code Status, Activities of Daily Living (ADLs) and Discharge Planning immediately. She stated typically she completes those areas first and then goes from there over the next several days until the Care Plan is complete. She stated she was unaware of why none of the Focus Areas had dates prior to 1/20/25 for Resident #2. The policy titled Care Planning, approval date 12/2024, failed to address any timelines for the required completion of either a baseline or comprehensive care plan.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 3Number of residents cited: 1Based on clinical record review, family interview, staff interviews, hospital record review and policy review, the facility failed to properly supervise a resident and failed to implement interventions to prevent a fall for 1 of 3 residents reviewed. Resident #49 sustained a femur fracture after she fell from the commode. The facility reported a census of 43 residents. Findings include:According to the Minimum Data Set (MDS), dated [DATE], Resident #49 had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive ability). She was admitted to the facility on [DATE], and totally dependent on staff for hygiene, dressing, and transfers. Resident #49 had impairment on both sides of her lower extremities, was frequently incontinent of urine and always continent of bowel. Her diagnoses included: Multiple Sclerosis (MS), malnutrition, anxiety disorder, depression and muscle spasm. The Care Plan dated 3/20/25, showed that Resident #49 was admitted to the facility for a short-term respite stay and scheduled to discharge on [DATE]. Her husband was her main caregiver and she preferred to have him involved in discussions of her care. Resident #49 was at risk for falls, related to deconditioning. Staff were to assist her to the bathroom upon request and to be sure her call light was within reach. The resident had been educated on being safe on the commode, and staff encouraged her to have supervision, but she declined and choose to have privacy. The resident used physical restraints, described as a chest strap, used while she was in the wheelchair to keep her from falling out. Staff were to ensure that the resident was positioned correctly with proper body alignment while restrained. Resident #49 had constipation related to MS, staff were to ensure that her feet were flat on the floor or flat on an elevated support during evacuation and her knees were at a 90 degree or above hip height to promote ease of evacuation.A Fall Risk Data Collection document dated 3/20/25 at 5:23 PM, showed that Resident #49 was unable to come to a standing position independently and she was a low risk for falls. A document titled: Device/Restraint Evaluation, dated 3/21/25 at 7:09 PM, showed that the staff were using a chest strap in the wheelchair that allowed the resident to sit up without falling over. She was unable to get out of the wheelchair on her own related to MS and muscle deconditioning.An Incident Report dated 4/2/25 at 9:30 PM, showed that on that date, a Certified Nurse Aide (CNA) found Resident #49 on the floor shortly after they had put her on the commode. The resident told the nurse she thought she had broken her leg, and they sent her to the emergency room. According to the Emergency Medicine History and Physical dated 4/3/25 at 1:40 PM, when Resident #49 presented to the emergency room, Orthopedic service was consulted for an evaluation of possible bilateral distal femur fractures. The patient reported that she struck her legs on the bed frame in front of her. She had significant swelling of left knee and mild bruising of her right. After X-rays, she was found to have an acute fracture of the distal left femur, no surgical intervention was recommended at that time. She was to keep the knee immobilizer on at all times.The following was found in the facility Nursing Progress Notes: a. On 3/21/25 at 3:51 PM, upon admission, Resident #49 requested to use a Gait Belt (GB) while she was sitting on the commode. The resident was educated on the designed use of a GB and it would be considered a restraint, so the facility would not be using that. The resident voiced understanding. b. On 4/2/25 at 9:52 PM the nurse was alerted by the CNA that the resident had fallen from the commode. c. On 4/2/25 at 11:41 PM, the facility received a call from the husband that the resident had a broken leg and was admitted to the hospital. On 7/15/25 at 2:23 PM, a Family Member (FM) for Resident #49 said that when she was admitted to the facility, they provided a commode that the resident agreed to use. He asked them to put something around her to keep her in the chair so she wouldn't fall out while having a bowel movement. The FM told them he would sign a consent because that was how they had managed her toileting at home. He said that he bought the Velcro belt that supported her in the wheel chair, and they had used for years. At the time of admission, there were 4 people in the room, including the Administrator and the Director of Nursing. When he asked about a GB to secure her on the commode, they didn't seem to know how to answer, and they didn't say no so he thought they were going to provide that for her. The FM said that he didn't learn until after the fall that the facility hadn't actually used the gait belt while on the commode because it was considered a restraint. He said he hadn't signed a consent for the belt used in the wheelchair, and he would have been more than willing to sign a consent for one on the commode. When asked if the resident had told the staff that she didn't want anyone in the room while she was on the commode, he said he wasn't aware, but it didn't surprise him because she really needed her privacy. He said that he usually signed papers for her because

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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** Number of residents sampled: 3Number of residents cited: 3Based on observations, clinical record review, staff interviews, and policy review, the facility failed to prevent indwelling catheters from potential contamination by securing the urine drainage bag on a resident's trash can and allowing a drainage bag on rest on the floor for 2 of 3 residents reviewed (#3, #22). Staff also failed to don Personal Protective Equipment (PPE) or perform proper hand hygiene during indwelling catheter care for 1 of 3 residents reviewed (#29). The facility reported a census of 43. 1. On 7/14/2025 at 12:24 PM, Resident #22 was observed seated at a dining room table with an indwelling urinary catheter. At 2:21 PM, Resident #22’s urinary bag was observed hanging on the side of the trashcan to the right of his recliner. The Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated severely impaired cognition. It included diagnoses of chronic kidney disease, obstructive uropathy (blocked urine flow), and difficulty walking. It indicated he was independent with eating, dependent with oral hygiene and required maximum assistance with all other Activities of Daily Living (ADLs) and all forms of mobility. The Care Plan revised 8/15/24 directed staff to position catheter bag and tubing below the level of the bladder and away from the entrance door. On 7/16/25 at 1:48 PM, Staff I, Certified Nurse Aide (CNA), stated indwelling catheter tubing or collection bag should not touch the ground, the collection bag should always have a dignity cover, be hung below the level of the resident’s bladder, and secured under the resident’s wheelchair high enough to not touch the floor. She also stated the collection bag can be placed in a dedicated basin, or hung on the side of the trash bin but wasn’t sure it was an approved location. She was not sure whether hanging a urinary collection bag was directly addressed during training. On 7/16/25 at 2:00 PM, Staff J, CNA stated she received indwelling catheter care education upon hire and in school. She stated staff hangs Resident #22’s catheter bag on his trash can but they know they’re not supposed to. She stated there was nowhere else to hang it when he’s in his recliner. On 7/16/25 at 4:10 PM, the Director of Nursing (DON) stated staff should position the indwelling catheter drainage bag in compliance with Infection Prevention practices. A policy titled “Infection Prevention and Control Program” dated 2019 indicated the Infection Prevention and Control Program follows national standards and guidelines to prevent, recognize and control the onset and spread of infection whenever possible. A policy titled “Catheter Care, Urinary” dated 12/2024 directed staff to be sure the catheter tubing and drainage bag are kept off the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The MDS for Resident #29 dated 6/12/25 in progress revealed a BIMS score of 15/15 indicating normal cognitive function. The document revealed diagnoses of renal insufficiency, neurogenic bladder, end stage renal disease and benign prostatic hyperplasia with lower urinary tract symptoms. Resident #29’s Care Plan dated 7/8/25 under development revealed a Focus Area with a catheter with neurogenic bladder dated 7/26/24. Interventions for staff included catheter care, positioning of the catheter, monitoring and documenting the output and enhanced barrier precautions (EBP). A Focus Area for EBP due to wounds and urinary catheter was initiated on 9/16/24. Interventions for staff included resident education and staff to wear gown and gloves while completing high-contact resident care activities. On 7/14/25 at 1:05 PM observed personal protective equipment (PPE) on Resident #29’s door. On 7/14/25 at 1:10 PM Staff A, Licensed Practical Nurse (LPN), entered Resident #29’s room, completed hand hygiene, closed the resident’s curtain and donned gloves. Observed the resident's catheter bag hanging from the bed without a dignity bag. The staff removed the resident’s blankets, pants, and initiated opening the brief. The staff upon discovering the resident’s brief was slightly soiled, stopped, removed gloves, obtained wipes and donned new gloves. Staff A used the right hand to obtain wipes and the left hand to complete peri care. When additional staff and the resident’s roommate entered the room, Staff A used the left gloved hand to adjust the curtain. Staff A applied the treatment to the peri area using the right gloved hand. Following the treatment Staff A removed the right glove, had staff hand her an additional glove, donned the glove and completed donning of a clean brief, and pulling his pants up. Staff A placed a barrier on the ground with a graduated cylinder on top for emptying the catheter bag. The staff used an alcohol swab to wipe the tubing, emptied the catheter, wiped the tubing with a new swab and took the cylinder to the bathroom for emptying. The staff removed gloves, completed hand hygiene and adjusted Resident #29’s blankets. Staff A demonstrated inconsistent hand hygiene practices with glove removal/application, did not utilize a gown with medical treatment, peri cares, and emptying of catheter. On 7/15/25 at 2:00 PM the Director of Nursing (DON) stated the expectation was for all nurses and Certified Nurse Assistants (CNAs) to wear gowns and gloves when providing treatments and cares to residents with catheters. The staff stated she expected hand hygiene to be completed during glove changes, as well as maintain clean and dirty. The DON stated it was expected that dignity bags were used for catheter bags. The U.S. Department of Health and Human Services Centers for Disease Control and Prevention EBP sign on Resident #1 and Resident #32’s doors revealed providers and staff must wear gloves and gown during high contact resident care activities including dressing, bathing, transferring, hygiene, changing briefs or assisting with toileting, and wound care. 3. The MDS dated [DATE] for Resident #3 showed that she had a BIMS score of 15 (intact cognitive ability.) She required substantial assistance with hygiene and dressing and was totally dependent for transfers. The resident had an indwelling catheter and was always incontinent of bowel. Her diagnoses included: renal failure and urinary tract infections. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165383	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Rehabilitation & Health Care Center	615 SE Kent Street Greenfield, IA 50849

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan, last updated on 6/11/25, showed that Resident #3 had a catheter due to neurogenic bladder. Staff were to provide catheter care every shift, to monitor output and to position the catheter bag and tubing below the level of the bladder. On 7/15/2025 at 6:14 AM, observed Resident #3 in bed sleeping, her catheter bag resting on the floor and it looks to be empty. On 7/15/25 at 1:54 PM, the Director of Nursing (DON) said that all urinary catheters should be in a privacy bag and should never be on the floor. On 7/17/25 at 6:10 AM, Staff G Certified Nurse Aide (CNA) said that the catheter bag should never be on the floor. On 7/17/25 at 6:15 AM, Staff H, CNA said that they should always have a catheter in a privacy bag.