STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165555	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adel Acres	1919 Greene Street Adel, IA 50003

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on clinical record review, observations, family and staff interviews, and policy review, the facility failed to ensure nursing staff completed weekly assessments and provide timely intervention (resulting in worsening of skin impairment) when a resident exhibited a change in skin condition for 1 of 3 residents reviewed for skin concerns or had a change in condition (Resident #30), and failed to document if oxygen provided to a resident when the resident's oxygen saturations dropped below the physician's ordered parameters for 1 of 3 residents reviewed for oxygen (Resident #30). The facility reported a census of 44 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #30 had diagnoses of heart failure, cerebrovascular accident (CVA) (stroke), chronic lung disease, pleural effusion, pulmonary embolism, chronic non-pressure ulcer on her buttock, and dementia. The MDS revealed the resident had severely impaired cognition. The MDS indicated the resident had incontinence and required substantial to maximum assistance for bed mobility and toileting hygiene. The MDS indicated the resident had no wounds or skin conditions. The MDS documented the resident had shortness of breath with exertion, when sitting at rest and when lying flat, and on oxygen therapy during the 14-day lookback period. The Care Plan revised on 11/14/24 revealed Resident #30 had impaired skin integrity on her buttock related to incontinence and limited mobility. The Care Plan directed staff to check and change the resident to manage incontinence, perform treatments as ordered, and assess and document skin observations weekly. The Care Plan also revealed the resident had congestion heart failure. The Care Plan directed staff to monitor for use of accessory muscles and labored breathing, monitor pulse oximetry, apply oxygen at 3 liters per nasal cannula as needed (PRN) to maintain an oxygen saturation above 90%. The Care Plan revealed the resident took the oxygen off frequently. The Order Summary Report dated 4/7/25 revealed: a. Apply house barrier cream to sacrum in the morning related to a nonpressure chronic ulcer to the buttock started on 5/31/24 b. Weekly skin evaluation by licensed nurse every Monday on the day shift started on 6/27/24. c. Apply zinc cream to buttocks two times a day for wound care until area healed started on 3/27/25 (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Actual harm Residents Affected - Few	d. Wound Consult PRN to evaluate and treat ordered on 4/7/25 The EHR Weekly Wound Observation assessments revealed the last wound observation done on 6/3/24. The Skin Observation Tool revealed the following: a. On 3/10/25, skin C D I (clean, dry and intact). b. On 3/17/25, skin C D I. c. On 3/24/25, skin C D I. d. On 3/31/25, excoriation to coccyx and groin. Renew (house barrier) applied to the area BID (twice a day). The EHR Skin Observation Tool Assessment for Resident #30 checked by the surveyor on 4/7/25 at 3:13 PM and 4/8/25 at 12:19 PM revealed the last skin observation documented on 3/31/25. The Progress Notes revealed: a. On 3/24/25 at 3:06 AM, resident remains on antibiotic for pneumonia. No signs or respiratory distress. Pulse ox 95 % on room air. b. On 3/26/25 at 6:17 PM, the resident had redness to her buttocks. Order obtained for Zinc cream to buttocks BID until healed. c. On 4/7/25 at 12:47 PM, a new order received for a wound consult related to excoriation and pain to the buttocks. The progress notes 3/26/25 - 4/8/25 lacked documentation about open wound area(s). An E-interact Change in Condition Evaluation dated 3/17/25 at 5:41 PM, revealed the resident had a respiratory infection, CHF (congestive heart failure), and COPD (chronic obstructive pulmonary disease). The O2 saturation was 90% on room air. The resident had a cough and hoarseness. An E-Interact Change in Condition Evaluation dated 4/9/25 at 12:04 PM revealed the assessment in progress. The Change in Condition Evaluation was initiated after the surveyor spoke with the Director of Nursing (DON) about the resident's open skin areas. The Evaluation revealed the resident's skin wound or ulcer started on 4/9/25 afternoon and the provider was notified on 4/9/25 at 12:07 PM. The resident had a moisture associated skin disorder (MASD) to the groin, left buttock, and the right buttock. The left buttock had open areas measuring 1.0 centimeter (cm) x 1.0 cm x 0.1 cm and 0.5 cm x 0.5 cm x 0.1 cm, and the right buttock had an open area measuring 3.0 cm x 2.0 cm x 0.1 cm. The skin evaluation was indicated as the first observation. A wound consult was recommended. The Medication Administration Record (MAR) revealed the following orders: a. Amoxicillin (an antibiotic) every 12 hours for 7 days for pneumonia started on 3/17/25 and discontinued on 3/24/25. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	b. O2 at 3 liters via NC to maintain O2 saturation above 90% PRN related to COPD. The MAR lacked documentation the O2 was administered 3/1 - 3/31/25 and 4/1 - 4/7/25. c. Monitor pulse oximetry every shift related to COPD. d. The O2 saturation below 90% was recorded on the following dates: On the 6 AM to 6 PM shift: 3/8/25, 3/14/25, 3/15/25, 3/16/25, 3/17/25, 3/23/25, 3/26/25, 3/27/25, 3/30/25 On the 6 PM to 6 AM shift: 3/8/25, 3/15/25, 3/25/25, 3/26/25, 3/27/25, 3/30/25, and 4/3/25 The MAR and Treatment Administration Record (TAR) revealed no O2 at 3 L per NC documented on: 6 AM to 6 PM shift: 3/8/25, 3/14/25, 3/15/25, 3/16/25, 3/17/25, 3/23/25, 3/26/25, 3/27/25, 3/30/25 6 PM to 6 AM shift: 3/8/25, 3/15/25, 3/25/25, 3/26/25, 3/27/25, 3/30/25, and 4/3/25 The Weights and Vitals Summary reviewed 3/1 - 4/7/25 revealed the resident's pulse ox readings below 90 % and no O2 administration documented: 3/8/25 at 9:26 PM = 83 % (Room Air) 3/14/25 at 1:42 PM = 84 % (Room Air) 3/15/25 at 10:48 PM = 89 % (Room Air) 3/16/25 at 10:00 AM = 87 % (Room Air) 3/17/25 at 3:58 PM = 89 % (Room Air) 3/19/25 at 9:17 AM = 89 % (Room Air) 3/23/25 at 9:18 AM = 89 % (Room Air) 3/26/25 at 2:33 AM = 89 % (Room Air) 3/26/25 at 10:47 AM = 88 % (Room Air) 3/26/25 at 10:45 PM = 89 % (Room Air) 3/27/25 at 7:13 PM = 88 % (Room Air) 3/30/25 at 5:13 PM = 89 % (Room Air) 3/31/25 at 1:25 AM = 89 % (Room Air) 4/4/25 at 12:10 AM = 88 % (Room Air) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Observations revealed the following: a. On 4/7/25 at 9:26 AM, O2 not on the resident at this time. b. On 4/7/25 at 1:25 PM, Resident sat in broda chair in the dining room. No O2 on the resident. c. On 4/7/25 at 1:40 PM, Staff I, CNA, and Staff J, CNA, transferred Resident #30 from the Broda chair to the bed. Resident #30 hollered My butt, I need cream on it then asked What about the O2? Staff I exclaimed O2? The resident said O2. I [NAME] and puff. Staff J said she would let the nurse know about the O2. The resident hollered she needed cream put on her bottom. Staff J said she would let the nurse know about her needing cream on her bottom. Continuous observations on 4/7/25 from 1:50 PM to 2:36 PM revealed the following: a. On 4/7/25 at 1:57 PM, Staff J was observed at the nurse's station desk talking with the DON. b. No nurse had come to put cream on the resident's bottom, assessed the resident, checked the resident O2 saturation, or placed O2 on the resident. c. At 2:36 PM, the DON walked down the hall holding a box with a tube inside. The DON entered the resident's room. Resident #30 said she was hungry. The DON placed the medication box in her uniform pocket and offered the resident a snack from her bedside table. d. At 2:40 PM, the DON left the room but did not apply any cream to the resident's bottom or place O2 on the resident. At the time, the surveyor asked the DON about the cream and the resident's O2. The DON said the CNA put cream on the resident's bottom when they did pericare. The DON said she didn't know anything about the O2 but the resident only used the O2 PRN. Observations on 4/7/25 at 2:48 PM, Staff K, CNA, and Staff L, CNA, entered Resident #30's room and washed their hands and donned gloves. The resident yelled orator 1, orator 2. Staff L said that meant the resident wanted O2. Staff K stated she had tried to put the O2 on the resident earlier but the resident fought her. Staff L told Staff K to try putting the O2 on but if the resident didn't want it, she could leave it off. Staff L told the resident she needed to keep the O2 on to help her. Staff K attempted to apply the O2 on the resident but the resident hollered that's not what she wanted. Staff then removed the resident's wet brief. Staff K took a wet washcloth from the overbed table and cleansed the resident's groin and periarea front to back, then took another washcloth and cleansed the resident's buttocks area. The resident's labia and buttocks area were reddened. The right buttock had a quarter-sized open area and the left buttock had two small open areas. Resident #30 hollered it hurts. Staff asked the resident what hurt. The resident yelled her bottom hurt. Staff told her they would put cream on her bottom. The resident said she needed a lot of cream. Staff K applied Renew cream to the resident's buttocks. Staff L applied Renew cream to the front area and removed her gloves. In an interview on 4/7/25 at 9:38 AM, a family member reported there had been issues with the resident's oxygen use. The resident had O2 saturation reading at 85 % but the O2 tubing was coiled up and the O2 was found off. The resident had congestion and coughing and was on an antibiotic at that time. The nurse became confrontational when he inquired about why the O2 was not on. The resident's O2 level was 88 % and the nurse told him orders were written for keeping the O2 above 90%. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview 4/7/25 at 2:45 PM, Staff I, CNA, reported she told the DON that Resident #30 had asked to have cream on her bottom. Staff I stated she also told the DON about the O2 the resident had requested. During an interview 4/9/25 at 8:00 AM, Staff G, Registered Nurse (RN) reported the CNA's reported things to her about the residents. If the concern sounded emergent she checked the resident right away but if she was in the middle of a task such as passing medications and the concern was not emergent, she checked the resident after she completed the task. Staff G explained she assessed the resident and called the physician to get an order if applicable. Staff G reported she entered a progress note if she noted a skin condition and also passed it on in report. She was unsure if there was a skin assessment form to fill out. Staff G reported she told the staff what cares or things needed done for a resident during the staff huddle. Staff G reported Resident #30 tended to be very vocal and would pinch or lash out toward staff. The resident was bedbound and chairbound, and had stages of dementia. The staff tried to make sure her needs were met. Staff G reported every time they put O2 on, the resident pulled the O2 off. During an interview 4/8/25 at 11:30 AM, Staff A, LPN reported she just put some cream on Resident #30's buttocks. Staff A confirmed the resident had an open area to her right buttock and two open areas on her left buttocks. Review of the resident's record revealed no change in condition or skin assessment filled out regarding the open wounds. During an interview 4/9/25 at 9:44 AM, the DON reported each resident's Care Plan or Kardex was kept in a book at the nurse's station for staff to reference the cares that were needed for the resident. The DON reported Resident #30 had excoriation to her groin and buttocks for a week. Staff applied Renew house barrier cream to the areas. The DON reported a wound doctor consult requested to see the resident on 4/9/25. The DON claimed she was not aware of any open areas on the resident's bottom. The resident just had excoriation to the area. The DON also reported the resident had pneumonia and her O2 level desaturated to 89 % and that was why the resident had an order for O2. The DON reported the resident asked for O2 but then she won't let the staff put the O2 on her. It was hit or miss and depended upon the resident's mood whether she left the O2 on or off. The staff were expected to document the resident's O2 saturation, and document in the progress notes if the resident refused the O2. The DON was unsure if there was a way to trigger when the O2 saturation was low and to indicate the O2 was placed on the resident. During an interview on 4/9/25 at 11:50 AM, the DON reported routine skin evaluations on residents done weekly but she was a little behind in getting the resident skin evaluations entered. Skin assessment documented in the computer under forms. The DON reported they did not have a policy for change in condition. The staff notified the physician and family whenever a resident had a change in condition and an E-interact Change in Condition form filled out whenever a resident started on an antibiotic or had a change in condition. A Skin Evaluation policy reviewed on 1/3/25 revealed a head-to-toe skin evaluation performed and documented on a weekly basis on the Skin Observation Tool. Any Skin abnormalities identified through this evaluation may be documented in the Interdisciplinary Notes and the physician, wound nurse, and DON notified of any abnormalities. The Unit Manager/Wound Nurse reviewed and followed up on the assessment, documentation, and implemented the care plan interventions. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A Notification of a Change in Condition policy reviewed 2/6/25 revealed the physician and resident representation notified whenever a resident had a significant change in their medical baseline. Document the change in condition in the interdisciplinary team notes, along with notification to the physician and representative per Standards of Practice and Federal and/or State Regulations.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on clinical record review, observations, resident and staff interviews, and policy review the facility failed to carry out therapy recommendations and provide restorative exercises for 1 of 3 residents reviewed for rehabilitation services and/or limited range of motion (Resident #17). The facility reported a census of 44 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 had diagnoses of cerebrovascular accident (CVA) (stroke), lymphedema and a chronic non-pressure ulcer on his buttock. The MDS recorded the resident had a Brief Interview for Mental Status score of 15, indicating cognition intact. The MDS documented the resident had impaired range of motion (ROM) on one side of his body. The resident required substantial to maximum assistance for toileting, and partial to moderate assistance for transfers and ambulating 10 feet. The MDS recorded the resident had physical therapy (PT) services 7/21/23 to 8/18/23, and no days of restorative nursing program (RNP) during the 7 day look-back period. The MDS assessment dated [DATE] revealed the resident required substantial to maximum assistance for transfers, toileting, and ambulating 10 feet. The resident had dependence for ambulating 50 and 150 feet. The MDS recorded the resident had zero (0) minutes of physical therapy, and no days of RNP during the 7 day look-back period. The Care Plan revised on 12/16/24 revealed the resident had a stroke and physical limitations, and required assistance with activities of daily living (ADL's). The Care Plan directed staff to use a walker and one to two staff for transfers. The Care Plan lacked information about the resident's ambulation status or a restorative or functional maintenance exercise program (FMP). Review of the electronic health record plan of care (POC) ADL for walking dated 3/10/25 - 4/8/25 revealed the following out of 67 possible recorded entries: Walk 10 feet: required partial to moderate assistance 10 times, maximum assistance 19 times, not attempted 5 times and resident refused 8 times. Walk 50 feet with two turns: required partial to moderate assistance 3 times, maximum assistance 7 times, not attempted 3 times, and resident refused 1 time. Walk 150 feet: not attempted 15 times, resident refused 6 times, and not applicable recorded 37 times. The Progress Notes dated 12/1/24 to 4/8/25 revealed the resident used the therapy bike for 15 minutes on 2/12/25 at 4:10 PM and 2/28/25 at 4:30 PM. The Progress Notes lacked any other exercise or restorative activities performed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The PT Treatment Encounter Note dated 3/25/25 revealed the resident had a fall risk and lymphedema. A FMP in place for the SCIfit bike for lower extremity ROM as well as ambulation with staff using a FWW (four wheeled walker) and assistance of one. Per resident report the staff consistently completed this program when a certain CNA (certified nursing assistant) worked. The therapist recommended to encourage other staff learn the program to allow for ongoing consistency even when the CNA was not working. A Summary of Daily Skilled Services Note signed by Staff N, PT, on 3/25/25 at 4:39 PM revealed the resident had reached his maximum potential with skilled services. The resident consistently participated in lower extremity exercises and walked with staff. The PT discharge recommendations included a FMP in place to avoid functional decline. The established FMP included an ambulation program with a FWW and assistance of one, and ROM program with the SCIfit bike for 15 minutes for upper and lower extremity range of motion. The PT Discharge Summary dated 3/25/25 at 8:30 PM revealed the resident had diagnoses of muscle wasting and atrophy, lymphedema, and unsteadiness on feet. The resident had met the following goals: 1. Transitioned to standing out of a wheelchair requiring moderate to maximum assistance on the first attempt. 2. Ambulated 28 feet using FWW and contact guard assistance. 3. Consistently ambulated multiple times a week with staff using a FWW to the bathroom with minimum assistance. Therapy recommended a FMP for the resident's bilateral upper extremities and lower extremities in order to maximize the resident's functional potential. The resident wanted to use the SCIfit (exercise bike) and the lift hand weights. Observations revealed the following: a. On 4/6/25 at 12:50 PM, Resident # 17 sat in a wheelchair in his room. b. On 4/7/25 at 11:05 AM, Resident #17 sat in recliner with his legs elevated. c. On 4/7/25 at 1:30 PM, Resident #17 sat in recliner with his legs elevated and had lymphedema pants on. d. On 4/9/25 at 9:20 AM, Resident #17 sat in recliner in his room. In an interview on 4/6/25 at 12:50 PM, Resident #17 reported he had a stroke. He no longer got therapy services. Resident #17 stated the staff were busy and did not always get his walk done. The resident had a goal to get out of the facility but he needed to be able to do basic cares to take care of himself and he had to have help moving out of the chair. The resident said he sat in the chair all day and he had a sore on his bottom. On 4/9/25 at 10:40 AM, Resident #17 reported he wanted to get better so he could attend a family member's upcoming graduation and wedding events. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/8/25 at 1:45 PM, the Director of Nursing (DON) reported they do not have a restorative aide at the facility. In an interview 4/9/25 at 11:55 AM, Staff O, PT, reported he notified the social worker and the resident and/or family whenever therapy services were ended. Therapy sometimes referred residents to a FMP. Staff O gave the recommendations on what to do to nursing to set up the program. It could be a walk to dine or ROM exercise program. Therapy left the frequency open for nursing to determine what was needed. At the time, the surveyor asked Staff O if he had referred residents to a FMP/ Restorative Program after therapy, and if he had later seen a decline with any of the residents. Staff O replied therapy looked at residents every 3 months to see if a resident needed therapy services or if the resident had triggered for things such as a fall. Therapy re-evaluated the resident and whether the resident needed to be placed back on therapy services. Staff O reported the facility did not have a restorative person. Staff O reported a SCIfit bike in the therapy room for residents to use. Staff would have to let the resident into the therapy room to use the bike. The Facility's Establishment of an Individual Restorative Program Policy and Procedure reviewed 1/3/25 revealed a Restorative Program provided services to maintain and improve functional abilities. Therapy made a referral and recommendations for establishment of a restorative program and the restorative nurse and restorative aid implemented the program. An order for RNP described the program, the number of days per week, and the duration of the program.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49990 Based on direct observation, staff interview, facility documentation, and facility policy review, the facility failed to implement measures to ensure safety for each resident identified at risk of injury to themselves. The facility reported a census of 44. Findings include: The significant change Minimum Data Set (MDS) for Resident #7, dated 03/27/2025, documented the resident's Brief Interview for Mental Status score (BIMS) was documented as 02, indicating severely intact cognition. It also documented the following relevant diagnoses: hemiplegia or hemiparesis (partial or full paralysis), anxiety disorder, bipolar disorder, and cognitive communication deficit. A continuous direct observation on 04/06/2025 from 10:06 AM until 10:34 AM revealed the shower room door of the South Hall was open, the floor was visibly wet and the shower was still running. During the observation several residents were walking up and down the hall, with Resident #7 ambulating extremely slowly via wheelchair. During the observation surveyors positioned themselves near the door to the shower room to prevent Resident #7 from wandering into the shower room. At this same time, the hallways in South, West, and East halls were noted to be heavily cluttered with wheelchairs, mechanical lifts, and the treatment and medication cart. During the observation, while surveyors were placed across the hall from the shower room, the surveyors had to move to allow resident's through the hall due to the clutter. A direct observation on 04/09/2025 at 12:22 PM in the South hallway showed two cleaning carts blocking the hallway, with two residents attempting to navigate past the cleaning carts and hallway clutter. In an interview on 04/09/2025 at 12:30 PM with Staff B, Licensed Practical Nurse (LPN), she stated the door should never have been left open, especially not with the water running. She stated it posed a hazard to residents, and noted the door is to be closed and locked unless you're taking a resident into the shower room or leaving. She noted the facility was small, and they didn't know where else to put the clutter in the hallway. In an interview on 04/09/2025 at 12:40 PM with Staff J, Certified Nurse Aide (CNA), she stated the door to the shower room should not have been left open. She stated it posed a hazard to those in the facility who were cognitively impaired, and acknowledged Resident #7 wanders slowly. She also acknowledged the hallways were cluttered, and suggested this had been previously discussed by the facility. In an interview on 04/09/2025 at 10:56 AM with the Administrator, he acknowledged the shower room door should not have been left open, especially with the water running, and explained a CNA had left the door open while preparing another resident for their shower. The door is to remain closed and locked. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/09/2025 at 01:38 PM with the Director of Nursing (DON), she acknowledged the shower room door should not have been left open, and that the halls were cluttered. She stated the facility is small and the rooms do not have space to store resident wheelchairs. She stated the expectation is for staff to clear a path for residents attempting to ambulate through the facility. A policy was not available for review.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165555	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adel Acres	1919 Greene Street Adel, IA 50003

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on clinical record review, observations, staff interview, manufacturer recommendations, and policy review the facility failed to ensure a medication error rate of less than 5%. During observations of medication administration, the facility had 2 errors out of 30 opportunities for error resulting in an error rate of 6.67 % (Residents #19 and #22). The facility identified a census of 44 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 had a diagnosis of diabetes. The MDS documented the resident took insulin 6 of 7 days during the look-back period. The Care Plan initiated 3/26/25 revealed the resident had diabetes. The Care Plan directed staff to administer diabetes medication as ordered by the physician. The Order Summary revealed to inject Novolog flexpen 100 unit/ milliliter (ml) subcutaneous (SQ) after meals and at bedtime related to Type 2 Diabetes Mellitus as per sliding scale: if 150 - 199 = 3; 200 - 249 = 5; 250 - 299 = 7; 300 - 349 = 10; 350 - 399 = 12; 400 - 449 = 14. The Medication Administration Record (MAR) dated 4/1/25 to 4/30/25 for Resident #19 listed Novolog flexpen 3 units SQ administered on 4/8/25 for the 07:00 AM dose by Staff A, Licensed Practical Nurse (LPN). Staff A recorded the BS (blood sugar) of 198. The MAR listed the sliding scale as follows: if 150 - 199 = 3; 200 - 249 = 5; 250 - 299 = 7; 300 - 349 = 10; 350 - 399 = 12; 400 - 449 = 14; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The sliding scale order started on 4/8/25 at 6:23 AM. A plastic bin for Resident #19 had the following taped on the inside of the lid: An order dated 3/21/25 at 1:53 PM for Insulin Aspart (Novolog) injection SQ per sliding scale: If 200-249 = 2 units 250-299= 4 units 300-349 = 8 units 350-399 =10 units 400-449 = 12 units During observation on 4/8/25 at 8:00 AM, Staff A, Licensed Practical Nurse (LPN), took a plastic bin with supplies from the medication cart and took to Resident #19's room. Staff A checked Resident #19's blood sugar and reported the blood sugar of 198. Staff A reported the sliding scale insulin order kept on the inside of the plastic bin with insulin and blood sugar supplies. Staff A checked the sliding scale listed on the lid and reported she needed to administer 2 units of insulin. Staff A attached a needle on the end of a Novolog insulin flexpen and turned the dial on the flexpen to 2. Staff A inserted the needle into the resident's left upper arm, pushed the button on the end of the insulin flexpen then removed the needle after one second. Staff A did not prime the insulin pen prior to administering the insulin dose to the resident. During an interview on 4/8/25 at 11:30 AM, Staff A reported she went off the sliding scale listed on the inside of the plastic bin containing blood sugar supplies and insulin for the resident. Staff A stated she didn't realize the order was different in the computer than the sliding scale listed on the inside of the plastic bin. Staff A confirmed she was not aware she needed to prime the insulin pen prior to administering the medication. During an interview on 4/8/25 at 11:53 AM, Staff B, LPN, reported she gave insulin per sliding scale and the resident's blood sugar. The sliding scale was listed on the EMAR (electronic medication administration record) and also taped inside the insulin box for each resident. Staff B reported she always checked the MAR because the orders changed and she wanted to make sure she gave the correct dose. During an interview on 4/8/25 at 1:30 PM, Staff C, Registered Nurse (RN) reported the nurse processed and entered orders in the computer, or the Nurse Practitioner entered their own orders. Staff C stated she printed off the sliding scale order and placed it inside the plastic box with blood sugar supplies labeled with the resident's name. She checked the resident's blood sugar and then checked the sliding scale on the EMAR. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/8/25 at 1:45 PM, the Director of Nursing (DON) reported she processed and entered the physician's orders whenever a resident was admitted to the facility, otherwise the nurse on duty entered the orders. The DON explained the nurse printed off the order and was supposed to place the label inside the resident's plastic bin in the medication cart whenever the sliding scale orders changed. The DON reported she had been working the night shift and had not had a chance to check for any recent orders. She normally checked to ensure the label on the inside of the plastic bin got updated but she had not followed up to see if the label got updated. The DON reported Resident #19's sliding scale orders had recently changed on 4/6/25. The DON reported she expected the nurse to check the resident's MAR before they gave the insulin. The DON reported the facility did not have a policy for medication administration for the insulin flexpen. She expected staff to follow the manufacturer instructions whenever they used an insulin flexpen. During an interview 4/8/25 at 2:50 PM, Staff D, RN, reported for some reason the facility staff printed the sliding scale order and placed it on the resident's insulin box. Staff D stated she questioned if the box got updated when the insulin orders changed. Staff D reported she always checked the insulin before she gave it because she sometimes found the insulin not placed in the right box. During an interview 4/9/25 at 8:00 AM, Staff G, RN, reported she always verified the insulin order and dose to administer on the EMAR. Staff G reported the computer automatically calculated the insulin dose to administer when she entered the blood sugar reading in the computer. During an interview 4/9/25 at 9:05 AM, Staff H, Pharmacist, reported the insulin pens needed to be primed before the insulin dose administered, and the insulin pen needed to be held 5-10 seconds before the needle pulled out to ensure the full dose was administered. According to the Novolog Manufacturer instructions revised 2/2023 revealed the following procedural steps for Novolog insulin injection 100 units/ ml flexpen: a. Attach the needle and turn the dose selector to 2. b. Hold the Novolog flexpen with the needle pointing up. Tap the cartridge gently with your finger to make any air bubbles collect at the top of the cartridge. Keep the needle pointed upward. Press the push button all the way in. If no drop of insulin observed, repeat this step up to 6 times. c. Turn the dose selector to the number of units needed for injection. d. Insert the needle into the skin. e. Press the push button all the way in until the 0 lines up with the pointer. f. Keep the needle in the skin for at least 6 seconds and keep the push button pressed all of the way in until the needle has been pulled out from the skin to ensure the full dose given. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Medication Administration Guidelines policy dated 12/17 revealed medications administered as prescribed in accordance with good nursing principles and practices, and a medication distribution system to ensure safe administration of medications. The five rights (right resident, right drug, right dose, right route and right time) are applied for each medication being administered. The medication and dosage schedule on the resident's MAR are compared with the medication label prior to administration of any medication. The physician's orders are checked for the correct dosage schedule if the label and MAR are different and the container has not already been flagged indicating a change in directions or if there is any other reason to question the dosage or directions. When a medication order is changed and the current supply can continue to be used, the container should be flagged right away and the order change communicated to the pharmacy so the next supply of medication is labeled with the current directions. 2. The MDS Assessment date 2/2/25 revealed Resident #22 had diagnoses of gastro-esophageal reflux disease (GERD) (stomach acid backs up into the esophagus) and dysphagia (difficulty swallowing). Resident #22's Care Plan revealed the resident had a nutritional problem related to GERD and dysphagia. The Care Plan directed staff to administer medications as ordered. The Order Summary Report dated 4/8/25 revealed Omeprazole Delayed Release (DR) capsule (used to treat heartburn/ GERD) by mouth in the morning for GERD. During observation on 4/8/25 at 7:40 AM, Staff F, Certified Medication Aide, prepared Resident #22's medications: a. Two Tylenol 325 milligram (mg) tablets b. Omeprazole DR 20 mg c. Sertraline 50 mg d. Levothyroxine 137 microgram (mcg) Staff F placed the medication into a small bag and crushed the pills together, then mixed the contents with applesauce. Staff F took the medication to Resident #22 and administered the medication. At the time, Resident #22 sat in the dining room eating breakfast. In an interview 4/9/25 at 9:05 AM, Staff H, Pharmacist reported Omeprazole DR needed to be given 1/2 to 1 hour before a meal. Staff H also reported the DR medication should not be crushed or it won't be DR anymore. A Medication Administration Guidelines policy dated 12/17 revealed long-acting or enteric-coated dosage forms should not be crushed; an alternative should be sought. Some long-acting capsules can be opened and administered (without crushing contents). Consult with the pharmacist before opening capsules or for an alternative dosage form of the medication. Crushing medications should be indicated on the resident's orders and the MAR so that all personnel administering medications are aware of this need and the consultant pharmacist can advise on safety issues and alternatives, if appropriate, during medication regimen reviews.

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F 0760
 	
Level of Harm - Minimal harm or potential for actual harm
 	
Residents Affected - Few
	Ensure that residents are free from significant medication errors.
	
	NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 34817
	
	Based on clinical record review, observation, staff interview, manufacturer's instructions, and policy review the facility failed to administer insulin according to the physician's orders for sliding scale insulin and per manufacturer instructions to ensure the proper amount of insulin administered for one of two residents observed who received insulin during medication pass (Resident #19). The facility failed to update sliding scale orders inside the plastic bin with blood sugar supplies for one of seven residents who took insulin. The facility reported a census of 44 residents.
	
	Findings include:
	
	The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 had a diagnosis of diabetes. The MDS documented the resident took insulin 6 of 7 days during the look-back period.
	
	The Care Plan initiated 3/26/25 revealed the resident had diabetes. The Care Plan directed staff to administer diabetes medication as ordered by the physician and educate caregivers on the correct protocol for glucose monitoring and insulin injections.
	
	The Order Summary revealed inject Novolog flexpen 100 unit/ milliliter (ml) subcutaneous (SQ) after meals and at bedtime related to Type 2 Diabetes Mellitus as per sliding scale:
	
	if 150 - 199 = 3 (units);
	
	200 - 249 = 5;
	
	250 - 299 = 7;
	
	300 - 349 = 10;
	
	350 - 399 = 12;
	
	400 - 449 = 14.
	
	The Medication Administration Record (MAR) dated 4/1/25 to 4/30/25 for Resident #19 listed Novolog flexpen 3 units SQ administered on 4/8/25 for the 07:00 AM dose by Staff A, Licensed Practical Nurse (LPN). Staff A recorded the BS (blood sugar) of 198. The MAR listed the sliding scale as follows:
	
	if 150 - 199 = 3;
	
	200 - 249 = 5;
	
	250 - 299 = 7;
	
	300 - 349 = 10;
	
	350 - 399 = 12;
	
	(continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	400 - 449 = 14; The sliding scale order started on 4/8/25 at 6:23 AM. A plastic bin for Resident #19 had the following taped on the inside of the lid: An order dated 3/21/25 at 1:53 PM for Insulin Aspart (Novolog) injection SQ per sliding scale: If 200-249 = 2 units 250-299= 4 units 300-349 = 8 units 350-399 =10 units 400-449 = 12 units During observation on 4/8/25 at 8:00 AM, Staff A, LPN, took a plastic bin with supplies from the medication cart and took to Resident #19's room. Staff A checked Resident #19's blood sugar and reported the blood sugar of 198. Staff A reported the sliding scale insulin order kept on the inside of the plastic bin with insulin and blood sugar supplies. Staff A checked the sliding scale listed on the lid and reported she needed to administer 2 units of insulin. Staff A attached a needle on the end of a Novolog insulin flexpen and turned the dial on the flexpen to 2. Staff A inserted the needle into the resident's left upper arm, pushed the button on the end of the insulin flexpen then removed the needle after one second. Staff A did not prime the insulin pen prior to administering the insulin dose to the resident. During an interview on 4/8/25 at 11:30 AM, Staff A reported she went off the sliding scale listed on the inside of the plastic bin containing blood sugar supplies and insulin for the resident. Staff A stated she didn't realize the order was different in the computer than the sliding scale listed on the inside of the plastic bin. Staff A confirmed she was not aware she needed to prime the insulin pen prior to administering the medication. During an interview on 4/8/25 at 11:53 AM, Staff B, LPN, reported she gave insulin per sliding scale and the resident's blood sugar. The sliding scale was listed on the EMAR (electronic medication administration record) and also taped inside the insulin box for each resident. Staff B reported she always checked the MAR because the orders changed and she wanted to make sure she gave the correct dose. During an interview on 4/8/25 at 1:30 PM, Staff C, Registered Nurse (RN) reported the nurse processed and entered orders in the computer, or the Nurse Practitioner entered their own orders. Staff C stated she printed off the sliding scale order and placed it inside the plastic box with blood sugar supplies labeled with the resident's name. She checked the resident's blood sugar and then checked the sliding scale on the EMAR. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/8/25 at 1:45 PM, the Director of Nursing (DON) reported she processed and entered the physician's orders whenever a resident was admitted to the facility, otherwise the nurse on duty entered the orders. The DON explained the nurse printed off the order and was supposed to place the label inside the resident's plastic bin in the medication cart whenever the sliding scale orders changed. The DON reported she had been working the night shift and had not had a chance to check recent orders. She normally checked to ensure the label on the inside of the plastic bin got updated but she had not followed up to see if the label got updated. The DON reported Resident #19's sliding scale orders had recently changed on 4/6/25. The DON reported she expected the nurse to check the resident's MAR before the gave the insulin. The DON reported the facility did not have a policy for medication administration for the insulin flexpen. She expected staff to follow the manufacturer instructions whenever they used an insulin flexpen. During an interview 4/8/25 at 2:50 PM, Staff D, RN, reported for some reason the facility staff printed the sliding scale order and placed it on the resident's insulin box. Staff D stated she questioned if the box got updated when the insulin orders changed. Staff D reported she always checked the insulin before she gave it because she sometimes found the insulin not placed in the right box. During an interview 4/9/25 at 8:00 AM, Staff G, RN, reported she always verified the insulin order and dose to administer on the EMAR. Staff G reported the computer automatically calculated the insulin dose to administer when she entered the blood sugar reading in the computer. During an interview 4/9/25 at 9:05 AM, Staff H, Pharmacist, reported the insulin pens needed to be primed before the insulin dose administered, and the insulin pen needed to be held 5-10 seconds before the needle pulled out to ensure the full dose was administered. According to the Novolog Manufacturer instructions revised 2/2023 revealed the following procedural steps for Novolog insulin injection 100 units/ ml flexpen: a. Attach the needle and turn the dose selector to 2. b. Hold the Novolog flexpen with the needle pointing up. Tap the cartridge gently with your finger to make any air bubbles collect at the top of the cartridge. Keep the needle pointed upward. Press the push button all the way in. If no drop of insulin observed, repeat this step up to 6 times. c. Turn the dose selector to the number of units needed for injection. d. Insert the needle into the skin. e. Press the push button all the way in until the 0 lines up with the pointer. f. Keep the needle in the skin for at least 6 seconds and keep the push button pressed all of the way in until the needle has been pulled out from the skin to ensure the full dose given. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Medication Administration Guidelines policy dated 12/17 revealed medications administered as prescribed in accordance with good nursing principles and practices, and a medication distribution system to ensure safe administration of medications. The five rights (right resident, right drug, right dose, right route and right time) are applied for each medication being administered. The medication and dosage schedule on the resident's MAR are compared with the medication label prior to administration of any medication. The physician's orders are checked for the correct dosage schedule if the label and MAR are different and the container has not already been flagged indicating a change in directions or if there is any other reason to question the dosage or directions. When a medication order is changed and the current supply can continue to be used, the container should be flagged right away and the order change communicated to the pharmacy so the next supply of medication is labeled with the current directions.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 34817 Based on observation, menu review, record review, and staff interviews, the facility failed to serve the appropriate portions for two of two residents who received pureed diets (Resident #5 and #25). The facility reported a census of 44 residents. Findings include: The facility's Fall/Winter Week 3 Menu for Monday lunch identified chicken, the vegetable of the day (peas), and a dinner roll to be served as part of the planned pureed textured diet for the lunch meal served on 4/7/25. The facility's Resident Summary Report listing each resident's diet identified two residents on a pureed texture diet. During observation on 4/7/25 at 11:37 AM, Staff E, Dietary Cook, reported two residents on a pureed diet, but she planned to make one additional serving. Staff E placed three dinner rolls and three chicken breasts into a robot coupe container, added some chicken broth, and blended the contents together. Staff C poured the contents into a measuring cup and reported a total of two cups. Staff C then poured the pureed contents into a metal pan on the steam table. On 4/7/25 at 11:44 AM Staff E placed three ladles of peas into a robot coupe container. Staff E stated she didn't know the size of the ladle used, it had a green handle. Staff E blended the peas in the robot coupe, then checked the consistency and poured the contents into a measuring cup. Staff E reported a total of one and one-half cups. Staff C then poured the pureed contents into a metal pan on the steam table. The Dietary Manager and Consulting Dietician observed with the surveyor as Staff E prepared the pureed entrees. During the lunch meal service on 4/7/25 starting at 12:05 PM, Staff E, Dietary Cook, plated food for the residents. During the meal service Staff E plated food for the residents on a pureed diet (Resident #5 and #25). On 4/7/25 at 12:45 PM, Staff E reported she used the following serving sizes: One #8 scoop of pureed chicken One #12 scoop of pureed peas The serving chart revealed a #8 scoop the equivalent of 4 ounces (oz.), and a #12 scoop the equivalent of 2 1/2-3 oz. Review of the Pureed Diet Portion Sizes/Scoops posted on the wall near the Robot Coupe mixers revealed the residents on a pureed diet were supposed to get a #6 scoop (a total of 5 1/3 oz.) of pureed chicken and a #8 scoop (a total of 4 oz.) of pureed peas. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 4/7/25 at 12:50 PM, Staff E reported she checked the book that had the food entrees listed for each type of food texture (pureed, mechanical soft, regular diets) to know the size serving to serve for each entree. During an interview on 4/8/25 at 10:05 AM, the consulting dietician reported she expected staff to follow the menu and serve the proper serving sizes. She planned to do some staff education regarding the pureed serving size. She used to do the volume method but they now used a document that listed the scoop or serving size to use for each entree. The surveyor pointed out the dinner roll and broth were added to the chicken, which increased the volume on the pureed chicken. The dietician reported since the dinner roll and chicken were listed separately on the document but the cook puree the dinner roll and chicken together, then the dinner roll serving size and the chicken serving size should be added together to get the scoop/serving size. The dietician said she would review the serving size chart. A Pureed Meat Diet Guidelines policy updated 1/3/25 revealed the following procedural steps: a. Follow the recipe portion size b. Place the desired number of portions into a food processor or blender c. Add broth or other liquid as needed for product consistency d. Blend the mixture to a smooth consistency e. Pour the puree food into a container with calibrated volume markings. f. Divide the total volume of pureed food by the number of portions originally placed in the food processor to determine the portion size. For example: 4 cups total volume divided by 8 portions originally started with equals 1/2 cup serving.

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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 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. 49990 Based on observation, staff interview, and policy review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. The facility reported a census of 44. Findings include: A direct observation on 04/06/2025 from 12:21 PM until 01:31 PM revealed the following: At 12:22 PM the Dietary Manager touched the top of the plate while she served food to a resident. At 12:27 PM Staff B, Licensed Practical Nurse (LPN) placed a clothing protector on a resident, making direct contact with the resident's skin, then served the resident plate while touching the top of the plate without performing hand hygiene. At 12:32 PM Staff B, LPN, again made direct contact with another resident, did not perform hand hygiene, and then began feeding two residents at the same time with no witnessed hand hygiene performed while switching from one resident to another. The Dietary manager was also seen continuing to serve resident meals holding the plates with her thumb near resident food. At 12:35 PM the Dietary manage made direct contact with a resident's food with bare hands, the food was not replaced and it was consumed by the resident. At this same time marker Staff P, Certified Nurse Aide (CNA), was observed making direct contact with a resident's food. The food was not replaced and the resident was observed eating the food. A direct observation on 04/07/2025 from 11:50 AM until 12:25 PM revealed the following: At 12:00 PM Staff E, Cook, placed her hands on top of glasses and bowls as she served lunch from the kitchen. At 12:09 PM Staff L, CNA, was observed serving a resident a plate with her thumb on top of the plate making direct contact with resident food. The resident was observed eating this food. At 12:10 PM Staff L continued to serve residents food with her thumbs on top of the resident plate, again making direct contact with the food the resident was later observed eating. At 12:25 PM Staff L switched tasks and began to assist two residents with eating. She did not perform hand hygiene before assisting either resident and continued to switch tasks multiple times. Hand sanitation was never observed. In an interview on 04/08/2025 at 11:53 AM with Staff B, LPN, she acknowledged she should have avoided handling the eating surfaces of things like plates and silverware. She acknowledged that when she is feeding two residents at the same time she should be sanitizing her hands with hand sanitizer in between each bite. (continued on next page)

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Adel Acres	1919 Greene Street Adel, IA 50003

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/09/2025 at 12:23 PM with Staff L, CNA, she stated they should avoid touching or coming into contact with resident food during meal service. She stated they are instructed to avoid feeding two residents at the same time during meals, or they are required to sanitize their hands after every bite they offer. In an interview on 04/09/2025 at 12:40 PM with Staff J, CNA, she stated they are instructed to pick plates up from the bottom and to never place their thumbs on the tops of plates. If she came into direct contact with a resident, such as when touching them to place a clothing protector on, they are instructed to sanitize their hands. She stated if she made direct contact with a resident's food she would be expected to replace it. She also stated when feeding two residents at the same time they are instructed to sanitize after every bite offered to a different resident than who had been just assisted. In an interview on 04/09/2025 at 01:38 PM with the Director of Nursing (DON), she stated her expectation is for staff members to sanitize their hands every time they pass a tray to a resident, when they come into direct contact with a resident, and that they should only touch the bottom of the plate. She also stated her expectation is for staff members feeding two residents at the same time to sanitize their hands between each resident. Review of a facility provided document titled Food Handling and Use of Gloves last revised 01/03/2025, directs staff to use gloves and sanitize hands if making direct contact with resident food, and only when direct contact with resident food is required.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165555	A. Building B. Wing	04/09/2025

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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 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. 49990 Based on direct observation, clinical record review, staff interview, and facility policy review, the facility failed to protect the personally identifiable information of residents for 1 of 14 residents reviewed (Resident #96). The facility reported a census of 44. Findings include: The Care plan for Resident #96, completed on 04/07/2025, identified the resident had received a skin graft after cancer surgery. It did not document how often or how to bathe the resident. A direct observation on 04/06/2025 at 10:30 AM revealed a note, taped to the staff schedule and facing the dining room accessible to all visitors in the facility, where Resident #96's care information was posted. It documented Resident #96 had a skin graft, currently had a drainage port, and that the resident was limited to only receiving bed baths due to the skin issues. It identified Resident #96 by full name. A direct observation on 04/06/2025 at 01:31 PM revealed an unidentified staff member take the note down from the staff schedule after lunch dining service. In an interview on 04/09/2025 at 12:23 PM with Staff L, Certified Medication Aide (CMA), she acknowledged she had seen Resident #96's care data on the nursing schedule earlier in the week and that she didn't know who took it down. She stated it should not have been posted where the public could easily access it. She had meant to talk to the nurse whom she believed had placed it there. In an interview on 04/09/2025 at 12:40 PM with Staff J, Certified Nurse Aide (CNA), she stated resident charts and the electronic health record (EHR) is the only acceptable place to store information that could identify a resident beyond their name. She stated it should never be in plain view of the entire facility. In an interview on 04/09/2025 at 12:30 PM with Staff B, Licensed Practical Nurse (LPN), she acknowledged she was aware that Resident #96's identifiable care information. She was not the one who posted it, but stated she did not take it down because she was worried about newer staff missing something if it wasn't posted in plain sight. She acknowledged it should not have been posted there. In an interview on 04/09/2025 at 10:56 AM with the Administrator, he stated Resident #96's information should never have been posted where it was found. He stated it has since been taken care of. Review of a facility provided document titled Privacy Policy, last reviewed 01/03/2025, documented the facility is to limit use, disclosure, and requests of Personal Health Information (PHI) and make sure they meet HIPAA regulations. It further documented all workforce members are responsible for awareness of this policy and adherence to the given directions and guidance.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on clinical record review, observations, staff interviews, staff competency checklist and policy review, the facility failed to follow enhanced barrier precautions for 1 of 4 residents sampled and required enhanced barrier precautions and 1 of 1 residents observed for catheter care (Resident #26). The facility staff also failed to use a barrier when emptying the catheter. The facility staff also failed to follow infection control practices for 1 of 4 residents observed during cares (Resident #30). The facility reported a census of 44 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 had diagnoses of neurogenic bladder, urinary retention, diabetes, and non-Alzheimer's dementia. The MDS indicated the resident had an indwelling catheter. The Care Plan revised 5/20/24 revealed Resident #26 had a suprapubic catheter and chronic urinary tract infections. The Care Plan directed staff to utilize a gown and gloves for enhanced barrier precautions (EBP) during high-contact care activities including catheter care. During observations on 4/7/25 at 1:20 PM, Staff J, Certified Nursing Assistant (CNA) donned a pair of gloves and obtained a graduate container from the bathroom. Staff J placed the graduate on the carpeted floor next to the resident's wheelchair, removed the catheter bag from under the wheelchair, then removed the port from the catheter bag holder. Staff J unclamped the catheter, drained the urine contents into the graduate, clamped the catheter, and replaced the port into the holder on the catheter bag. Staff J hung the catheter bag under the wheelchair. Staff J picked the graduate full of urine up and carried the graduate across the room to the bathroom. Staff J used her gloved hand to open the bathroom door, then emptied the urine into the toilet. Staff J turned the water on, took the sprayer and rinsed the graduate container with water, and emptied the contents into the toilet. Staff J placed the graduate on the back of the toilet, then shut the water off and replaced the sprayer hose into the holder. Staff J removed her gloves and washed her hands. Staff J did not wear a gown when she emptied the catheter, did not cleanse the catheter port with alcohol before or after she emptied the catheter, and did not use a barrier prior to placing the graduate on the floor. During an interview 4/8/25 at 11:53 AM, Staff B, Licensed Practical Nurse (LPN), reported EBP's used whenever a catheter or wound care performed. A gown, gloves, mask, and goggles should be worn whenever staff worked with a catheter. During an interview 4/8/25 at 1:30 PM, Staff C, Registered Nurse (RN) reported EBP's used for any sick residents or if a resident had immune issues. The personal protective equipment (PPE) worn for EBP's depended on the resident's illness. Staff should at least wear gloves whenever they emptied a catheter. During an interview 4/8/25 at 1:45 PM, the Director of Nursing (DON) reported EBP's were required whenever a resident had a wound or a catheter. The DON expected staff to wear a gown and gloves during cares for the residents on EBP's. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Indwelling Catheter Competency Checklist revealed the following procedural steps when the down drain bag emptied: a. Assemble supplies b. Perform hand hygiene and don gloves c. Place disposable barrier on the floor below the down drain bag and put graduate on the barrier. d. Open the clamp and drain the urine into the graduate. e. Close the clamp and wipe the tip thoroughly with an alcohol pad, then replace the port into the holder. f. Empty the graduate into the toilet. g. Rinse the graduate then place a dry paper towel in the bottom of the graduate. Store the graduate in a plastic bag in the bathroom. h. Remove gloves and perform hand hygiene. An Enhanced Barrier Precautions policy reviewed 5/15/24 revealed the use of gown and gloves for high-contact resident care activities is indicated for residents with an indwelling medical device, including a urinary catheter. 2. The MDS assessment dated [DATE] revealed Resident #30 had chronic non-pressure ulcer on her buttock, cerebrovascular accident (CVA) (stroke), and dementia. The MDS indicated the resident required substantial to maximum assistance for bed mobility and toileting hygiene. The Care Plan revised on 10/16/24 revealed Resident #30 had impaired skin integrity on her buttock related to incontinence and limited mobility. The Care Plan directed staff to check and change the resident to manage incontinence. During observation on 4/7/25 at 2:48 PM, Staff K, CNA, entered Resident #30's room and washed her hands in the sink. Staff L, CNA, placed a washcloth in the bowl of the sink and ran the water over the washcloth. Staff L then left the room briefly. Staff L returned to the room and placed additional washcloths in the sink under the running water. Staff L poured peri wash on the washcloths then moved the washcloths to the edge of the sink and washed her hands. Staff L then placed the wet washcloths on a dry washcloth on an overbed table. Staff K took a wet washcloth from the overbed table and cleansed the resident's groin and periarea front to back, then took another washcloth and cleansed the resident's buttocks area. The resident's brief was wet and a small amount of stool was present between the buttocks. The resident's labia and buttocks area were reddened. The right buttock had an open area and the left buttock had two small open areas. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview 4/9/25 at 9:44 AM, the DON reported Resident #30 had excoriation to her groin and buttock for a week. The staff put a house barrier cream on the resident's bottom. The DON reported she was also the Infection Preventionist at the facility. The DON reported washcloths used for cares should not be left in the same sink used for handwashing. The sink would be considered a dirty area. The DON confirmed Resident #30's roommate also used the same sink for her handwashing and personal cares.