STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165622	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Suites at Western Home Communities	5301 Caraway Lane Cedar Falls, IA 50613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff interview, and policy review, the facility failed to implement Enhanced Barrier Precautions (EBP) practices during a routine transfer for 1 of 1 resident reviewed for pressure ulcer (Resident #4). The facility reported a census of 70.Findings include:The Minimum Data Set (MDS) dated [DATE] revealed that Resident #4 had one unstageable pressure injury presenting as a deep tissue injury that was not present on admission.The Care Plan initiated on 3/15/24 indicated that Resident #4 required EBP related to wounds. It directed staff to wear gloves and gown for transferring the resident. It also indicated that he had an actual skin impairment related to the left heel and directed staff to provide wound care per Medical Doctor (MD) orders.The Physician's Order dated 11/18/25 indicated to use EBP due to wound to the left heel every shift. In another order dated 9/24/25 it directed staff to apply Betadine topically to the left heel ulcer at bedtime.The Electronic Health Record (EHR) identified the location of the pressure ulcer as the left heel and that it was in-house acquired on 8/3/25. In an assessment of the wound on 3/24/26 it indicated that the wound was healed or closed with continued monitoring and measurements of 1.01 cm length and 0.97 cm width with an area of 0.76 cm. It lacked assessment of the wound bed. The picture included with the assessment shows what appears to be a scabbed area to the left heel. The EHR also indicated that the pressure ulcer was considered healed or closed with continued monitoring starting on 3/10/26.During an observation on 3/25/26 at 7:38 AM Resident #4's room did not have an EBP sign on the door or Personal Protective Equipment (PPE) available outside of the room.During an observation on 3/25/26 at 7:40 AM Staff A, Certified Nurse Aide (CNA), and Staff B, CNA, rolled Resident #4 from side to side in bed and put a mechanical lift sling under him. They attached the sling to a mechanical lift and transferred him to his wheelchair. He wore soft padded boots in bed. Neither staff member wore a gown during the procedure.In an interview on 3/25/26 at 7:50 AM Staff B stated Resident #4 wore padded boots in bed as he used to have a wound on his left heel. He still wore them for protection, but the wound is healed now. Stated she didn't know if he needed EBP when he had the wound.In an interview on 3/25/26 at 7:55 AM Staff C, Registered Nurse (RN) Nurse Mentor, stated Resident #4 had a scabbed area to his left heel. Staff C described it as an unstageable pressure area. When asked if he should be in EBP, she stated it depended if it is covered and not draining, then he would not typically be in EBP.In an interview on 3/25/26 at 10:38 AM the Administrator stated they removed Resident #4 from EBP precautions the previous week as the wound didn't drain. Added that she looked at CDC guidance and the decision tree in their transmission-based precautions policy.In an interview on 3/26/26 at 7:20 AM when questioned if Resident #4's pressure wound was scabbed over, the Administrator replied, yes. She also stated she wouldn't call his wound healed.In a policy titled Transmission Based Precautions/Isolation & PPE Use revised 12/25, directed to practice infection control guidelines as recommended by the Centers for Disease Control (CDC) to reduce and/or prevent the spread of disease-causing agents among residents, employees, visitors and other stakeholders. It contained an EBP algorithm for nursing homes from the Department of Health and Human Services. At the top of the algorithm, it indicated they indicated EBP for residents who have wounds, regardless of multidrug-resistant organism colonization status. The algorithm indicated if a (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had a covered or contained open wound contained in a dressing, then EBP would be indicated.