STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165440	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winslow House Care Center	**3456 Indian Creek Road , Marion, Iowa, 52302**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
✓ F0000 KBS	INITIAL COMMENTS Correction date: 11.25.2025 The following deficiencies resulted from the facility's annual recertification survey and investigation of complaints #1767812-C and #2587463-C conducted from September 22, 2025 through September 25, 2025. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.	F0578		

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 reverse for further 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
MSDA-DCD, LNHA	Administrator ✓	11/28/25

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F0578 SS = D	Continued from page 1 (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interviews, and policy review the facility failed to maintain code status records for 1 of 3 residents reviewed (Resident #21). The facility was unable to locate code status documentation after a resident's return from the hospital. The facility reported a census of 48 residents. Findings include: The Minimum Data Set dated 6/26/25 for Resident #21 revealed the resident scored 14 out of 15 on a Brief Interview for Mental Status exam (BIMS), which indicated intact cognition. The MDS further indicated diagnoses of coronary artery disease, mild persistent asthma with acute exacerbation, and obstructive sleep apnea. The resident's Care Plan did not include the resident's preference for Cardiopulmonary Resuscitation (CPR) or Do Not Resuscitate (DNR). The resident's Electronic Health Record (EHR) did not include the resident's preference for CPR or DNR. The resident's paper chart did not include the resident's preference for CPR or DNR. On 9/23/2025 at 3:01 PM Staff H, Licensed Practical Nurse (LPN) confirmed he worked mostly overnight which meant he was the only nurse on duty. He stated code status documents should be in the front of the resident's paper chart. Staff H looked through chart sections more than two times and he was unable to find code status documents. When asked if there was any reason it would be removed, Staff H stated the resident had been to the hospital and indicated the nurse overseeing the resident's return to the facility was	F0578	TAG F0578 – PLAN OF CORRECTION (POC) 1. Corrective Action for Resident Affected: Resident #21's code status documentation was immediately re-obtained and placed directly under the front cover of the resident's chart per facility policy. The resident, responsible party, and attending physician were contacted to verify and reconfirm the resident's current code status. The updated and signed code status form is now present in both the paper chart and the electronic medical record. 2. Identification of Other Residents Potentially Affected: A facility-wide audit of all residents' charts was completed to ensure code status documentation was present, accurate, and correctly filed in the chart. Any missing or incomplete forms were immediately corrected by contacting residents, responsible parties, and physicians. All updated code status forms were placed in the required location and uploaded into the electronic medical record. 3. Systemic Changes to Prevent Recurrence: The admission and readmission process has been revised to require completion of a Code Status Verification Checklist. This checklist ensures the code status form is obtained from the hospital, copied prior to the resident's arrival, and placed under the chart cover upon entry. Continued on next pg.	

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F0578 SS = D	Continued from page 2 supposed to put the documents back in the chart. When asked where else the information might be found, Staff H did not know where else to look and was not able to communicate the resident's code status. When asked if he would do CPR on this resident without the form in the chart, Staff H looked through the chart again and did not answer. On 9/23/2025 at 3:04 PM, the Director of Nursing (DON) confirmed Resident #21 came back from the hospital recently. She stated the care coordinator was in charge of the paperwork that came back and signatures. She contacted him and he did not think he had her code status documentation. During a follow up with the DON on 09/23/2025 at 4:03 PM, she indicated the facility was unable to locate the document and would correct it. On 9/24/2025 at 1:11 PM, the Administrator said that unfortunately the nurse sent the original code status form to the hospital without making a copy for the chart. She confirmed the resident went to the hospital 9/14/25 and came back 9/16/25. A policy titled Cardiopulmonary Resuscitation (CPR) Policy Resuscitation Policy effective 2/10/17 documented each resident's resuscitation status will be maintained in the clinical record as follows: A signed CPR policy indicating the resident's choice of CPR or do not perform CPR will be placed directly under the front cover of the resident's chart.	F0578	Continued from next pg: 3. All licensed nursing staff were re-educated by the DON on the CPR and Code Status Policy, including the requirement to know and communicate residents' code status and the correct location of forms. Staff were educated on the procedure for copying and securing original documents prior to hospital transfer. 4. Monitoring to Ensure Ongoing Compliance: The DON or designee will conduct weekly audits of 10 resident charts for the presence and proper placement of code status forms for 8 weeks. Audits will then be completed monthly for 4 additional months. Any missing or incorrect documentation will be corrected immediately, and additional staff retraining will occur as necessary. Audit findings will be reviewed during monthly QAPI meetings. 5. Completion Date: The facility achieved full compliance by 11.25.2025	
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion	F0641	TAG F0641: 1. Corrective Action for TAG F0641: Resident #7's MDS assessments dated 12/30/2024 and 6/27/2025 were immediately reviewed. Corrections were completed to accurately reflect the resident's PASRR Level II status and the diagnosis of schizoaffective disorder, bipolar type. The resident's electronic record now includes the complete and current PASRR Level II information and corresponding diagnoses. No adverse outcomes were identified for the resident. 2. Identification of Other Residents with Potential to Be Affected A facility-wide audit of all current residents with PASRR Level II determinations was completed to ensure all corresponding diagnoses and PASRR-required MDS responses are accurately coded in the electronic health record and on the most recent MDS. Any discrepancies identified were corrected at the time of discovery.	

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F0641 SS = D	Continued from page 3 of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to accurately code all diagnoses and Preadmission Screening and Resident Review (PASRR) for 1 of 1 resident reviewed for Minimum Data Set (MDS) assessments (Resident #7). The facility reported a census of 48 residents. Findings include: Record review of Resident #7's Notice of PASRR Level II Outcome dated 5/22/2024 revealed the resident had short term approval until 5/22/2025, and determined to be a Level II (a comprehensive, in-depth evaluation for individuals determined to have a Serious Mental Illness (SMI), Intellectual Disability (ID), or related condition that requires specialized services.) The PASRR documented the resident had the diagnosis of schizoaffective disorder, bipolar type (a mental health condition that combines symptoms of schizophrenia and bipolar disorder). The PASRR also included the following direction to the facility: The facility should document yes to the following question on the MDS "Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?". The MDS dated 12/30/2024 for Resident #7 documented the following question response was marked no: Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or	F0641	3. Systemic Changes Implemented to Prevent Recurrence The MDS Coordinator and interdisciplinary team were re-educated on: • Accurate incorporation of PASRR Level II outcomes into the resident record. • Proper coding of Section A (PASRR fields) and Section I (Diagnoses) per RAI Manual guidance. • Requirements to ensure all PASRR-directed diagnoses are reflected in the MDS and care plan. A revised PASRR/MDS Verification Procedure was implemented requiring: • PASRR Level II outcome review upon admission, quarterly, significant change assessments, and prior to MDS completion. • Confirmation that all PASRR-related diagnoses are active in the medical record and appear in MDS Section I. • Secondary review by the DON or designee before MDS submission when a resident has a PASRR Level II. 4. Monitoring to Ensure Ongoing Compliance The DON or designee will complete a PASRR-to-MDS accuracy audit on: • All new admissions with PASRR Level II – 100% review prior to MDS submission. • A random sample of 5 residents with PASRR Level II determinations weekly for 8 weeks, then monthly for 3 months, to validate correct MDS coding and presence of required diagnoses. Audit findings will be reviewed during the monthly QAPI Committee meeting. Any identified issues will result in immediate re-education and corrective action. 5. Date of Compliance The facility has achieved compliance by 11.25.2025.	

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F0641 SS = D	Continued from page 4 intellectual disability or a related condition? The MDS also lacked documentation of her diagnosis of schizoaffective disorder, bipolar type. The MDS dated 6/27/2025 for Resident #7 lacked documentation of schizoaffective disorder. During an interview on 9/25/2025 at 12:21 PM with the Director of Nursing (DON) informed Resident #7 MDS's dated 12/30/24 and 6/27/25 should reflect her current PASRR Level II status and her diagnosis of schizoaffective disorder, bipolar type. She also informed she followed the Resident Assessment Instrument (RAI) manual.	F0641		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on interview and clinical record review, the facility failed to obtain a resident's Level II Preadmission Screen and Resident Review (PASRR), failed to implement Level II requirements, and failed to resubmit the Level I after expiration for one out of one resident reviewed (Resident #7). The facility reported a census of 48 residents. Findings include: The Minimum Data Set assessment for Resident #7 dated 12/30/25 included diagnoses of Bipolar disorder and	F0644	TAG F0644: 1. Corrective Action: Resident #7's PASRR Level II documentation was immediately obtained and placed in the medical record. The Care Plan for Resident #7 was updated on 09.29.2025 to include all PASRR-directed specialized services, behavioral health needs, and rehabilitative services as outlined in the Level II PASRR dated 5/22/24. The Minimum Data Set (MDS) assessment was reviewed and corrected to ensure Section A1510 accurately reflects the resident's Level II PASRR status and PASRR-identified condition(s). A new PASRR submission was completed to address the lapse in short-term approval ending 5/22/25. 2. Prevention of Potential Resident Reoccurrence: A facility-wide audit of 100% of current residents with any PASRR Level I positive determination, any Level II PASRR on file, or any behavioral health diagnoses (e.g., SMI, ID/DD, related condition) was initiated on 09.26.2025. The audit verifies: PASRR Level II documentation is present in the chart, MDS Section A1500/A1510 accurately reflects PASRR status and conditions, PASRR-directed specialized services and recommendations are incorporated into the resident's Care Plan. Any discrepancies identified during the audit will be corrected immediately, including obtaining missing PASRR Level II documents, submitting new PASRR reviews if expired or missing, and updating resident Care Plans.	

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F0644 SS = D	Continued from page 5 cancer. The Brief Interview for Mental Status (BIMS) reflected a score of 11 out of 15, which indicated moderately impaired cognition. Review of Resident #7's Preadmission Screen and Resident Review (PASRR) dated 12/18/24 reflected following determination: Level 1 positive, No status change, and further documented did not require further PASRR evaluation due to lack of significant change since previous PASRR Level II evaluation. PASARR paperwork revealed the resident's previous summary of findings remained valid for the resident's stay at the nursing facility, should accompany resident if transferred to another nursing facility, and services in previous PASARR remained appropriate and should continue to be delivered. The PASRR directed since was determined resident had a PASRR condition, the facility needed to document the PASRR condition in important Medicaid nursing facility paperwork, and directed the following question should be marked yes on the MDS: Is the resident currently considered by the stated level II PASRR process to have a serious mental illness and/or instinctually disability or a related condition? PASRR paperwork directed that Resident#7's specific PASRR condition should be checked in question A1510, Level II PASRR conditions (on MDS). The PASRR outcome explanation revealed a PASRR Level II evaluation not required as no status change occurred and the current PASRR evaluation remained valid. The Level II PASRR for Resident #7 dated 5/22/24, obtained by the facility on 9/24/25, reflected approval for a short term stay that ended on 5/22/25. The PASRR Level II reflected mental illness as schizoaffective disorder, bipolar type. The Level II PASRR for Resident #7 directed specialized services for her behavioral health and/or developmental condition were required. The nursing facility was required to Care Plan in a PASRR compliant fashion for all identified services including Specialized Services and Rehabilitative Services. The Care Plan for Resident #7 dated 12/27/24 failed to address PASRR recommendations. On 9/24/2025 at 7:40 AM, Resident #7 reported she failed to sleep well last night related to bad dreams. On 9/25/2025 at 8:44 AM the Activity Director reported Resident #7 reported yesterday morning she failed to sleep well the night before due to nightmares.	F0644	3. Systematic Changes: 1. PASRR Policy Revision: The facility developed and implemented a revised PASRR policy outlining the requirements for: Obtaining Level I and Level II PASRR determinations upon admission, Ensuring copies of Level II PASRR paperwork are present in the medical record, Reviewing PASRR Level II expiration/short-term approvals, Incorporating PASRR-directed specialized services into individualized Care Plans, Completing required MDS data elements (A1500–A1550) accurately and consistently. 2: PASRR Tracking System: A PASRR Tracking Log was implemented to monitor: Level II approved dates and expiration dates, Need for resubmissions, Receipt of updated Level II determinations, Required Care Plan updates. 3. Mandatory Interdisciplinary Team (IDT) Review: PASRR documentation is now reviewed at all of the following checkpoints: Admission Readmission MDS assessment completion Quarterly Care Plan meetings Any significant change in condition 4. Staff Education: All licensed nursing staff, MDS Coordinators, and the DON received education on: PASRR Level I and II requirements The importance of obtaining and maintaining Level II documentation Required specialized services Correct completion of MDS Section A (PASRR items) Care Plan requirements related to PASRR Education was completed by [date] and any new staff will receive this training during orientation.	

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F0644 SS = D	Continued from page 6 On 9/24/2025 at 2:37 PM, the Registered Nurse Consultant (RNC) MDS Coordinator, reported the facility obtained the PASRR Level I and placed in Resident #7's record. She reported the facility failed to obtain a copy of the PASRR Level II and they failed to complete a resubmission due to the short-term approval expired on 5/22/25. The RNC reported she expected the facility to obtain the Level II PASRR put the recommendations in the Care Plan and she expected the a new PASRR completed before the expiration of the short-term approval. On 9/24/2025 at 2:52 PM the Director of Nursing (DON) reported she failed to know Resident#7's Level II PASRR existed. She reported she expected the Level II PASRR addressed on the Care Plan. She stated she failed to know of a policy or procedure that addressed PASRR.	F0644	4. How will the facility monitor its corrective actions to ensure the deficient practice will not recur? The MDS Coordinator or designee will conduct weekly audits for 8 weeks, then monthly audits for 3 months, reviewing: Accuracy of MDS Section A1500–A1510 Presence of the most current PASRR Level I and Level II documentation Care Plan updates reflecting PASRR-directed services Results will be reported to the Quality Assurance & Performance Improvement (QAPI) Committee monthly. QAPI will review audit results and adjust monitoring as needed to maintain compliance and ensure sustained correction. Facility achieved compliance by 11.25.2025	
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interviews, and policy review the facility failed to provide a resident unable to carry out Activities of Daily Living (ADLs) independently the necessary services to maintain adequate personal hygiene and grooming (Resident #28). The resident was admitted to the facility 9/4/25 and was bathed/showered 1 time between 9/4/25 and 9/25/25. The facility reported a census of 48 residents. Findings include: The Minimum Data Set (MDS) for Resident #28 dated 9/10/25 documented diagnoses of stroke, non-Alzheimer's dementia, and depression. Section GG indicated the resident required supervision or touch assistance with tub/shower transfers and bathing. The resident's Brief Interview for Mental Status score was 2/15 which indicated severe cognitive impairment. The Care Plan for Resident #28 indicated she was at risk for skin breakdown due to incontinence and impaired mobility. It further documented her ability to complete Activities of Daily Living (ADLs) had deteriorated related to dementia and impaired mobility. An intervention dated 9/17/25 indicated the resident	F0677	TAG F0677: Immediate Intervention: Resident #28 received a comprehensive hygiene care review on 9/26/25. Bathing and grooming needs were addressed immediately. Staff were re-educated on offering alternate bathing methods, including bed baths, when a resident refuses. Staff Education and Competency: All CNAs and licensed nursing staff received in-service training on: Resident-specific bathing schedules and care plans. Protocols for documenting refusals and alternate interventions. Communication with the provider and responsible party regarding refusals or hygiene concerns. Competency checks conducted for all staff on proper documentation and refusal management. Policy and Procedure Revision: Bathing policy revised to include: Steps to follow when a resident refuses bathing, including reapproach attempts, alternate methods, and documentation requirements. Requirement for notification of provider and responsible party if repeated refusals occur. Policies reviewed and approved by the Administrator and DON.	

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F0677 SS = D	Continued from page 7 should get a whirlpool/shower two times per week. The care plan did not address bathing refusals or interventions. Observation on 9/22/2025 at 11:21 AM revealed the resident in the dining room with her hair up in partial pony tail. The hair in back that remained down appeared matted against the back of her head. On 9/23/2025 at 12:11 PM Resident #28's hair remained pressed against the back of her head and appeared stringy. The small pony tail was still in her hair with portions sticking out and twisted as though slept on. On 9/24/2025 at 8:12 AM the resident was at her table in the dining room. Her hair appeared stringy with strands clumped together around her ears and the back of her head. A final observation on 09/25/2025 at 7:55 AM revealed the resident's hair remained stringy around her ears. On 9/24/2025 at 2:52 PM, bathing sheets requested from the DON (Director of Nursing). She provided a document from the Electronic Health Record (EHR) titled Point of Care Audit Report which indicated the resident had scheduled bathing times on 9/8/25 at 1:59 PM, 9/10/25 at 1:41 PM, 9/16/25 at 1:46 PM, and 9/19/25 at 1:50 PM. An additional record titled Documentation Survey Report revealed that on 9/8/25 the resident received a bath/shower. On 9/10/25, 9/16/25, and 9/19/25 the resident refused. A review of the resident's progress notes revealed that on 9/10/25 at 5:18 PM the resident refused her shower 3 times that day. The progress notes did not include documentation that the resident refused any other days, whether or not she was offered alternate options such as a bed bath, or if any additional interventions were tried during the month. The progress notes did not include documentation that the Provider had been notified of the refusals, or that they had been communicated to the resident's responsible party. During an interview on 9/25/2025 at 8:20 AM Staff F, Certified Nurses Aide (CNA), stated residents who refused a bath or shower were offered a bed bath. Three approaches would be made and then they would usually not get a bath or shower until their next scheduled day. On 9/25/2025 at 12:21 PM Staff G, CNA stated that when a resident resident refused a bath or shower they	F0677	Care Plan Update: Resident #28's care plan updated to reflect: Specific bathing frequency and method (including whirlpool or shower as appropriate). Interventions for refusals and contingency plans. Documentation expectations and responsible staff assignments. Monitoring and Auditing: Daily audits conducted for 30 days by DON or designee to ensure scheduled baths/showers occur or refusals are documented appropriately. Weekly review of audit results for 90 days by QAPI Committee to monitor compliance. Feedback provided to staff, and additional education conducted if gaps are identified. Responsible Party: Director of Nursing – oversight of care plan compliance, staff education, and audits. Nursing Staff – implementation of resident-specific bathing interventions and proper documentation. Outcome Goal: Resident #28 and all residents will consistently receive appropriate bathing and grooming services per their care plans, with proper documentation of refusals, alternate interventions, and communication with providers and responsible parties. Facility achieved compliance by 11.25.2025	

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F0677 SS = D	Continued from page 8 notified the nurse and documented why the resident refused. She stated they would try the next day if there was time, otherwise the resident would wait until their next scheduled day. Staff G stated she had only gotten Resident #28 in for bathing once. She reported the resident had recently been changed to evening bathing but was not sure if that was working. When asked who completed bathing when she was out of the building, Staff G said it varied and there was not a set plan. On 9/25/2025 at 10:58 AM the Director of Nursing (DON) stated bathing schedules were determined at admission and residents were integrated into the list. Baths were offered Monday, Tuesday, Thursday, and Friday. If a resident refused they were reapproached and it was documented on the Point of Care list she had provided. The DON confirmed she was aware the resident was refusing bathing and thought they were eventually getting her to do it. Documentation lacked this occurred. The Administrator was asked for a bathing policy. On 9/25/2025 at 10:23 AM she provided documents titled Bathing Prompts that listed the steps staff should follow for showers and whirlpool baths. The documents were not specific to Resident #28 and did not include steps to take if a resident refused.	F0677		
F0732 SS = C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides.	F0732		

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F0732 SS = C	Continued from page 9 (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff interviews the facility failed to update as needed and provide current daily staffing information for residents and visitors. The facility reported a census of 48 residents. Findings include: During an observation on 9/22/2025 at 9:17 AM, the facility's staffing posting on the wall at the main facility entrance was observed to be dated 9/19/25. Review of Daily Staff Posting records from September 1 to September 23, 2025 had no edits or changes in staffing for the month. During an interview on 9/24/25 at 2:40 PM Staff D, Registered Nurse (RN) and Staff E, RN informed they did not have anything to do with the Daily Staff Posting and the Director of Nursing (DON) completed them. During an interview on 9/24/25 at 2:45 PM with the DON, informed it was on the night nurses responsibilities to	F0732	Steps Taken to Correct the Deficiency: The Director of Nursing (DON) immediately updated the Daily Staff Posting as of 9/25/25 to reflect current staffing. All staff, including night shift nurses, were re-educated on the responsibility to update the Daily Staff Posting daily, and the process was clarified. Temporary oversight measures were implemented whereby the DON verifies postings daily until compliance is maintained. Measures to Prevent Recurrence: The facility revised the policy and procedure for Daily Staff Postings to clearly assign responsibility to specific night shift nurses, with the DON performing daily audits for accuracy. Staff education and training were completed on 9/26/25 for all nursing staff regarding proper posting, updating, and verification of staffing information. Ongoing monitoring will be conducted through a Daily Staffing Posting Audit Tool, completed by the DON or designee, to ensure postings are updated and accurate. Any discrepancies identified during audits will be corrected immediately, and repeated failures will result in disciplinary action as per facility policy. Date of Compliance: All immediate corrections were completed by 9/26/25. Facility achieved compliance by 11.25.2025.	

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F0732 SS = C	Continued from page 10 change them over. During a follow up interview on 9/25/25 at 12:20 PM with the DON, informed she was the only one that updated the Daily Staff Posting records. She also revealed she had had new night shift nurses who were supposed to change it over, and thought they had forgot.	F0732		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F0880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0880 SS = E	Continued from page 11 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, clinical record review, staff interviews and facility policy review the facility failed to utilize Enhanced Barrier Precaution (EBP) for 4 out of 4 encounters with residents (Resident #3 and Resident #32) and their environment, and failed to personal protective equipment (PPE) while handling dirty laundry. The facility reported a census of 48 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #3 dated 8/1/25, listed diagnoses of pressure ulcer of the left heel, and diabetes mellitus (DM) The MDS listed the Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition.	F0880		

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F0880 SS = E	Continued from page 12 The Care Plan for Resident #3 dated 10/3/25 reflected she needed for EBP related to wound care. On 9/22/2025 at 10:25 AM Staff K, Certified Nurse Aide (CNA) reported the EBP sign on the door of Resident #3's room because of her wound. 1. On 9/23/2025 at 2:03 PM Staff A, Certified Nurse Aide entered Resident#3's room washed her hands. The Care Coordinator stood back to observe. Staff A applied gloves. Staff B, CNA entered the room, washed her hands, and put gloves on. Staff A and Staff B applied the gait belt and with the slide board, and moved Resident #3 to the bed in a slow smooth motion. Staff A put the resident's feet up on the bed. On 9/23/2025 at 2:10 PM, Resident #3 stated she needed to get back for cake and ice cream activity. Staff A sat her back up on the side of the bed, and both CNA's moved Resident #3 back in the wheelchair (w/c). Both CNAs failed to use EBP. The EBP sign hung on the room door and the supplies hung on the back of the room door. 2. On 9/24/2025 at 7:55 AM, Staff B, CNA staff entered Resident #3's room to make her bed, They talked about her leaving at 9:30 for the wound clinic. Staff B reported they needed to get her boot on, they forgot right away this morning. Staff B put the w/c pedals on Resident #3's w/c and put the arms on her w/c. Staff B failed to use any EBP when she made the bed, put the arms, w/c pedals and placed the boot on Resident #3. 3. The MDS for Resident #32 dated 8/21/2025 included diagnoses of stroke, hypertension and anxiety. The MDS listed the BIMS score of 15 out of of 15, which indicated intact cognition. The Care Plan for Resident #32 dated 9/17/2025 identified stage II pressure ulcers to her right and left buttocks. The Care Plan directed the resident needed EBP. On 9/24/2025 at 8:07 AM Staff C took Resident #32 into the bathroom. Staff C failed to wear a gown or gloves in the bathroom or as she walked Resident #32 to her recliner. Staff C confirmed she just got Resident #32 up for breakfast. The sign that hung on the room door for Resident #3 and Resident #32 directed stop, Enhanced Barrier	F0880		

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F0880 SS = E	Continued from page 13 Precautions. Everyone Must: clean their hands, including before entering and when they leave the room. Providers and staff must also: Wear gloves and a gown for the following high contact resident care activities. Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding, tube, tracheostomy. Wound Care: any skin opening requiring a dressing. 4. On 9/2/2025 at 10:02 AM, the black water pipe that hung above the hanging clean clothes in the laundry room held 1/2 an inch thick by 2 feet long debris. The 12-inch fan that hung on the wall over the folding table held 4 gray balls 1/2 inch thick of debris. On 9/2/2025 at 10:02 AM, Staff I, Laundry reported she failed to know who cleaned the pipe above the clean hung laundry, and she reported Environmental Supervisor cleaned the fan. Staff I failed to wear an apron while she removed dirty clothes form the basket and placed them in the washer. She reported she needed to wear a gown with isolation items but failed to need other PPE with moving dirty laundry. Staff I opened the cabinet and pointed out the PPE for the isolation. On 9/25/2025 at 10:17 AM the Environmental Supervisor reported the gowns, gloves, and goggles were in the cabinet the laundry. She reported the staff in the laundry room needed to use the PPE when isolation is used or if the laundry is really dirty, gloves and gown otherwise glove with dirty laundry out of the tube. She acknowledge the dirty fan on the wall. On 09/25/2025 at 9:43 AM Staff J, Registered Nurse (RN) reported the staff needed to use the EBP for residents with wounds, catheters, colostomy, any tubes from their bodies. She stated the staff are expected to use the EBP when they come in contact with the wounds or tubes. She said the EBP isn't needed to put foot rests in place on the wheelchair (w/c) or adjusting the resident in then w/c, and they didn't need EBP to remake the resident bed. On 9/25/2025 at 12:22 PM the Director if Nursing (DON) reported she expected the staff to use EPB as directed by the signs on their room doors with contact of the residents and their personal items. The DON reported she needed to check the policies for the personal protective equipment (PPE) the staff needed to use with dirty laundry. On 9/25/2025 at 12:51 PM the DON reported the appropriate PPE is an apron with moving dirty laundry	F0880	TAG F0880: Immediate Correction: All current staff were immediately in-serviced on proper use of Enhanced Barrier Precautions (EBP) and PPE for resident care and laundry handling. Resident #3 and #32 care plans reviewed and updated to reinforce EBP requirements. Laundry and environmental areas cleaned and sanitized; PPE (gloves, gowns, aprons, goggles) ensured to be readily accessible. Policy Review and Revision: Infection Prevention and Control policy revised to clearly define: Specific EBP requirements for wound care, catheters, colostomies, devices, and resident contact. Appropriate PPE usage when handling dirty laundry, including use of apron, gloves, and additional protection as needed. Policy distributed to all nursing, CNA, and environmental services staff. Staff Education and Competency: All staff completed mandatory in-service training on EBP and PPE protocols. Competency checklists implemented to validate correct PPE use and adherence to EBP for resident care and laundry handling. Education to include correct hand hygiene, gowning, gloving, and handling of soiled linen.	

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F0880 SS = E	Continued from page 14 from the bin to the washer. The facility provided a policy titled Infection Prevention and Control-Laundry dated 8/1/2017, that directed soiled linen shall be handled as little as possible and with minimum agitation to prevent gross microbial contamination of the air and of the person handling the linen. Staff will wear gloves and other appropriate PPE when handling soiled linen.	F0880	Monitoring and Auditing: Infection Control Nurse (ICN) to conduct weekly audits of resident care and laundry PPE practices for 8 weeks. Audits to include direct observation of staff compliance with EBP, proper PPE use, and documentation of any deviations. Any noncompliance immediately addressed with re-education and documentation. Sustainability Measures: Monthly audits will continue ongoing to ensure sustained compliance with EBP and PPE standards. Results of audits reviewed in monthly Quality Assurance and Performance Improvement (QAPI) meetings. Any trends of non-compliance will trigger immediate corrective action and additional staff education. Facility achieved compliance by 11.25.2025.	